

# Better Health, Better Care, Better Value: National Expert Commission, Part 1

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## Abstract

Since about the midway point of the First Ministers' 10-year plan to strengthen healthcare, its impending expiry in 2014 has prompted the leading health professions to consider "what comes next," how to influence that decision and then, how best to position their messages in the politics of whatever might emerge. The Canadian Nurses Association (CNA), which has a century-long history of engagement in health policy, was no exception.

**Beginning in 2009, CNA's** board of directors began a long deliberation about what nurses believed should follow "the Accord" (as we've come to know it). What funding structures and/or agreements would be best for the health of Canadians? What would strengthen healthcare? And in whatever strategy was chosen by governments, what would be the most effective mechanism(s) to bring nursing science and practice into the policy dialogue in forceful, credible ways?

## Re-casting nurses as actors in the policy game

In whatever CNA chose to do around the 2014 issue, its leaders knew that two underlying goals were important for nursing. First, the board believed that nurses had to approach and engage in any set of negotiations about the health system fortified with knowledge, evidence and importantly, a clear and integrated story about population health, healthcare, economics and nursing. Secondly, CNA

knew that to be successful in the big leagues of policy, nursing had to be strategic, focused and pragmatic.

What did CNA mean by this? We have all heard examples given by nurses where the story, while emotionally compelling, may not be entirely true – in fact many of us, with the best of intentions, have said these things ourselves as leaders:

- “Home care is cheaper.”
- “Nurse practitioners cost less than doctors.”
- “ER wait times are over the top because everyone uses the ER instead of going to their family doctor.”

Well, maybe – but maybe not. For example, home support for seniors may be cheaper than admitting them to long-term care. But, is sending a nurse to a home setting to do a surgical dressing cheaper than having the patient drive himself to a clinic for that care (if one existed)? Likely not. Do nurse practitioners cost less than a physician? Maybe, in some cases. But maybe the real issue is that their care provides a better outcome for the same cost – as Gina Browne said to the National Expert Commission, “more effective, and no more expensive.”

These are small, and yet critical, differences in language and tone. One cannot expect to stroll into a national-level policy dialogue and be credibly received if one is not clear about the story, the evidence, the costs and the facts. Too many other people know them, and nurses have to have a clear story in their minds and on the tips of their tongues.

So the first underlying goal of CNA was to create the conditions that would generate information to enable nurses to speak with authority to policy decision-makers, other health professionals and the public.

And CNA knew that if it was successful in achieving this first aim, it would have done its due diligence to better position nursing for its second goal – which was to recast, at least in part, the ways nurses are perceived as actors in national-level policy decision-making. Despite the high trust accorded to nurses, we continue to run headlong into the age-old issue that governments, media and even the public often turn first to physicians for information and opinions – even when the issue at hand is about nursing practice.

In deliberations about this second aim, there was no covert, disrespectful tone towards medicine or anyone else. In fact, quite the opposite was the case, and CNA was deliberate in its efforts to further strengthen its relationship with the Canadian Medical Association, a relationship that is at a historic high. The inten-

tion was purely to put nurses and nursing in the best position to speak, and in turn to be consulted and spoken about, credibly in whatever policy negotiations might emerge around the expiry of the Accord.

### The National Expert Commission is born

The CNA board considered a number of potential responses and strategies – among them studies, task forces, consultations, reviews and conferences. But by 2010, CNA was homing in on the idea of launching a commission, which it believed would bring the structure, attention, prestige, integrity and focus needed to achieve its goals. The weight of and fiscal investment in a National Expert Commission (NEC) and its fallout also could, de facto, imply a change in direction of the course of policy and business for CNA, which would be left holding the ball in terms of responding to at least some of the recommendations of its own commission.

In all this, CNA was aware that, while it held the promise of laying down exciting new ideas and directions for nursing, for the health system, for Canadians and for CNA, launching a commission was a very high-stakes manoeuvre indeed. Risk was further exacerbated by the courageous decision to position the NEC as an arms-length, independent entity reporting to two external co-chairs – a non-nurse, Maureen McTeer, and a nurse, former CNA President Dr. Marlene Smadu. While they were charged to operate within a defined mandate and limits, and to produce a clearly identified set of deliverables, “independent” meant that the commissioners could have made recommendations challenging to CNA’s own values and policy directions, or with which its board simply did not agree.

With the assistance of the co-chairs beginning early in 2011, a group of esteemed Canadians was recruited to serve as commissioners and a small operational team was assembled. By the end of May 2011, the commissioners had met for the first time and the NEC was officially launched. A spectacularly high level of activity followed over the next year that included:

- in-person meetings of the NEC;
- extensive background research;
- consultations with the public across the country, brokered and led by MASS LBP and hosted by YMCA Canada;
- a national roundtable on Aboriginal health and healing, hosted by their Excellencies, Governor General and Mrs. Johnston, at Rideau Hall;
- individual and small group meetings with nurses and other health professionals, government officials, and business and academic leaders across Canada;
- online consultations;

- formal public opinion polling through the services of Nanos Research;
- a process to encourage and receive formal and informal written submissions from nurses and organizations across the country (including a formal brief from the Academy of Canadian Executive Nurses); and
- commissioning of three peer-reviewed research syntheses, managed by the Canadian Health Services Research Foundation.

During the NEC's tenure, the game changed when Prime Minister Stephen Harper announced, just before Christmas 2011, a decision not to enter into any negotiated, conditional fiscal agreement with the provinces when the 10-year plan expires in 2014. Rather, it was decided that the Canada Health Transfer would continue to increase by 6% annually until fiscal year 2016–2017, with no further conditions. After that, the transfer will be tied to GDP growth and again, with no further conditions. CNA was clear with the commissioners that this shift made no difference to the mandate and work of the NEC: unfolding population health needs, set against rising costs, have made it plain that a radical transformation of our views about health and healthcare is warranted regardless of federal–provincial fiscal transfers. In fact, the absence of conditional funding perhaps made the work of groups like the NEC even more urgent.

The NEC released its final report and a large menu of supporting documents and other resources in June 2012 in Vancouver. It featured a nine-point action plan, based in evidence that, as co-chair Maureen McTeer said clearly, was to be “doable, affordable, and ensure the sustainability of the public healthcare system.” The report was well received by participants at the CNA biennial convention in Vancouver, although some expressed disappointment because they had expected something more radical or “new.” Commissioners made plain that their mandate was to uncover evidence and innovations to inform recommendations that could improve population health, strengthen healthcare, optimize value for dollars invested, and maximize the roles and potential of registered nurses where appropriate. In all this they were to reach recommendations to support sustainability of the publicly funded, not-for-profit medicare system.

And so the commissioners offered an action plan in accordance with those conditions, noting that there is ample evidence – some of it going back 40 years – about the sorts of structures and services known to coincide with better health, better care and better value. On this evidence and from the lessons they heard across the country during 2011–2012, they wrote their report and based their recommendations.

Join us in the next issue for Part 2 of this column, where we will discuss reactions to the NEC's report and CNA's actions in response to its nine-point plan.