CANADIAN NURSES ASSOCIATION

CARING
for Vulnerable Canadians

Canada's registered nurses speak out for palliative and compassionate care

Submitted to the Parliamentary Committee on Palliative and Compassionate Care

November 25, 2010

This document was prepared by the Canadian Nurses Association (CNA) in pursuit of its mission, vision and goals. The information presented in this document does not necessarily reflect the views of the CNA board of directors.

CNA is a federation of 11 provincial and territorial nursing associations and colleges representing 139,893 registered nurses and nurse practitioners. CNA is the national professional voice of registered nurses, supporting them in their practice and advocating for healthy public policy and a quality, publicly funded, not-for-profit health system.

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Key messages & recommended investments

Over the next decade we will be part of a health system undergoing massive change – both because of issues we're facing now and others that we can't foresee. We need to adjust to the changes thrust upon us by the realities of an aging population, the society and environment within which we live, and the need for a more efficient and affordable health-care system. But we can also make change happen thanks to the evidence we have in-hand; we have the opportunity to invest in change that reflects innovation, new knowledge, new technology and new ways of thinking.

The Canadian Nurses Association (CNA) invites the federal government to join us in looking at health care in new and different ways – to see the big picture and understand that health care will be delivered in Canadians' homes and community clinics as much as it is in hospitals and doctors' offices; that federal leadership is crucial to the transformational change our health system needs; and that listening to nurses – the health-care providers who spend more face time with Canadians than any other – is a crucial step toward finding the solutions.

The nurses of Canada know that our medicare system certainly is sustainable. But we can and must make it more vibrant, more cost-effective and more efficient without giving up our ability to provide safe, compassionate, competent and ethical care. It is the foundation upon which so many of our values are built and upon which our most vulnerable citizens rely so heavily. We ask you to share in our vision and to let us help you revitalize the system.

What is needed?

1. A comprehensive, **national poverty reduction strategy**.
2. A **national housing strategy** that provides decent, affordable, safe and appropriate housing.
3. A **national pharmaceutical strategy** (with a particular focus on catastrophic drug coverage) to ensure that access to pharmaceuticals is equitable throughout Canada.
4. A **comprehensive, national approach to home- and community-based care** that is based in a broad primary health-care framework.
5. An integrated strategy to provide **comprehensive mental health care** for all Canadians.
6. A **national strategy on aging and health** focusing on the broad theme of aging in place – from infancy to old age – supporting human health by addressing the broad range of health determinants through comprehensive primary health-care principles.
7. **Universal standards for provision of safe, compassionate, competent and ethical end-of-life care** regardless of setting that includes assured access to broad range of basic and advanced EOL services (comprehensive) and coordinated care.
8. **Removal of federal barriers** that prevent nurse practitioners and other health professionals from practicing to their full scope (narcotics prescribing for pain management, discharging to appropriate care and treatment plans).

Investing in a compassionate and just society

Canada's public, not-for-profit medicare system was built in the 1960s and has been groomed since then to provide a range of acute, in-patient and outpatient services to Canadians on the basis of need rather than ability to pay. Despite its downfalls, our universal acute care system achieves many admirable outcomes and is envied around the world. However, like all complex systems, the health-care system in Canada has significant gaps that we need to close.

Our acute care sector functions pretty well overall for most people when they are in need (and superbly when they require the most urgent and emergent care). However, gaps across the health system create bottlenecks in acute care and these bottlenecks in turn contribute to gaps elsewhere in the system, as illustrated by the following examples:

- A lack of primary care providers for physical and mental health care sends too many Canadians to emergency departments for primary care.
- A lack of home care means that many patients are admitted to acute care beds when what they really need is access to supports and services within their own homes and communities.
- As a result of our failure to act on the knowledge that some of our most vulnerable citizens – the dying, the frail elderly, and the mentally ill – simply need help to manage their conditions and symptoms, they are inappropriately admitted to cure-focused, acute medical, surgical and even intensive care beds. In many cases, an elderly person fails at home because of a temporary strain caused by a temporary illness, such as the flu. In these cases, what should be a small setback – such as difficulty getting groceries while ill or accomplishing personal care tasks – becomes too great a burden. Rigid home care system rules do not allow for additional supports, which can result in patients getting unnecessarily stuck in the acute care system. Nurse practitioners could help in these situations by providing home visits, following up on acute care admissions, and discharging patients back to the community, if this option were within their scope of practice.

Promising Practice…

In Ontario, the Geriatrics Emergency Management program has advanced practice nurses (APN) working in emergency departments seeing frail elderly patients. However, APNs are able to coordinate emergency response teams in the community to prevent admission and continue with increased supports at home, which is what people want and need. Expanding the scope of APNs (such as nurse practitioners) to admission and discharge would allow for more appropriate and effective use of acute beds.

The reason we have tended to stream all health and illness problems toward physicians and hospitals is not hard to understand: publicly funded health care historically has largely been restricted to in-patient, acute hospital beds, or at least to hospital-based care. However, we are in a very different world now.

Since medicare was established, acute care has expanded to include a vast array of new services available to patients in a much wider age range, which has created equally vast new demands. The acute care system has responded to the increased demand: nearly 100 per cent of diagnostic services are now provided in outpatient settings, and most surgery is delivered on a same-day admission basis. Lengths of stay have been slashed to the bare minimum because of patient demand and changing fiscal pressures that have pushed acute care away from hospitals and into outpatient settings, homes and communities.

Services that would have been delivered only in critical care units a decade ago are now routinely offered on highly acute hospital wards. The patients who used to be in those ward beds are now at home with highly acute care needs that are not being adequately covered through provincial administration of medicare. These include patients who are recovering from surgery or are at the end of their life who often need very complex care (including pain control) around the clock.

Frail seniors, who could manage at home if they had adequate social and environmental support services, may end up in acute care beds because health professionals and administrators who are working in homes, communities and emergency departments have few or no alternatives. There needs to be more flexibility in home care services to respond to changing needs.

These kinds of challenges and shortfalls combine to jam the acute care system with patients who have a range of health and social needs that would be better addressed in completely different settings with more flexible home and community care supports. In 2007-2008, 5 per cent of hospitalizations and 14 per cent of hospital days in Canada involved patients awaiting an alternative level of care in a more appropriate setting (Walker, Morris & Frood, 2009). One result is the wait-times problem for acute medical and surgical care that has characterized so much of our dialogue over the last decade. However, at the same time, decision-makers continue to pour money into highly visible acute care, while funding for public health, primary care and a broader roster of upstream and prevention services based on a primary health-care framework has remained essentially stagnant despite growing demand.

Since its inception, CNA has argued the importance of putting in place services that are driven by population health needs and are delivered in the places where people live, work and play. Courageous decision-makers can fill in the current gaps in the health-care system and reposition acute care as just one element in a continuum of care that includes wellness visits with a health-care practitioner, health promotion, acute illness care, mental health care and care of the dying. This range is especially important to citizens who are more vulnerable by virtue of poor health, their ethno-cultural or language background, advanced age, mental illness and/or addictions.

Looking beyond hospital walls: Health and social services impact the health of Canadians

Significant cohorts within Canada's population are especially vulnerable – from infancy to old age – in areas where federal government action can improve their lives significantly. Many infants, children, mothers, First Nations, Inuit, Métis, people with chronic illnesses and seniors are especially vulnerable to the ravages of poverty, under-employment and expensive, unsafe housing. Certain drugs and types of health care can be out of their financial reach.

Canada does acute treatment and "rescue" care quite well, and in many cases it is remarkably successful in reducing morbidity and mortality. However, the costs are tremendously high, and we know from international standards that there are many areas in which we lag significantly behind countries that invest a similar level of resources in health care.

If we are to improve the health of Canadians, our conception of health care must be much broader than acute care of illness and injuries. As we have known for centuries – and certainly as we have all agreed since the 1970s – health is the product of a wide range of social and environmental

determinants. Canada's nurses, who work with citizens of every age and in every condition of health – in the streets, community health centres, homes, hospitals, nursing homes and schools – and who hold hands with those at the end of life know that health and health "care" are about much more than the hospitals in which so many of us work.

Canada needs its federal government to exert leadership and use its authority to put the programs in place that decades of research have demonstrated will help Canadians to live longer, healthier and more productive lives. Key among such programs are (a) income security (where the youngest and oldest Canadians are especially vulnerable), (b) secure, accessible and affordable housing, (c) access to affordable prescription drugs, and (d) access to services that prevent illness and injury, promote health and wellness, and treat disease in homes and communities.

Poverty among seniors. According to the Conference Board of Canada, "elderly poverty is both a social and a fiscal problem that will be exacerbated as higher percentages of populations in developed countries move into the over-65 demographic. Poverty rates among the elderly tend to be highest among women, particularly widows over the age of 75. This is largely due to pension allowances that have traditionally been linked to employment history" (Conference Board of Canada, 2009, Putting elderly poverty in context, para. 3). It is worrying to note that after years of slow declines, the poverty rate among seniors began to climb again by the end of the 1990s. The Conference Board also notes that as private pensions have grown (to reduce reliance on public pension systems), "the most vulnerable among the elderly are being put at greater risk of poverty" (2009, Putting elderly poverty in context, para. 4). The problem can have a particularly strong impact on single older women who did not take part in the formal workforce during their lives.

Secure, accessible, affordable housing. In a November 2010 article, *The Globe and Mail* noted a report from the Research Alliance for Canadian Homelessness, Housing and Health concluding that some 400,000 Canadians live in conditions "with the same devastating health risks as people living on the streets" (Scofield, 2010, para. 1). Efforts have been made to improve this situation, but more coordinated work is needed and the pace must be picked up. The Wellesley Institute notes that "the federal government is investing billions of dollars in affordable housing annually, but without a national housing framework, it is hard to determine the value of those investments" (Wellesley Institute, 2009, p. 2). They go on to say that "without a national housing strategy, efforts to meet the needs of the one-in-four Canadian households who are precariously housed remain fragmented and unco-ordinated" (Wellesley Institute, 2009, p. 2).

> The Research Alliance on Canadian Homelessness, Housing and Health concludes that 400,000 Canadians are "vulnerably housed," and are left open to the same severe health issues – mental and physical – as homeless Canadians.

Vulnerable housing is an important policy issue because it results in tremendous costs for individuals and communities. In their *Street Health Report 2007*, Street Health and the Wellesley Institute make plain the links among poor housing/homelessness, higher disease burden (morbidity) and premature deaths (Khandor & Mason, 2007). According to the Wellesley Institute, its research "shows that supportive and affordable housing is not only good for residents, but it also benefits the surrounding community. Our research, including *Poverty Is Making Us Sick* – the most comprehensive review of income and health in Canada – shows that the impact of income and housing is not just among the very poor and the very rich. There is a gradient which demonstrates that smart interventions along

the spectrum of low, moderate and middle-income households yields [sic] positive results" (Wellesley Institute, 2009, p. 1).

Canada is one of the world's wealthiest nations. We can do better than this, and we must do better.

Home- and community-based care. Home- and community-based primary health care has been a vital resource in Canada's health system for more than a century. Over the past decade, it has been the keystone of the system's ability to dramatically reduce acute hospital lengths of stay. It still has the potential to help resolve challenges for the dying, the mentally ill and older Canadians, most of whom want to remain as healthy and comfortable as possible in their own homes for as long as possible. However, the non-hospital sector and its human resources are under tremendous stress; the money simply has not followed the policy. Home care has, in many cases, become "hospital in the home," in which complex acute care services are transplanted from hospitals into the homes of Canadians.

One unintended consequence is that the needs of chronically ill and aging citizens are placed in competition for home care resources with the needs of people requiring complex post-surgical care and palliative care. The latter are often seen as being higher in priority; however, the needs of those other Canadians are just as pressing, and our failure to attend to them will come back to haunt us if these individuals become sicker and/or need admission to hospital to treat problems that timely care at home could have prevented. Too many vulnerable Canadians are forced to turn to (or remain in) acute health-care settings for problems that could have been prevented or treated in more cost-effective ways.

The perpetual under-resourcing of home and community care in favour of acute hospital care has had a chilling effect on recruitment, has eroded morale, and strains access to the care Canadians need. The stark disparity in salaries alone is a barrier to recruiting and retaining health-care practitioners in most areas outside of acute care hospitals. If this continues it will compromise the ability of Canada's health system to effectively meet the needs of its aging population and hamper our ability to respond to the challenges of changing health-care policies, including the containment of costs.

Recommendations: Poverty and income security

1. The federal government should, in collaboration with provincial and territorial governments and relevant stakeholders, develop a comprehensive national poverty reduction strategy that is linked to and supportive of provincial and territorial poverty action plans.
2. The federal government should implement a mix of policies and programs to contribute to income security, especially for older Canadians.

Recommendation: Secure, accessible and affordable housing

3. Federal leadership should, in collaboration with provincial and territorial governments and relevant stakeholders, develop and implement a national housing strategy that provides decent, affordable, safe and appropriate housing for all Canadians. This is especially important for vulnerable and homeless Canadians.

Recommendation: National pharmaceutical strategy

4. The federal government should, in collaboration with provincial and territorial governments, fulfill its commitment to implement a national pharmaceutical strategy (with a particular focus

on catastrophic drug coverage) to ensure that access to pharmaceuticals is equitable throughout Canada. This issue is especially salient for older Canadians and patients receiving palliative care who may have fixed or shrinking incomes and may be faced with new and unaffordable drug costs.

Recommendation: Home- and community-based care

5. The federal government should partner with Canadians, provincial/territorial governments and health-care providers to implement a comprehensive national approach to home- and community-based care that is based in a broad *primary health-care* framework.[1] Such a strategy should encompass long-term planning for adequate health human resources, appropriate technology, and support for unpaid family and friend caregivers. The strategy should support:
    - making home- and community-based care an essential component of all federal/provincial/territorial health-care strategies and initiatives;
    - collaboratively developing, implementing and evaluating standards, as well as innovative and cost-effective models of home and community care, at the provincial, regional and community levels with federal support; and
    - improving health system sustainability by shifting health dollars to home and community care using tested models that successfully provide cost-effective, safe, quality care.

Strategies to make it all happen

- Invest in primary health care that involves teams of health-care professionals working in a coordinated way to reduce wait times and ensure that patients can access the most appropriate health-care provider – nurse, physician, dietitian, or other – at the right time in the right place.
- Create tax and other incentives to support effective health and wellness programs that reduce illness and injury, and implement mechanisms to reward individuals for healthy behaviours. Continue to discourage risky behaviours through taxation of junk foods and cigarettes, for example.
- Use the policy options available to the federal government through employment insurance and tax programs to enable Canadians to be home to provide care to seriously ill family members without risking their jobs, homes and incomes.
- Re-invest in nursing science to address gaps in knowledge and expertise (generation, dissemination and application) related to the impacts of nurses on health care, health outcomes and health systems. Implement and increase enrolment in programs to educate more advanced practice nurses (nurse practitioners, clinical nurse specialists) to improve access to the full range of primary health care services for all Canadians.
- Address and resolve the wage disparity for registered nurses working in the home care sector and in sectors outside acute care hospitals.

[1] This recommendation is supported by a collaborative comprising the Canadian Healthcare Association, the Canadian Home Care Association, the Canadian Nurses Association, the College of Family Physicians of Canada and VON Canada.

Reducing the vulnerabilities of people requiring mental health care, seniors, and people requiring end-of-life care

Although treating illness will always be a priority of the health system, health promotion and disease prevention are essential to the health and well-being of Canadians. Those activities take place where they should: in our communities. Our current primary care system is not working as well as it needs to because it is based on having a single health-care provider treat illnesses. We need a vibrant primary health-care system with teams of professionals – nurses, physicians, pharmacists, dietitians, psychologists, physiotherapists and others – working closely together to care for people at all stages of life to not only treat illness, but to also prevent illness, promote wellness and ensure that supports are available to the vulnerable populations in their communities. Lack of investment in a comprehensive system of cost-effective and satisfying home and community care services to meet the needs of an aging population has an impact on access to care and, ultimately, the overall quality of health services Canadians receive.

Three areas in which investments would benefit vulnerable Canadians and reduce pressure on acute care merit particular attention by governments because they are amenable to high-level leadership and policy intervention:

- mental health care
- vulnerable seniors
- end-of-life care

Mental health care

Mental health issues affect Canadians of all ages and income levels. Mental health problems can become significant and chronic health conditions, and one in five Canadians will be affected by them at some point in their lifetime.

An Ontario government report points out that in total (including lost productivity, law enforcement, disability claims, drug costs and employee assistance claims), mental health and addictions cost Ontario at least $39 billion per year (Ontario Ministry of Health and Long-Term Care, 2009). "Every $1 dollar spent on mental health and addictions saves $7 in health costs and $30 in lost productivity and social costs" (Ontario Ministry of Health and Long-Term Care, 2009, p. 16).

If we are to control the tremendous personal costs to individuals, families and communities and to rein in the impacts on the public purse, the importance of strategic investment in mental health and addictions services cannot be overstated. Furthermore, secure funding is needed to educate all health-care professionals in mental health and addictions to promote early screening, assessment, early recognition and diagnosis and immediate intervention.

As with physical health problems, care and treatment of mental and emotional illness must be about more than acute, hospital care. The Senate of Canada noted that dealing with mental health illnesses often requires the assistance of psychiatrists and psychologists (Standing Senate Committee on Social Affairs, Science and Technology, 2006). However, there are long waits for psychiatric care, and this care often focuses on drug therapy. Provincial health plans cover only care by psychiatrists, leaving Canadians to struggle to bear the full costs of the therapeutic psychological services they may require. In practice, this puts necessary care beyond the reach of many Canadians.

Seniors' mental health. The rates of certain mental health conditions among seniors are particularly alarming. The Canadian Association of Retired Persons cites a Canadian Mental Health Association report finding that mental health problems (ranging from depression, addictions and anxiety, to various forms and degrees of dementia), affect between 17% and 30% of older adults, and if sub-clinical depression and anxiety are added, estimates rise to 40% (CARP, 2010b). Those over 65 years of age have the highest rates of hospitalization for anxiety disorders and are impacted more significantly than younger people by delirium complications – as high as 50 per cent of the time – after surgery. Suicide rates are high among men over the age of 80. The Canadian Coalition for Seniors' Mental Health (2008) states that at least *a million* Canadian seniors currently are living with a mental illness.

Recommendations: Mental health care

6. The federal government should work with its provincial/territorial counterparts and the Mental Health Commission of Canada to invest in an integrated strategy to provide comprehensive care for all Canadians experiencing and affected by mental illness.
7. The federal government should, as part of this strategy, develop and evaluate innovative and more seamless interprofessional models of mental health care that are sensitive to the unique lives and realities of these highly vulnerable Canadians.
8. To help realize this goal, the federal government should maintain its investment in the Mental Health Commission of Canada and direct the commission to accelerate work on access to mental health services, including insured access to psychologists, therapists and other appropriate providers.

Maintaining and improving the health of older Canadians requires a re-imagination of health-care services – a generational vision shared by governments, health systems and the public.

Vulnerable seniors

In a society that places increasing value and emphasis on youth and vigour, there is arguably no group more vulnerable than our oldest, often most frail, fellow Canadians. There are a lot of them, and the country's well-known demographics mean there will be a lot more of them in the near future. They have special social and health needs that, when met, can help to keep most of them healthy, active and in their homes until the ends of their lives. However, those services need to be planned and implemented in a pan-Canadian way, which requires the broad leadership and capacity that only rests with the federal government.

Registered nurses and advanced practice nurses have the necessary leadership skills, clinical knowledge and abilities to address the issue of the aging population: they have particular strengths in addressing the unique needs of the individual and coordinating the efforts of the interdisciplinary team. Geriatrics has grown from interdisciplinary roots, and there is a wealth of knowledge and skill that can be tapped to optimize the provision of efficient, appropriate and effective services.

Dementia. Seniors are the group of Canadians most burdened with dementia. According to the Alzheimer Society of Canada (2009), there were nearly 104,000 new dementia cases in Canada in 2008. If current trends continue, that number will rise to nearly 258,000 new cases in 2038, amounting to one new case diagnosed every two minutes. That means 1,125,200 Canadians (2.8 per cent of the population) are expected to be living with dementia in less than 30 years from now.

Of course, that burden of illness comes with costs. Currently, some 231 million hours of care are provided annually by informal caregivers, such as families, to Canadians with dementia. That number will rise to some 756 million in 2038. The economic cost is staggering – somewhere in the range of $15 billion in 2008, rising to $153 billion in 2038. By 2038, the cumulative incidence of dementia will be more than 5.5 million Canadians, with a cumulative economic cost of $872 billion (Alzheimer Society of Canada, 2009).

The Alzheimer Society of Canada (2009) recognizes the need to "turn the tide" of dementia. It recommends evidence-based interventions in the areas of increased physical activity, delayed onset of dementia, caregiver training and support, and system navigation that could reduce the economic burden over the coming generation. Mental health challenges and dementia are life conditions, often chronic, with far-reaching impacts on families, friends and society. They do not need to be further medicalized; rather they bring challenges that need to be managed. Both are areas where Canada's nurses can intervene to provide cost-effective, high-quality care to individuals, families and communities over the long term.

Day care providers are required to maintain a ratio of one worker for every five children. Such stringent regulations are not present at the old-age end of the continuum, resulting in questions about quality of care in many long-term care facilities. In long-term care facilities with patients with complex dementia and Alzheimer's disease, the ratio can be one worker for every 12 patients. We must work together to place a higher value on the quality of care and safety of these most vulnerable citizens by providing the right kinds and numbers of staff to care for them and by paying those providers appropriately.

Nurse practitioners…

- possess the kinds of clinical leadership, expertise and authority necessary to help manage the needs of individuals across the continuum of care, including the assessment, management and evaluation of pain in long-term care residents (Hadjistavropoulos et al., 2009).
- can alleviate some of the acute care burden if their scopes of practice allowed admission, discharge and follow-up of patients between institutions and communities/homes.

Pain. Pain in older adults is both under-diagnosed and undermanaged in long-term care environments in Canada, particularly for seniors who are afflicted with cognitive impairment, such as dementia or Alzheimer's disease. Approximately 25 per cent to 65 per cent of community dwelling seniors, and up to 80 per cent of older adults living in long-term care facilities, are estimated to live with pain (Gibson, 2003). Prevalent pain-related conditions in older adults include myriad musculoskeletal conditions, degenerative spine conditions, arthritic conditions, neuropathic pain (e.g., post-stroke pain syndromes, post-herpetic neuralgia, painful peripheral diabetic neuropathy, ischemic neuropathy and other idiopathic, painful neuropathies) and cancer pain (Pickering, 2005).

Elder abuse. Abuse of older adults is an issue of growing importance and concern in Canada. Defined as any action by someone in a relationship of trust that results in harm or distress to an older person, commonly recognized types of elder abuse include physical, psychological or financial abuse, neglect, and denial of entitlement protected by law (Government of Canada, 2009). It is expected that because of the increasing age of the population, there will be an increase in the number of seniors at risk. Supports must be put in place to increase awareness of elder abuse, improve laws and

regulations to protect older persons, and improve interventions and preventions available to caregivers and families. Recent investments by federal and provincial governments to improve such resources are promising, but the distribution of these valuable resources must be accelerated to ensure they reach those most at risk for elder abuse.

Recommendations: Care for vulnerable seniors

9. The federal government should adopt a strategy to deal with its aging population. The government should act on its opportunity to lead the Organisation for Economic Co-operation and Development by developing a national strategy on aging and health with the broad theme of aging in place – from infancy to old age. The strategy should support human health by addressing the broad range of health determinants through comprehensive primary health care and by reducing the demands on the acute (and pricey) side of the health system for generations to come.
10. The federal government should work with its provincial/territorial counterparts to provide financial support for family members and friends who participate in the care of their loved ones to lessen the burden on these informal caregivers. Placing an emphasis on patient-and family-centred approaches to caring for persons with dementia or palliative conditions and others who wish to die in their own homes will ease the growing demand for acute services across the continuum of care and throughout the Canadian health-care system.
11. The federal government should target funding to support the implementation of multidisciplinary geriatric teams working in long-term care settings across Canada.

Thinking in new ways about aging in Canada…

CNA joins the Canadian Association of Retired Persons (CARP) in its call for a new vision of aging and health that includes:

- "equitable and timely access to high quality health care that is linguistically and culturally appropriate;
- uniform and affordable access to medicines and medical devices;
- equitable and timely access to aging at home options;
- adequate support and legal rights for caregivers; and
- easy access to dependable information and resources for healthy living" (CARP, 2010a).

End-of-life care

CNA's position is that "Most individuals desire an end-of-life experience that is peaceful and dignified and in which they are able to exercise their own autonomy and remain in control to the greatest extent possible. Many individuals are concerned that if they become incapable, they might receive treatments they would not have chosen when capable. There is considerable research that suggests there is significant room for improvement to be made in the provision of end-of-life care to all age groups in Canada. Indicators of inadequate end-of-life care include admissions to intensive care units, emergency department visits, insufficient symptom relief (particularly of dyspnea and pain), limited availability of home health services, limited access to palliative care services and lack of continuity of care" (Canadian Nurses Association [CNA], 2008, pp. 4-5).

The vast majority of the 220,000 Canadians who die each year, principally of old age and progressive ill health, do not have access to specialized hospice or palliative care services. This is because hospice and palliative care capacity is unevenly distributed, across geographic regions and sectors or

programs, for example. In fact, most dying Canadians are at risk of receiving minimal or inappropriate end-of-life care (Wilson et al., 2008).

In its position statement on end of life care, CNA notes that "As the number of elderly people increases and medical interventions become more advanced, more people are experiencing lengthier periods of chronic illness" (CNA, 2008, p. 4). Improvements in neonatal care have increased survival rates for infants. Seventy per cent of people are likely to face a decision around withholding and/or withdrawing life-sustaining treatment at some point in their lives (Kelly, 1995; Matzo, 1997). These decisions must be supported by impartial, informative discussions with the health-care team.

End-of-life situations are not limited to elderly people or to people with cancer. These situations can be encountered by individuals of all ages, including infants and children, and in relation to a broad spectrum of medical conditions. Nor are these situations confined to palliative care units: people at the end of life can be found throughout the health-care system, in acute and long-term care facilities, emergency departments and intensive care units, as well as in their homes, in residential hospices, in shelters or on the street. As Wilson and colleagues (2009) have noted, the places where death happens is changing around the world.

Palliative care is optimized when it is provided by a team in which each member has a role that meets a particular need of the client.

Advanced nursing practice. Federal legislation allowing health-care providers other than physicians to prescribe controlled substances (e.g., narcotics) was passed in 1996 – 14 years ago. The regulations have been in development since that time, with incredible delays. Every year, CNA hears from provincial and territorial regulatory bodies that nurse practitioners could bring more palliative services to people at home and in long-term facilities if these regulations were finalized and enacted. The federal government has not been able to complete this work. A person receiving care from a nurse practitioner still cannot have a prescription for pain relief adjusted without waiting for or going to see a physician. Collaborative, patient-centred care in this case is being hampered by a federal failure to complete the required processes.

As stewards of the health of Canadians, federal policy-makers have an opportunity and obligation to strengthen end-of-life care by putting in place resources to improve its quality, develop the range of required services, work with provincial/territorial counterparts and health professionals to ensure that care is provided when and where it is needed, and respond to societal and technological changes and challenges by investing in innovations, research and education.

Recommendations: End-of-life care

12. The federal government should implement universal standards for provision of safe, compassionate, competent and ethical end-of-life care, regardless of setting, and ensure access to a broad range of basic and advanced end-of-life services and coordinated care.
13. The federal government should remove federal barriers that prevent nurse practitioners and other health professionals from practising to their full scope (e.g., prescribing narcotics for pain management, discharging patients to appropriate care and developing treatment plans).
14. The federal government should promote supports that will allow all health-care providers to attain their full scope of practice.

15. The federal government should work with provinces, territories and associations to implement best practices and models of end-of-life care that include appropriate interprofessional collaboration, health professionals working to their full scope of practice, and patient access to the right provider at the right time. Palliative care is optimized when it is provided by a team in which each member has a role that meets a particular need of the client.
16. The federal government should invest in technology and innovation that will improve care and efficiency.
17. The federal government should support research and education that will maximize interprofessional collaboration, health outcomes and quality of care.
18. The federal government should develop and support the capacity for nurse leadership in the continuum of care for palliative and compassionate care. It should support interprofessional practice and encourage appropriate staff mixes, with all providers working to their full scope of practice and offering access to a full spectrum of services.

Summary

Over the next decade we will be part of a health system undergoing massive change – both because of issues we're facing now and others that we can't foresee. We need to adjust to the changes thrust upon us by the realities of an aging population, the society and environment within which we live, and the need for a more efficient and affordable health-care system. But we can also make change happen thanks to the evidence we have in-hand; we have the opportunity to invest in change that reflects innovation, new knowledge, new technology and new ways of thinking.

That, at its core, is what nurses are asking you to do: to look at health care in new and different ways – to see the big picture and understand that health care will be delivered in Canadians' homes and community clinics as much as it is in hospitals and doctors' offices; that federal leadership is crucial to the transformational change our health system needs; and that listening to nurses – the health-care providers who spend more face time with Canadians than any other – is a crucial step toward finding the solutions.

The nurses of Canada know that our medicare system certainly is sustainable. But we can and must make it more vibrant, more cost-effective and more efficient without giving up our ability to provide safe, compassionate, competent and ethical care. It is the foundation upon which so many of our values are built and upon which our most vulnerable citizens rely so heavily. We ask you to share in our vision and to let us help you revitalize the system.

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