

LIBERAL BIENNIAL CONVENTION 2012 POLICY SESSION REPORT

Name of session:

“Evidence Based Policy: Sustaining Our Healthcare System: Transformative Change”

List of all participants (including moderator, panellists, Caucus reps, NPEP representative and rapporteur):

- Lucienne Robillard, Moderator
- Dr. Hedy Fry
- Dr. Jason Sutherland, Panelist
- Dr. Jeanne Besner, Panelist
- Glenn Brimacombe, Panelist
- David Hurford, NPEP
- Senator Jane Cordy, Rapporteur

Approximate number of delegates/observers in attendance:

Room was filled to capacity

Key points raised by Caucus rep:

- Over the last 2 decades Canada’s health care system has begun to buckle under the weight of evolving stresses and challenges.
- It is a victim of its own success. Canadians now live longer, & tech allows people to live with chronic diseases that once used to cause premature death.
- The debate about sustainability of the system tends to focus on two simplistic choices: private vs. public.
- Evidence shows that the debate is more complex.
- It is no longer enough to simply say we support the Canada Health Act.
- Because while the principles of the Act are still very valid. It only requires the fed government to fund hospitals and physicians.
- Yet evidence shows that today, hospitals are not the only place to deliver care and physicians are not the only ones who can do so.
- Evidence also shows that the federal government can no longer hide behind narrow jurisdictional arguments and just write cheques to the provinces leaving them to sink or swim.... Not the way to create unequal access and system collapse.
- In fact evidence tells us there is need for transformative change in the system.
- The 2004 health Accord signed by under pm Pal mar was the vehicle to make that happen. It opened the door to a new era of trust and co-operation between fed provincial and territorial governments and jurisdictional flexibility in the era of health care.

- Governments recognised that a major area for change was to shift away from the doctor and hospital based model to one where home and community based care by multidisciplinary teams could achieve more effective outcomes. And part of that was the need to address Health Human resources.
- The Accord also recognised that while Medicare to date had done many things well, that were gaps in the system that prevented access to the care they need when they need it and that included access to prescription drugs outside of a hospital setting
- It also agreed that a sustainable system should not only focus on illness care but should include disease prevent and population health.
- The federal government agreed to fund these transformative changes, and to evaluate best practices but it also committed to work collaboratively with the provinces to develop: pharmaceutical strategy, health human resources strategy, and models for home care.
- To date the federal government has failed to act on many of these commitments for collaborative strategy development.
- So, some of the challenges facing the Health care system have not been addressed. As the health council of Canada reported: due to lack of federal leadership.

Key points raised by panellists:

Dr. Jason Sutherland

- Baby boomers are only accounting for very little growth in health care costs. Rather it is higher utilization and technology costs that determine growth.
- We need to think about new models for delivering and funding care.
- The evidence says that global budgets – large, untargeted lump sum funding - is not working.
- Practitioners in Denmark, Sweden and Norway get paid for the kinds of patients they treat. This has been more affordable, has reduced wait times, without lowering quality.
- What concrete actions can we take to increase health and lower costs?
- Many are struggling to pay for drug costs which results in poorer health, and drives utilization of higher cost health care up (emergency rooms).
- Home care – cheaper to deliver care in homes.
- Now is the time for transformations. One example: management of hospital beds. We have 75,000 hospital beds available. The patients in these beds are medically able to be discharged, but there is nowhere to discharge them to.
- Questions: how do we align incentives to get hospitals and physicians working together?
- How to we reduce the cost of drugs for the poor and disadvantaged?
- How do we think about whether we've overinvested in hospital care?

Dr. Jeanne Besner

- Going to talk about Health Human resources and how they relate to transformation
- Some progress has been made.
- Evidence suggests we can use HHR more effectively.

- Since 04, care has begun to be organized into teams.
- Teams were focus on health promotion, chronic disease management, joint planning with patients.
- HCC has suggested progress.
- However in some areas, care is still focused in hospitals.
- Nursing practice is about disease promotion, illness management etc. – it makes sense to encourage greater incorporation of nurses into primary health care.
- We miss opportunities to deal with care when it is needed – can be prevented if we pay attention to signs and symptoms.
- Evidence suggests we have not done well on increasing population needs driven approach to health.
- Many questions remain as to whether non-physicians have simply duplicated physician resources rather than offer new services.
- Nova Scotia has implemented a new collaborative care model in their district hospitals to deliver patient-centric health care, which includes housekeeping staff, janitors (non-health providers) which has reduced inefficiency, reduced duplication, reduced cost (even though it was not designed to do this).
- This model of care has not been widely taken up – why?
- Should we not be looking at adopting this model – would this not be a role for the federal government?
- The feds could play a lead role in incorporating this model into the sectors they have responsibility for.

Glenn Brimacombe

- There are several defined areas that the feds have a natural role in within healthcare – enforcing the CHA, regulating products, provision of services to military, First Nations, veterans, prisoners, public health, health research (0.80 per dollar from feds), transfers.
- This last area is particularly important; this transfer can be tied to performance measures like primary care reform.
- Cash v tax points – some say this is on the table; this would remove the federal government from a key component of the system.

David Hurford

- Party had an online voting process – 23 submissions on health; 5 going forward, 2 are priorities (woman's right to choose, homecare) + mental health, medical isotopes, homecare expansion
- Of the 18 not going forward, there were a lot of positive comments – 8 on public health care, national pharmacare, support for euthanasia and alternative medicines (these were mixed support), tax exemptions for obesity education, access to drugs in Africa.

Highlights of Q and A session:

Q – Are we seeing the right trajectory on transformation, or are we in real danger.

A – Since 2006, no. The plan was collaboration on making real change, but the current government walked away from the agreement.

Q – How do we reframe the debate on the taxes cuts to pay for all of this?

A - (Fry) I think if you look at the way health care is paid for, it is paid for by taxes. (Glenn) This is a debate about choices. Ontario is about to have this conversation post-Drummond report about hard policy choices around financing. (Besner) We also need to look at how effectively we are using existing resources; more is not necessarily the answer.

Q – Is there an opportunity to incorporate social determinants into the next accord?

A (Glenn) There is an opportunity. I think the feds are interested in this dialogue, regardless of how they have framed it.

Q – Is our party committed to evidence-based policy on measures like harm reduction?

A (Fry) – That is exactly the approach the last Liberal government took. The conservatives walked away from this, but were overruled in the Insite case.

Q – How do we use incentives to make care more efficient?

A – Is it inequitable to fund hospitals based on the complexity of injury? I don't think so. Secondly, on variable degrees of access, absolutely we can. We need to think about incentives to pull patients out of hospital and to more efficient means of care like home care.

Q – How and when will we break down the silos in health care?

A- (Glenn) this has been an ongoing challenge. Team-based care is an attempt to restructure this. But we haven't moved to a more networked system of care. (Besner) Decision-makers all need to be involved in decision making on this, can't just speak to each group individually. (Sutherland)

Q – Should we have a policy to prevent drain of international health resources?

A – Besner. Yes, we must become self-sufficient. To do otherwise is immoral and unethical.

Q – What should we do about HHR who become injured or handicapped and can no longer perform their duties?

A – (Besner) There are lot of jobs for health resources that can be tapped into.

Q – Why not fee per patient instead of fee for service or activity based funding?

A – Full fee for service funding in Canada is not the way to go. Northern regions will create monopolies and fee for service won't work there.

Q – What is the impact of medical information sharing on the efficiency and patient psychological well-being?

A – Sutherland – I am a huge supporter of e-health for what it offers in these areas.

Q – What do we do about things like C-Difficile?

A – (Glenn) This is where team based care can help. (Besner) This approach has drastically reduced this in NS. Cleanliness in hospitals has been shown to reduce infections.

Q – What is our responsibility to take more punitive measures to reduce poor health behaviours?

A – Fry. I don't agree with this. It is not only behaviours that contribute.

Notable proposals, ideas, suggestions (research to be undertaken, outreach or seminars, roundtables or conferences to be organized, or ideas for caucus interventions in Parliament):

N/A

Positive/negative feedback from audience and general mood in the session:

There was very positive feedback from delegates and the participants. Delegates made particular mention of the thoughtfulness of the interactions with panelists, and felt the session was engaging and smoothly executed.

Additional notes:

N/A

Conclusion (consensual objectives for the next 24-months, key elements of a work plan to guide us to the 2014 Policy Biennial):

The discussion began with a review of the past several years since the Health Accords, charting both the successes and failures of the Accord's transformation agenda. There were comments regarding how performance-based funding can be realigned, and how we are still far from fully implementing the kinds of team based care that can improve care while also lowering costs. There was also a dialogue about the places where the federal government can exert influence in health care.