



Speaking Notes

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Department of Health and Wellness

Canadian Academy of Health Sciences
Smarter Caring for a Healthier Canada: Embracing System
Innovation

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(Slide1)

I'd like to thank the board for inviting me here today. I appreciate the chance to share what's happening "on the ground."

As deputy minister you might think I see from only a "bird's eye". Yet every day, there are many decisions that need to be made "on the ground" – decisions that could affect someone you know, a neighbour or a family member.

To make these decisions, we need proven scientific research, clinical results, and evidence to help us get it right.

We need guidance and information from experts and organizations like the academy and from those who work throughout the system...

and from people like me, who receive thousands of phone calls and letters about what is happening in the health system and in communities.

As Dr. Whiteside has said, this is not just another debate on sustainability. We will explore the impact of "disruptive innovations" – some of which have been proven by experience to work.

I have a Nova Scotia story to tell you, about an innovation that seems to be working.

But before I do, I'd like to offer up these caveats, from the American Economist Tsung-Mei Cheng on the Universal Laws of Health Care Systems:

- No matter how good the health care in a particular country, people will complain about it.
- No matter how much money is spent on health care, the doctors and hospitals will argue it is not enough.
- The last reform always failed.

I certainly hope that what we are doing in Nova Scotia through government's Better Care Sooner plan will disprove Mr. Cheng's last universal law!

(slide 2)

We cannot have an informed conversation about sustainability without looking at the financial picture of the health system.

My example is Nova Scotia. However, rising costs and declining revenues are a challenge for all governments.

For many jurisdictions the costs have doubled in the last decade. This source is the CIHI NHEX database (2010 is forecast) on per capita spending.

Canadian Doctors for Medicare in its paper, *The Myth of Health Care Unsustainability* sites pharmaceuticals and prescribed drugs, public health and dental care as some of the key cost drivers.

The article says that “the change in the share of provincial budgets, however, is not primarily due to increased health care spending. It is the result of decreases in other provincial spending to accommodate political decisions to cut taxes.”

It goes on to say that deep cuts in federal transfers to the provinces in the mid-1990s were compounded by provincial tax cutting policies ... later in the decade, leading to large reductions in total provincial budgets.

Well, we've been living that for some time.

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Today, Nova Scotia devotes a higher percentage of its provincial income to health spending. And this has grown in the last few years.

(slide 4)

Revenue growth is declining at a greater rate than health spending.

(slide 5)

Health is continuing to take up more and more

of the provincial budget. It is now at 45.2% of the entire budget.

We are working to get the province's books back to balance so that we can afford the services people need. That requires us to shift resources from administrative costs -- which have gone down in this year's health authority and IWK business plans -- and redirect revenue into patient care.

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When you look at this graph, you see the Department of Health and Wellness Estimates on Growth over 5 Years in millions of dollars. You can see our efforts this year to stem that growth.

But is it sustainable?

I was told that people remember lists.

So I'd now like to share with you my own 13 universal laws on health care systems...

formed from years of experience, planning, building and running a community health service, as a former health authority CEO, as a leader in human resources at the province's largest hospital, and today, as Deputy Minister of Health and Wellness.

Here they are, in no particular order.

Number 1: I don't know the key to success, but the key to failure is to try to please everyone.

(eg. generic drug costs and pharmacists)

Number 2: The risk of doing nothing is greater than the risk of doing something. Or you could say it this way, the cost of doing nothing is greater than the cost of doing something.

I am not just talking about financial cost.

There is a tragic human cost to not addressing, for instance, overzealous prescribing.

We are seeing the heartbreak from this practice in some of our communities concerning opiates.

We need to establish standards and guidelines that will stop this.

Number 3: If we do not change the way we pay for health, it will not be possible to go from paying for volume – which entails more money – to paying for results.

The volume of the need is increasing.

In Nova Scotia, we have some of the highest rates of cancer and chronic disease in Canada.

We have an aging population that requires more complex services and treatment.

Only half of Nova Scotians report being physically active on a regular basis -- more than half are overweight or obese.

We have some serious health disparities.

Evidence shows that despite higher overall use of health services, people in lower socioeconomic status groups are the least healthy in the population.

So how can we get results? (eg.?)

Number 4: We may not have all of the resources that we want, but we can use better the resources that we have.

Number 5: We need to stop doing some things -- the procedures, tests or therapies that, though commonly used, do not alter patient outcomes (knee scopes, heart tests for cataract patients).

Dr. Steve Morgan of the UBC Centre for Health Services and Policy Research, says the real threat to the sustainability of health care is rising acute-care costs and more reliance on specialists and diagnostic tests – rather than simply the needs of an aging population.

Dr. Morgan told the Vancouver Sun that “The trends that drove health system costs in Canada were the result of factors within the control of policy makers and professionals, such as fees paid for services provided.

He says that “the health care system is as sustainable as we want it to be.”

Number 6: Our biggest resisters to change are stakeholders (physicians, unions)

Number 7: No matter what change we make in health care, it affects the income of someone.
(pharmacists and pharmacy assistants, CAs and nurses, NPs and physicians, paramedics and RNs)

Number 8: Provinces have to stop out-bidding one another for health care providers.

That's more of a wish than a universal law.

We do need to improve the quality of health workplaces and work-life balance to improve health services.
That will help us recruit and retain qualified people to fill vacant positions, especially in rural and remote areas.

We need to align human resources with the health needs of the population and ensure optimal workforce deployment – skill mix, scope of practice models of care, etc.

Number 9: You can't create a change in the system by just declaring a vision for it.
The system must be designed for specific outcomes. (emergency room standards, chronic disease targets)

Number 10: Accountability -- we need evidence to show that we are and have been accountable and responsible in our use of public money and federal money -- as we approach negotiations for future federal funds for improving health care. (other examples?)

Number 11: We can no longer afford to wait.
If we fail to act until we have the perfect solution,
it will be too late.

Number 12: We have to stop investing in buildings and start investing in care in the community.

Here's a Nova Scotia story that puts into action all of these universal laws....

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Annie Chagnon's 11-month-old daughter was running a high fever. So she took the tiny girl to a new place in the small town of Parrsboro – the South Cumberland Collaborative Emergency Centre.

The baby was immediately assessed by paramedics and nurses on site, who recommended a plan that provided the best treatment.

Anyone who has children knows that when their little one is sick, you want answers right away. Annie said that without the collaborative emergency centre she may have waited hours to see a doctor and by then her daughter's condition could have worsened.

The South Cumberland Collaborative Emergency Centre is the first of its kind in Canada and is a key commitment under the province's Better Care Sooner plan.

Within weeks of opening, nearly a thousand people – like Annie and her baby – have had shorter waits and received expert 24/7 emergency care from highly trained doctors, nurses and paramedics.

Patients can now get the appropriate treatment before a minor health issue turns into a health crisis.

The services at the CEC in Parrsboro include:

- access to primary health care by a team of professionals, including doctors and nurse practitioners, between 8:30 a.m. and 8:30 p.m., seven days per week
- same-day or next-day access to medical appointments
- 24/7 access to emergency care.

Emergency room problems -- long waits, overcrowding and unplanned closures -- have plagued Nova Scotia's health care system for years.

Collaborative emergency centres are helping us address these issues -- by keeping emergency rooms open, reducing patient wait times and by providing a team-based approach with continuity of care.

We brought emergency departments and local family practices together.

During the day, doctors are available at the collaborative emergency centre to treat patients. Between 8:30 p.m. and 8:30 a.m., an advanced care paramedic, teamed with a registered nurse, staffs the centre to ensure patients get the care they need.

An Emergency Health Services oversight physician provides assistance by phone.

The health authority CEO has told us that the new model is working very well. Patients are enjoying improved access to primary care and the community is pleased that ER closures are no longer a regular occurrence.

Staff and physicians -- as well as the paramedics who team up with our nursing staff to provide overnight coverage -- are also supportive of this collaborative approach.

We are planning on opening three more CECs by March 31 and four more the year after.

I wouldn't call this new model a "disruptive" innovation. But it is adaptive ... to the specific needs of a community, and to the individuals within that community.

That brings me to my final universal law.

Number 13: The quality of our health care is a reflection of the strength of our relationships.

Whether we are talking about setting up a new model of care in a community, or establishing new roles within that model...

Or developing "patient-relationship-centred care" to manage chronic diseases and cancer...

Or establishing standards for improving clinical practices and patient outcomes, or guidelines for improving quality and patient safety...

Or designing new models for physician compensation or negotiating new contracts with health care professionals...

Or negotiating new funding formulas across jurisdictions for the Canada Health Transfer...

Our future success will be based on those relationships and how we innovate together.