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Evidence to Practice: Maximizing our Investment in Health Care

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You have seen the headlines: health care remains the most pressing issue for Canadians, according to a Nanos Research poll released March 31. It echoed earlier findings that “health care had outstripped jobs and the economy” as the chief concern.

Meanwhile, during the federal election campaign and in our provinces and territories conversations are all about money. The Government of Nova Scotia is discussing its budget this week.

So our discussions here about Evidence to Practice: Maximizing Our Investment in Health Care are both urgent for 2011-2012 and prescient for 2014 discussions on the Health Accord and the Canada Health Transfer.

Today, as deputy ministers, we were asked to talk about some of the pressures, issues and challenges facing health ministries and the health system. Of course, we could talk about this all day -- and till long after the May election.

But like Letterman’s Top 10, I’ll stick to 10 pressures, issues and challenges, PICs for short. Here are my Top 10 PICs, in no particular order.

Pressures, Issues and Challenges:

Number 1 -- Public Opinion

Media coverage of a new experimental treatment, procedure or drug can trigger a tidal wave of emotion from the public and a sudden shift in political pressure.

Public opinion plays a key role in developing health policy. The public is often sifting through the “noise” of media and interest group pressures.

Marketing campaigns directed at providers of health care provide additional pressures.

Getting the correct information out is critical.

PIC Number 2:

A Culture of More -- the possibilities are endless

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

The constant pressure for “more” draws attention away from questions regarding maximizing our investment in health care, for instance...

- Is what we are doing appropriate?
- Is there inefficiency?
- Is there a marginal benefit in how we are currently allocating resources?

We’ve got to make tough decisions in order to separate the concept of “demand” from actual “need”.

To do so, requires a rigorous framework for decision-making in an informed process – such as CADTH's Common Drug Review and Nova Scotia's Provincial Cancer Systemic Therapy Policy Committee.

PIC Number 3: Non-stop emergency

Emergency room problems have plagued Nova Scotia's health care system for many years.

Every year, there are about 665,000 visits to the ER. Yet only about 1 per cent of these people -- particularly in smaller communities -- have an actual emergency.

Too often, they come to the ER because they can't get in to see a doctor. In some communities, people have to wait six and seven weeks to get a doctor's appointment.

We want families to get appointments with their doctor or other health care professionals that they need to see more quickly.

In December, we released a plan to provide *Better Care Sooner*. It lays out how we can reshape our health care so that every patient gets the care they need -- where and when they need it.

The plan is based on Dr. John Ross's report on emergency care. It sets standards and raises the bar for quality care -- that sets out in clinical terms what better care sooner means.

The standards address everything from how long a patient should be in an ER, to patient satisfaction, to equipment.

*Better Care Sooner* is using a \$3-million emergency department fund already in place for seed money. Our goal is to provide care in the most appropriate way, not the most costly way.... Which brings me to ...

PIC Number 4: The buck ... stops.

Governments have implemented tax cuts: there is resistance to new taxes. That means there are fewer resources to fund health and other government programs -- many that directly and indirectly affect our health and wellbeing, such as education, housing, and social programs.

Moreover, depending on negotiations for the renewal of the Health Accord and the Canada Health Transfer in 2014, there is the potential for more pressure on the ability of provinces to fund health care.

Adding more pressure still are federal funds that are time-limited – and often announced due to public pressure.

For example, federal money for medications for Fabry's Disease ended after three years. Then the provinces and territories needed to make a decision about absorbing those costs.

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

The province now spends forty-five (45) per cent of the provincial budget on health care – three point six billion dollars (\$3.6 billion).

In an effort to balance Nova Scotia's books, all government departments and agencies were asked to look at how we can reduce costs.

In March, we announced that the province is holding the line for the coming year on the budgets of the nine district health authorities and the IWK Health Centre.

Government asked them to manage with the same amount of funding they received last year. And, like all other departments and publicly-funded organizations, districts and the IWK are also expected to manage and control any cost pressures.

Moreover, as health authorities plan their budgets, Government expects them to protect patient care and mental health and addictions services as work continues on a mental health strategy for the province.

They must also ensure that Government's *Better Care Sooner* action plan can be implemented.

Back to pressures, challenges and issues ...

PIC Number 5: Chronic disease and complex needs.

In Nova Scotia, we have some of the highest rates of cancer and chronic disease in Canada. In fact, seven chronic diseases are responsible for 60 per cent of health system costs.

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 are setting targets for acute and chronic disease reduction – Government has committed to this and views this as a priority. Our work to reduce and manage chronic diseases depends on your assessments of drugs and technology that will help us meet those targets.

Pressures, Issues and Challenges:

Number 6 -- Doing things differently

Finances...health outcomes...politics ...spirit of collaboration...and many other factors are creating the environment to reshape our healthcare systems.

The opportunities are there to ...

- Expand chronic disease self-management.
- Increase access to primary health care teams.
- Increase use of services like our 811 nurse line.
- Provide clearer, more comprehensive patient information.
- Further develop IT projects -- electronic health and medical records, digital diagnostic imaging and telehealth.
- Drug information systems.
- Improve access to appropriate diagnostic tests, therapies and treatments.
- Provide services to an increasingly diverse population.
- Strengthen and develop provincial programs strategies -- to make sure that no matter where you enter the system, you will get the care you need.

To do things differently, new investments might be required – that in itself is a challenge. But there may also be resistance to change from established groups.

Early this year, I was at a meeting in Halifax where ER doctors asked me what they could do to help sustain our health care system.

I said, “Don’t tell us what we should be doing. Tell us what not to do.”

Dr. Brett Taylor, a researcher, lecturer and emergency pediatrician in Halifax, expanded on this in an article for the CBC.

He said, “Physicians... could best serve public policy by defining waste within the system: those procedures, tests or therapies that, though commonly applied, do not appear to alter patient outcomes.”

We need to reduce inefficiencies – as the health authorities and the IWK Health Centre are doing through shared services and purchasing agreements.

We need to gain extra value for money – as we are doing in our consultation for fair drug prices.

We need to build collaborative team approaches – as we are doing through the expansion of collaborative care clinics and emergency centres, and provincial approaches such as through Cardiovascular Health Nova Scotia and the stroke strategy.

We need to bring innovation and ideas from outside the health sector in.

We need to look at partnerships among education and research institutions, the private sector, health-care organizations and professionals, and patients and communities.

And, our governments need to create the environment that encourages innovation and partnership.

PIC Number 7 -- Addressing 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.

We need to reduce these disparities not only because it's the right thing to do but also because those efforts will reduce pressure on the health care system.

Getting at gaps in health equity is complicated.

Nova Scotia's Cultural Competence Guidelines are the first in Canada and a first step. They help ensure the delivery of better healthcare for all Nova Scotians and their families.

The guidelines prompt workers in all areas of health to consider and respond to the history and lived experience of all those we serve.

It also means that we identify the disparities and pay close attention to the special needs in health care delivery according to nation of origin, level of ability, gender, sexual orientation, gender identity, race, ethnicity, socio-economic status and religious affiliation.

Understanding and recognizing who we are and where we are on bridging the gaps in health equity is essential to delivering on our vision and mission – *generations of Nova Scotians living well*.

PIC Number 8: Balancing stakeholder needs.

This brings us back to number 1, public opinion ... married to expert opinion.

Of course, the fine balance is identifying and defining needs versus wants. And in light of dwindling financial resources, conversations are often about priorities and ensuing trade-offs.

I sometimes feel there is an assumption that government does its work in isolation. Everyone here knows that is not the case – especially not these days. Governments are more consultative and engaging than ever before.

Within Nova Scotia's government we are working together – and maybe like never before. There is a team of Ministers working on Better Health Care – from Labour and Workforce Development, Education, Justice, Community Services, and Health and Wellness.

Supporting the Ministers is a Deputy Ministers' committee, co-chaired by me and the Community Services Deputy Minister.

It's crucial to understand the pressures, issues and challenges from those most affected. Peter Drucker called it "bringing the outside in."

In recent months in Nova Scotia, the Department of Health and Wellness has held public consultations on ...

- fair drug pricing.
- emergency care and an ER strategy, and a broader government health care strategy called *Better Care Sooner*.
- a mental health strategy – in consultation with Nova Scotia Health Research Foundation on the parameters for gathering research.

- Caregiver benefits and other supportive programs.
- a Midwifery review
- changes to the Human Organ and Tissue Donation Act.
- and a Quality and Patient Safety Advisory Committee.

We all believe that government is in the business of making decisions on behalf of the people, and that there is a need for the people to be able to provide input.

Everyday, we have hundreds of stakeholder conversations to make sure that happens.

PIC Number 9: Myriad difficult decisions.

Sometimes decision makers -- like me and my colleagues -- lie awake wondering whether we are doing the right thing. How can we know?

We need to ensure we are providing the best possible health care for Nova Scotians and their families.

That means providing care based on proven scientific research, clinical results, and whatever evidence we can pull that helps us make the right choices.

We need guidance and information from organizations like the Canadian Agency for Drugs and Technology in Health. In fact, we depend on it.

For more than a decade, CADTH and the Common Drug Review have led the way in evidence-based decision-making.

CADTH has offered the Rapid Response Service over the past few years, answering urgent requests from government, DHAs and hospitals about devices, equipment and drugs.

We worked with CADTH in Nova Scotia on the Diabetes Care program, on the self-monitoring of blood glucose, to develop a monitoring strategy for physicians and diabetes educators.

The aim is to decrease the number of times that those with Type 2 Diabetes need to monitor, when their condition is being controlled on oral agents or diet alone.

This is all based on the best evidence in this area of care.

CADTH has also been researching for us the use of laser therapy for vein treatment versus standard vein stripping and indications for the use of positron emission tomography – PET.

The Drug Evaluation Alliance of NS has been a contributor and partner in implementing CADTH work in the area of Proton Pump Inhibitors, and Self-monitoring of Blood Glucose.

This Nova Scotia group routinely uses evidence to improve practice in the area of drugs. They identify an issue and use evidence to improve the prescribing -- by way of multi-disciplinary educational initiatives, online sessions, academic detailing, etc.

The Nova Scotia Health Research Foundation is helping us frame our research for our Mental Health Strategy.

A foundation report was also a key component of the decision-making process regarding the integration of continuing care within the DHAs, with a strong emphasis on accountability.

We need guidance from the Canadian Institutes of Health Research, such as its role in collaborating with the MS Society of Canada and with leading North American experts in multiple sclerosis -- to identify research priorities for Canada in this area.

We look to reports from the Canadian Institutes of Health Information, to provide us with national and international perspectives and province-to-province comparisons, to help us plan health services.

In Nova Scotia, we need to continue to improve the way we incorporate evidence into decisions on devices and equipment and other non drug health issues.

## PIC Number 10: Policy with politics

Government decision-making is complex and balances policy with politics. Decisions are never independent of policy and politics but are sometimes beyond the realm of clinical evidence.

Without the adoption of evidence, politics tends to win.

Decision-making cycles usually involve steps such as ...

- Agenda setting.
- Choosing policy instruments and designing them.
- Government deliberates on the public policy decisions.
- Then there is implementation of the policy.
- Then evaluation.

Of course, timing is everything. Timing of elections, timing of changes in health care leaders – like Deputy Ministers.

Timing of commitments, budgets, and changes in government all affect policy development and implementation.

We're seeing this on the national stage right now.

Every government and most households are in a time of fiscal restraint, where we need to do more with less.

It is important to know government's agenda – to understand how decisions fit into that agenda, the process for decision-making, and the influences.

In Nova Scotia, government has a one-page plan that lays out the key priority commitments. Almost half of the commitments are health-care related.

This plan is public, and is available to staff and others to see so they understand government's priorities. This is what we are working on and what guides us in our work.

The process will involve a number of steps, possibly a number of departments and bodies, and key officials, political staff and politicians.

We need Canadians in all provinces and territories to speak with a united voice about maintaining the equality of health care, educational opportunity and social services.

We need Canadians to speak out to protect this equality through transfers requires that the federal government take into account smaller populations, aging populations, fiscal capacity and other regional particulars.

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

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

We need evidence to invest in prevention rather than illness.

As Dr. Brett Taylor said, “Discovering what not to do may be our most important health care objective.”

Like ... unnecessary tests for healthy people undergoing cataract surgery, unnecessary chest X-rays, unnecessary and intrusive knee scopes when we could use MRIs ... evidence for new modalities, new treatments, new ways of doing things...

How do you make the good evidence more public?

We need experts – and the public too -- to speak out about the need for more information on the efficacy of drugs, without the lobbyists and marketing hype.

In fact, we need marketing to stop doing things that are inappropriate and unnecessary.

We need citizens to speak out about the need for decisions to be made based on evidence.

Every province and territory is working on the sustainability of its health care and we need to work in partnership with the federal government on this.

We need to work with organizations like CADTH to get the information that will help us make the right decisions.

The Provinces and Territories already committed in 2004 to reducing wait times, advancing issues such as health human resources, home care, pharmaceutical coverage, primary care, and health promotion.

The Premiers have outlined several commitments for work toward 2014 – such as working together to bring 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.

Evidence to Practice is the proven route to sustainable health care and the most convincing argument to make at all levels of government for Maximizing Our Investment.