COMMUNITY HEALTH NURSES OF CANADA

INFIRMIÈRES ET INFIRMIERS EN SANTÉ COMMUNAUTAIRE DU CANADA

Canadian Nurses Association (CNA) National Expert Commission

Community Health Nurses of Canada (CHNC): Brief in Response to the CNA National Expert Commission Call for Submissions.

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The Community Health Nurses of Canada (CHNC) Brief

Creating a System for (Community) Health

If we are serious about improving the health of all Canadians we must shift our voice and share power and responsibility differently.

Aboriginal Peoples and Communities: Health Care reform conventionally does not simultaneously include the health and health care of Canadian Aboriginal peoples; they are often addressed separately as a 'vulnerable' population subject to unique legislation and governance. This approach permits us to continue to overlook their spectrum of experience - including capacities and unique knowledge - but more importantly some situations of abject circumstances that should not be a part of any Canadian landscape.

The Impact of Expertise: The present Health Care System (HCS) reflects 'expert' driven solutions, decision-making and resource allocation. Yet there is consensus opinion that the current HCS is unwieldy and inefficient. Predicted demographic and epidemiological trends that include an aging population and ever increasing mental and chronic illnesses require better understanding of the drivers of health care costs (CIHI, 2011). Conventional HCS reform typically includes repeating the same; by people who are 'experts' at reproducing the norm (Maioni, 2011; Denis, 2011). We need to acknowledge power and whose voice has most impact on HCS decision-making, while honestly appraising their qualifications to determine infrastructure and functioning of a HCS. Experts and governments tend to seek quick fixes for high visibility issues such as wait lists without careful attention to the upstream 'symptoms' that create burden of demand for certain health services (Maioni, 2011). This contributes to cycles of short term allocation of resources without long term benefit to the HCS or the recipients of care.

Public Participation: There is a critical lack of citizen voice at all levels beyond tokenism. This is contrary to the value that Canadian health care providers, organizations and governments place on the principles of Primary Health Care (PHC). The Canadian people are experts in the impact of policy on the conditions of their daily lives (CSDH, 2008). They have solutions to offer about the type and quality of services needed and the conditions to deliver care and to protect dignity.

The Importance of Place: Despite rhetoric that values PHC, Tertiary Care continues to be prioritized in terms of resource allocation, overlooking the important 'places' where care is most needed. Home Health services are essential to provide care to support Canadians' health, comfort, healing and dignity. Home Health care delivers increasingly complex services to Canadians experiencing acute and chronic illness and to families who require end of life support. Demographic and epidemiologic trends will exert greater pressure and need for Home Health services across Canada over time. Public Health programs and Community Health Nurses (CHN) contribute to essential health promotion in the places where Canadians live, work, learn, worship and play (CHNC, 2011).

A Principled Approach: The principles that support the current Canada Health Act are valued, but insufficient. The principles do not extend to the home. Canadians have inequitable access to the medications and technologies to support their chronic illness and prevent complication. Service demands erode the principles of the Canada Health Act resulting in increasing use of private health services (Steinbrook, 2006). Health professionals are drawn to private organizations, depleting the human resources needed to deliver equitable public services. Health care is becoming an asset for those who are able to pay. Governments have not established satisfactory accountability mechanisms to ensure equitable access to care for all Canadians.

Parallel HCS: We have created a parallel HCS through our reliance on community-based organizations to provide essential services to our most vulnerable populations (CPRN, 2009; Goldenberg, 2004). Some Canadians may not fit conventional norms of conduct or expression. Consequently they may experience inequitable access to institutional health services. The result over time is increased economic and human cost and failure of institutions and organizations to fulfill their original mandates.

Health and Wellbeing: Despite our concerns about the HCS we must not lose sight of the reality that OECD rankings reveal Canadian *health* outcomes remain enviable (cited in Denis, 2011); a reminder that health *services* have limited impact on life expectancy or quality of life. The most important determinants of health are the social and environmental factors that influence the conditions of daily life for all Canadians, including Aboriginal peoples. It is important that the HCS run effectively and efficiently, but we must ensure that emphasis on HCS benchmarks do not create increased inadvertent risk to the health, wellbeing and quality of life of all Canadians.

Healthy Public Policy: In 2005, Canada signed on to contribute as one of twelve country partners of the WHO Commission on Social Determinants of Health, committing this country to act on any recommendations forthcoming. This should mean "seeking to frame policies and programmes, across the whole of society, that influence the social determinants of health and improve health equity" (CSDH, 2008). Given current trends we can predict Canadians will experience increased disability and need for care-giving. This will require *flexible* Public Policy to support maximum citizen capacity and engagement for health service recipients and their care-givers (family and others). For example, Canadians with full or partial disability and their caregivers require access to social benefits that provide sufficient income support regardless of employment status so as to protect their quality of life, in addition to access to respite care.

Economic Models: Conventional approaches to economies of savings include reallocation of tasks to less expensive care providers and application of cost-benefit models to prioritize access to service and technologies. This approach may have short term budgetary benefit but is less reliable in supporting health and sustaining budgets over time (Drummond, 2011). Additionally, focus on Gross Domestic Product (GDP) in health and economic policy may obscure important factors that support Canadians' health and quality of life (CIW, 2001).

Access without Appropriateness: Emerging literature reveals that expert response to 'priority' arenas for action in response to wait lists may simply create increased demand in competing domains (Maioni, 2011). More importantly in terms of human and economic cost is the reality that increased access to technology, including pharmaceuticals, may result in inadvertent harm to Canadians who submit to unwarranted and costly testing and intervention. This trend has been linked to a cost-benefit approach that does not fully calculate the risk of certain technologies and treatments (Deber, 2008).

Health Human Resources: Canadian's have long believed they should have access to a physician to protect their health; physician shortage issues make prime news and are a major source of concern. In contrast, the CHNs who are ideally situated to work with and for Canadian families; who can monitor and report on the impact of policy on the conditions of daily life; who can and do contribute to upstream health promotion remain largely invisible to Canadians and policy makers. Consequently there is a significant dearth of research and evidence to support the contribution CHNs make to the health and wellbeing of all Canadians, including vulnerable isolated and marginalized populations. CHNs are not able to exert their full contribution to Canadian society as they are not working to full scope of practice (CHNC, 2011).

Professional Teams: The accepted consensus is that integrated health teams are required to contribute to seamless care across the PHC continuum. Team work and service delivery require new competencies. Current economic models and the genuine desire to improve access within reasonable costs result in task shifting to low cost service providers; which may decrease long term health outcomes. Decisions need to be informed by evidence (CNA, 2005) and take into account the general community population profile (CIHI, 2001).

The CHNC Brief: Recommendations

We must *walk the talk* via collective action to endorse the principles and values we espouse.

Status Quo is Unacceptable: We must seek innovation and simple solutions while taking collective ownership of our capacity and responsibility to speak and act across all levels of the Health Care System (HCS). We need to stop accepting the difficulties navigating the HCS simply because 'that's the way it's done'. **We need to redefine 'expertise' to include the voices of all Canadians and a range of intersectoral partners.**

The 2014 Health Accord: must prepare the terrain to expand the Canada Health Act (CHA) across the PHC continuum to include home, palliative and pharma-care for all Canadians. A renewed CHA must reflect full implementation of the Ottawa Charter for Health Promotion values and strategies. This will ensure upstream PHC health promotion and illness/injury prevention in balance with curative, restorative and maintenance services. The CHA must expand the definition of essential services to include those provided by CHNs. We must ensure accountability to Canadians by collectively determining pragmatic ways to support and enforce an improved, renewed CHA. We propose the addition of 'Appropriate' as a grounding principle

to support evidence informed care. This will serve to support the PHC principle of 'appropriate technology' within decisions about 'access' to care. Desired outcomes include improved value for and application of low tech physical health assessment skills and better use of expensive, potentially risk-inducing high technology.

Integrate the UN Declaration on the Rights of Indigenous Peoples into HCS renewal. CHNC recognizes solutions must involve all Canadians working in partnership to address the issues and strengths of our Aboriginal peoples. It will be important to build on the Canadian Government's endorsement of the UN Declaration on the Rights of Indigenous Peoples. We are more likely to improve integrated and reciprocal knowledge transfer if we address Aboriginal health simultaneously within the general Canadian HCS renewal context. While acknowledging the complexity of integration over time, we do encourage addressing built environments – including transportation and housing adapted for climate conditions - and education to improve access to equitable opportunity for health and culturally acceptable health services.

Citizen Engagement and 'Voice': We must **listen** carefully to solutions generated within and beyond the conventional health sector. Most importantly, we must listen to the stories and solutions offered by the Canadian people; including Indigenous peoples who have unique experience, perspective and evidence to contribute. It is essential that all players in Health Accord and HCS renewal establish structures and processes to require that the 'voice' of Canadians contribute in meaningful and substantive ways to policy decisions and delivery of health care services.

Intersectoral Collaboration: Intersectoral approaches promote long term action and government accountability for public policy (Mendel, 2009). We need to partner with architects, engineers, economists, city planners etc… to create health care environments, processes and policies conducive to clientele and workers. We should investigate the feasibility of adapting successful workplace initiatives to the PHC context. One example is the *TCAB* initiatives that involve nurses in transformative care (O'Connor, 2011; Rutherford, Moen, & Taylor, 2009).

We Support the Canadian Index of Wellbeing (CIW): as a mechanism to achieve **balance** in resource allocation to the health care system versus the determinants of health and quality of life (2011). The index provides an evidence base to ensure progressive policy that better reflect the 'voice' of Canadians in terms of values and broad determinants of health. The CIW provides a template to expand the definition of health service 'benchmarks' within upcoming Health Accord discussions. Governments, decision-makers and health professionals should adopt the CIW and endorse it with the public.

Healthy Public Policy: must be flexible and responsive so as to protect the dignity of all Canadians. Healthy Public Policy is a mechanism to balance attention to the HCS with those factors that contribute to wellbeing and quality of life. Examples of flexible policy include adapted disability criteria to supplement part time work with social benefits and flexible

employment options, conditions and pay mechanisms for care-givers. Health inequalities resulting from difference in social determinants of health should be seen as unacceptable in a society that places a high value on equal access to good health. The reduction of income inequality and measures to reduce poverty should be pursued as priority health strategies (Toronto Public Health, 2008).

Economic Models: We should supplement cost-benefit models with risk-benefit approaches, appropriate use of technologies, pharmaceuticals and health promotion; and avoid excess focus on GDP. Solutions that do not rely on privatization and respect the Canada Health Act should inform Health Accord and Canada Health Act renewal (Falk, Mendelsohn & Hjartarson, 2011).

Health Human Resources: **All Canadians should know their Community Health Nurse**. CHNs are essential partners in navigating the determinants and systems that influence health. CHNs "take collaborative action to promote, protect and restore the health of Canadians within the context of the important places and experiences of their daily lives" within a continuous lifespan approach (CHNC, 2011, p. 2). Canadians should know about the range of health promotion and protection activities developed and delivered by CHNs. ***Canadians should be informed that they can and should have access to their local CHN in equity with access to Physicians.*** It is imperative that governments support CHN by redirecting research priorities to include CHN practice, education and administration; to capture the impact of CHN processes and care on individuals, families, groups, populations and communities.

Health Care System Renewal Initiatives: should recognize the limitation of task shifting models and include professional development initiatives to help health care providers prepare for expanded responsibilities and new contexts in care delivery; including team work, networking and case management. "A strong community health system has the potential to effectively and efficiently address disease and injury issues upstream to prevent them from occurring, delay their onset, or care for those affected closer to home to restore health" (CHNC, 2011, p. 17). Essential to any reform is proactive planning in anticipation of population trends and need. We must also ensure that all health professionals enact the competencies necessary to deal effectively and humanely with society's marginalized peoples; and that physical spaces are designed to protect dignity, confidence and trust. We must free our community based organizations to fulfill their potential to be a force for the type of social innovation that creates a prosperous, just and caring Canadian society (Goldenberg, 2004).

Respectfully submitted by: Community Health Nurses of Canada.

Use of the term 'Community Health Nurse' in this brief includes health professionals commonly known as community health nurses, home health nurses and public health nurses, amongst other nurses who provide care in physical settings outside the Tertiary Care health system.

The term 'system for (community) health' represents CHNC's endorsement of the Ottawa Charter for Health Promotion's values and strategies; and builds on Carolyn Bennett's call to transform health care systems into 'systems for health' (CHNC, 2011).

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