CANADIAN FEDERATION OF NURSES UNIONS

WWW.NURSESUNIONS.CA
INFO@NURSESUNIONS.CA

2841 RIVERSIDE DRIVE
OTTAWA, ONTARIO K1V 8X7
CANADA

T 613-526-4661
F 613-526-1023

1-800-321-9821

Submission

to the Senate Standing Committee
on Social Affairs, Science and Technology

Examination on the progress in implementing the 2004
10-Year Plan to Strengthen Health Care

The Canadian Federation of Nurses Unions (CFNU) represents over 156,000 nurses and student nurses. Our members work in hospitals, long-term care facilities, community health care and our homes. CFNU speaks to all levels of government, other health care stakeholders and the public about evidence-based policy options to improve patient care, working conditions and our public health care system.

Canadian Federation of Nurses Unions
2841 Riverside Drive
Ottawa, ON K1V 8X7
Tel: 613-526-4661; 1-800-321-9821
Fax: 613-526-1023

November 2011

Summary of Recommendations
Senate Committee Review of the *Ten-Year Plan to Strengthen Health Care*

Health Human Resources	*Safe staffing*	**Recommendation 1:** Commit to reducing turnover, overtime, injury and absenteeism in the health care workforce with measurable targets through safe staffing policies and practice funded, coordinated and accounted for through a Ten-Year Plan.
	Education, training	**Recommendation 2:** Reduce the financial burden for students and increase cooperation between health, post-secondary education and labour market sectors by allowing the use of EI for job laddering in health care and for forgiving student loans for health care workers returning to school.
	Pan-Canadian coordination	**Recommendation 3:** Require that all levels of governments establish effective advisory committees for HHR that include unions, professional associations, health, education and labour ministries or departments and government as well as a pan-Canadian observatory.
National Pharmacare	*Pharmacare*	**Recommendation 4:** The federal government begin immediately to work with other governments in Canada to implement a national Pharmacare program with the goal of providing first-dollar coverage rather than catastrophic, to ensure comprehensiveness, universality, accessibility, portability and to best contain costs through a single payer system.
Accountability	*Cost containment*	**Recommendation 5:** All governments in Canada commit to not-for-profit delivery along the continuum of care as a key strategy for cost containment and improved patient outcomes.
	Enforce ban on user fees	**Recommendation 6**: That governments ensure that the principles that they have agreed to are upheld through enforcing regulations banning user fees and extra-billing.
	Transparency and reporting	**Recommendation 7:** Governments act on 2008 recommendations by the Standing Committee on Health to improve accountability, specifically for governments to agree on a set of comparable data and indicators to ensure proper assessment of progress and that this set of indicators is relevant to its client groups and that a report to Parliament is issued on the progress in the implementation of the *Blueprint on Aboriginal Health*, the development of the Aboriginal Health Reporting Framework, and specifically on the fulfillment of its work for First Nations and Inuit populations.
	Audit federal support	**Recommendation 8:** The Office of the Auditor General of Canada undertakes an audit on federal support of health care delivery before the end of the *Ten-Year Plan*.

Introduction

The *Ten-Year Plan to Strengthen Health Care* is a model to be followed for the future of public health care in Canada, specifically the provision of long-term, stable, escalating funding for an agreed upon set of objectives to be implemented under an agreed upon set of principles enshrined in federal legislation.

The *Ten-Year Plan* has led to improvements, but failed to meet key objectives and was ultimately too narrow in its ambitions. It also was flawed by omission, silent as it is for example, on long-term care and mental health.

Our submission will look at the *Ten-Year Plan* critically from the perspective of its commitments in the areas of health human resources and Pharmacare. We will conclude with an eye to improving outcomes through a greater commitment to public delivery and public reporting.

What Worked

Seven years ago, all governments agreed that for the next ten years, the federal government would substantially increase the funding it sends to the provinces for health care and increase that amount by 6% every year, to cover the rising costs of acuity, population growth and inflation. In return, the provinces agreed to follow the *Canada Health Act*, decrease wait times and take other steps to improve health care.

When the *Canada Health Act* was adopted, the federal government paid for about 25% of public health care costs. By the end of the 1990s, the federal government contribution to health care had fallen to close to 10%.[1] Because of the Accord, the federal share of provincial health care is back up to around 25%.

As a result of reinvestment in health care, Canada has:

- Gained more than 27,000 nurses. This represents an increase of 9% in the number of working nurses over five years.[2]
- Hired 6,479 more physicians. This represents a 19.7% change between 1999 and 2009. Currently, there are more active physicians in Canada than there have ever been, and the number of active physicians in Canada is increasing at a faster rate than that of the population.[3]
- Increased by 70% the number of MRI scanners and 36% the number of CT scanners.[4]
- Reduced wait times in priority areas.[5]

The *Ten-Year Plan* has been a successful funding mechanism in that it provided long-term, predictable federal funding for agreed upon goals with an escalator that covered costs of growing acuity, inflation, population and aging.

Health Human Resources

> *First Ministers agree to continue and accelerate their work on Health Human Resources action plans and/or initiatives to ensure an adequate supply and appropriate mix of health care professionals. First Ministers commit to involving health care providers in their work in this area. First Ministers acknowledge the need to foster closer collaboration among health post-secondary education and labour market sectors. Governments agree to make their action plans public. The federal government commits to: measures to reduce the financial burden on students in specific health education programs… and to participate in health human resource planning with interested jurisdictions.*
>
> Excerpts from *Ten-Year Plan to Strengthen Health Care*, 2004

In our 2008 submission to the House of Commons Standing Committee on Health Review of the *Ten-Year Plan*, we noted that there were signs of hope that the dwindling of our health human resources was slowing down, but called for renewed efforts for healthy workplace initiatives, to improve pan-Canadian coordination, and for the federal government to do more to reduce the financial burden on students. This submission, unfortunately, needs to repeat these recommendations.

Despite a much needed increase in supply, the ratio of nurses to the Canadian population has still not returned to what it was in the early 1990s.[6] Considering only the nursing workforce, Canada is currently short 11,000 FTE (full-time equivalent) Registered Nurses (about 16,500 persons). Without immediate intervention, this labour shortage will increase to 60,000 FTE RNs (about 90,000 persons) by 2022.[7]

The cost of this shortage in paid overtime alone is $660.3 million annually. Public sector health care nurses worked the equivalent of 11,400 full-time positions in paid and unpaid overtime in 2010.[8] One in five nurses in the hospital sector leave their jobs annually, costing a minimum of $25,000 per nurse as a result of the transition.[9] Turnover also negatively affects patient care – medical errors are 38% more likely for every 10% increase in the turnover rate.[10]

Research shows that fostering a culture change in health care workplaces improves retention, recruitment and patient outcomes.[11] Without changing health care workplaces, adding more personnel can be likened to adding water to a leaky bucket. Innovation in the workplace leads to plugging the holes, by decreasing overtime, absenteeism, turnover, nurse fatigue and improving quality of care.

- Improvements in working conditions, opportunities for professional development and skills upgrading would convince at least half of nurses contemplating retirement to extend their careers.[12]
- Reducing nurse absenteeism from the current average of 14 days/year to seven days would be equivalent to 7,000 new nurse FTEs entering the workforce in three years.[13]
- Strengthening leadership and empowering nurses can reduce turnover rates by more than half.[14]

It takes time and commitment to transform the health care system from a silo approach to a system where health care providers working together deliver safe, efficient, quality-driven, client-focused services. The federal government has supported partnerships between unions,

professional associations, employers and governments outside of the Ten-Year Plan to transform health care workplaces to deliver better quality care while reducing costs in 10 jurisdictions.

These projects addressed:

- Capacity building in rural/remote areas, community sector with vulnerable populations
- Client-centered practice/safety
- Positive culture change within organizations
- Exploration of inter-jurisdictional or multiple jurisdictional approaches
- Inter-professional practice and effective models of care
- Mentoring
- On-the-job professional development

The *Research to Action* project, which wrapped up in 2011, demonstrated strong results – a 10% decrease in turnover, overtime and absenteeism, and a 147% increase in the number of nurses reporting a high level of leadership and support. As one nurse participant put it, “I was constantly feeling overwhelmed and was contemplating leaving ICU prior to this course. Now I wake up looking forward to work. I feel like I give my patients so much better care.”[15]

The Health Council of Canada in 2005 called for governments to “invest in financial and non-financial incentives to improve recruitment and retention, and report publicly on the progress of healthy workplace initiatives.”[16]

Recommendation 1: Commit to reducing turnover, overtime, injury and absenteeism in the health care workforce with measurable targets through safe staffing policies and practice funded, coordinated and accounted for through a Ten-Year Plan.

Also in 2005, the Health Council of Canada recommended that governments create more interim training and certification steps along pathways to health careers.[17] To accelerate progress to this objective and those stated by First Ministers in the *Ten-Year Plan,* we request that governments forgive student loans to health care workers that have gone back to school to upgrade skills. For example, a personal care worker that is seeking to upgrade skills to become a Licensed Practical Nurse (LPN), or an LPN seeking to become an RN, or an RN seeking to become a Nurse Practitioner could all benefit from this program, as financial cost is a common barrier to skills upgrading. Nursing research shows that a rich skill mix is associated with increased patient outcomes and decreased costs.[18]

Under the current program for apprentices in trades, apprentices are paid by their employer during periods of practical training. During the classroom portion of their training, apprentices are eligible for regular benefits under Part I of the *EI Act*. Depending on the regional and local priorities of the province or territory, the apprentice may receive EI Part II support to cover classroom-related expenses.

A similar tiered-pathway approach through modular education and laddered credentialing would provide health care students the option to graduate into the workforce at various stages of

training. This would be of particular value for engaging Aboriginal Canadians and internationally educated health care workers in skills upgrading.[19]

Recommendation 2: Reduce the financial burden for students and increase cooperation between health post-secondary education and labour market sectors by allowing the use of EI for job laddering in health care and for forgiving student loans for health care workers returning to school.

To facilitate the success of the above recommendations, there is a great need to improve coordination of health human resource strategies nationally. The *Ten-Year Plan to Strengthen Health Care* requires provinces and territories to develop Health Human Resource Action Plans. Funding needs to be found to ensure national coordination that includes input from stakeholders.

The existing Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources (ACHDHR) would need to have its mandate and membership expanded to include active participation from stakeholders in order to better function as effective honest broker and communications centre for information sharing, identification of best practice, and planning and action on HHR among F/P/T governments and stakeholders. Alternatively, a national observatory for HHR, as exists in many other regions of the world, should be created to undertake analysis, data collection, information sharing, action planning and consensus building. Either option needs to effectively engage stakeholders, such as universities and colleges, ministries of health and education, professional associations, employers and unions of health care workers. We stress again that engagement with stakeholders is the only way to ensure appropriate and accountable action targets and timeframes.

For example, national observatories for human resources for health were set up in 22 countries in 1998 as part of an initiative by the Pan American Health Organization (PAHO), WHO's Regional Office for the Americas, to counteract the neglect of health workforce issues in Latin America during the 1980s and early 1990s. They have helped raise the profile of the health workforce agenda, improve the information base, and strengthen health sector stewardship. Their common characteristic is multiple stakeholder participation involving universities, ministries of health, professional associations, corporate providers, unions and user representatives.

Canada needs its own version of an Observatory on Health Human Resources, led by the federal government to coordinate dialogue, strategy, action and evaluation.

Recommendation 3: Require that all levels of governments establish effective advisory committees for HHR, that include unions, professional associations, health, education and labour ministries or departments and government as well as a pan-Canadian observatory.

Pharmacare

> *First Ministers direct Health Ministers to establish a Ministerial Task Force to develop and implement the national pharmaceuticals strategy and report on progress by June 30, 2006.*
>
> Excerpts from *Ten-Year Plan to Strengthen Health Care,* 2004

As far back as 1964, the Royal Commission on Health Services recommended that a universal drug insurance plan be established for all Canadians. The National Health Forum in 1997 recommended universal drug coverage, and the 2002, the Romanow Commission recommended catastrophic drug coverage as a first step.

In 2004, the Premiers agreed that no Canadian should suffer undue financial hardship in accessing necessary drug treatment, noting the federal government had made a formal commitment to this priority. Premiers agreed that a national pharmaceutical program should immediately be established and that the federal government should assume full financial responsibility for a comprehensive drug plan for all Canadians, and be accountable for the outcomes.[20]

The federal government in September of 2004 agreed to partner with the provinces and territories to develop and implement the national pharmaceuticals strategy and report on progress by June 30, 2006, as part of the *Ten Year Plan to Strengthen Health Care*. Four years later in 2008, the provincial and territorial ministers of health said publicly that they can't move forward on several key elements of a national pharmaceutical strategy unless the federal government is willing to take leadership and share costs.[21]

In 2010, the Premiers agreed to work to control drug costs through the establishment of a pan-Canadian purchasing alliance. Whereas this is an important step, the federal government is required to move forward on other aspects of ensuring that no Canadians face financial hardship due to drug costs. We are on the eve of 2012, and Canadians are still waiting for a national Pharmacare plan that will provide access to prescription drugs through first-dollar coverage, control drug costs through a national drug formulary and bulk purchasing, and increase the safety and efficacy of drugs.

Recent research has modeled savings that could be gained from implementing a public insurance plan for pharmaceuticals and from changing drug pricing practices.[22] For example, if Canada modeled its Pharmacare program after New Zealand's in how it tenders and prices drugs, Canada could shave as much as $10.2 billion annually from its current drug expenses. With savings from dispensing fees, cheaper administration and removal of tax subsidies from private plans total savings could be $10.7 billion annually. Importantly, this would not require tax increases.

We also recommend the Committee read *More for Less: Pharmacare – A National Drug Plan* which presents the evidence for a universal rather than catastrophic coverage.[23]

Recommendation 4: The federal government begin immediately to work with other governments in Canada to implement a national Pharmacare program with the goal of providing first-dollar coverage rather than catastrophic, to ensure comprehensiveness,

universality, accessibility, portability and to best contain costs through a single-payer system.

Accountability

> *First Ministers have come together and agreed on an action plan based on the following principles:*
>
> - *universality, accessibility, portability, comprehensiveness, and public administration;*
> - *access to medically necessary health services based on need, not ability to pay;*
> - *reforms focused on the needs of patients to ensure that all Canadians have access to the health care services they need, when they need them;*
> - *collaboration between all governments, working together in common purpose to meet the evolving health care needs of Canadians;*
> - *advancement through the sharing of best practices;*
> - *continued accountability and provision of information to make progress transparent to citizens; and*
> - *jurisdictional flexibility.*
>
> Excerpts from *Ten-Year Plan to Strengthen Health Care*, 2004

Whereas the *Ten-Year Plan* has resulted in improved access to certain procedures, the principles agreed to on universality and accessibility based on need and not ability to pay have been compromised and continue to be compromised through the use of for-profit deliverers of surgical and diagnostic services and the charging of extra-billing and user fees.

The following are myths:

- as long as the public purse pays, it does not matter who delivers;
- private delivery releases pressure from the public system;
- only the private sector can innovate; and
- only by contracting to the private sector will the public sector be sustainable.

Evidence abounds that shows:

- it is more costly in the private sector for governments and patients;
- patient outcomes are better in publicly delivered facilities;
- capacity is reduced in the public system when there is a parallel for-profit, as there are labour shortages across the health professions; and
- innovation occurs in the public system.[24]

The continued promotion and use of alternative service delivery mechanisms raise serious concerns for patient outcomes as well as public interest, transparency and accountability.[25]

Recommendation 5: All governments in Canada commit to not-for-profit delivery along the continuum of care as a key strategy for cost containment and improved patient outcomes.

Recommendation 6: That governments ensure that the principles that they have agreed to are upheld through enforcing regulations banning user fees and extra-billing.

The Standing Committee on Health made a number of recommendations to strengthen accountability in its report on the 2008 review of the *Ten-Year Plan,* that the Canadian Federation of Nurses Unions agrees with. [26]

RECOMMENDATION 2
That the federal government, in collaboration with the provinces and territories and in partnership with the Health Council of Canada and the Canadian Institute for Health Information, agree on a set of comparable data and indicators to ensure proper assessment of progress under the 10-Year Plan; that the federal government ensure that this set of indicators is relevant to its client groups; and that this work be completed by the end of 2008-09 fiscal year.

RECOMMENDATION 5
That the federal government table a report to Parliament on the progress in the implementation of the Blueprint on Aboriginal Health, the development of the Aboriginal Health Reporting Framework, and specifically on the fulfillment of its work for First Nations and Inuit populations before the end of 2008-09.

Excerpts from the final report of the Standing Committee on Health 2008 Review on Progress in Implementing the *10-Year Plan*

Recommendation 7: Governments act on 2008 recommendations by the Standing Committee on Health to improve accountability.

The Office of the Auditor General of Canada last audited Federal Support of Health Care Delivery in 2002, and recommended a separate transfer to improve accountability, among many other things. This recommendation was acted upon in the creation of the Canada Health Transfer, however, the impact on accountability and progress on other measures has not been evaluated by the OAG since 2002.

Recommendation 8: The Office of the Auditor General of Canada undertake an audit on federal support of health care delivery before the end of the *Ten-Year Plan*.

Conclusion

The Canadian Federation of Nurses Unions joins the chorus of voices calling for a renewed effort to transform health care within the public system through federal commitment to funding, knowledge transfer, stewardship and enforcement.

We look forward to working with the Senate Committee to identify the roadblocks that are impeding progress and to develop strategies to ensure that Canadians receive quality, medically necessary care when and where they need it, no matter what province or territory they live in, based on need and not ability to pay.

---

[1] [1] http://dsp-psd.pwgsc.gc.ca/Collection/CP32-79-13-2002E.pdf
[2] http://secure.cihi.ca/cihiweb/products/nursing_report_2005-2009_en.pdf
[3] http://secure.cihi.ca/cihiweb/products/SMDB_2009_EN.pdf
[4] http://www.cihi.ca/cihi-ext-portal/internet/en/document/types+of+care/specialized+services/medical+imaging/release_22jul2010
[5] http://www.waittimealliance.ca/media/2011reportcard/WTA2011-reportcard_e.pdf
[6] Canadian Institute for Health Information. (2010). *Regulated Nurses: Canadian Trends, 2005 to 2009.* Ottawa: Author.
[7] Canadian Nurses Association. (2009). *Tested Solutions for Eliminating Canada's Registered Nurse Shortage*. Ottawa: Author.
[8] Infometrica. (2011). *Trends in Own Illness or Disability-Related Absenteeism and Overtime among Publicly-Employed Registered Nurses: Quick Facts (2011).* Ottawa: Canadian Federation of Nurses Unions. http://www.nursesunions.ca/news/trends-in-own-illness-or-disability-related-absenteeism-and-overtime-among-publicly-employed-re

[9] O'Brien-Pallas, L., Murphy, G.T., & Shamian, J. (2010). *Understanding the Costs and Outcomes of Nurses' Turnover in Canadian Hospitals.* Canadian Health Services Research Foundation. Retrieved from http://www.hhrchair.ca/images/CMSImages/TOS_Final%20Report.pdf.

[10] Ibid.

[11] See the following for example: The World Health Report 2006, Romanow and Kirby reports 2002, the Nursing Sector Study 2006, the Canadian Nursing Advisory Committee reports of 2002, the CHSRF report of 2001, and the Quality Work Life-Quality Healthcare Collaborative.

[12] Ontario Nurses' Association. (2006). *Patients Matter: The Roots of a Health Care Problem and How to Alleviate It.* Author.

[13] Ibid, 9.

[14] Thomas Group. *Nursing Retention*. As accessed at http://www.thomasgroup.com/eLibrary/Industry-Insights/Healthcare-and-Life-Sciences/Nursing-Retention.aspx

[15] Canadian Federation of Nurses Unions. *Research to Action: Applied Workplace Solutions for Nurses*. Author. www.thinknursing.ca/rta

[16] http://healthcouncilcanada.ca/docs/papers/2005/HCC_HHRsummit_2005_eng.pdf

[17] http://healthcouncilcanada.ca/docs/papers/2005/HCC_HHRsummit_2005_eng.pdf

[18] Canadian Nurses Association. (2009). *The Value of Registered Nurses.* Factsheet. Ottawa: Author; and Canadian Nurses Association (2004). *Nursing Staff Mix: A Literature Review.* Ottawa: Author.

[19] Health Council of Canada. (2005). Summary report from meeting on Health Human Resources. Author.

[20] Council of the Federation. (July 30, 2004). *Premiers' Action Plan for Better Health Care: Resolving Issues in the Spirit of True Federalism*. Communiqué. Available: http://www.councilofthefederation.ca/pdfs/HealthEng.pdf

[21] Health Council of Canada. (2009). *Health Council of Canada Calls for Renewed Action on the Stalled National Pharmaceuticals Strategy*. Media Release. January 29, 2009. Available: http://healthcouncilcanada.ca/docs/PR/2009/HCC_NPS_PR_Janaury%2029%202009.pdf

[22] Gagnon, Marc-André. (2010). *The Economic Case for Universal Pharmacare*. Ottawa: Canadian Centre for Policy Alternatives.

[23] Canadian Health Coalition. (2007). *More for Less: Pharmacare – A National Drug Plan*. Author. http://pharmacarenow.ca/wp-content/uploads/2010/01/moreforless2.pdf

[24] Canadian Doctors for Medicare. (February 10, 2011). *New study finds that extra billing is back. Private clinics charge patients for medically necessary services, provide excessive care.* Author. http://www.canadiandoctorsformedicare.ca/new-study-finds-that-extra-billing-is-back-private-clinics-charge-patients-for-medically-necessary-services-provide-excessive-care.html; Collier, R. (2008). Aggressive billing techniques confusing Canadians. *CMAJ*, October 21, 2008; 179 (9); Mehra, N. (2008). *Eroding Public Medicare: Lessons and Consequences of For-Profit Health Care Across Canada*. Ontario Health Coalition; Romanow, R. (2002). *Building on Values: the Future of Health Care in Canada – Final Report*. Commission on the Future of Health Care in Canada; Pollack, A.M., Shaoul, J. & Vickers, N. (2002). Private finance and 'value for money' in NHS hospitals: a policy in search of a rationale? *British Medical Journal*, 324; Devereaux, P.J. et al. (2002). A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals. *Canadian Medical Association Journal*, 166:11; Devereux, P. J. (2002). Comparison of mortality between private for-profit and private not-for-profit hemiodialysis centers: a systematic review and meta-analysis. *Journal of the American Medical Association* 288 (19): 2449-57; American Hospital Association. (2006). Statement of the American Hospital Association before the United States Senate Committee on Finance on Physician-owned Specialty Hospitals: *Profits before Patients*. May 17, 2006; Hall, J. et al cited in S.J. Duckett. (2005). Living in the parallel universe in Australia: public Medicare and private hospitals. *Canadian Medical Association Journal.* 173 (7): 745:747; Armstrong, W. (2000). *The Consumer Experience with Cataract Surgery and Private Clinics in Alberta: Canada's Canary in the Mine Shaft*. Consumers' Association of Canada (Alberta); Munro, J. (1994). NHS waiting times grow while surgeons work for the rich. *Healthmatters*, issue 20, 1994/95; Guyatt, G. et al. (2007). A systematic review of studies comparing health outcomes in Canada and the United States. *Open Medicine:* 1(1), e27–36, 2007. http://www.openmedicine.ca/article/view/8/1; Rachlis, M. (2005). *Public solutions to health care wait lists.* Canadian Centre for Policy Alternatives. http://www.policyalternatives.ca/sites/default/files/ uploads/publications/National_Office_Pubs/2005/ Health_Care_Waitlists.pdf.

[25] Office of the Auditor General. (1998). *Assessing Alternative Service Delivery Arrangements*. Discussion paper. Author. http://www.oag-bvg.gc.ca/internet/English/meth_gde_e_10195.html
[26] Smith, J. (2008). Statutory Parliamentary Review of the *10-Year Plan To Strengthen Health Care*: Report of the Standing Committee on Health.