Briefing Note to Premier on the 2014 Health Accord

January 12, 2012

Mary Lee, President and CEO
Health Association Nova Scotia
2 Dartmouth Road
Bedford, N.S. B4A 2K7

HEALTH ASSOCIATION NOVA SCOTIA

LEADERSHIP. SERVICES. SUPPORT.

Briefing Note to the Premier on the 2014 Health Accord

Executive Summary:

In December, the Conservative government announced that the 6% escalator would be maintained until the 2016-17 fiscal year, after which transfers will be based on nominal GDP and will be guaranteed not to fall below 3%. The funding will also shift to a per capita model. This gives Health Association members concern, as the Atlantic region generally has an older and sicker population than the rest of the provinces, and therefore must spend more per capita in order to provide healthcare to their citizens.

The members of Health Association also believe that a per capita funding model rewards young, healthy and wealthy provinces. Health Association has been on the record for over a decade challenging the per capita funding methodology and advocating for a more balanced, Canada Health Act principled population health funding methodology.

Health Association Nova Scotia supports a pan-Canadian approach to health, while recognizing that the provinces and territories require flexibility in responding to their unique situations. It is essential that we determine the changes that we want to see, establish indicators, and regularly measure those indicators for progress. The effort to achieve change and success is cross jurisdictional and cross departmental. We must all be working collaboratively towards achieving the best health outcomes for all residents of Nova Scotia.

The following are the 4 priority areas for action:

1. Health Promotion, Primary and Community Care
2. Innovation & Effective Utilization of Resources
3. Quality & Accountability
4. Chronic Disease Management

Introduction:

Health Association Nova Scotia is a membership-driven association, representing health and community services organizations spanning the entire health continuum in Nova Scotia. Our members include the District Health Authorities and the IWK Health Centre, over 90 continuing care organizations, and other health related agencies. Collectively, our members represent over 2 billion in health care dollars and employ more than 30,000 individuals.

In December, the Conservative government announced that the 6% escalator would be maintained until the 2016-17 fiscal year, after which transfers will be based on nominal GDP and will be guaranteed not to fall below 3%. The funding will also shift to a per capita model, something the Atlantic Premiers have expressed concern over, as the Atlantic region generally has an older and sicker population than the rest of the provinces, and therefore must spend more per capita in order to provide healthcare to their citizens. Policy experts have also expressed concern that a per capita funding model will increase disparities between the provinces; the opposite intent of federal transfers.

The members of Health Association also believe that a per capita funding model rewards young, healthy and wealthy provinces. Health Association has been on the record for over a decade challenging the per capita funding methodology and advocating for a more balanced, Canada Health Act principled population health funding methodology. Albeit this may take time and expert resources to develop, we believe that the outcome in the long run is more beneficial and in line with the principles of accessible, equitable health care for all Canadians.

While the delivery of health services is a provincial and territorial responsibility, the federal government has traditionally used its constitutional spending power to assert the *Canada Health Act* and achieve pan-Canadian objectives for health. Health Association Nova Scotia supports this pan-Canadian approach, while recognizing that the provinces and territories require flexibility in responding to their unique situations.

Key Priority Areas:

1. Health Promotion, Primary and Community Care

Federal funds for health and social programs and tax reductions that will both reduce poverty and improve the health and social wellbeing of Canadians are needed even more during these challenging economic times. In a poll conducted by Ipsos Reid that was released on July 21, 2011, nine in ten respondents "agreed" that the federal government should play a leading role in the transformation of the health care system[1].

There are key areas which, if appropriately addressed, will contribute significantly to the sustainability and efficiency of our health system. Greater attention must be paid to the two

ends of the spectrum: *wellness* and *continuing care*. While not neglecting the ongoing importance of acute care, critical decisions must be made around prevention/promotion and continuing care services to lessen the pressures on the acute care sector.

Now is the time to reorient the allocation of resources to support population health and primary health care. Not only does a health promotion and disease prevention strategy make sense from a health perspective, the evidence regarding its potential to help address fiscal sustainability is mounting. Such a strategy is also very much in line with the Council of the Federation's July 2011 declaration, in which disease prevention and health promotion were highlighted as essential means to improve the health of Canadians.

The 2008 *Canadian Population Health Initiative* report by the Canadian Institute for Health Information demonstrated that the inequalities in social economic status (SES) of Canadians were directly linked to health care costs. According to this report, there were significant variances in hospitalization rates between low-, average-, and high-SES of people living in urban centers across Canada. The indicators examined resulted in statistically significant information. For example, hospitalization rates resulting from mental health issues were the highest among those with a low SES, whereas hospitalizations decreased among those with average and high SES[2]. For injuries, the hospitalization rates were extraordinarily similar.

The recent emergence of H1N1 influenza, the re-emergence of other diseases such as measles and mumps, and the growing burden of chronic diseases, have served as reminders that public health services and infrastructure have an important role to play in ensuring the collective health of Canadians. For example, the findings of a recent study published in the July 2011 edition of *The Lancet* demonstrate that healthy living can help prevent Alzheimer's disease. The study shows that in the United States, inactivity is the leading problem because a third of the population is sedentary[3]. Alzheimer's cases are expected to triple worldwide by 2050, to around 106 million people. The study identifies the modifiable risk factors including smoking, depression, low education, diabetes, too little exercise, obesity and high blood pressure. Health promotion and prevention initiatives can help reduce these risk factors by as much as 25%[4].

In Canada, the estimated economic burden of physical inactivity on a per capita basis was $300; for obesity $343; tobacco use $341; and alcohol $223. Moreover, the most costly chronic disease is mental health disorders, with an estimated per capita cost of $1,056 or $34 Billion in direct and indirect costs in 2003[5]. Enhancing the current use of innovative facilities (e.g. community-based clinics) that help bring appropriate care to Canadians will not only result in improving access to information and care, but would also be designed to accommodate the advanced treatment and services that help get people home safer and faster[6]. Preventable chronic diseases and illnesses impose a heavy social and economic burden on Canadians (e.g. health care expenditures; disability pensions; lost productivity; etc). In 2005, the World Health Organization estimated that within the next 10 years, Canada would lose $500 Million in national income from premature deaths due to heart disease, stroke and diabetes[7]. As both direct and indirect costs of chronic disease are

significant, an effective prevention approach can indeed minimize the economic and social burden to the health of society as a whole[8].

The health of mothers and children is essential to a healthy society. We simply cannot sustain an adult health system if the "inputs" – the children – enter adulthood as unhealthy or compromised in their growth and development. Recent studies have shown that young Canadians are more obese, sicker and weaker than ever before. More than 25 percent of Canadian children are considered overweight – but that number is closer to one in three in Nova Scotia. Almost thirty percent of children in Nova Scotia enter school with either a physical or psychological vulnerability – already predetermining an unhealthy future. Early childhood intervention, wellness programs, and health and safety support and education for families are critically needed to ensure a healthy next generation, and a sustainable system.

Pan-Canadian strategies must be developed that will affect the health and well-being of Canadians. These include, but are not limited to, the renewal of the National Immunization Strategy, continued support for a national mental health strategy, a Federal Tobacco Control Strategy, a national Sodium Reduction Strategy, and national strategies related to poverty reduction, housing, transportation, water supply and other social determinants of health which require a coordinated, pan-Canadian response.

We must also attend to the realities of the growing portion of our population that requires dignified and respectful care, including palliative care in the home, or long term care environments. Canada's demographic is changing and we have not used our resources effectively to address the needs that these changes bring. The health system urgently needs the appropriate use and funding of home care and facility-based long term care. This is essential for both the sustainability of the health system and to respond to the health requirements of the aging population.

2. Innovation & Effective Utilization of Resources

What is needed is an integrated, Canada-wide leadership and innovation strategy. Such a strategy presents an opportunity for strategic federal leadership around agreed upon, specific efficiency and effectiveness indicators. The Federal Government can assume the role of enabler, not unlike the pivotal role it played with the establishment of the Mental Health Commission of Canada. In doing so, it can facilitate the development of an *inter-provincial strategy* to coordinate the improvement of healthcare *quality* and system *performance*.

A high-level, health leadership and innovation agenda for Canada, focused on health system quality, access and overall performance, would be federally enabled but be owned and

implemented by the provinces and territories. It would restore Canada to the status of international top performer in the areas of:

1. Population outcomes,
2. Improved patient care and experience, and
3. Sustainable costs *and* value for money.

The innovation strategy would encourage the sharing of best-practices in quality improvement and patient safety *and* identify the most meaningful approaches to quality measurement.

We know that there is scope for improvement in the cost-effectiveness of Canada's healthcare systems and that improving how health funding is spent is the way to achieve better value *and* outcomes. The Organization for Economic Cooperation and Development (OECD) has observed that "one of the most important developments in health care over the past decade has been a popular awakening to problems of quality... there is a large and expanding bank of evidence of serious shortcomings in quality that result in unnecessary deaths, disability, and poor health, and that add to costs.[9]" Quality and cost effectiveness go hand in hand.

Aging infrastructure and equipment demands on all health care facilities in all provinces are a major challenge. Quality and innovative care can be directly associated with supporting the acquisition and maintenance of new equipment. This could once again be a federal role for government. Maintaining or replacing aging infrastructure so that the demands of today's health needs can be met in an innovative and efficient way will also lead to quality care.

3. Quality & Accountability

In the last decade there has been a good deal of activity focused on health system quality in Canada, with the creation of a number of provincial arms-length organizations. To date, there is no pan-Canadian forum to coordinate such activity or to foster the sharing of experiences and success. A new *Health Quality Collaboration* would provide the provinces with a forum to encourage the spread of innovation and the uptake of best practices. The Health Quality Collaboration would have four core functions:

1. A mechanism for enhanced accountability
2. A knowledge translation hub and clearing house
3. A convener and knowledge broker
4. A vehicle to spread best practices

Building on the acknowledged successes of key initiatives such as patient wait times agreements – and the federal-provincial cooperation that produced them – the Collaboration would be enabled by the Federal Government with multiple-year funding, drawn from existing and newly allocated money, but it would be owned and directed by the

provinces[10]. Funds would not limit provincial and territorial discretion and autonomy but *enable change*.

To promote an agenda of quality and performance improvement, the Collaboration would facilitate performance measurement using a set of meaningful, comparable quality indicators *for the whole health system*, including: primary care, public health, acute care, mental health and continuing care. These indicators would create an accountability structure through which provinces can close gaps and reduce variations in practices, care and outcomes. The collaboration would ensure the public disclosure of meaningful information. The steady flow of timely, comprehensive, and accurate information would, in turn, facilitate more accountable, efficient, and transparent decision-making.

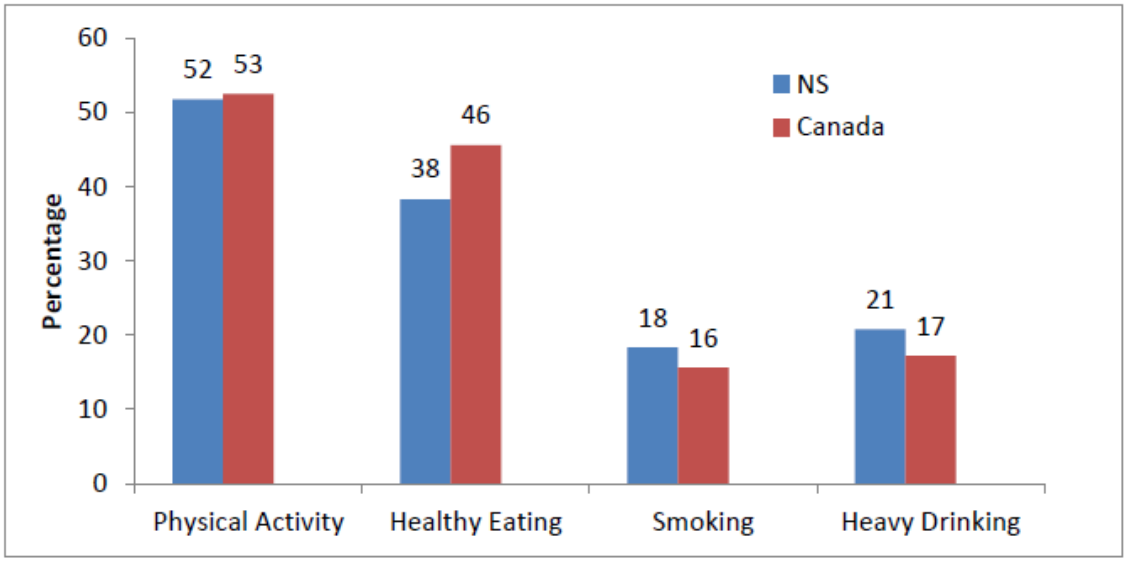
A set of mutually agreed upon core indicators would enable benchmarking within Canada and internationally. Experience demonstrates that the mutual observation facilitated by such indicators can highlight effective practices and the circumstance in which they work. The Collaboration, supported by an *Innovation Fund*, will, by bringing experience, evidence and new ideas together, help policy makers and system managers meet their quality and performance improvement challenges. Best practices developed in Canada can, in turn, become models for the rest of the world.

4. Chronic Disease Management

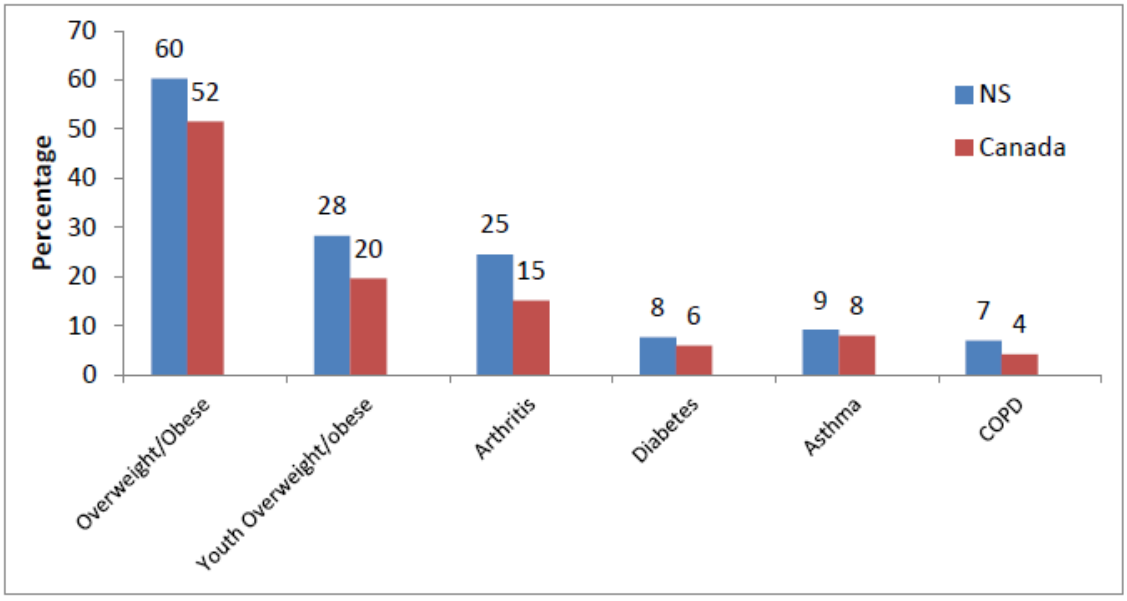
A significant proportion of chronic disease and general poor health can be attributed to *modifiable* risk factors such as inadequate nutrition/poor eating habits and physical inactivity. Chronic disease poses a huge burden to the health system and society as a whole through direct medical costs, lost productivity and premature death. While genetics and other factors play a role, much of this burden can be reduced through the adoption of a healthy lifestyle. Understanding the barriers and ways to best support healthy eating and active living across the lifespan and in all environments – homes/where people reside, schools, communities, and workplaces – will help to reduce the impact of chronic disease on the population and the burden of care on the health system.

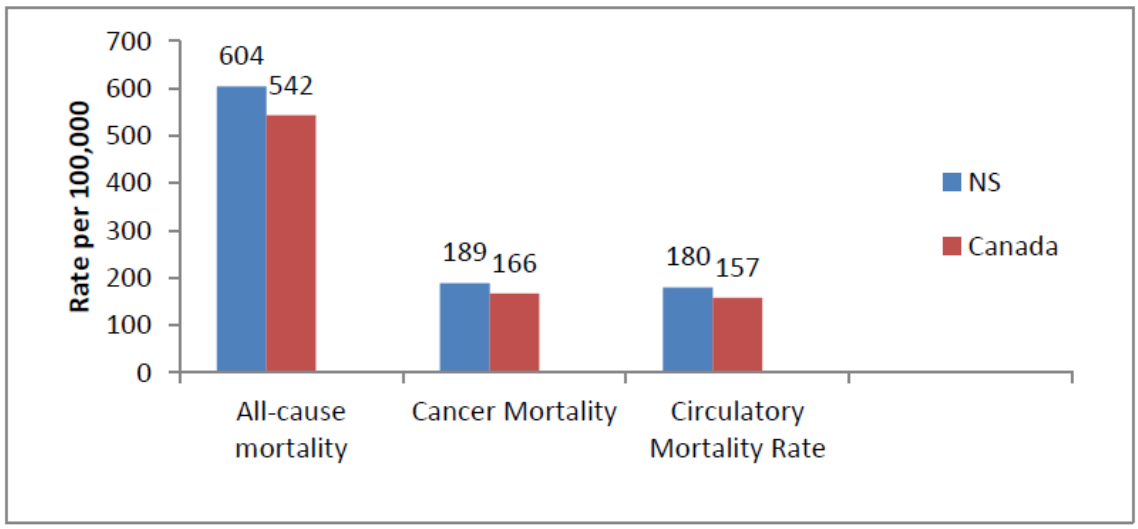
Chronic disease accounts for nearly three quarters of deaths. In 2002, the economic burden of chronic disease was estimated to exceed $93 billion. It is estimated that 25% of all direct medical costs are attributable to a small number of risk factors such as smoking, obesity, physical inactivity, and poor nutrition.

- ***Nova Scotians do not have healthy <u>lifestyles</u>…***



- ***Not surprisingly Nova Scotians also have higher rates of chronic disease…***





(as per CIHI 2010 data)

Lifestyle factors impact the well-being of individuals across the entire lifespan, from birth to death. Chronic disease impacts the health system across the entire continuum, from primary, to acute to continuing care. Healthy lifestyles are attributable to not only *individual* behavior's but other factors outside the sphere of influence of individuals. A population health approach identifies 12 social determinants of health or factors which influence health. Creating supportive climates which encourage and enable individuals to pursue healthy lifestyle choices (and do not actively discourage them from doing so) are the focus of efforts to improve population health.

References

1 Ipsos Reid. (2011). Gap Between Perceived Level of Importance and Rating of Performance Suggests Ample Room for Improvement in the Eyes of Canadians. July 21, 2011.
Available at: http://www.ipsosna.com/news-polls/pressrelease.aspx?id=5293

2 Canadian Institute for Health Information. (2008). Reducing *Gaps in Health: A Focus on Socio-Economic Status in Urban Canada*. Ottawa: ON.: CIHI

3 Barnes, D. and Yaffe, K. (2011). The projected effect of risk factor reduction on Alzheimer's disease prevalence. *The Lancet*. Early online publication.
Available at: http://www.thelancet.com/journals/laneur/article/PIIS1474-4422%2811%2970072-2/fulltext#

4 Barnes, D. and Yaffe, K. (2011). The projected effect of risk factor reduction on Alzheimer's disease prevalence. *The Lancet*. Early online publication. Available at:
http://www.thelancet.com/journals/laneur/article/PIIS1474-4422%2811%2970072-2/fulltext#

5 Patra, J., Popova, S. et al. (2007). *Economic Cost of Chronic Disease in Canada 1995 – 2003.* Ontario Chronic Disease Prevention Alliance.
Available at: http://www.ocdpa.on.ca/OCDPA/docs/OCDPA_EconomicCosts.pdf

6 Health Council of Canada. (2005). *Healthcare Renewal in Canada: Accelerating Change*. Toronto, ON: Author

7 World Health Organization. (20050. Preventing Chronic Diseases A Vital Investment. *WHO Global Report.*
Available at: http://www.who.int/chp/chronic_disease_report/en/)

8 Patra, J., Popova, S. et al. (2007). *Economic Cost of Chronic Disease in Canada 1995 – 2003.* Ontario Chronic Disease Prevention Alliance.
Available at: http://www.ocdpa.on.ca/OCDPA/docs/OCDPA_EconomicCosts.pdf

9 See recent reports from the Commonwealth Fund and the OECD

10 The precise nature of the Collaboration model will need to be agreed upon: whether it will be a new entity, for example, or an amalgamation of existing entities, but it should be an interprovincial agency operating at arm's length from the federal level. The federal government has sponsored and/or established agencies such as the Canadian Patient Safety Institute (CPSI), Canada Health Infoway (CHI), Canadian Institute for Health Information (CIHI), Canadian Agency for Drugs and Technologies in Health (CADTH), and the Health Council of Canada (HCC). These agencies support health intelligence, performance reporting and knowledge transfer.