Alberta

Unleashing Innovation

Daily Report

Unleashing Innovation in Health Systems
ALBERTA'S SYMPOSIUM ON HEALTH

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log on to the Symposium web site at www.health.gov.ab.ca/symposium/.

Highlights from Tuesday May 3, 2005

A unique symposium begins in a unique way

Picture this. Over 400 people. Leading health experts from nine countries around the world - from France, the United Kingdom, New Zealand, Australia, Sweden, United States, the Netherlands and Germany. Representatives from all health regions in Alberta. Physicians, nurses, pharmacists and physiotherapists. Advocates for mental health and national health organizations. All together in one room sharing ideas and talking about a single goal - better health and better health care.

Alberta's Symposium on Health is a unique experience for Alberta. And it began in a uniquely Alberta fashion - with a reminder that concern for health and health care began with Alberta's first peoples. With stories of his father searching for medicinal plants and herbs, Elder Frank Weasel Head launched the symposium with a prayer of blessing spoken softly in his Blackfoot language.

Unfortunately, Premier Ralph Klein was unable to join the opening due to illness. But Deputy Premier Shirley McClellan ably took his place. Her message echoed the Premier's call for a "third way" to health care in Alberta, starting with the Mazankowski report and seizing the best ideas and best practices here in Alberta, across Canada and around the world. While there's no expectation that Alberta's health system will "turn on a dime" as a result of the symposium, it will be a very important step in the ongoing process of change in Alberta's health system.

Minister Evans thanked the Deputy Premier and said, "This International Health Symposium is designed as a forum for ideas. We want to improve Alberta's health care system and make a good system even better."

As Master of Ceremonies, Dr. Matt Spence outlined the goals for the symposium: to act as a forum for new ideas, to foster a culture of innovation, and to continue working towards a high performing health system.

Session 1 focuses on high performing health systems

What makes a high performing health system and what can we learn from others about what it takes to get there?

Dr. Glen Roberts

from The Conference Board of Canada put things in perspective, starting with highlights of two reports prepared for Alberta Health and Wellness. Their comparison of Canada's health system with six leading countries came to the following conclusions: money alone isn't the answer (Canada already spends more than many countries); Canada must do more to control the escalating cost of drugs; a satisfied and

productive workforce is vital for high performing health systems; Canada needs to focus more on achieving good health and the factors that affect health; Canada's aging population doesn't have to result in a more expensive health care system; investing in ICT is critical; user fees and other cost-sharing methods work well under some circumstances; and a publicly funded health system without user fees needs to have adequate surgical capacity if it wants to avoid long waiting times.

Dr. Gerard de Pouvourville

from the Centre for Health Economics and Administration Research in France shared his perspectives on the strengths and weaknesses of France's health system on four dimensions: freedom, sustainability, equity and efficiency. France's experience with a mix of public and private delivery shows that competition has benefits, but it has to be managed well. Decisions about what should be covered or not covered in a publicly funded system or through supplementary insurance should be made through public debate. People in France are satisfied with their health system because it provides freedom of choice, but that affects the efficiency of the system.

Dr. Ken Kizer

from the United States gave a snapshot of changes in publicly-funded Veterans Health Care in the U.S. Faced with a series of problems in the 1990s and a firm belief that the only answer was more money, the VA took a different approach. It involved complete re-organization, a move from hospital care to universal primary care, increased focus on prevention and promotion, reduced staff, electronic health records, a new funding allocation system that everyone understood, a new performance measurement system, and a clear commitment to quality.

Session 2 - It starts with better health!

It's a message we've heard before. But the speakers brought the message into sharp focus - whether it's children, Aboriginal/indigenous people, or in mental health, the best approach is to find better ways of preventing illness, not just treating people when they're ill.

Dr. Fraser Mustard

highlighted research consistently showing the impact of experience-based brain development in a child's first few years on their future health, learning and behaviour. In spite of this evidence showing the best investments are made in a child's early years, across Canada, major investments don't typically begin until children are in school. He talked about the importance of community parenting centres linked to the primary education system and echoed the view that, "We cannot afford to postpone investing in children until they become adults nor can we wait until they reach school - a time when it may be too late to intervene."

Dr. Mason Durie

began by extending greetings from the Maori people of New Zealand. Experiences of indigenous people around the world are similar and are characterized by similar socio-economic disadvantages, demographic trends, and poor health outcomes. In New Zealand, deliberate actions and policies have produced substantial gains in health status for Maori people, but life expectancy is still almost eight years less than the non-Maori population. The New Zealand approach is guided by important principles: the fact that indigenous world views and spirituality have to be addressed, the importance of integrating their world views into clinical protocols, and the recognition that technology and cost containment do not replace human values as a driver of quality.

Dr. Ian Anderson

echoed similar views from the Australian perspective. Life expectancy for Australian Aboriginal people is 20 years less than non-Aboriginal people and they have significantly poorer health and social outcomes. Increased political action by Aboriginal people in the 1960s combined with an emphasis on primary health care is beginning to show good results. Dr. Anderson also encouraged a broad approach to primary health care, including "stitching together" factors such as health education, food supply and nutrition, safe water and sanitation, maternal and child health, immunization programs, prevention of diseases, injury control, oral health and traditional medicine.

Senator Michael Kirby

and his Senate Committee are engaged in the first national study of mental health in Canada. And his message was clear: meaningful improvements in health are impossible until and unless we make meaningful improvements in mental health. In spite of the fact that one in five Canadians will experience some kind of mental health disorder (and two thirds of them won't get treatment), why has little or no action been taken? Because there's still stigma attached to mental health. Because the mental health system isn't a system at all but a fragmented bunch of services. Because people who work in mental health are at the bottom of the pecking order. And because people with mental illnesses are impoverished, have no voice, and no organized lobby. The solution involves thinking outside the box, developing a continuum of care, and focusing more on prevention, especially with children.

Session 3 - A focus on people

Health care is a people business, and it depends on having an adequate supply of a full range of health providers.

Dr. Jennifer Zelmer

put the challenge in perspective: How can the health system become an employer of choice while, at the same time, providing the highest quality of care possible? Information from the Canada Institute for Health Information shows an aging health care workforce, varying satisfaction among health care providers, depending on where they work, and changing patterns of work. Illness and injury among health care providers is a serious problem - if we could reduce health workforce illness, we'd have the equivalent of 13,000 more health care providers on the job, including 5,500 nurses.

Cecilia Mulvey

outlined key features of a magnet recognition program for achieving nursing excellence. Benefits of the approach are clear for patients and for nurses and include: reduced patient mortality and morbidity, increased patient satisfaction, lower length of stay in hospital, lower turnover of nurses, lower vacancy rates and burn out rates, and higher nurse satisfaction rates.

Dr. Alan Maynard

from the United Kingdom entertained the symposium with anecdotes about the UK system under Prime Minister Blair. But his message was a serious one: there are a range of proven, cost effective interventions for the management of chronic care that all health systems around the world have failed to deliver. The UK system has put stringent performance measures in place and hospitals are graded on their performance. But Dr. Maynard's view is that people have to stop measuring whether patients live or die and start measuring whether treatments improve the well-being of patients.

Dr. Orvill Adams

spent ten years working for the World Health Organization and, in his view, health systems around the world have done a poor job of planning, managing and anticipating needs for health providers. He called for a long term vision for the health system, and understanding of the model we want for delivering services, and then ensuring we have the necessary health human resources to make it work. In spite of the fact that health providers consume 60 - 80% of the costs of the system, there's very little research or planning being done.

Matt Spence wraps up the day

Tough to summarize what came out of a packed day, but here are some highlights:

- The system is complex and changing around the world, but lessons can be learned from others around the world.
- Money alone is not the answer.
- Leadership is needed, and we need public debate.
- A culturally sensitive approach is needed, coupled with accountability.

- The challenge is to make sure children get a healthy start.
- The serious problem of mental health has to be addressed.
- We need to study and plan for health human resources.
- It's about evolution not revolution.

Some words to think about

"Modern health care is the most information intensive industry in the world, but we keep records the same way we did a hundred years ago."

"I'm not supporting revolution anymore. I'm supporting drastic evolution in health care."

"Making decisions based on facts is a novel idea, especially in government!"

"The business of health care today is all about taking care of chronic disease."

"Good health is not possible where there are huge disadvantages in socio-economic status."

"Money is a means to an end, not an end in itself. Figure out what needs to be done, then figure out how much it would cost."

"With mental health, we need to focus more on children. 60% of adults with mental illness had that illness when they were children."

"It's high time we stopped using the prisons and the streets as the mental health asylums of the 21st century."

"If you're going to make change, you can't do it by brute force. You have to do it through incentives."

"How can we get people to understand that investing in poor kids is more important than reducing waiting times for surgeries?"

Stay tuned for day 2.

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