

# A nursing call to action



**The health of our nation, the future of our health system**

**National Expert Commission**

Better Health. Better Care. Better Value. Best Nursing.

**Everything you need to know about the National Expert Commission  
can be found at <http://www.cna-aiic.ca/expertcommission/>**



**Including:**

1. About the National Expert Commission
2. Final reports of the research syntheses prepared for the National Expert Commission through a partnership with the *Canadian Health Services Research Foundation*
3. Summary report of cross-country consultation with nurses and other professionals, and YMCA Canada public consultations, prepared for the National Expert Commission by LBP MASS
4. Summary report of public polling conducted for the National Expert Commission by Nanos Research
5. All written submissions to the National Expert Commission
6. Fact sheets and other documents prepared to support the final report of the National Expert Commission
7. Reference lists
8. Bibliography of key resources

---

This report has been prepared by the independent National Expert Commission as mandated by the Canadian Nurses Association's Board of Directors. The views and opinions expressed in this paper do not necessarily reflect the views of the Canadian Nurses Association's Board of Directors.

All rights reserved. No part of this document may be reproduced, stored in a retrieval system, or transcribed, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without written permission of the publisher.

© Canadian Nurses Association

50 Driveway, Ottawa, ON K2P 1E2

Tel.: 613-237-2133 or 1-800-361-8404

Fax: 613-237-3520

Commission Website: <http://www.cna-aiic.ca/expertcommission/>

Canadian Nurses Association Website: [www.cna-aiic.ca](http://www.cna-aiic.ca)

ISBN 978-1-55119-387-8

Revised September 2012

Disponible en français



# Nurses

through their sheer numbers and collective knowledge are a mighty force for change.

**Registered nurses are deeply engaged in system transformation because they care about human health and about delivering responsible health care.** But more than caring, it is the professional and social responsibility of nurses to take a strong leadership stand on behalf of Canadians.

Nursing science and practice have to be at the core and centre of a new health system, because we know nursing care is effective, it's affordable and it makes sense. Canada's nurses can and must act in collaboration with other health professionals and system leaders to ensure better health, better care and better value for all Canadians.

Through their sheer numbers and collective knowledge, nurses are a mighty force for change. Canadians expect nurses to harness that power and act. We present this report to bolster their actions going forward and to support nurses so they are equipped to do their part in shaping Canada's health-care delivery system in the decade ahead.

## A Note about our Terminology

### Patients

Canadians and their families may see themselves in many roles as they access health services at different times of life and in different parts of the health-care system. For example, we might join a community support group, or be a member in a local gym where we walk on a treadmill to increase our fitness. Another day we might be a caregiver, providing help to an elderly parent who is a nursing home resident. Or we might be a patient, having an operation in a hospital. We know that not everyone who is using a health service sees him or herself as a “patient.” But to simplify language and reduce repetition, in some places we chose that term to refer to people who are receiving many different kinds of health services.

### Primary health care and primary care

It is important to distinguish between primary health care and primary care. These are two different and important ideas that often are confused. Primary health care is more comprehensive, referring to a framework of specific health system policies for a population.<sup>1</sup> Starfield said primary health care-oriented systems are “generally more effective in achieving better health (particularly at young ages) at lower costs than is the case for systems more oriented to disease management and specialty care.”<sup>2</sup> The World Health Organization<sup>3</sup> says that primary health care encompasses:

1. Education for the identification and prevention/control of prevailing health challenges;
2. Proper food supplies and nutrition; adequate supply of safe water and basic sanitation;
3. Maternal and child care, including family planning;
4. Immunization against the major infectious diseases;
5. Prevention and control of locally endemic diseases;
6. Appropriate treatment of common diseases using appropriate technology;
7. Promotion of mental, emotional and spiritual health; and
8. Provision of essential drugs.

Primary care is one of the elements necessary in a broader framework of primary health care services. It is “largely clinical, having to do with...first contact accessibility and use, identification with a regular source of care that is person (rather than disease) focused care over time, comprehensiveness of services available and provided, and coordination (when care from other places is required).”<sup>4</sup> Many of us think of our family doctor, nurse practitioner or a walk-in clinic as the place we access primary care – that is, our first point of care for health and illness needs.



## Table of Contents

2	A Note about our Terminology
4	Message from the Commissioners
6	The Need for Change
8	The Changing Demographics and Health of Canadians
18	Better Health
23	Better Care
26	Better Value
30	The Role of Nursing in Supporting Better Health, Better Care and Better Value
38	Our Plan of Action
48	Conclusion: Transformation is Possible
	Acknowledgements – inside back cover

---

Look for these icons throughout the Report that indicate an additional resource on the National Expert Commission website. Go to <http://www.cna-aiic.ca/expertcommission/> and select the corresponding title from one of the categories of information.



**Read a report**



**Watch a video**

## Message from the Commissioners

**The Canadian Nurses Association (CNA), the professional voice of Canada’s 268,500 registered nurses, plays a key role in developing policies and models of care to enhance the health of Canadians.** In May 2011, CNA established an independent National Expert Commission, made up of leaders in nursing, medicine, business, law, academia, economics and health-care policy. Guided by the motto *“Better Health, Better Care, Better Value, Best Nursing”* (based on the Institute for Healthcare Improvement’s triple aim initiative)<sup>5</sup>, we set out to discover the most efficient, effective and sustainable ways to meet the changing and pressing health needs of Canadians in the 21<sup>st</sup> century.



We heard from people across the country – the public, nurses and other health professionals and policy makers – in person and via the Internet. We commissioned research, welcomed written submissions, and conducted public polling.

This report distills what we learned into practical, evidence-based recommendations...

The people we heard from told us Canadians need and deserve a health system centred on individuals and families, one that would focus on building lifelong health, while continuing to take care of sickness and injury. It should be based in a robust primary health-care system, run by teams of professionals, offering care and attention to Canadians in their homes and communities. Adopting such a model would have a profound, positive impact on the health of our nation, and ensure better care for individuals and better value for money.

But we did not stop with envisioning an ideal. We also looked at what needs to be done to re-invigorate our current system. We have concluded its sustainability and ability to evolve depends on eliminating waste, taking greater advantage of existing human resources and technology, and establishing options for a broader model of care delivery.

This report distills what we learned into practical, evidence-based recommendations about how nurses – working collectively and collaboratively – can take action to transform the way we deliver health services in Canada to ensure the ongoing health and wellness of all Canadians.

Respectfully submitted,

**Marlene Smadu, RN, EdD**  
Co-chair

**Maureen A. McTeer, BA, MA, LLB, LLM, LLD (hons),**  
Co-chair

# 268,500

registered nurses work with Canadians at every age and every stage of life — in clinical settings and in education, research, administration and policy across Canada.



---

The Honourable Sharon Carstairs, PC, BA, MAT, LLD (hons)  
Thomas d'Aquino, BA, JD, LLD, LL.M  
Robert G. Evans, OC, PhD  
Robert Fraser, RN, MN  
Francine Girard, RN, PhD  
Vickie Kaminski, RN, BScN, MBA  
Julie Lys, RN, NP, MN  
Sioban Nelson, RN, PhD, FCAHS  
Charmaine Roye, BSc, MDCM, FRCSC  
Heather Smith, RN  
Rachel Bard, RN, MAEd (*ex officio*)  
Judith Shamian, RN, PhD, LLD (hon), DSci (hon), FAAN (*ex officio*)  
Michael Villeneuve, RN, MSc (*ex officio, executive lead*)

## The Need for Change

**Over the Commission's year of work, we have learned that Canadians consider how we achieve health, maintain it, strengthen it and pay for the system to be crucial national concerns.**<sup>6</sup> They want a system that helps them be healthy, is there for them when they need treatment and will support them at the end of life – and one which is affordable, efficient and sustainable. What is more, a country's commitment to health is a measure of its wealth, success and status in the world.<sup>7</sup> We need the finest health-care system in the world to attract and retain the best people, and to realize together all the benefits of living in a successful, productive, competitive society.

Much more can be done to increase freedom from disease and disability, as well as to promote a state of well-being sufficient to perform at adequate levels of physical, mental and social activity.

Hon. Mark Lalonde, 1974

However, studies show we often fall short of that vision.<sup>8,9,10</sup> Canadians are living longer and developing more chronic conditions and diseases, such as obesity, diabetes and heart disease. They require ongoing management and care, better delivered at home and in the community than in an institution. At the same time, in hospitals, waits for emergency care and surgery remain unacceptably high. Safety in health care is a serious concern; our fragmented approach to using information technology and electronic records is wasteful and can even put patients at risk.

When public health insurance schemes were introduced, most care Canadians needed was delivered in hospitals and doctors' offices. Today, whether a person has a disease, is living with a chronic condition, or recovering from an accident or surgery, technology and highly trained health-care professionals offer possibilities for care not even imagined when medicare was established. But we have not yet acknowledged those profound changes with a formal shift to a new model of care that puts the emphasis on wellness, including programs to promote good health (such as smoking cessation and exercise programs) as well as focusing on the external factors that influence health (such as social status, education and living conditions).

---

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

From the Declaration of Alma-Ata, World Health Organization, 1978

---



# Canadians

are living longer and developing more chronic conditions and diseases, such as obesity, diabetes and heart disease.

For these possibilities to become real options and choices, new models of organization and funding must be developed.<sup>11,12,13,14,15,16</sup> We set out to learn about models of care delivery that would meet the changing needs and expectations of Canadians. We concluded the model we chose must offer several of these elements:

- It should be centred on what individuals and families need, rather than on how providers and organizations want to function.
- It should treat the individual as a whole person, part of a family and community, not just a collection of body parts and problems.
- It should broaden the health-care system beyond hospitals and other institutions to offer care in the community and at home.
- It should address the social, economic, environmental and Indigenous determinants of health – especially poverty, housing, food insecurity, and social exclusion – that play such major roles in determining our individual health.
- It needs to draw upon the progress made in Canada to develop public health and population-based policies and programs to ensure the greatest possible health outcomes for all Canadians.
- It should ensure all health professionals, including nurses, work to their full scope of practice.
- It should be financed by public health insurance and monitored for effectiveness and efficiency.

# The Changing Demographics and Health of Canadians

Canada's population was 33.5 million in 2011.<sup>17</sup> Our life expectancy is among the world's highest and expected to grow.<sup>18</sup> The population is aging steadily, with more than 4.7 million Canadians aged 65 and older – and 1.2 million of those over the age of 80.<sup>19</sup> The number of people under the age of 15, however, has dropped to a record low.<sup>20</sup> Our fertility rate is less than half what it was in 1950,<sup>21</sup> which means Canada's population growth comes mainly from immigration.<sup>22</sup>

## Did you know that...

...Canadians spend nearly a third less than the U.S. on health care (relative to GDP) and live 2 years longer?

...the citizens of Australia, Sweden and Japan live longer lives than Canadians while spending less on health care?

University of California Atlas of Global Inequality, n.d.

## An immigrant-rich nation

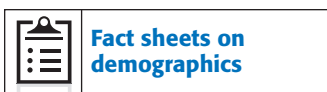
The number of Canadians from visible minority groups nearly quadrupled to 4 million people between 1981 and 2001,<sup>23</sup> reversing the immigration pattern of a century ago when three-quarters of new Canadians came from Europe. Today, 84 per cent of immigrants to Canada come from outside Europe and 75 per cent are from visible minority groups. These 5 million Canadians are predominantly South Asian, Chinese, Black and Filipino,<sup>24</sup> are younger than average Canadians<sup>25</sup> and tend to settle in Toronto, Vancouver or Montreal.<sup>26</sup>

## Aboriginal Peoples

The Canadian Constitution distinguishes three groups of Aboriginal people: First Nations, Métis and Inuit, a total of more than 1 million people (almost 4 per cent of the Canadian population).<sup>27, 28</sup> More than half (54 per cent) of Aboriginal people live in urban centres<sup>29</sup> and eight of 10 live in Ontario and the four western provinces.<sup>30</sup> The Aboriginal population grew 45 per cent between 1996 and 2006 (compared to just 8 per cent for the non-Aboriginal population). Aboriginal people are younger (27 years) on average than the non-Aboriginal population (40 years).<sup>31</sup>

## Canadians and the determinants of health

Compared to people in much of the world, Canadians live long and healthy lives, reflecting the nation's affluence, enviable living conditions and health and social-service systems. Scientific advances – from antibiotics in the 1940s to robotic surgery in the 21<sup>st</sup> century – have redefined health care. Many diseases, once fatal, are managed as chronic health problems or cured altogether. But, as the make-up of the population changes, other health problems come to the fore. As well, our understanding of how external factors can affect health is greatly increasing. Made up of social, economic, environmental and Indigenous factors, the “determinants of health” include issues like income, social support, level of education, security of housing and food, literacy, employment, working conditions and gender. Their impact means some people are at increased risk for health problems.



# Nearly a third

of all homeless persons are between 15 and 24 years of age.



---

**Young people who feel cared for and supported and have a sense of belonging and engagement report better health and self-worth, and are less apt to be involved in unsafe behaviour.**

## Youth

Social and economic factors, including a lack of parental and family support, poverty, unsafe neighbourhoods and lack of good schools can all contribute to poor health among the young.<sup>32</sup> A poor start can affect a person's entire life,<sup>33</sup> limiting choices and opportunities and the capacity to make a successful transition to adulthood.<sup>34</sup> Young people who feel cared for and supported and have a sense of belonging and engagement report better health and self-worth, and are less apt to be involved in unsafe behaviour.<sup>35</sup> Abuse or neglect at home can have damaging effects on young people, pushing some to leave home, sometimes leading to homelessness.<sup>36</sup> Nearly one-third of all homeless persons are between 15 and 24 years of age.<sup>37</sup> Young people who are homeless, of a sexual minority, Aboriginal, visible minority or immigrants are particularly vulnerable.<sup>38,39,40,41</sup>

## Older Canadians

No factor puts older Canadians at more risk than poverty. They are more vulnerable to it than any other group and nearly one in five older persons lives near the poverty line.<sup>42</sup>

About 70 per cent of seniors' incomes come from fixed sources: pensions and government supplements.<sup>43,44</sup> For many older people, the cost of day-to-day living can be a challenge. Poverty rates for the elderly tend to be highest among those who live alone, women (especially those over 80) visible minorities and immigrants.<sup>45</sup> Poverty affects the ability of older people to pay for proper diet, housing and medication, and can also keep them from support services and care.

## People with disabilities

In 2006, approximately 4.4 million Canadians (14.3 per cent of the population) reported having a disability — physical, mental, emotional, or a combination of them.<sup>46</sup> Rates of disability are rising as the population ages and chronic conditions increase.<sup>47</sup> People who are disabled are more likely to have low incomes,<sup>48</sup> to live in inadequate housing,<sup>49</sup> and to live alone.<sup>50</sup> They have considerable difficulty finding employment, gaining skills and building careers.<sup>51</sup> More than 40 per cent of Canadians with disabilities are out of the labour force, and many depend on social assistance benefits.<sup>52</sup> Those who are employed earn 22.5 per cent less, on average, than adults without disabilities.<sup>53</sup>

People with disabilities have less access to health-care services and more unmet health needs — especially those with mental disorders.<sup>54</sup> In 2005-2006, 14.8 per cent of adults with disabilities could not obtain needed health care or social services.<sup>55</sup> Furthermore, those with severe disabilities are less apt to know how to get the health care they require.<sup>56</sup>

---

“The impact of chronic conditions on quality of life is most pronounced for the poorest Canadians.” Recent research found that people receiving social assistance had the highest prevalence of 38 chronic diseases. Life expectancy decreases and risk of developing chronic illness rises as one's position in the socio-economic hierarchy drops. What is more, “Some people are poor because of their disabilities, while others are ill because of their socio-economic conditions, and both cases reinforce each other.”

Canadian Academy of Health Sciences, 2010

---

Costs of care, and accessing transportation to get to the places care is offered are frequent barriers for people with disabilities.<sup>57,58</sup> If they are employed, many disabled people work in jobs that do not offer generous employee benefits and so they may have considerable out-of-pocket costs for visits to health professionals (especially those with severe disabilities).<sup>59</sup>

## Health inequality and the determinants of health

Health inequality can be “the result of genetic and biological factors, choices made or by chance.”<sup>60</sup> Often, however, it arises from unequal access to key factors that influence health, like income, education, employment and social support.<sup>61,62</sup> Those with low levels of income and education, who live in inadequate housing, with limited access to health care and a lack of early childhood support and social supports, are more prone to poor physical and mental health outcomes than those living in better circumstances.<sup>63</sup>



People with disabilities have less access to health care services and more unmet health needs — especially those with mental disorders.

A rigorous synthesis conducted for the Commission by Muntaner, Ng, and Chung<sup>64</sup> confirmed the findings of the leading research on determinants of health: there is a clear and direct association between income and health. Low-income Canadians have the highest rates of death, illness and health-care use, while middle-income individuals and families have worse health outcomes than the highest-income groups...“regardless of whether income is measured at individual, household, or neighbourhood levels.”<sup>65</sup>

“Income, housing, food insecurity, and social exclusion are four major determinants in generating and reproducing health inequalities over the life-course,”<sup>66</sup> but nothing drives bad health like poverty. The *Make Poverty History* campaign<sup>67</sup> says more than 10 per cent of Canadians live in poverty and the rate is increasing among young families, youth, immigrants and people of colour. Furthermore, we know that income inequality is a strong health determinant across a society and that “taxes and benefits reduce inequality less in Canada than in most OECD countries.”<sup>68</sup> Here the Conference Board of Canada gives Canada a “C” grade — ranking twelfth of 17 peer nations — noting a significant increase in the income gap in Canada between 2000 and 2006.<sup>69</sup>



## Impact on disease

Poverty makes health problems worse. For example, Aboriginal Canadians are at greater risk of acquiring tuberculosis infection than other Canadians;<sup>70</sup> poor living conditions and overcrowded housing, together with limited access to health professionals in remote areas, play a significant role.<sup>71</sup> Urban homeless people also are at higher risk.<sup>72</sup>

Poverty, homelessness, lack of social support, sexual and physical abuse and lack of education contribute to the spread of HIV<sup>73</sup> and other communicable diseases.<sup>74,75,76</sup> People living in poverty are three to four times more likely to report only fair or poor mental health.<sup>77</sup> They are more likely to be hospitalized repeatedly for mental illnesses<sup>78</sup> and “suicide rates in the lowest income neighbourhoods were...almost twice those seen in the wealthiest neighbourhoods.”<sup>79</sup> The basics that help maintain mental health – such as a balanced diet, regular physical activity, proper sleep, avoiding overuse of alcohol or illegal drugs, coping mechanisms for stress and a support network<sup>80</sup> – are often missing from the lives of people with low incomes.

## Meeting the future health needs of Canadians

Canada’s population could exceed 40 million by 2036<sup>81</sup> with one in four Canadians expected to be foreign-born by 2031.<sup>82</sup> A third of us will belong to a visible minority group, and the Aboriginal population could reach 2.2 million.<sup>83</sup> Nearly a quarter of us are likely to be over the age of 65<sup>84</sup> and the number of centenarians could triple or quadruple.<sup>85</sup>

We are already seeing changes in the patterns of illness. Most of the communicable diseases that killed Canadians in the 19th and early 20th centuries are now controlled by vaccination and other public-health measures, and people are much more likely to live for many years with chronic diseases. Nowadays, non-communicable diseases cause 89 per cent of deaths in Canada<sup>86</sup>, and chronic illnesses are the major drivers of health-care costs and lost productivity. More than 40 per cent of Canadian adults report having “at least one of seven common chronic conditions – arthritis, cancer, emphysema or chronic obstructive pulmonary disease, diabetes, heart disease, high blood pressure, and mood disorders, not including depression.”<sup>87</sup>

Many of those conditions are amenable to healthy public policy, preventive care and treatment focused on monitoring and maintenance of health. But such approaches will require us to change our approach to health care in fundamental ways, and reshape what we understand to be essential services. Today, a patchwork of health services is offered in the community; and public funding for health is still focused on hospitals, despite changing demographics and our knowledge of the impact of the determinants of health. Canadians may be uncertain about the value of more spending in

---

Commissioners believe that prevention, early identification, and management of chronic diseases are fundamental to controlling future health care costs as our population ages. Healthy aging and chronic disease management both align well with the knowledge and practice of nurses.

---

areas beyond acute care. Public opinion of the system does seem to improve when more is spent in areas like hospital care, while “spending in other health-care domains is not clearly associated with improved public assessments” of the system.<sup>88</sup> Perhaps this result reflects all the focus on hospitals, even when Canadians realize on some level (as we discovered) that the system is not working for us as it should.

Meeting the changed and changing health and wellness needs of Canadians in the 21<sup>st</sup> century means shifting our focus from hospitals to primary health care networks, run by teams of professionals that ensure continuity of care. Public health policy and education that encourage healthy life choices need to be emphasized. As well, the providers and organizations offering these new types of care will need to embrace cultural awareness, be able to offer care in multiple languages, and be sensitive to the traumatic backgrounds of many Aboriginal people and those from areas of political and military unrest. Services will have to be designed to meet the needs of a growing proportion of older patients.

### Health in older age

Statistics Canada projects that the number of seniors could more than double to 9.8 million by 2036.<sup>89</sup> Aging is a phase of life, not a disease, and in Canada “the majority of seniors perceive that their health is generally good.”<sup>90</sup> More than nine in ten seniors “live at home and want to stay there as long as possible.”<sup>91</sup> Nevertheless, it is a time when the percentage of people with overall good health and independence “declines sharply.” After age 65, per capita health spending doubles every decade, hitting \$8,425 at age 75, then \$16,821 at age 85.<sup>92</sup>

Three quarters of home care clients are seniors, nearly a third of clients have high needs and one in five has dementia.

An aging population, living longer, has more (and different) health needs. The Canadian Community Health Survey showed rising rates of cancer, diabetes and high blood pressure among seniors between 2003 and 2009.<sup>93</sup> The vast majority of dementia occurs in people over 65. The risk of falls increases; about 40 percent of admissions to nursing homes by older people are due to falls.<sup>94</sup>

Threats to health are not just physical. Seniors who lack social interaction are vulnerable to social isolation and loneliness<sup>95</sup> and 10 to 15 per cent of seniors suffer from depressive symptoms or clinical depression,<sup>96</sup> with older men particularly at risk for suicide.<sup>97</sup> Older people are also vulnerable to abuse, which can take many forms at home, in the community or in institutional settings.<sup>98</sup>

The situation calls for increased attention to disease prevention and health promotion to keep older people as healthy and independent as possible, postpone chronic disease and reduce disability. We will also need support for family and caregivers, and affordable and accessible resources in communities and homes. Such strategies would reduce health-care costs and the need for long-term care.<sup>99</sup>



### Access to prescribed drugs

The Canadian Institute for Health Information reports that in 2009, “among eight Organisation for Economic Co-operation and Development (OECD) comparator countries, Canada had the second highest level of total drug expenditure per capita, after the United States.”<sup>100</sup> However, the same study showed public funding covers only about 39 per cent of total drug spending in Canada – the second lowest of eight comparator OECD nations and just ahead of the United States.<sup>101</sup> In Denmark, England, France, Germany, the Netherlands and Sweden, public health insurance covers medication prescribed outside of hospitals, with limited or no co-payments by patients. In Canada, it’s mainly people on social assistance and seniors for whom some or all of their prescription drug costs are covered. Others

A Canadian Medical Association study found that costs keep one in ten Canadians from obtaining required medications – and the problem is worse when income is lower.

may get coverage through their employee benefits (in Quebec, anyone without workplace coverage is eligible for a provincial plan). A Canadian Medical Association study found that costs keep one in ten Canadians from obtaining required medications – and the problem is worse when income is lower.<sup>102</sup> Cost is also the reason about 13 per cent of adults with disabilities (and nearly a quarter of those with very severe disabilities) were unable to obtain medication, or took less of it at least once during 2005-2006.<sup>103</sup>

The idea that drugs are an adjunct to hospital care is out of step with a 21<sup>st</sup> century approach to health care. In his 2002 review of the health system, Roy Romanow observed that, “prescription drugs continue to be on the sidelines of Canada’s health-care system rather than integrated, as they should be, with primary health care and with other aspects of the health-care system.”<sup>104</sup> Responding, first ministers agreed, saying “No Canadians should suffer undue financial hardship in accessing needed drug therapies,” and directed their ministers of health to develop and implement a national pharmaceuticals strategy.<sup>105</sup> However, that has not happened. It is time for pharmaceutical care to be included in medicare.

### Home care

The move to more care at home is an inevitable result of a health-care system focused on the needs of patients. Even when they are gravely ill, most people want to be at home, not in a hospital. Although we heard some concerns about the need for more long-term care beds, there was little call in our consultations or in the research evidence we gathered for more care inside hospitals and other institutions. If people must go to an institutional setting for care, most want to be home as soon as possible.

Home care must be safe,<sup>106</sup> and must be designed to serve health needs in two major areas:

- To support those who cannot live fully independently; this includes older Canadians, people living with chronic illnesses (mental or physical) or disabilities, and children with special needs; and
- To provide services after hospital care for an acute or episodic illness – medical, surgical or post-partum for example – and for palliative patients.





# 4.7 million

Canadians are aged 65 and older — and 1.2 million of those are over the age of 80.



---

**No factor puts older Canadians at more risk than poverty. They are more vulnerable to it than any other group and nearly one in five older persons lives near the poverty line.**

Home care could be a source of significant cost savings. Moving 25 per cent of the 6,000+ palliative care patients in Ontario from acute-care beds (costing \$19,900/patient annually) to home care (costing \$4,700/patient annually) could mean savings of more than \$15,000 per patient. We also know that 5 per cent of Ontario's population accounts for 84 per cent of costs, in large part because of high hospital readmission rates. Readmissions of patients having co-morbid chronic conditions, and who are high users of hospitals services could be reduced by better home care. Looking just at those high users in Ontario, some 130,000 patients, even a 10 per cent reduction in the \$8 billion it costs to provide their hospital care could result in potential savings of \$800 million annually.<sup>107,108</sup> Projected nationally, Browne, Birch, and Thabane calculate that \$2.4 billion in savings could be "used to enhance community care and social determinants of health."<sup>109</sup>

...“90 per cent of Canadians who die can benefit from palliative care” but some 70 per cent do not receive these services.

Carstairs, June 8, 2010



So home care holds the promise to provide effective, affordable services as a mainstay of health care in Canada. The challenge, however, is to fund it properly. Like other health services that didn't exist when our hospital- and physician-oriented public health insurance plans were developed, home care is not necessarily covered by medicare. Some services, including medications, prescribed by a physician to continue care begun in a hospital may be covered, but many are not. As a result, there is "variability in access to and provision of home-care services and differences in the use of and application of co-payments and user fees" that create inequities among Canadians.<sup>110</sup> Commissioners call upon the federal government to make the development and funding of national home care a priority to be achieved by 2017.

### Palliative and end-of-life care

Canada's growing and aging population inevitably means an increase in the number of deaths, which is expected to grow to some 300,000 per year within a decade – up from 235,000 in 2007.<sup>111</sup> The Canadian Hospice Palliative Care Association estimates that "each death in Canada affects the immediate well being of an average of five other people, or almost 1.25 million Canadians each year disrupting their lives, affecting their income, and causing grief and other psychological issues, including depression and anxiety."<sup>112</sup>

Although more Canadians are dying at home or in long-term care,<sup>113</sup> most of us still die in hospitals or other institutions.<sup>114,115</sup> The Canadian Institute for Health Information found just 16 to 30 per cent of Western Canadians have access to and receive palliative or end-of-life care.<sup>116,117</sup> By contrast, "90 per cent of Canadians who die can benefit from palliative care" but some 70 per cent do not receive these services.<sup>118</sup>

# \$47 trillion

Estimated cost to the global economy over the next 20 years from cancer, diabetes, mental illness, heart disease and respiratory illnesses.

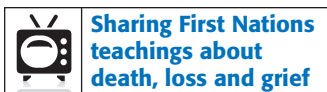
A report to the Senate, *Raising the Bar: A Roadmap for the Future of Palliative Care in Canada*, made 17 recommendations to create palliative care for Canadians that would be “intensely human and caring” – and focused on life and living.<sup>119</sup> It was widely endorsed, including by the Canadian Hospice Palliative Care Association and Royal Society of Canada’s Expert Panel on End-of-Life Decision Making. The society said efforts should be made to ensure “resources that could be better used for wanted palliative care are not diverted to unwanted acute care.”<sup>120</sup> Commissioners fully endorse the report to the Senate on palliative care and call upon governments to act upon its recommendations by 2017.

## The impact of disease beyond the patient

The impact of chronic disease is not limited to the suffering of the patient. Caregivers of people with chronic diseases are more likely to have insufficient time for sleep, self care and exercise, to feel isolated,<sup>121</sup> and those who are highly stressed are more likely to suffer clinical depression and use more prescription drugs and alcohol.<sup>122</sup> Highly stressed caregivers had a higher mortality rate over a four-year period.<sup>123</sup>

Caregivers of people with chronic diseases are more likely to have insufficient time for sleep, self-care and exercise, to feel isolated...

Across society, chronic disease has resulted in significant productivity loss. People with chronic diseases are more likely to be disabled and absent from work, and report decreased workplace effectiveness and work quality.<sup>124</sup> They also may die prematurely. Productivity losses are projected to grow as more working age Canadians aged 34 to 64 live with chronic disease.<sup>125</sup> In fiscal terms, “chronic diseases cost Canadians at least \$190 billion annually.”<sup>126</sup> Kirby and Keon<sup>127</sup> concluded that mental health problems and illness not only affect millions of Canadians, but also cost the national economy up to \$33 billion a year. On a global level, a study commissioned by the World Economic Forum estimated that cancer, diabetes, mental illness, heart disease and respiratory illnesses could cost the global economy \$47 trillion over the next 20 years.<sup>128</sup>



## Better Health

**There is no question that ensuring the better health of Canadians will require concerted action and leadership by all levels of government working together.** The evidence is clear that better health for Canadians will require public spending on a broad range of social and economic programs beyond health care, to level life's playing field and give those who face disadvantages a better chance of equality in health.<sup>129</sup> "The best way to achieve sustainable health is to address the inequities at the determinants of health level. Health will follow."<sup>130</sup> But we are equally adamant that individual Canadians must take responsibility for their own health. Research clearly shows that many of the conditions from which we suffer are heavily influenced by our individual circumstances and lifestyle choices. That means each of us has at least some power to control our health and lessen the impact of those conditions in the first place.

"The best way to achieve sustainable health is to address the inequities at the determinants of health level. Health will follow."

Reading & Reading, 2012

### Becoming a healthier nation

In our national consultations, we heard Canadians say that we all need to be more active in achieving and maintaining health. Our Fall 2011 public poll, conducted by Nanos Research, revealed about 13 per cent recommended more activity, and a further 13 per cent healthy eating, as the change they thought would best improve the health of Canadians. People told us about the effectiveness of healthy breakfast programs in schools, walking clubs in workplaces and about tax incentives for joining a gym. We also heard about the importance of starting young. Many people suggested daily physical activity should be compulsory in all grades in all schools. Our April 2012 Nanos Research poll found that 85 per cent of Canadians agree and another 10 per cent somewhat agree that regularly scheduled physical activity should be compulsory in all schools, from kindergarten to high school. Despite these findings, the most common answer to our original question about what would improve the health of Canadians was "unsure," so Canadians seem to need vision and information about improving population health.

### Aboriginal health: a case study

As we discuss the role of personal choices and responsibilities for our own health and treatment, we cannot ignore the fact that for many Canadians, changing their life circumstances is a difficult, if not impossible, task. Canada is a privileged nation, but our wealth and opportunities are not equitably distributed. Dramatic differences in life chances observed within countries worldwide<sup>131</sup> are found in Canada too – where they can be stark and shocking. Canada placed sixth in the 2011 ranking of nations based on Human Development Indicators, which include life expectancy, education and economic well-being.<sup>132</sup> But the story is very different for Aboriginal people.<sup>133</sup>



# 121

Number of First Nations communities across Canada under drinking water advisories as of March 31, 2012.



Photo: cattroll.com

**Despite the many hurdles Aboriginal people face, we also heard a strong message about their hope and strengths, about forgiveness and healing, and about ideas for change.**

We decided this report would be enhanced by an in-depth analysis of the impact of the social, economic and environmental determinants of health on Canada’s Aboriginal peoples. This situation is of particular interest to the Commission because so much of the health care of First Nations, Inuit and Métis peoples falls to nurses, especially in isolated northern communities. With the support and leadership of Her Excellency, Sharon Johnston, we held a national Round Table on Aboriginal Health at Rideau Hall on March 27, 2012.

“...it is the ratio of social service expenditures to health service expenditures that is better associated with improved outcomes in key health indicators and not the amount spent on health services expenditures.”

Browne, Birch, & Thabane, 2012

No group in Canada suffers greater discrimination and ill health than our Aboriginal people. On reserves, many live in Third World conditions, while in cities many live on the street, without jobs, education or hope. Aboriginal women are nearly three times as likely as non-Aboriginal women to be victims of violence.<sup>134</sup> Aboriginal people are vastly over-represented in our prison system (for example, making up 87 per cent of women prisoners in Saskatchewan) where little is done to address the many reasons for their health and related problems. Women prisoners in general are twice as likely as men to have a mental health diagnosis at time of admission<sup>135</sup> and three times as likely to suffer depression. Ninety per cent of women in federal

prisons have a history of physical or sexual abuse. We know that Aboriginal women are already at increased risk for all these problems that plague other women prisoners.

Aboriginal youth are more likely than non-Aboriginals to drop out of school.<sup>136,137</sup> By leaving school without graduating, these young people increase the possibility of lifelong unemployment or low wages.<sup>138</sup> The unemployment rate for Aboriginal people aged 25-64 “remains almost three times the rate of non-Aboriginal.”<sup>139</sup>

At our Rideau Hall meeting, 28 leaders from across Canada discussed the social, economic and environmental determinants of health, chronic diseases, and children, families and communities, to inform action on Aboriginal health and healing. The ideas, knowledge and insights they shared were a stark confirmation of how the interplay of many factors beyond health care determines health. Many Aboriginal people grow up in crowded dwellings without enough food; even access to clean water is an issue. (As of March 31, 2012, 121 First Nations communities across Canada were under drinking water advisories.<sup>140</sup>) Home environments are often unstable and spousal violence and alcohol abuse are common.<sup>141,142,143</sup>

The Public Health Agency of Canada has said “poorer socio-economic circumstances and social exclusion can entrench feelings of helplessness, hopelessness, alienation and mistrust among vulnerable populations and can increase the likelihood of adopting unhealthy or risky behaviours.”<sup>144</sup> That shows in the statistics: Aboriginal people live shorter lives in poorer health than non-Aboriginals.



They “bear a disproportionately higher burden of some chronic illnesses than do non-Aboriginal Canadians.”<sup>145</sup> They are over-represented in the HIV epidemic across Canada<sup>146</sup> – dramatically so in the case of Aboriginal women.<sup>147</sup> The tuberculosis rate among Aboriginal people is almost six times that of non-Aboriginals (and far worse than that among Inuit<sup>148,149</sup>), and the suicide rate more than double.<sup>150</sup> In fact, among First Nations youth and adults up to 44 years of age, suicide and self-inflicted injuries are the leading causes of death<sup>151</sup> and Inuit youth suicide rates “are among the highest in the world, at 11 times the national average.”<sup>152</sup> Many encounter sexual abuse in childhood and grow up at a greater risk for substance abuse, depression and suicide.<sup>153,154</sup>



Photo: Pte Ariane Montambeault

Fjola Hart Wasekeesikaw, interim executive director of the Aboriginal Nurses Association of Canada, with Their Excellencies during opening smudge ceremony at Rideau Hall on March 27, 2012.

“We need a culturally sensitive toolkit, similar to what Kwanlin Dun Health Centre [in Whitehorse] has developed. Every professional needs to have this to understand the needs of Aboriginal people.”

Her Excellency Sharon Johnston, 2012

These disparities have been perpetuated by colonization and the system of residential schools that dismantled Aboriginal families, cultures, traditions and languages, and led to a process of alienation, displacement, oppression and marginalization.<sup>155</sup> We heard dramatic stories at Rideau Hall about entire generations growing up without the skills to structure their lives. Many do not know how to function as contributing family and community members, how to find and keep a job, or how to run a household or raise children.

But despite the many hurdles Aboriginal people face, we also heard a strong message about their hope and strengths, about forgiveness and healing, and about ideas for change. There was great eagerness to tackle the complex factors that contribute to the alarming health and social conditions of Canada’s Aboriginal people, and to make recommendations for definitive action. Commissioner

---

We must become proactive and support communities, cities, provinces, territories and a country in producing citizens in good health, physical and mental well-being and productivity. Passively waiting for illness and disease to occur and then trying to cope with it through the health care delivery system, is simply not an option. Hence, we must address all of the factors that influence health and through a population health approach, overcome inequities and foster well being and productivity.

Subcommittee on Population Health, Standing Senate Committee on Social Affairs, Science and Technology, 2009

---

and nurse practitioner Julie Lys noted that “Many Aboriginal people have started their healing journey and show us how profoundly this balance changes their lives and the lives of their families and communities in a positive way.”

Non-Aboriginal people want the inequities rectified but are unsure how to proceed and turn to the federal government for leadership; our April 2012 Nanos Research survey revealed that more than half of respondents (55.7 per cent) believe that a greater role for the federal government is needed to improve the living conditions of Aboriginal People. But that role has to be rooted in a partnership: At Rideau Hall we heard clearly that success lies in supports and solutions that are community-driven and not imposed on Aboriginal Peoples from the outside.

We heard that nurses need to be equipped to support health in all its physical, mental, emotional, spiritual and social dimensions.



### Aboriginal and non-Aboriginal people face common challenges

Experts at the Rideau Hall round table talked with urgency about the need to move away from isolated funding, service-delivery and policy actions in favour of a broadly-integrated approach to person- and community-centred health care and wellness programs. We heard that nurses need to be equipped to support health in all its physical, mental, emotional, spiritual and social dimensions.

The case of Aboriginal people, while more urgent than many, aligns well with the needs of all Canadians. Health is the result of many forces in all our lives. A secure home life, the conditions in our workplaces and schools, the safety of the roads, the availability of clean water and the ability to buy good food all contribute much more significantly to our health than the narrow range of health-care services we traditionally associate with better health.

We believe that one step toward reshaping our understanding of health and health effects is to examine key pieces of social and economic policy through a “health lens.” This is not a new idea for Canada. At the federal cabinet level for example, there has been experience with subjecting proposed government policies to their regulatory, competitive or environmental impacts. This structure is already in place elsewhere: Finland’s Minister of Health and Social Services, Dr. Liisa Hyssälä, notes that, “While the health sector has gradually increased its cooperation with other government sectors, industry and nongovernmental organizations in the past four decades, other sectors have increasingly taken health and the well-being of citizens into account in their policies.” Key to this development was that “health and well-being are shared values across the societal sectors.”<sup>156</sup>



## Better Care

**The importance of social and environmental factors does not lessen the need for good health care.** Indeed, in a research synthesis conducted for the Commission, Browne, Birch, and Thabane<sup>157</sup> said the complexity of the personal and environmental factors that determine health underscore the need for both a high quality primary health-care system and for investments in social programs. However, despite the scientific evidence of the power of good primary health care to mitigate inequity in health, Canada persists in focusing health spending on acute care and treatment of illnesses and injuries. Growing consensus on the need to reform primary health care<sup>158</sup> has not changed that. For the past decade spending on hospitals and other institutions, drugs and physician care has hovered around 70 per cent of total public spending on health care. The services hospitals and physicians provide are undeniably important. But estimates suggest that some 75 per cent of good health is the result of factors beyond direct health care<sup>159</sup> and some say it's even higher. We believe better primary care and a national commitment to preventive care and promoting good health could go a long way to ease demands on an overstretched (and often outdated) system. It should also free up funds for fixing some of the problems of our health-care system.

“Innovative health information technologies can make patients safer and improve health care.”

The Conference Board of Canada, 2012

### Fixing the system we have

We encountered many concerns about the current system in our work.<sup>160</sup> People are worried about waits for care<sup>161</sup> – including in the emergency department,<sup>162</sup> for diagnostic tests and for surgery.<sup>163</sup> Access, safety and quality of care are key concerns,<sup>164,165,166</sup> as are communication<sup>167,168</sup> and patient-centeredness.<sup>169</sup>

We also heard repeatedly in our consultations and in research about the need to scale up the use of technology to support patients, improve timeliness, reduce errors and streamline care. The Conference Board of Canada puts the benefits bluntly: “Innovative health information technologies can make patients safer and improve health care.”<sup>170</sup> But despite the billions of dollars spent over the past 20 years, for example, Canada ranked dead last in a Commonwealth Fund study in the area of physicians’ use of electronic health records (for their patients’ files). It found that even in the most wired Canadian jurisdictions, only about 50 per cent of physicians use electronic records. In seven of the Commonwealth Fund’s comparator countries, the rate exceeds 90 per cent. Digital records and information lead to fewer medical errors and are essential for safer care.<sup>171,172</sup>

Safety and quality of care are ongoing concerns in Canada. In 2011, the Conference Board of Canada said, “By focusing on delivering safer and higher-quality health care, Canada will not only help patients but will also control health spending by reducing costly complications and preventing unnecessary hospitalizations.” It concluded that, “Canada’s middle-of-the-pack performance on mortality rates due to medical misadventures...points to the need to focus on patient safety and the quality of health care.”<sup>173</sup>



## Expanding to the system we need

We received many ideas about better care in written submissions to the Commission. Interestingly, the value of humanity and compassion in patient care, which is often overwhelmed by time constraints and our increasing focus on technological solutions, was raised repeatedly as a critical component of improved care.

There was a clear call for embracing a preventive health-care model focused on health promotion and disease prevention and management. The system should emphasize education and interventions to help people take responsibility for their health. There was a prominent theme around shifting our emphasis from acute-care treatment to investing in community and home care, and in taking services to people where they live, which reflects the published research.



There was a clear call for embracing a preventive health-care model focused on health promotion and disease prevention and management.

Nurses and others called for improved quality of life — and death — in long-term care settings, echoing the findings in the report to the Senate on palliative care.<sup>174</sup> They told us a transformed health-care system would offer better options for hospice, palliative and end-of-life care, as well as educating and training health professionals in those areas.

---

In April 2012 polling conducted for the Commission by Nanos Research, one in two respondents (49.5%) said that they would be comfortable accessing care from a team of health professionals not necessarily led by their family doctor if it improved their access to timely care. These respondents ranked their comfort with this healthcare provision model an 8, 9 or 10 out of 10, on a scale where 1 was not at all comfortable and 10 was very comfortable. A further one in three respondents gave middle comfort ratings of 4-7 out of 10.

---

# 75 per cent

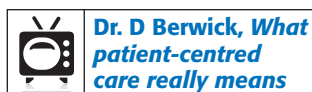
of good health is the result of factors  
beyond direct health care...

There were some calls for more doctors and nurses, but with some 425,000 registered nurses, licensed practical nurses, registered psychiatric nurses and physicians,<sup>175,176</sup> (and tens of thousands more providers of other types) we are not convinced asking for more providers makes sense. That's especially true when we consider the mismatch of supply and demand for registered nurses – so we hear about nursing shortages in one part of the country at the same time as we hear there are no jobs and an over supply in another.

We are more inclined to agree with Canadians who called for the roles of health professionals (including nurses, midwives, pharmacists and paramedics) to be expanded, to make better use of their abilities and make the system more efficient, and with those who spoke of the need to promote multi-disciplinary, team-based care to make better use of the resources we have. Suggestions for how nurses could contribute to better care included extending the ability of registered nurses to prescribe medication, and making more use of nurse practitioners and registered nurses in primary, community, long-term and acute care. The value and impact of nurse practitioner-led clinics, such as those established in Ontario, was emphasized.

We are confident we can build a more balanced system blending health promotion, illness prevention, and institutional care. Emerging from both science and our consultations, our goals for a transformed health-care system are:

- to move beyond episodic, urgent and emergency acute care models to provide accessible, integrated<sup>177</sup> health-related services and programs;
- to base it on a foundation of patient- and family-centred primary health care, accessible, as much as possible, in the home and community; and
- to ensure quality by using the most up-to-date technology, evidence, clinical guidelines and best practices.



## Better Value

**It costs about \$200 billion – in some provinces, close to 50 per cent of the budget – to keep Canada’s health system operating each year.** Measured as a per capita percentage of GDP, it’s the world’s sixth-most-expensive health-care system.<sup>178,179</sup> At 70.6 per cent the public portion of this spending (down from 74.5 per cent in 1990) was slightly less than the OECD average of 71.7 per cent in 2009.<sup>180</sup>

In a March 2012 report, the Standing Senate Committee on Social Affairs, Science and Technology concluded that, in key areas that could bring better value for dollars spent on health (such as primary care reform, electronic health records and catastrophic drug coverage), “real systematic transformation of health-care systems across the country had not yet...occurred despite more than a decade of government commitments and increasing investments.”<sup>181</sup>

We believe the time for change has come and the place to begin is with the system we have today. By searching out waste, taking advantage of technology, and streamlining care, Canadians can get better value for the money we spend, and free up money for the transformation we envision.

### Let’s start with care for chronic disease

If we did nothing else, managing care for chronic disease would go a very long way to transforming Canadian health care. As we have mentioned, chronic disease is widespread and increasing. It causes tremendous suffering for millions of people – and takes a proportionate toll on society:

- The Public Health Agency of Canada estimates chronic diseases cost Canadians at least \$190 billion annually in direct and indirect costs;<sup>182</sup>
- The World Economic Forum says productivity losses as a result of chronic diseases exceed 400 per cent of the direct medical care costs;<sup>183</sup>
- The 2007 Ontario framework for *Preventing and Managing Chronic Disease* estimated every 10 per cent reduction in expenditures for chronic illness would save the province \$1.2 billion annually;<sup>184</sup> and
- The Centre on Global Health Security says “Modest investments to prevent and treat non-communicable diseases could bring major economic returns and save tens of millions of lives” and adds every dollar spent on managing non-communicable diseases realizes three dollars in return.<sup>185</sup>

Public opinion data suggest that Canadians are increasingly concerned about the future viability of public health care. They remain highly supportive of universal health care in principle, and largely pleased with their own interactions with the system.

Soroka & Mahon, 2012

Continuing to fund acute, episodic care at the expense of preventing and treating non-communicable diseases “simply perpetuates ineffective, inefficient and costly care.”

Registered Nurses Association of Ontario, 2011

# \$200 billion

...what Canadians spent on health care in 2011.

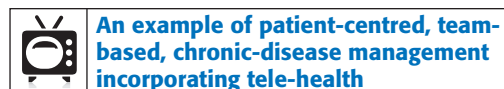
Managing chronic disease is not just theory; we know from evidence that there are actions that work. The World Health Organization presents evidence that “the price tag for scaled-up implementation of a core set of non-communicable disease ‘best buy’ intervention strategies is comparatively low”, and offers practical ideas for tackling five of them.<sup>186</sup>

Self management is one strategy that is effective in symptom management and quality of life for those with chronic diseases.<sup>187</sup> Here, as in many community and home-based strategies, nurses can play a valuable role. Synthesizing evidence on the *Effectiveness of Registered Nurses and Nurse Practitioners in Supporting Chronic Disease Self-management*,<sup>188</sup> the CNA lists goal-setting, monitoring, coaching, telephone support and group education as potential roles for nurses. CNA’s synthesis confirmed that enhanced roles for registered nurses and nurse practitioners were associated with better patient outcomes, including reduced smoking, reduced use of alcohol, more appropriate office visits, fewer hospital admissions and reduced length of stay, all of which can “favourably affect health and functional status, mortality rates, use of hospitalization and nursing homes, and costs” while improving quality and patient satisfaction.<sup>189</sup>

Some chronic disease management can be done at home. Other aspects would be better offered at a local health centre. Evidence shows community health centres in Ontario are better at orienting their programs to the needs and realities of the communities they serve than other models,<sup>190</sup> offer superior chronic disease management,<sup>191</sup> and their clients have lower rates of using emergency departments.<sup>192</sup>

## More options to improve value

Where else could we improve the current system and save money? We have already mentioned the potential of technology to improve care, from quick and delicate robotic surgery to managing paper work. The potential of technology to reduce waste in the system is enormous; electronic records alone could mean huge savings. If they are used properly, they should reduce duplication of tests and treatments, and reduce errors in care (which waste money as well as hurt patients). They can also send prompts – for example to remind a patient to take a medication, or check a patient’s response to it (again, avoiding harm). Text message prompts could easily remind a patient to come in for a scheduled appointment, so time isn’t wasted. At this point we have barely tapped the technology already in our hands.



We need to structure care to suit patients' needs better. Every day, an average of 14 per cent (5,200) of all acute hospital beds in Canada are occupied by patients who could be cared for safely in some other setting, if it were available. In some centres, the number reaches a third of beds on some days. And 20 per cent of these patients stayed more than a month in hospital after the point when they did not need to be there.<sup>193</sup> Many of those patients are waiting for a place in a nursing home. But better planning, focused on using community care to allow patients to return home, rather than moving to an institution, could result in significant savings. In Ontario, "Doubling the home care daily maximum to \$200/day to maximize care for these persons at home (to cover the cost of a personal support worker/day and professional visits per week) would save \$250/day in hospital costs per patient or \$750,000 per day per 3,000 Ontarians times 365 days. This would result in a total of \$27,375,000 per year in hospital costs that could be reallocated to home care."<sup>194</sup>

“Even the best evidence and most consistent public support fail to change policies when interests in maintaining the status quo have the power to thwart change.”

Starfield, 2011

One of our challenges is that our funding model – and its flaws – are self-perpetuating. How we fund dictates what care is delivered, and the stranglehold of acute care comes from the fact that it is what we fund. Our focus on acute treatment makes family physicians gatekeepers, and their training is to send patients for specialized diagnostics and treatment, which in recent years have often been offered in hospitals and other institutions. We cannot break out of the cycle of sickness-doctor-acute care until we make the choice to fund differently and reinforce the shift to team-based community care with plans for more accountability for health spending – including monitoring treatments and outcomes.

### Why change hasn't happened

The Commission received many written submissions about innovations in nursing and health-care delivery; we found more in our other research. Many emphasized delivering much more care outside hospital walls and establishing more places to get care, through teams of providers at times and in places that make sense for the lives of Canadians. Others called for expanding the scopes of practice for nurses, doctors, midwives and others, again to give patients more options and better care. With so much evidence about strategies to improve health in hand, some of it decades old, the Canadian public can be forgiven for asking: “Why has this transformation not yet happened?”

In his 2002 national report, Roy Romanow commented that the system is “replete with examples of excellence in innovation, many of them world-class. The bigger issue is whether we have the right information and the courage we need to make the choices that support sustainability.”<sup>195</sup> It's clear we need vocal champions of change who are willing to make courageous decisions. That is especially the case when it comes to the discussions of funding and control.

No discussion of “better value” for dollars spent in our publicly funded health-care system can be complete without addressing the question of how we pay care providers. As noted at the beginning of this report, an acute, treatment model drives Canada's system, where the physician acts as gatekeeper to specialized diagnostics and treatment – often offered in hospitals. Yet evidence shows that this model is insufficient to meet current and future health and wellness care needs of Canadians. Unlike the other major players in the health-care team, the physician has control over what she or he will be paid for specific services and which of these will (and will not) be paid through public funds.

The *fee for service* model underpins the system of payment and the model of acute care. We know that while this model suited doctors and most Canadians when medicare was first introduced, times have changed. That model – delivered so often in and around hospitals – is a very costly, and ultimately inefficient, way to meet the needs of Canadians now. This is one reason why we propose the funding of an integrated primary health-care model and urge governments to undertake the work needed to do this. Evidence of greater effectiveness exists and can form the basis of their work.



“Canada’s challenge ahead is to adjust priorities appropriately, ensuring our funding follows the needs of those who require care at home and within the community.”

John Abbott,  
Health Council of Canada  
March 8, 2012

There are different models for funding health care all over the world; it is not within our scope to recommend specific choices, but we can define what a new model must accomplish. We need funding to support the delivery of evidence-based care through strong primary health care networks, with teams working together to increase access to well-integrated care. Care should be accessible wherever it is most safe, effective and affordable. To extract maximum value for dollars, the most appropriate provider should deliver care in each situation. Nurses are ready and able to take their place in the leadership of a transformed system, with a foundation of team-based primary care. The focus on health promotion, wellness and treatment close to home fit safely and effectively within the domain of nursing practice.

---

We have had a physician-led model of health care...and an insured, physician-led model for the past 50 years that has focused on episodic acute care. In the present context of people with multiple chronic conditions, it is time to test the value of a nurse-led, proactive, targeted model of comprehensive chronic care with a physician as a member of the team, all doing what they do best and the nurse enlisting all the health and social services that augment the determinants of a person’s health.

Browne, Birch, & Thabane, 2012

---

# The Role of Nursing in Supporting Better Health, Better Care and Better Value

**More than 268,500 registered nurses work with Canadians at every age and every stage of life – in clinical settings and in education, research, administration and policy across Canada.** Licensed practical nurses and registered psychiatric nurses add almost another 90,000 to that number. Using nurses more effectively will be a key part of transforming health care to a system that better balances primary and acute care.

Nurses are already contributing innovations to ensure better health and better care for their patients and better value for health-care dollars. Their ideas are transforming our out-of-date, hospital-and illness-focused system into one that looks at the whole patient through the lens of the social and economic determinants of health, and provides care to people that reflects how they live in their community. Part of our mandate, in our research and consultations, was to assess current nursing interventions and study the innovations led by and involving nurses that are already transforming our health-care system to meet changing health needs.

## Outcomes of nursing interventions

We heard frequently that registered nurses are essential to achieving better health and better care for Canadians and better value for the health system as a whole.<sup>196,197</sup> Research in clinical settings shows a quantifiable link between higher nurse staffing levels and lives saved in hospitals. In particular, this meant “reduced hospital-related mortality, hospital-acquired pneumonia, unplanned extubation, failure to rescue, bloodstream infections acquired in the hospital, and length of stay.”<sup>198</sup> In purely fiscal terms, the value of future productivity to the families and country of patients who die in hospital from complications, based on their age distribution, would average \$222,400 per life saved.<sup>199</sup> The human value cannot be calculated.

### What we heard

Emerging most strongly as priorities for nurses, other professionals and the public during our consultations across Canada were four unifying themes:

#### Lead system transformation

Accelerate the transition from acute care to community-based care, and promote greater integration amongst health service providers.

#### Focus on the social, economic, environmental and Indigenous determinants of health

Rising inequality and poverty are affecting the health of Canadians; we need to address these and other root causes of poorer health and use of the health-care system.

#### Promote healthy lifestyles

Canadians need clearer guidance and support when it comes to healthy living.

#### Strengthen the voice of advocacy for and by nurses

Nurses are solutions to many of the problems before us. We heard a call for nurses to be champions for excellent care and caring in all clinical settings, and especially to champion primary and preventative care. Nurses are a trusted and prominent voice advocating on behalf of Canadians and in partnership with other professionals.



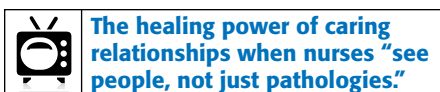
Our researchers found the value of nursing can be difficult to quantify. Browne, Birch, and Thabane (2012) noted that even in systematic reviews and vigorous analyses, there tends to be too narrow a focus on the question “does it work?” rather than “who, with what characteristics, and under what circumstances, most benefits from nursing interventions...in what way do they benefit and at what cost?” That narrow “does it work?” approach needs to be expanded to allow assessments of nursing that take into account all the factors that perpetuate problems or determine health.<sup>200</sup> Commissioners note that the new National Nursing Quality Report initiative could help close these gaps by focusing on outcomes of care provided by nurses that have a direct impact on patient care and system quality.<sup>201</sup>

Nevertheless, despite conceptual and data challenges in assessing the influences and outcomes of nursing interventions, Browne and her team classified 29 nursing interventions based on the economic evaluation framework they developed. They assessed only studies where at least 50 per cent of the intervention was nurse-provided. Some involved nurse replacement (for physician) models and in others, nurses were used to supplement the “usual” care, either alone or as part of a multi-disciplinary team. Some of their findings:

- Fourteen of the 29 nursing interventions they looked at were classified as “more effective than usual care” and 12 of those were also less costly;
- two of the 14 studies were classified as more effective and no more costly than usual care;
- seven of the 29 were classified as equally effective as usual care but less costly; and
- five of 29 studies were classified as equally effective and equally costly compared to usual care.

We note only three of the 29 studies were classified as “equally effective but more costly.” Looking at the sustained economic benefit of nurse interventions, the researchers found only three of the 29 qualifying studies followed patients more than 18 months after the intervention. Those three showed the intervention was more effective than usual care; in two of them the cost equaled usual care and in the other it was less expensive. In almost every study, the nursing interventions were as or more effective than usual care for the same or less cost. If we change usual care, so it is funded and structured to be led by nurses, we could free up the time of other professionals, improve outcomes and rein in costs.

Commissioners believe it is critical to imbue the entire health system with the compassionate, hands-on spirit of caring that we know is healing – and that Canadians demand. Whether they are healthy or ill, Canadians want to be acknowledged, engaged, and treated with respect, caring and concern. There is no place in nursing or any caring profession for anyone who is unable to live out these values in practice every day.



## Nursing innovation at work: Practical Canadian examples

The CNA's report, *Registered Nurses: On the Front Lines of Wait Times – Moving Forward*<sup>202</sup> paints a picture of registered nurses mobilizing resources and innovative thinking to improve health outcomes for Canadians. We list here some of the nurse-led and collaborative innovations from that report, along with others brought to our attention, where nurses are improving access, care outcomes and costs.

- Research on the internationally recognized Nurse-Family Partnership (being tested in Hamilton and elsewhere) finds that home visits conducted by public health nurses are far more effective than those done by paraprofessionals trained to assist them – and every dollar invested in the partnership generates more than five dollars in reduced health and social costs.

Comprehensive School Health is an internationally recognized framework that supports improvements in educational and health outcomes in a planned, integrated and holistic way.

Community Health Nurses of Canada, 2012

- Nurse “navigators” for cancer patients in the Montérégie region of Quebec have improved symptom management, patient follow-up, use of resources, personalized care, patient and family experience and links to home care, and rapid detection and management of oncological emergencies. They have also reduced visits to emergency departments and increased patient knowledge and empowerment.
- Patients who attended a surgical spine clinic led by a nurse practitioner at the Toronto Hospital’s Western Division experienced significantly shorter waits between referral and initial examination by a spine surgeon. Diagnoses by the nurse practitioner matched those of the surgeon in every case.
- The multi-professional Complex Chronic Disease Management Clinic in Calgary has treated hundreds of patients and reduced the number of hospital admissions by 25 per cent and the lengths of stay for those who are admitted by 50 per cent.
- Best practice guidelines developed by the Registered Nurses Association of Ontario have led, for example, to reduced falls and related injuries in older adults; decreased prevalence of pressure ulcers; increased satisfaction with pain control; 100 per cent screening of patients for delirium, dementia and depression and pain upon admission.
- The collaborative primary care model at the Family Medical Centre in Winnipeg, has freed physicians to spend more time with complex patients and guaranteed access to primary care within three days for all its patients.
- A master of nursing concurrent diploma in anesthesia care, along with a diploma at the post-master level, offered at the University of Toronto’s Lawrence S. Bloomberg Faculty of Nursing allows nurse practitioners to collaborate with anesthesiologists to prepare patients more quickly for surgery. An anesthesia care nurse practitioner at Sunnybrook Health Sciences Centre has created a protocol that means standard hip fracture patients stay in hospital five to six days, rather than twelve.

- The Reimer-Kent Postoperative Wellness Model established by Vancouver-based clinical nurse specialist Jocelyn Reimer-Kent has helped Royal Columbian Hospital's cardiac surgery department to move from helping 300 patients to 800 per year. The model of care is based in evidence and contributes to the cardiac surgery department's fast-track surgery and rapid recovery approach to helping patients feel better and get home faster. Taking a proactive stance to controlling pain, nausea, constipation, and food intake, for example, post-operative patients are able to be discharged much more quickly without feeling they are being "pushed out" of hospital too soon.
- Ontario Family Health Teams that include a nurse practitioner are able to accept an additional 800 patients into the practice.
- The use of laptops for documentation by a group of home-care nurses in Quebec enabled the nurses to increase time spent in direct care by 14 per cent and enabled the team to make 780 more home visits per year.

### Case studies: Nurses in action

Our research and consultations gave a sense of the depth and breadth of nursing's impact on health and health care. We've chosen to delve deeper into two examples to show how nursing leads to a more holistic and balanced approach to care and will be an essential part of delivering better health, better care and better value to Canadians:

#### Wound care – a common and costly problem

Michelle Toduruk-Orchard is a registered nurse and clinical nurse specialist at Winnipeg's Leila Avenue Clinic. She has played a pivotal role in the development of a regional approach for wound prevention and management and developing it into recommendations for the province. Teaching by example every day, she is also an active cheerleader for advanced practice education options. Many young nurses are inspired by her to obtain advanced practice credentials.

Part of a team of specially-trained nurses, Toduruk-Orchard sees a steady stream of patients with post-operative wounds, catheter changes, pressure ulcers, venous leg ulcers, arterial ulcers and diabetic foot ulcers, any of which could lead to complications if not treated effectively. "No-touch" techniques and evidence-based protocols ensure consistent, healthy results. Ambulatory patients are sometimes in and out of the clinic in 10 minutes.

The clinic operates under the Winnipeg Regional Health Authority home-care program and takes referrals from local hospitals, family physicians, clinics, long-term care facilities and home care seven days a week. "We've reduced all of the waiting and the complicated referral issues that make treating these patients frustrating, for them and for their health-care providers," Toduruk-Orchard says. In addition to speeding up healing and reducing emergency department visits, the clinic offers ongoing

Ambulatory patients are sometimes in and out of the clinic in 10 minutes.



social and educational support to help patients make decisions about health, nutrition and exercise. “Early and consistent interventions by nurses can prevent chronic returns to hospital and vastly improves the quality of life for a lot of people,” she says.

### Avoiding unnecessary emergency room care

Toronto Western Hospital created its mobile nursing program with the goal of reducing unnecessary, sometimes traumatic, visits by elderly patients to emergency departments. The program is staffed by hospital-based nurses who make house calls to long-term care homes to see residents who might otherwise have to go to hospital.

Evidence has proven its positive impact on patient care, emergency department waits, nursing practice and costs, says registered nurse Mary Jane McNally. She adds that the program, now permanently funded and being replicated in Toronto and across Ontario, has also created a bond between the mobile nurses and staff nurses working in local long-term care homes.

“Everybody wins — patients, their families and the nurses on both sides of the equation.”

Mary Jane McNally, 2012

“The most exciting thing about this program has been to witness nurses working at full scope and acting as leaders,” says McNally, now the senior director of nursing at the University Health Network and Toronto Western Hospital. “Their leadership has produced impressive system change. This model allows our trained emergency department registered nurses to take their acute care expertise directly to the long-term care resident’s bedside,” says McNally “Along the way the mobile nurses offer substantial peer-to-peer coaching and mentoring to the nurses based in the residence, building their skills, confidence and capacity. Everybody wins — patients, their families and the nurses on both sides of the equation.”

Data collected shows the formula definitely works: during the first seven months of the project, 209 consultations, or 79 per cent were with residents who, without the program, would have been sent to emergency department and the mobile nurse provided care for 159 residents who would otherwise have been transferred to a hospital. In the first year, the pilot realized a 13 per cent decrease in ambulance transfers. Early data suggest that the mobile nurse visit costs about 21 per cent less than a trip to the emergency department. Anecdotal evidence suggests the approach improves quality of life for residents.

---

“Patients with pressure ulcers, treated in the community and non-acute settings with best practice nursing, resulted in a reduction in healing time that yielded savings of \$18,000 per client. \$338 million in annual community costs could be saved by leading practices of nurses in leg ulcer wound care; \$24 million in further savings is possible as a result of reduced hospitalizations for infections and amputations. There are about 90,000 diabetic foot ulcer patients and 15,000 more patients with leg ulcers in Ontario alone.”

Studies cited in Browne, Birch, & Thabane, 2012

---

# Technology

will never replace human caring. Rather, it can free up human resources to intensify the humanity of health care.

## Advancing science and technology

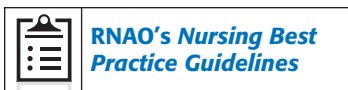
Technology has advanced more rapidly than we dared to dream a generation ago. In 2003, the project to map the human genome – a pipedream 20 years ago – finished two years ahead of schedule. Some of the chemotherapy for cancer now administered in patients' living rooms by nurses (or even family members) once required a hospital admission and a team of physicians behind a sterile field. Surgery that within the past decade required huge incisions and long hospital stays is now done through tiny punctures, with the help of robotics, and requires almost no time in hospital. It is not hard to flash forward to the idea of same-day transplants of our own cloned organs or nanotechnology eliminating surgery or radiation treatments altogether – all within the careers of today's nursing students.

Whether we are doing a good job of preparing students for that world is the question. Nursing students today are members of the most technology-savvy generation in history, raised in a world of instantaneous, brief communication; they resent maintaining outdated methods for tradition's sake. They don't understand the need to enter lengthy, hand-written descriptions of a wound into a file when they could snap a photograph and enter assessment data using a smart-phone, then share it instantly or drop it into a digital record.

They could – but for our failure to implement digital health records. That failure, despite the billions of dollars spent, is difficult for Canadians to understand when they can access their bank accounts, book seats on airplanes, or purchase virtually any item from any country on earth through online accounts they establish and help maintain. While the clinical technology directed at hands-on patient care is often state of the art, Estonian president and chair of the EU Task Force on eHealth, Toomas Hendrik Ilves, concluded that "in healthcare we lag at least 10 years behind virtually every other area in the implementation of IT solutions." This is the case, he said, even when

"Psychiatric consultation and follow-up delivered by tele-psychiatry produced clinical outcomes that were equivalent to those achieved when the service was delivered face-to-face."

O'Reilly, Bishop, Maddox, Hutchinson, Fisman, & Takhar, 2007



IT applications “can radically revolutionise and improve the way we do things.”<sup>203</sup> In Canada, where electronic records do exist, they are fragmented and often are not linked to other providers or a public health monitoring system that could help detect patterns of disease. Worse, very few provide patients with the ability to access and control their own health information.

Nurses have been leaders and inventors of technology, quick to adopt technologies that do things to and for patients as part of diagnostics and treatment. We challenge nurses, their teachers and employers, to imagine the potential improvements in patient safety and education, cost savings and efficiency if nurses vigorously demanded the latest information and communication technologies (which many of them use outside of clinical settings). They should not need to demand them: health-system leaders should be requiring their use as essential equipment. There is no excuse for nurses not having the same tools other Canadians take for granted in their every day lives. This is particularly true of the internet; while the majority of Canadians polled for the Commission by Nanos Research have yet to adopt mobile or online health tools, a growing number do consult the internet for information to help manage their health.

Technology will never replace human caring. Rather, it can free up human resources to intensify the humanity of health care. The challenge for nurses will be to take advantage of technology doing its work to focus on human connections, exchanging knowledge, helping, quelling fear, and delivering the caring and healing Canadians need.

Nursing students don't understand the need to enter lengthy, hand-written descriptions of a wound into a file when they could snap a photograph and enter assessment data using a smart-phone, then share it instantly or drop it into a digital record.



---

In the United Kingdom, a £1,000 investment in remote monitoring demonstrated that technology “can accrue considerable potential savings, in terms of avoided visits to hospital and improved general health, to recoup the system cost several times over.” The equipment is reusable by multiple patients over several years.

Royal College of Nursing, 2012

---

## Implications

We are convinced by the evidence and exciting examples we have found that well-educated, trained and experienced nurses, practicing to their full scope of practice, are essential for the transformation of care for Canadians. Nurses understand the imperative to take on more work to speed things up, streamline administration and make care less fragmented. Using nurses more effectively is key to a transformed system that will better balance acute care with primary care that is patient-centred, holistic, and offers many more services in communities and patients' homes. We know this approach to care delivery is what will most effectively meet the changed health and wellness needs of Canadians in the decades ahead.

**The Commission has high expectations of Canada's nurses, based on what they have already accomplished and do every day, and faith in their ability to meet the challenges of independent action, education, technology and training that a transformed health-care system will demand. Nurses are caregivers, health professionals and innovators. To develop, implement and maintain a new model of care delivery, we believe Canada's nurses must act in four areas:**

1. Intensify their role as leaders of system transformation, including a far-reaching overhaul of the ways we deploy and employ nurses. That will mean supporting and expecting every nurse to practice to the top of his or her scope of practice. But the scope must also be expanded appropriately to meet changed and changing health needs, to encompass functions including, but not limited to, prescribing, and admitting and discharging patients across all types of health facilities.
2. Address the health and social issues raised by the social, economic, environmental and Indigenous determinants of health (including poverty, housing, food insecurity and social exclusion) especially for Aboriginal people and new Canadians.
3. Play a leadership role in promoting healthy lifestyles for all Canadians.
4. Advocate forcefully for health-care transformation, working in partnership with the public, patients, caregivers, Aboriginal people, older Canadians, and people who face health inequities.

**To ensure Canada's registered nurses are able to take on these important roles, we call on all professional nursing associations, educators, scientists, unions and employers to:**

- Work collaboratively to reach consensus on the scientific knowledge, education, competencies and skill sets demanded of effective 21<sup>st</sup> century registered nurses;
- Work within nursing and across disciplines to build the education system and science necessary for registered nurses to be effective leaders and advocates in health;
- Put the funding models and support structures in place to deploy nurses to work to their full scope of practice, as team members, leaders and advocates in a more effective patient- and family-centred system of health and health care; and
- Modernize regulatory frameworks to allow nurses broader scope, including greater autonomy in decision-making.

## Our Plan of Action

**Achieving a system that offers Canadians better health, better care and better value will take a radical shift in thinking by all of us.** This is not just about altering aspects of care delivery, although that must be done too. Health-care transformation demands a fundamentally new vision of health and health care. In our year of work, we have learned:

- Improving the health of our nation will take a large-scale transformation, starting with a focus on promoting health and working to redesign and streamline care. That means developing programs to support Canadians as they learn to take personal responsibility for lifestyle and health decisions; working to improve the “determinants of health,” particularly the social and physical environment, and the educational, financial and employment status of all Canadians; and accelerating work to improve the quality and accessibility of our current health-care system.
- A transformed system will begin with implementation of primary health care, led by multi-disciplinary teams of providers who will offer publicly funded, accessible, efficient care in ways and places that reflect the needs of Canadians, rather than the funding patterns and customs of traditional health care.
- Some groups of Canadians are at risk of poorer health, and creating a healthier country overall means working with those groups to identify and mitigate the disadvantages they face and the gaps in the care they encounter, and to identify what’s needed to ensure their better health over time.

“Incrementalism has not delivered us the healthcare system we need in 2012 and it is not helping the people who most depend on healthcare.”

Coutts & Sullivan, 2012

### Nine actions for transformation

The public has strong expectations of Canada’s nurses and so does this Commission. We believe informed, well-educated and committed nurses are central to taking action on these issues. The success of our *Plan of Action* depends on nurses to lead transformative change and real innovation. Where nurses lead to improve health, care and value in health care and where they collaborate to build a healthier Canada, we know the public, other health professionals and governments will not fail to join in.

Canadians need to understand both the cost of health care and the benefits of prevention and health promotion underpinning all these efforts. We recommend an information campaign, featuring some typical health-care treatments. It could juxtapose the cost of caring for chronic lung disease with the cost of a smoking cessation program; the cost of amputating a foot with the cost of diabetic foot care; and the cost of care in an acute hospital bed with the cost of home care. This strategy would help Canadians understand both what their tax dollars are paying for and the importance of transforming health care.



# Time for action

Enough talking...here is our plan.



---

**The public has strong expectations of Canada's nurses and so does this Commission. We believe informed, well-educated and committed nurses are central to taking action on these issues.**

## 1. Top five in 5 years

***A birthday gift to ourselves. Canada will celebrate its 150th birthday in 2017 and the Commission challenges all Canadians to ensure our country ranks in the top five nations for five key health outcomes to mark that milestone.***

### Getting started

Getting to the *Top five in 5 years* will take work and commitment from all Canadians – individuals and health professionals, educators, policy and decision makers, business leaders and all levels of government. It will take action in communities, classrooms, homes and workplaces. Together we should use the best evidence to identify and then act first in the areas where we can realize the greatest return on investment.<sup>204</sup> The Commission urges nurses to be leaders in innovation and collaboration with policy makers, other health professionals researchers and scientists to select five meaningful health and system indicators and set national goals for improving Canada’s ranking on them. We urge nurses to champion a celebratory national program of community engagement and rewards for progress toward achieving our *Top five in 5* goal.

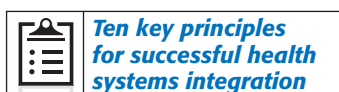
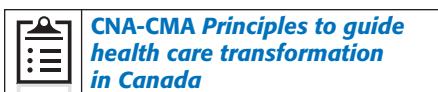
We urge nurses to champion a celebratory national program of community engagement and rewards for progress toward achieving our *Top five in 5* goal.

## 2. Put individuals, families and communities first

***Pan-Canadian goals – local solutions. Reaching Top five status requires health services be designed to meet the diverse and changing health and wellness needs of Canadians. We need a world-leading model of care delivery that will achieve national goals through local solutions tailored to communities and the people who live in them.***

### Getting started

Nurses are well placed to lead *Top five in 5* because they work in all parts of health care in every community in Canada. Nurses should partner with governments, other health professionals and the public to move us beyond our current, institutional vision of health and ensure services that are patient- and family-centred, promote health and prevention, manage chronic disease, integrate all forms of care and provide better health, better care and better value.



### 3. Implement primary health care for all

***We can achieve and afford health for all. To achieve Top five status, a network of primary health care services for all Canadians should be in place by 2017, merging health and social-service workers in multi-disciplinary teams, working in consultation with the citizens they serve.***

#### Getting started

Communities, governments, health professionals and social-service agencies will have to come together quickly to transform primary health care services by 2017. We propose a national summit of stakeholders in late 2012 to begin working on a system that will ensure timely access to services to prevent illness and injury, promote health and manage and treat health problems.

The transformation we are talking about need not start from scratch. Canadians have generated numerous innovative and practical ideas for improving health and reforming health care. Among the most recent are, *Time for Transformative Change. A Review of the 2004 Health Accord*, by the Standing Committee on Social Affairs, Science and Technology,<sup>205</sup> the *Mental Health Strategy for Canada* from the Mental Health Commission<sup>206</sup> and the report to the Senate, *Raising the Bar: A Roadmap for the Future of Palliative Care in Canada*.<sup>207</sup> The specialty nursing associations that are members of the CNA could show leadership by working with CNA, governments, decision-makers and the public to implement key recommendations from these studies.

Nurses must work with other professionals to focus on preventing, treating, caring for and managing chronic diseases. Nurses are well positioned to partner with Canadians individually and as communities to promote health education, healthy lifestyle choices, self-sufficiency and patient- and family-centred care.

There are many aspects to effective primary health care; two that need particular attention in Canada are access to medication and palliative care. Nurses should urge governments to implement publicly funded pharmacare programs, which can use bulk buying to stay cost effective. Nurses must also be advocates for safe, comprehensive and insured palliative and end-of-life care, delivered with compassion in the settings where patients are most comfortable.

Since 2008, the multi-professional *Complex Chronic Disease Management Clinic* at the Peter Lougheed Centre in Calgary Alberta has treated hundreds of patients – reducing by a quarter the number of hospital admissions, and by half the length of hospital stay of those who do need admission.

#### 4. Invest strategically to improve the factors that determine health

***Rebalance the ways we invest in health. Many social, economic, environmental and Indigenous factors and conditions affect human health; access to health care is just one of them, yet we focus health spending on care for illnesses. We need to invest more strategically to improve factors that determine health, focusing particularly on poverty, inadequate housing, food insecurity, and social exclusion.***

In April 2012 polling conducted for the Commission by Nanos Research, six in ten (60.0 per cent) respondents said that the federal government should have a greater role in helping Canadians live a healthy lifestyle by regulating things such as the salt or fat content in foods. Two in ten (21.4%) said the government should have the same role it already has.

##### Getting started

*Top five in 5* means that Canadians – individually and as communities – must rapidly become more engaged in improving this country’s health. At the personal level, that will take education, self-awareness and commitment. Communities will need to offer more options for healthy living and more support to follow them. Nurses have an important role to play in encouraging collaboration among all levels of government, non-governmental organizations and funders (both philanthropic and corporate) to create effective partnerships for engaging the public in creating a healthier nation overall.

The most important measure we can take as a society to improve health is to acknowledge the impact of the determinants of health on Canadians and to strive to improve the conditions of peoples’ lives, particularly striving to reduce poverty, poor housing, food insecurity and social exclusion, which have the greatest effects on health.

Nurses can also lead action on other important public health issues – from ensuring access to safe drinking water, to regulating salt content in prepared foods, to discouraging smoking, alcohol consumption and use of drugs and encouraging physical activity. Nurses who work in health and social agencies could provide programming, services and resources to support older Canadians to live well at home.

## 5. Pay attention to Canadians at risk of falling behind

**Focus resources where they are most needed. Identify the health and care needs of vulnerable and marginalized people and communities at increased risk of health problems, then focus health resources where they will do the most good. Aboriginal people, children, older Canadians, those with low incomes, the disabled and some racial and ethnic groups are often at greater risk.**

### Getting started

Groups and communities at risk for poorer health must be a priority of a transformational approach to health and health care. We held a roundtable to draw together health and wellness leaders from Aboriginal communities to discuss the key issues of how to achieve better health, better care and better value for Aboriginal peoples. One of its main conclusions was the need to immediately accelerate action on Aboriginal health and healing, using Aboriginal knowledge and strengths to help improve social and economic status and living conditions, both on and off reserve. The roundtable urged the highest possible priority be given to ensuring safe, accessible drinking water is available in all Aboriginal communities within five years.

Nurses provide a great deal of the care on reserves and in rural and remote communities and often work closely with urban Aboriginal people as well. That makes them well suited to bringing health and social-service professionals and governments together to work with Aboriginal peoples to identify relevant, community-based solutions to support healing, better health and better care in all communities. The goal is to develop policy frameworks, shared jurisdiction, and appropriate funding models to support better health outcomes for all Aboriginal peoples, no matter where they live in Canada. Nurses and other health professionals also need to collaborate with communities to develop, use and evaluate culturally sensitive research and evidence to improve health outcomes.

Children are another vulnerable group; they need appropriate supports and resources for early childhood development. Nursing and other health professions must continue to conduct research and provide evidence on improving health through early childhood development and ensure effective programs are put in place to promote it. Older Canadians also are at risk and require networks of supports for daily living, health and wellness promotion, and treatment of their episodic illnesses. We would like to see seamless, integrated systems of supports, based in communities, schools and homes, both for early childhood development and for vibrant, healthy aging in this country. Special attention must be paid to the issue of dementia, looking ahead to the potentially large number of Canadians who will be diagnosed with some form of dementia over the coming generation. Adolescents and young adults also need services directed to their special needs.

### ***Health Café for Youth, Fort Smith, Northwest Territories***

After focus groups showed that teens were sometimes reluctant to go to the main health centre, nurses opened a Health Café in the local high school, enabling students to discuss issues with a public health nurse, be treated by a nurse practitioner, or talk to a specialist in health promotion.

### ***The Seniors Managing Independent Living Easily (SMILE) program***

VON Canada's SMILE program enables frail and elderly seniors to receive help with the activities of daily living and make their own decisions about care. With the right supports in place, maintaining independence and staying at home is possible.

## 6. Think health

***We urge governments to integrate health in all policies. All governments should create processes to support healthier lives for Canadians. All proposed policies, laws and public programs should be assessed for their impact on health before they are introduced.***

### Getting started

Governments should take into account the impact all policies, laws and public programs may have on health as part of the planning process. This strategy could help avoid the types of situations we've seen in the past, such as dropping compulsory physical education from schools, despite the long term effect on health, or closing mental-health institutions without providing community services. Nurses should urge governments to establish processes that support healthy policies for Canadians and work with other health professionals to research the impact of public policy on health status.

“As a result of health and wellness being shared values across societal sectors over a number of years, Finns are “healthier than ever, the health of the elderly is constantly improving, the increased years of life are predominantly healthy years, and we have also been able to prevent major diseases.”

Dr. Liisa Hyssälä, Minister of Health and Social Services, Finland, cited in Ståhl, Wismar, Ollila, Lahtinen, & Leppo, 2006

## 7. Ensure safety and quality in care

***Above all do no harm. Safe, high-quality health care and services should be a national goal, with common standards based on evidence and measures tracked and monitored to ensure that goal is met. Health professionals, health-care organizations and governments must be accountable for meeting the high standards Canadians have a right to expect.***

### Getting started

Nurses deliver more care than any other group in the health system. They are a key link in the chain of safety and must be leaders in developing and sustaining a comprehensive national commitment to safety and quality in health care and services. As an initial step, nursing practice in all settings should be driven by evidence. Nurses must be educated to be leaders in quality improvement and work with health-care organizations, other professionals and the public to develop quality improvement frameworks and processes encompassing efficiency, effectiveness, safety and timeliness. Policy makers and funders should set quality goals and provide incentives for attaining them – and disincentives for unsafe or poor quality care.

Rapid spread and uptake of the best evidence for improving care is critical and yet even the most compelling facts can take years to move from theory to practice. Establishing a national clearinghouse for evidence, innovations and leading practices would be a good start. Health-care professionals, researchers and organizations should be expected to share effective ideas. Governments could offer incentives to encourage knowledge transfer, and regulatory and accreditation bodies could help by assessing how well new evidence is integrated into practice.

## 8. Prepare the providers

***A new system needs new service providers. Turning around health and health-care systems the way we envision will require radical change in health-care education. New topics, teaching methods, science and research are all needed to prepare health professionals for a very different health system.***

### Getting started

Nothing is more fundamental to transforming health care than the way professionals are educated, but curricula are out of date and out of step with the transformations ahead. Because it takes a number of years to graduate nurses, doctors and other professionals, action must begin now, in 2012, so by 2017 we have a workforce in step with our goals and targets for system transformation. It is important for nursing leaders to prepare nurses to meet the demands of a new health system, including roles as navigators, case managers, and coordinators of care to support patient- and family-centred care. The Commission believes the Canadian Nurses Association has the expertise and networks to lead a movement that would see a restructuring of nursing programs to make them team-focused and instill public policy, advocacy, political and leadership skills at every level. The CNA could also organize a national consensus conference to determine key elements of a fully inter-professional, team-focused curriculum.

In all discussions about nursing and health system transformation, we encourage the CNA to continue to create structures that are inclusive of registered nurses who are not its members – and as well to seek and include representation from licensed practical nurses, registered psychiatric nurses, and the team members who work most closely with nurses in Aboriginal communities.

Nurses and other health professionals should advocate for and actively support the recruitment, education, employment and retention of First Nations, Métis and Inuit people, as well as visible minority Canadians into the health professions.

Because it takes a number of years to graduate nurses, doctors and other professionals, action must begin now, in 2012, so by 2017 we have a workforce in step with our goals and targets for system transformation.

## 9. Use technology to its fullest

**21<sup>st</sup> century health care demands 21<sup>st</sup> century tools. We need an unparalleled escalation in our use of technology to drive a transformed health-care system. Properly used, today's technology has the potential to provide rapid access to evidence and best practices for providers, to information and education for citizens and tools for communication and collaboration among health-care providers – all of which will enhance patient safety.**

### Getting started

Nurses must urge their organizations and their colleagues to understand the power of technology to ensure better health, better care and better value – and to act rapidly to identify, invest in, support and require the use of technology, such as point-of-care devices, that can lead to immediate improvements in care. These tools hold the potential to change the face of health promotion, improve timely access to care, and put valid and reliable information and research into the hands of patients, families and providers. All health professionals should scale up use of available technology – such as smart-phones, e-mail, Skype and telehealth – to provide services and support in a fashion and time suited to Canadians. To be effective in a highly technological society, we need to make it normal and even mandatory for nurses to use online tools. Learning to take full advantage of technology should be just as important a part of education and employer orientation as learning about medications.

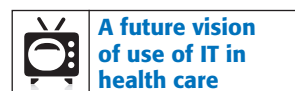
Technology will also be a crucial tool for nurses working with Canadians to support personal health-care responsibility, whether that's working together to research healthy personal choices, organizing care by booking appointments online, or having nurses remotely monitor health data such as blood pressure and heart rate.

Implementation of electronic health records must be rapidly accelerated to make health records of all Canadians fully accessible, portable and interactive. Nurses can help urge the federal government to establish and coordinate pan-Canadian interoperability, and press provincial and territorial governments to get electronic health records in place. Nurses must be equipped to use fully digital records and also to contribute to their design to ensure standardized nursing information essential for promoting health and preventing illness is gathered and used.

The **West Carleton Family Health Team** in Carp, Ontario provides a broad range of family practice services augmented by the skills of nurse practitioners, pharmacists and mental health team workers. Their Patient Health Portal has tools for patients and providers and allows patients to view and add to the information stored in their personal Electronic Medical Record.

At **Trillium Health Centre in Mississauga**, Ontario, the intensive care unit's doctors, nurses, pharmacists, dieticians, and social workers are equipped with blackberries, helping to improve and streamline the team's communication, resulting in better care.

### Examples of cutting-edge thinking in healthcare IT...





# We can do it

Indicators and targets must be agreed on by July 2013  
if our *Top five in 5* goal is to be met.

## Measuring success

In this *Plan of Action* we have tried to offer practical strategies. But to know if we have succeeded means we must agree on measures and gather and evaluate data to gauge effectiveness and progress and inform decision-making. Part of the work ahead is to select indicators capable of reflecting and measuring our new national vision of better health, but which are also meaningful at regional and community levels. We think a core system of indicators and targets must be agreed on by July 2013 if our *Top five in 5* goal is to be met. Furthermore, health-care organizations will have to provide resources and supports, including sharing their measurement and reporting systems, to contribute to the big system goals. Nurses and other health providers will have to be willing to collect data and use information in new, challenging ways to move the health of Canadians to a new level, improve care and ensure better value in the health-care system.



Co-chairs Marlene Smadu and Maureen McTeer during the February 2012 meeting of the Commission in Ottawa.

## Conclusion: Transformation is Possible

**Our research and national consultations have made it plain our health system is not working as it should to provide efficient, effective care for Canadians. What is more, its current structure and services are insufficient to tackle the population health concerns looming before us.**

This report to Canadians proposes an action plan to transform the way the system is organized, funded and measured so we can improve health and deliver the care Canadians will need over the coming decade. We have offered evidence and recommendations to show how this can work, and particularly emphasized the role we expect nurses to play in creating a transformed and sustainable system.

We are not the first to tread this path or to call for a radical shift in thinking about health and health care. But now the country is at a transformation tipping point. Commissioners believe that an intensified effort by Canada's nurses could help to push the agenda forward into real and meaningful change for Canadians.

Our challenge as a society is to build and shape health and treatment services that can meet the health needs of Canadians in the 21<sup>st</sup> century. This *Call to Action* is focused on the ways nursing can contribute and be used more effectively, but it is not just a story for nurses. Its impact, if carried out, will be felt by every Canadian.

We, the Commission, come down firmly on the side of a large-scale transformation to care that, above all, is focused on the needs of Canadians and their families; on high functioning teams over solo practices; and on proactive, safe, effective, affordable health promotion and treatment services that are informed by evidence and delivered in timely ways, in communities, and in the places where Canadians live, work, learn and play.

**We are honoured to have had this opportunity to contribute.**

## Acknowledgements

We are grateful to the members of the public, students, nurses, doctors, scientists and teachers, political and policy leaders, business leaders, social advocates, and all the others who welcomed us into their communities and came out to share their ideas with the Commission in every part of our country.

We sincerely thank the members of the National Expert Commission – the Honourable Sharon Carstairs, Thomas d’Aquino, Dr. Bob Evans, Robert Fraser, Dr. Francine Girard, Vickie Kaminski, Julie Lys, Dr. Sioban Nelson, Dr. Charmaine Roye, Heather Smith, Dr. Judith Shamian, Rachel Bard, and Michael Villeneuve, for their tremendous and engaged contributions over the past year. They were dedicated in sharing their leadership, expertise and personal time so willingly to give life to this important work to support the nurses of Canada and improve the lives of their fellow Canadians. Thank you all.

None of the Commission’s work would have been possible without the dedication of the Commission secretariat. We thank Donna Dewar, Laurie Sourani, Senka Pivac and Joy Varona for their constant support through a challenging year.

We want to acknowledge and thank the Canadian Nurses Association – its president, Dr. Judith Shaiman, chief executive officer, Rachel Bard, and Board of Directors for making the decision to undertake this landmark work. We are grateful to the members of the Canadian Nurses Association across Canada for funding this important work and for hosting so many of our consultations with nurses and others as we travelled. Thanks to all the staff at CNA for their hard work since the Commission was struck in May 2011.

Sincere thanks go to our external partners – the Canadian Health Services Research Foundation, Nanos Research, Mass LBP and YMCA Canada. Thank you for the enthusiastic support lent to us by Lisa Robertson and Susan Wright from The Hillbrooke Group, Jane Coutts from Coutts Communicates for her superb writing and editing skills, Nancy Field of HHRM Consulting for her editorial assistance, Edie Wawrychuk from Traffic Design for her design of our online and final printed products, and Michèle Béliveau and Liette Petit, for their French translation and revision of the final report. Thank you all.

Marlene Smadu  
RN, EdD  
Co-chair

Maureen A. McTeer  
BA, MA, LLB, LLM, LLD (hons)  
Co-chair



## **National Expert Commission**

Better Health. Better Care. Better Value. Best Nursing.

<http://www.cna-aiic.ca/expertcommission/>

