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Remarks for Evidence Informed Healthcare Renewal

Working Group Meeting

Montreal QC

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Dr. Tamblyn asked me to say a few words --
as lead province in Health Accord deliberations -- and to share some of the challenges and issues that the provinces and territories are facing in the lead up to 2014.

During the recent provincial election,
the Prime Minister committed to the six per cent escalator for the Canada Health Transfer.

The question is for how long -- over 10 years,
like the last Health Accord, which expires in 2014?

Of course, a six per cent escalator is not the answer to everything. For one thing, health care costs are increasing by at least eight per cent.

That two-per-cent difference represents
billions of dollars that the provinces and territories must now fund.

Few of us here would say the answer is to simply throw more money at health care.

Of course, there will be strings attached to the transfers – such as the need to prove accountability and the cost of doing that.

During the last Health Accord In 2004, the Provinces and Territories committed to reducing wait times, advancing health human resources, home care, pharmaceutical coverage,
primary care, and health promotion.

Wait times are proving to be a narrow, distorted measure for how we are doing.

For instance, some provinces have reduced cardiac surgeries in order to do more orthopedic procedures.

Whereas in Nova Scotia, we have some of the longest wait times on joint replacements --
yet we do better on cardiac care.

For a long time, experts in health care have said that quality and safety and population health
would be better measures…

And they could lead to national standards and much needed funding for national plans for home care, dementia care, catastrophic drug coverage, mental health, and addictions.

Each jurisdiction is doing its part to work on the sustainability of its health care system.
But are we doing enough to work together?

In negotiations coming up to the renewal of the Health Accord, jurisdictions are handling the preparations in different ways – in different departments.

It's difficult to get a consensus on national approaches and plans. Yes, we have been successful in our united positions on healthy weights in children and sodium reduction – but not on, for instance, a national drug pricing strategy.

We need united goals and common measures.
We need agreed upon accountability.
We need the same expectations at the provincial and territorial levels for how we do business as the health services we fund.
What are the pressures, issues and challenges facing the provinces and territories?
What are the questions we need to ask?

The main question is about access.
How do we make sure that no matter where you live you can get the health care you need?
Health human resources continue to be a major issue in finding the answer.

Like many of us, nurses and doctors are aging.
And they want to live in urban areas.
They are not choosing to live in areas with fewer people and fewer amenities.

Another issue is how jurisdictions are creating their mix of public and private health care services – how they are interpreting the Canada Health Act, and how this is rippling out to other parts of the country.
A strong pressure is public opinion.
Media coverage, including social media, on new experimental treatments, procedures or drugs can trigger a tidal wave of emotion from the public.

Another pressure is a culture of "More."

The health sector is often described as a framework of almost infinite demands and limited supply.

A huge challenge is there are fewer resources
to fund health and other government programs today, many that directly and indirectly affect our health and wellbeing, such as education, housing, and social programs.

The federal government has shifted costs to the provinces and territories.

An example is federal funds that are time-limited. Funding for medication for Fabry's Disease ended after three years and then needed to be picked up by the province.

H1N1 is another example.
Funding for anti-virals and vaccines was
60 per cent federal and 40 per cent P/T.
But supplies and delivery of the health care fell to the jurisdictions. It was very expensive.

(The Public Safety Commission supports floods and fires. Why not outbreaks?)

In just 10 years, our provincial health spending has more than doubled, according to the
Canadian Institute of Health Information.

Chronic disease and complex needs are on the rise. 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.

How can we address 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.

How can we balance stakeholder needs?
How do we identify and define those needs
versus wants?

In light of dwindling financial resources, conversations are too often about priorities and ensuing trade-offs.
How can we make sure the federal government gets funding formulas and national standards right?

For one thing, we need to have conversations at the national level – like the ones we will have today – discussions about standards for the quality and equality of health care.

The Premiers have outlined several commitments for work toward 2014, one being working together to bring the growth of health care costs to a more sustainable level.

Every jurisdiction in Canada needs evidence
for its decisions on how to do this.

We need evidence to show that we are and have been accountable and responsible in our use of federal money to support our negotiations for future funds to support health care.

We are working across jurisdictions and with leaders in health care, education, and communities to make sure the federal government has all the facts for the right decisions.

We need the data and evidence that supports investments in best practices and innovations.

We need evidence for change – for letting go of the past.

We need evidence to invest in prevention rather than illness.

We need citizens to speak out about the need to protect the equality and quality of our health care
-- and the need for decisions to be made based on evidence.

We need to work with organizations like the Canadian Institutes of Health Research and the Institute of Health Services and Policy Research -- to get the right information to help us make the right decisions.

How can we make sure the federal government gets it right?

Universal access to vital programs such as health care, education and social services, is a defining characteristic of Canadian federalism.

The provinces and territories welcome the opportunity to work with the federal government on innovative programs that take into consideration regional concerns and lead to decreased costs and improved outcomes.

And, as I said, the Premiers have already committed to working together to bring growth of health care costs to a more sustainable level.

We need evidence to show that we are and have been accountable and responsible in our use of federal money -- to support our negotiations for future funds for improving health care.
Today we have a chance to talk about how the CIHR's Institute of Health Services and Policy Research and this working group can help us develop the evidence and strategies for ensuring the quality and equality of health care for Canadians.