



CFNU Canadian Federation of Nurses Unions

FCSII Fédération canadienne des syndicats d'infirmières / infirmiers

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Submission to the House of Commons Standing Committee on Health

Nurses' Perspective

Review of the 10-Year Plan to Strengthen Health Care

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Introduction

The Canadian Federation of Nurses Unions (CFNU) represents 138,000 nurses in nine provinces, as well as over 20,000 associate members who are part of the Canadian Nursing Students' Association. Our members work in hospitals, in long-term care facilities, in communities and in our homes. The 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.

We thank the Standing Committee on Health for the opportunity to share our views. We are here to submit to you 10 renewed calls to action which we believe are essential to fulfilling the next step of the vision set out by the First Ministers in 2003 and 2004. These recommendations revolve around two main themes: **Health Human Resources**, a theme intimately bound up with the endemic wait times crisis; and **Accountability**, a concept upon which any sustainable progress must be built.

Health Human Resources

I. Claims of the 10-year Plan

Canada's health human resource deficit, and the unacceptable wait times crisis it has spawned, were problems that already loomed large for the First Ministers who authored the 2003 Accord on Health Care Renewal and the ensuing 10 Year Plan to Strengthen Health Care. **As part of the effort to reduce wait times, the First Ministers agreed 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."**¹ They also recognized the important contribution of health care providers in facilitating reforms, and committed to involving them in their work in this area.

The First Ministers were wise to see the need for urgent action to address a concern that strikes at the core of one of the five principles of Canada's medicare system: accessibility. As the Ministers said, "access to timely care across Canada is our biggest concern and a national priority."² This concern resonates all the louder in light of the Canadian Medical Association's estimate that 4 to 5 million Canadians do not have a family physician.³

The nursing sector does not fare any better. The Canadian Nurses Association is predicting a shortfall of 113,000 nurses by 2016.⁴ There are currently 126,000 unfilled nursing positions across the United States, and one study has predicted that hospital nursing vacancies there will reach 800,000, or 29%, by 2020.⁵ As the Canadian Medical Association note, "[d]elivering on timely access will not be achievable without an adequate supply of doctors, nurses and other health care professionals."⁶ If wait times are our greatest concern, addressing our deficit in health human resources must be our first plan of attack.

The First Ministers also recognized the need to support and develop Canada's home care sector as an essential vestige of our health care system. A mature home and community care sector can help relieve the financial, structural and human resource burdens that currently afflict hospital acute care. With this in mind, the First Ministers of 2004 agreed to provide first dollar coverage by 2006 for services such as two-week provision of case management for short-term acute home care and community mental health home care, and for end-of-life case management.⁷

The First Ministers also recognized the health care challenges that are particular to Canada's northern and rural communities. Though the Canadian health human resource shortage is ubiquitous, it does not affect all areas and populations equally, and none, perhaps, are feeling the pinch as much as northern Canadians. In light of these considerations, the federal government proposed a \$150 million funding increase to the territories as part of the 10 year plan.⁸

II. HHR Progress Report

A. What Has Changed in the Last Five Years

There are slight signs of hope that the dwindling of our health human resources is slowing down. For instance, while the number of nurses per capita has decreased since the early 1990s, the Organisation for Economic Cooperation and Development reports that this trend has been halted and has started to reverse since 2002.⁹ Indeed, CIHI reported a 4.8% increase in the number of nurses between 2003 and 2006.¹⁰ The Ontario Government, for one, has helped create nearly 6,000 new nursing positions between the fall of 2003 and the fall of 2007.¹¹

B. Problems That Remain

Despite these modest gains, all of the evidence suggests that we must ratchet up our efforts if we wish to truly extricate ourselves from our human resource crisis. Growth in nursing personnel, for example, is easily offset and overshadowed by the rising average age of nurses and the frightening number that are available for retirement.

Canada is home to over 250,000 nurses of which over 80% are unionized. But working conditions are far from satisfactory. For example, it is estimated that the annual cost of illness and disability in Ontario hospitals is \$1 billion.¹² Reports from Manitoba suggest a paucity of 1600 nurses there, and Alberta and British Columbia report shortages of 2000 each. The number of new nurses must be dramatically increased if we are to meet the exasperating numbers of nurses leaving the profession. The number of nurses projected to retire in the coming ten years is significant. In Canada, in 2006, 20.8% of nurses were over the age of 55, 8% were over the age of 60 and 1.9% were over the age of 65.¹³ According to the 2005 Nursing Sector Study, in order to offset retirement of nurses, assuming nurses stay working until age 65, enrolment rates would have to be 41,314. In order to keep up with projected demand we would need to graduate about 12,000 nurses per year. Currently we only graduate approximately 8,400.¹⁴

The shortfall has already led to overworking our current workforce. In 2005, RNs worked an estimated 349,800 hours per week (18.2 million hours annually) of paid and unpaid overtime, or the equivalent of 10,054 full time equivalents.¹⁵ The results of the overworking strategy reveal just how poor a solution it is. A 2005 survey of nurses revealed that RNs working full-time had a rate of absence due to illness and injury that was 58 per cent higher than the rate found among the overall full-time employed labour force (7.9% compared with 5.0%). Moreover, when compared to 47 broad occupational categories, RNs had one of the highest rates of illness and absenteeism due to injury.¹⁶

Short term, stop-gap measures such as over-utilizing existing nursing staff,¹⁷ i.e. calling nurses back to work on their days off, and placing excessive (paid and unpaid) overtime demands on nursing staff¹⁸ as ways to address the nursing shortage are untenable in the long term. Indeed these strategies have a negative effect on the health and well-being of nurses and contribute to burnout and attrition. Nurses are older; more stressed, more injured, more ill, and working more overtime than most other Canadian workers, and this poor state of affairs cannot but affect patient care.

III. Our Suggestions

So, what can be done to build on our successes and to address the many problems that continue to plague us?

A. Government Planning

There is a great need to coordinate health human resource strategies. Saskatchewan, Prince Edward Island and Newfoundland & Labrador, for example, lose as much as 30% of their nursing graduates to other provinces.¹⁹ As such, planning for health human resources must be pan-Canadian, taking into account such mobility and the policy levers that will affect the degree of mobility between provinces. Too often, employers are expending resources competing for the same nurses and doctors. Moreover, much time and energy is lost in addressing the workplace shortage because the knowledge of successful innovations and planning models is not crossing regional barriers. The First Ministers and the federal government are in a unique position to help rectify these health labour problems.

Recommendation 1 A pan-Canadian health human resource strategy is a wise investment towards a more prosperous future for all Canadians. To this end, and in conversation with nursing stakeholders, the Federal Government's Office of Nursing Policy, Health Canada, should establish a clearing-house for “best practices” in nursing management, practice and staffing models, and for innovations in workplace health and well-being.

B. Research, Education and Training

Studies have confirmed the impact of labour shortages on the health care system and have identified many innovations to retain and recruit health care professionals. Retention and

recruitment strategies and healthy workplace initiatives are the foci of the Canadian Federation of Nurses Unions' continuous work with the Office of Nursing Policy, Health Canada. Research is an important part of identifying and evaluating innovation. In 1998, the federal government funded the Nursing Research Fund, administered by the Canadian Health Service Research Foundation. The commitment was for \$25 million for 10 years. It is important that this commitment to research continue past 2008. Research and the innovative ideas it spawns must stretch beyond academia and come to fruition in workplace pilot projects that translate into long-term solutions.

Retaining graduates in the Canadian workforce is critical. Research shows that training and advancement opportunities result in workers more satisfied and less likely to seek early retirement.²⁰ A 'tiered-pathways' approach through modular education and ladderized credentialing would provide students the option to graduate into the workforce at various stages of training. The CFNU, partnering with local employers in Cape Breton and Regina, is currently managing the pilot project Workplace Skills Initiative (WSI) from Human Resources and Social Development Canada (HRSDC) with the goal of increasing the retention and recruitment of nurses. The WSI is comprised of an on-job skills upgrading program for rural nurses, a mentorship program to enhance the work experience of senior nurses and the retention of new graduates, and an initiative to develop greater training and support capacities within health workplaces. This type of program is particularly valuable for rural and remote areas and would attract more Aboriginal Canadians into the health care workforce – concrete steps towards sustainable services. Further investments in projects such as WSI will build stronger local partnerships and lead to solutions that will ease the human resource strain within our health care system.

Recommendation 2 Renew funding to the Nursing Research Fund so that valuable research continues to shed light on the road to progress. Governments, in concert with nursing stakeholders and employers, need to develop retention initiatives for novice and mid to late career nurses such as continuing education, programs to encourage experienced nurses to participate in nursing education, differential benefit plans, mentoring programs and healthy work life balance initiatives. Building on the wealth of valuable studies and research projects, the provinces, territories and federal government must increase support for pilot projects as the next stage in addressing the current labour deficit.

C. Retention and Recruitment

Policy-makers should recognize that improving worklife for nurses needs to be an integral feature of a long term strategy to remedy the nursing shortage. A healthy and vibrant workplace will draw in new recruits and retain valued employees longer, buoying our health care workforce and reducing wait times for the Canadian people. What benefit will be gained by increasing the supply of nurses if, on the other end of the equation, nurses are leaving the field because of unacceptable working conditions? Health care must be a field that welcomes health professionals and rewards their efforts without ever abusing the professional's compassion by the placement of undue burdens.

Recommendation 3 Governments, employers and nursing unions must develop strategies to advance the implementation of healthy workplace initiatives, workload management systems, innovative staffing initiatives (for example, standardized nurse-patient ratios) and strategies to enhance the productivity of nurses, i.e. relieving nurses of non-nursing duties (e.g. housekeeping, clerical, and porter functions), providing appropriate technologies to improve efficiency, creating ergonomically efficient workplaces, and promoting nurse autonomy in all aspects of nursing practice.

A lack of stable funding for post-secondary education, combined with cutbacks in seats to health care programs in the 1990s is a key contributor to today's health professional shortage. Canada graduated more registered nurses in 1972 than in 2002 – and the population increased by some 50% during that time.²¹ Indeed, many of the critical problems now plaguing our health care system are the result of years of tax cuts beginning in the early 1990s, along with a reduction in the federal share of health care spending. Such practices, which do provide short-term gains, are ultimately fiscally irresponsible as solutions become more and more difficult and expensive.

Financial constraints continue to limit schools' ability to hire faculty and limit access to clinical placements. Half of the nursing programs in Canada in 2004-2005 reported that they did not have sufficient resources for the number of students currently enrolled. A 2004 survey report by the Nursing Sector Study Corporation indicated that currently 60% of schools report having insufficient faculty and clinical placements, 70% have inadequate financial support for students, and 40–50% have inadequate space.²² With increased resources to post-secondary education for nurses, 50% of schools could increase enrollment from 10-25%, 40% could manage an increase of 50%, and 30% could double their enrollment.²³ The 2008 federal budget allocated \$400 million to recruit police officers across the provinces and territories, and we applaud this decision. We only ask that similar consideration be given to the urgent crisis facing health human resources. Starting in 2010-2011, the 10-Year Plan's Wait Times Reduction Fund earmarks \$250 million a year to be used primarily for health human resources. (cf. 10-Year Plan funding chart) Wise investments in retention and recruitment strategies and in educational facilities could provide the impetus we need to overcome our shortages and look to the future with hope.

Recommendation 4 Through the 10-Year Plan to Strengthen Health Care: “The federal government commits to... measures to reduce the financial burden on students in specific health education programs...”²⁴ We urge the federal government to honour this commitment. Ensure adequate funding for students and their clinical placements. Particular emphasis must be placed on the recruitment of young people into the nursing profession, in particular First Nation, Inuit and Métis.

Recommendation 5 Explicit targets for enrolments, funding (and other support), new faculty, the appropriate technology etc. must be established by governments and educational institutions.

D. Homecare

Home and community care is the fastest growing sector of Canada's health care system. VON Canada reports that the number of persons receiving homecare increased by over 60% in just 7 years between 1995 and 2002!²⁵ Unfortunately, government funding has not been proportionate to this remarkable increase. The logic of an increased investment in home care is clear. Home care cases that are treated in hospital settings are neither cost-effective nor an efficient use of health human resources. By further developing our home and community care system we can make the most efficient use of our resources, resulting in the provision of better care for all.

Recommendation 6 Echoing the pleas of VON Canada we call on the Federal Government to create and support an Expert Advisory Panel on family caregiving to develop a multi-sectoral strategy to better support caregivers across Canada.

Accountability

I. Claims of the 10-year Plan

Accountability, as this government has emphasized, is vital in all areas of government and healthcare is certainly no exception. Goals cannot be targeted or assessed if there are no markers to measure progress or individuals and groups to bear responsibility. The First Ministers of 2004 were well aware of the need to have accurate and detailed performance reports to gauge the progress and shortfalls of our health system. They agreed that the newly formed Health Council of Canada should "prepare an annual report to all Canadians, on the health status of Canadians and health outcomes."²⁶

The First Ministers of 2004 recognized that access to medically necessary drugs was integral to the quality healthcare promised to Canadians. As the Ministers said, **"Affordable access to drugs is fundamental to equitable health outcomes for all our citizens."**²⁷ In this vein, the First Ministers called for a national pharmaceutical strategy which would include a national drug formulary, purchasing strategies and potentially catastrophic pharmaceutical coverage.

II. Accountability Progress Report

A. What Has Changed

The first step towards accountability is accurate reporting. To this end, the 2007 Federal budget allocated an extra \$22 million per year to the Canadian Institute for Health Information which serves to quantify the goals, landmarks and achievements in different areas of our health system.

B. What Remains To Be Done

Though transfers to the provinces increased dramatically as a result of the 10 year plan to strengthen health care, the increase in funds has not always been matched with an increase in accountability. Health Canada's 2006-2007 *Canada Health Act Annual Report* suggests a paucity of information which leaves Health Canada unable to judge whether the provinces are complying with the *Canada Health Act* or not. In the *2003 Health Accord* the First Ministers agreed to the creation of the Health Council to monitor and make annual public reports regarding the fulfillment of the Accord. The Health Council's mandate, however, does not include reporting on the rapid increase of for-profit delivery of medically necessary services, financial barriers to insured services and queue jumping – actions which directly contravene the *Canada Health Act*.

Part of the problem stems from the fact that non-compliance with the five criteria and two conditions of the *Canada Health Act* are only subject to a discretionary rather than a mandatory penalty. We must ask what level of discretion is being applied when we read the following line from the latest (2006-2007) report: "To date, the discretionary penalty provisions of the Act have not been applied."²⁸ This is not because the *Act's* principles have not been breached. As we will soon consider, infractions are on the rise. What is more, there has not been an audit of the federal support for health care since 2002 – before the increase in federal transfers and the adoption of the 10-Year Plan.

As the Romanow commission highlighted, private diagnostic facilities have permitted individuals to purchase faster treatment by paying for their services before returning to the public system where they jump ahead of those waiting for publicly administered diagnosis. This offends against the criterion of *universality* because services are not available on 'uniform terms and conditions,' but depend, rather, on ability and willingness to pay. *Accessibility* is also offended because, for all intents and purposes, charges present an impediment to care for many Canadians. These criteria are supposed to ensure that no financial barrier exists to publicly funded health care services.

In order to highlight the pervasiveness of such infractions and to spell out some of their more pernicious ramifications, the Canadian Federation of Nurses Unions, in partnership with the Canadian Union of Public Employees, has launched the website www.yourmedicarerights.ca. This site documents and explains the effects of phenomena like extra-billing, user fees, co-mingling, queue-jumping and others. Moreover, it serves as a tool for the public to register complains directly with their respective provincial authorities.

III. Our Suggestions

A. The Canada Health Act

The delivery of health care is a provincial responsibility, and this makes the First Ministers and Health Ministers the guardians of one of Canada's most treasured institutions. Administering health care is the prerogative of the provinces and territories and no one is suggesting that we infringe on their mandate. **Compliance with the**

Canada Health Act's five criteria and two conditions, on the other hand, is a matter of federal law, especially given the involvement of federal tax dollars via the Canada Health Transfer. The *Act* is the law of this institution and the key to ensure that it flourishes. Despite the deep respect Canadians hold for our national health care, its principles are being flouted now more than ever. The resources of provincial and territorial governments are already stretched thin. We cannot expect them to report on such matters if they are not asked to and if they are not called to task for not complying. The latest report to Health Canada, for example, offers the mildest of rebukes: “Currently, the most prominent concerns with respect to compliance under the *Canada Health Act* relate to patient charges and queue jumping for medically necessary health services at private clinics. Health Canada has made these concerns known to the provinces that allow these charges.”²⁹

The Health Council of Canada could be the natural organ by which Canada and the provinces measure the fulfillment of the *Canada Health Act*. The proliferation of private clinics, extra billing and queue-jumping, which slowly but surely work to create a two tiered health system in Canada, is cause for concern. There is a deep-seated disconnect between the aims of medicare, centered on patients, and the aims of the market, centered on profits. We cannot let the drive for profits destroy our cherished institution. Yet without accurate reporting we cannot measure the effects of these infractions. Canadians stand to lose the battle for equitable health care without ever knowing it was being waged.

Recommendation 7 On behalf of the Minister of Health, the Health Council of Canada should have the authority to ask provinces and territories to report on matters concerning the *Canada Health Act* in their annual report to Health Canada. Furthermore, Health Canada should make use of their discretionary powers to enforce the principles and conditions of the *Canada Health Act* with respect to its transfers and report back to parliament.

Recommendation 8 To aid in these matters, the Auditor General should perform an audit on the federal monies transferred to the provinces in support of health care delivery.

B. Pharmacare

The federal government has a unique opportunity to help Canadians and show leadership in a national pharmaceutical program. A national drug plan would save money through bulk purchasing and reduced administrative costs. CFNU believes a national pharmacare program will be more accessible and more cost-effective than the current patchwork of systems that exists from province to province.

The cost of prescription drugs rose 77.4 percent between 1996 and 2006 and is now the second largest share of total health spending. Most of this increase is due to the substitution of older drugs with newer, more expensive drugs. While newer, improved drugs that combat conditions more effectively are vital to our health care system, in Canada the substitution of these newer drugs has generally not added therapeutic advances over existing therapies.

Coming to the table as a full partner on a national pharmacare program would make the federal government more responsible for decisions it makes on drug approvals and pricing. It would ensure that all Canadian have universal access to essential drug therapies. It would also assist in addressing provincial concerns that health expenditures are too high relative to their revenues. The federal government can use its bulk buying power and review processes to get the best prices and ensure that newer more expensive drugs that offer no advantage over older ones do not artificially inflate our prices. This is not fancy or wishful thinking. Australian government drug managers negotiate an acceptable price with manufacturers and pay about 10% less than Canadians and New Zealand achieves 50% savings using its coordinated bargaining methods.³⁰

Recommendation 9 The Federal government should develop a national pharmaceutical program to facilitate bulk purchasing and equitable access, relieving the burdens Canadians suffer due to expensive prescription drugs.

C. The 10-Year Plan

The 2003 First Minister's Accord on Health Care Renewal and the 10 Year Plan to Strengthen Health Care were pivotal moments in the history of Canadian health care. Provincial, territorial and federal governments came to the table to remedy the shortcomings of our under-funded and under-staffed health system. The First Ministers did not fear commitment; they feared the consequences of not being committed. Their meetings were a response to the call of Canadians for a more efficient health system with transparency in its processes. The plan, however, will be for naught if it becomes another dead letter, a mere dream of what could have been.

Real and substantial progress is still possible. This review gives us the opportunity to take stock of the small gains that have been made and to redouble our efforts. The goals of the 10-Year Plan are not lofty ideals; they are the future Canadians want for their health system. For this reason we thank the Standing Committee on Health for conducting this review. We only ask that similar and more frequent reporting vis-à-vis the 10-Year Plan may continue in the future.

Recommendation 10 The Health Ministers of each province and territory should prepare a yearly report to the Advisory Committee on Health Delivery and Human Resources on the 10-Year Plan, taking into account its objectives and proposed funding program. The Advisory Committee (ACHDHR) can in turn report to the Federal Health Minister as well as key health care stakeholders.

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Summary of Recommendations

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| Health Human Resources | <i>Government Planning</i> | Recommendation 1 <u>A pan-Canadian health human resource strategy</u> is a wise investment towards a more prosperous future for all Canadians. To this end, and in conversation with nursing stakeholders, the Federal Government's Office of Nursing Policy, Health Canada, should establish a clearing-house for “best practices” in nursing management, practice and staffing models, and for innovations in workplace health and well-being. |
| | <i>Research, Education and Training</i> | Recommendation 2 <u>Renew funding to the Nursing Research Fund</u> so that valuable research continues to shed light on the road to progress. Governments, in concert with nursing stakeholders and employers, need to develop retention initiatives for novice and mid to late career nurses such as continuing education, programs to encourage experienced nurses to participate in nursing education, differential benefit plans, mentoring programs and healthy work life balance initiatives. Building on the wealth of valuable studies and research projects, the provinces, territories and federal government must increase support for pilot projects as the next stage in addressing the current labour deficit. |
| | <i>Retention and Recruitment</i> | Recommendation 3 Governments, employers and nursing unions must develop strategies to <u>advance the implementation of healthy workplace initiatives</u> , workload management systems, innovative staffing initiatives (for example, standardized nurse-patient ratios) and strategies to enhance the productivity of nurses, i.e. relieving nurses of non-nursing duties (e.g. housekeeping, clerical, and porter functions), providing appropriate technologies to improve efficiency, creating ergonomically efficient workplaces, and promoting nurse autonomy in all aspects of nursing practice. |
| | | Recommendation 4 Through the 10-Year Plan to Strengthen Health Care: “The federal government commits to... <u>measures to reduce the financial burden on students in specific health education programs...</u> ” We urge the federal government to honour this commitment. Ensure adequate funding for students and their clinical placements. Particular emphasis must be placed on the recruitment of young people into the nursing profession, in particular First Nation, Inuit and Métis. |
| <i>Homecare</i> | Recommendation 5 <u>Explicit targets for enrolments, funding (and other support), new faculty, the appropriate technology etc.</u> must be established by governments and educational institutions. | |
| | Recommendation 6 Echoing the pleas of VON Canada we call on the Federal Government to <u>create and support an Expert Advisory Panel on family caregiving</u> to develop a multi-sectoral strategy to better support caregivers across Canada. | |
| Accountability | <i>The Canada Health Act</i> | Recommendation 7 The Health Council of Canada should ask provinces and territories to report on matters concerning the <i>Canada Health Act</i> in their annual report to Health Canada. Furthermore, <u>Health Canada should make use of their discretionary powers to enforce the principles and conditions of the <i>Canada Health Act</i> with respect to its transfers.</u> |
| | | Recommendation 8 To aid in these matters, <u>the Auditor General should perform an audit on the federal monies transferred to the provinces in support of health care delivery.</u> |
| | <i>Pharmacare</i> | Recommendation 9 The Federal government should <u>develop a national pharmaceutical program</u> to facilitate bulk purchasing and equitable access, relieving the burdens Canadians suffer due to expensive prescription drugs. |
| | <i>The 10-Year Plan</i> | Recommendation 10 The Health Ministers of each province should <u>prepare a yearly report</u> to the Advisory Committee on Health Delivery and Human Resources on the 10-Year Plan, taking into account its objectives and proposed funding program. The Advisory Committee (ACHDHR) can in turn report to the Federal Health Minister as well as key health care stakeholders. |