Health Reform Observer -
Observatoire des Réformes de Santé

Volume 10 | Issue 2 | Article 2

The Newfoundland and Labrador Health Accord

Stephen Bornstein, *Memorial University, St. John's, Newfoundland, Canada*

20 June 2022

A Commentary

Recommended Citation: Bornstein S. 2022. The Newfoundland and Labrador Health Accord *Health Reform Observer - Observatoire des Réformes de Santé* 10 (2): Article 2. DOI: https://doi.org/10.13162/hro-ors.v10i2.5109

Abstract

In February 2022, a task force appointed by the Premier of Newfoundland and Labrador submitted a report that he had commissioned 14 months earlier. The task force's objective was to devise a 10-year strategy for modernizing and reforming the province's healthcare system and bringing health outcomes in the province up to Canada's high standards. The report will be followed this month (June 2022) by two more documents, an 'implementation blueprint' and an 'evidence report.' This commentary examines the report, summarizing both its devastating findings on the current health system and its comprehensive and ambitious proposals for reform.

En février 2022, un groupe de travail nommé par le premier ministre de Terre-Neuve-et-Labrador a soumis un rapport commandé 14 mois plus tôt. L'objectif du groupe de travail était de concevoir une stratégie sur 10 ans pour moderniser et réformer le système de santé de la province et lui permettre de rattraper son retard sur les normes élevées du Canada pour ce qui est de la santé. Le rapport sera suivi, ce mois-ci (juin 2022), de deux autres documents, un « plan de mise en œuvre » et un « rapport de preuves ». Ce commentaire examine le rapport, résumant à la fois son constat sévère sur le système de santé actuel et ses propositions de réforme ambitieuses dans tous les aspects du système.

1 COMMENTARY

In 2021, the University of Toronto Press published *Newfoundland and Labrador: A Health System Profile* edited by me, John Abbot, Victor Maddalena, Aimee Letto, Melissa Sullivan, and Pablo Navarro (Bornstein et al. 2021). It is the fourth volume in a series of provincial health system profiles curated by *Health Reform Observer - Observatoire des Réformes de Santé* founding Editorial Board Member, Dr. Gregory Marchildon: Saskatchewan (Marchildon 2007), Nunavut (Marchildon 2013) and Nova Scotia (Fierlbeck 2018). The team that I put together started work in 2018 and concluded its efforts over the course of three long years. Our examination of the Newfoundland and Labrador (NL) health system began with an appreciation of how Canada's newest and poorest province had, since joining Confederation in 1949, managed to use limited provincial resources and federal support to develop a version of the Canadian system that provided programs and services similar to those provided in other parts of the country for a small population that is widely dispersed across a large, rural and remote territory and is characterized by pervasive and persistent health challenges (Bornstein et al. 2021, 24). We found that the NL system was the most costly per capita in the country and one of the least effective. Health outcomes such as life expectancy and rates of chronic disease, although they had improved considerably over the post-Confederation period, remained at or near the bottom of the country's league tables. The performance of the province's physicians and health institutions in handling preventable diseases and avoidable deaths remains comparatively poor (Bornstein et al. 2021).

Specifically, we found that the province's primary health care system is fragmented and uncoordinated, with the vast majority of physicians working on their own or in small, shared practices with few interprofessional collaborative teams. The adoption of digital data management equipment and techniques by physicians was slow and partial while patients' access to both family practitioners and specialists is difficult even in the province's few urban centres, but especially in rural and isolated communities. A number of important specialties such as geriatrics and rheumatology lack adequate personnel and the system relies heavily on foreign-trained and partially licensed physicians, with many positions being filled by locums or by frequently rotating visitors, resulting in limited continuity of care. The utilization of acute services is comparatively high and emergency departments are being utilized at a much higher rate than the national average. Our chapter on recent health reforms (Bornstein et al., 115-122) demonstrated that the province has been slow to introduce and implement changes featured in other parts of the country and the government's few policy ventures tend to feature 'plans' and 'frameworks' rather than full programs. In addition, transparency is limited: the government and its health institutions provide the citizenry with limited reporting on population health or health system performance (Bornstein et al., 132-133). While our analysis revealed a health system that is not doing a very good job, we also found that people in the province were generally satisfied with their health and health care and that the weaknesses of the system, other than its cost, were not

a prominent feature of media discussions, parliamentary debates, or electoral competition.

As we were putting the finishing touches on the final draft of our volume, this seemingly paradoxical situation took what may be a significant turn. In August 2020, the governing Liberal Party of the province selected a new leader, Dr. Andrew Furey, who, a few months after assuming the premiership, announced the creation of a Task Force on Health Care with the aspirational name of Health Accord NL. It was to be chaired by two veterans of the existing system, Dr. Elizabeth David, a former CEO of the province's largest regional health authority, and Dr. Patrick Parfrey, a retired professor of nephrology and the founder of Quality of Care/Choosing Wisely NL—a quality assessment and research team connected to Memorial University. Their mandate was to "reimagine the health care system" on a 10-year timeframe by producing "short, medium and long-term goals for a health system that better meets the needs of Newfoundlanders and Labradorians" (Government of Newfoundland and Labrador 2020). In the concluding pages of our volume, we noted the announcement of this initiative but expressed skepticism about what it was likely to accomplish. Fourteen months later, the Task Force released part of its Final Reports (Health Accord NL 2022). This report, submitted to government on 17 February 2022 and immediately released to the public by the Premier, is one of three intended products. It will be followed by an 'implementation blueprint' presenting detailed plans and financial analyses and by an 'evidence report' presenting the sources on which the final report's findings and proposals were based. This dissemination strategy means that, at the time of writing, it is possible to comment only on the general shape of the report and not the specifics nor the budgetary implications.

Like *Newfoundland and Labrador: A Health System Profile* (Bornstein et al. 2021), the Health Accord NL final report begins with an analysis of the current health of the province's people and of the performance of the existing health system. It provides an even more devastating critique of the system than what we presented in our volume. Its analysis aligns with our key findings and presents what it calls "a compelling case for change." One of the most significant features of the report is the emphasis it places on the social determinants of health (SDH) rather than on the institutions and practices of the health system. Its fifth chapter on the SDH is subtitled "What Really Matters" and one of the 'key messages' is the contention that social determinants and population genetics account for 75% of any jurisdiction's health outcomes while the health system contributes much less (Health Accord NL 2022, page A). Among SDH, the Health Accord NL report places considerable emphasis on the shrinkage and aging of the province's population. These are seen as complicating the challenges facing the province's health system in terms of chronic disease incidence, health human resources and costs. The report also devotes timely attention to the climate emergency. The Health Accord NL report pays little attention to the few reforms attempted by the province in recent years nor does it examine their impacts, especially on primary care.

Whereas *Newfoundland and Labrador: A Health System Profile* deliberately set out to describe and examine the present situation, the mandate of the Health Accord Task

Force was focused largely on the future, its report provides an impressive list of 57 calls to action involving a total of 389 objectives. In doing so, the authors repeatedly call attention to the social determinants that shape health outcomes and the need for 'rebalancing' the institutions and practices of the health care system to address these. Although its teams included few representatives of government departments other than health, the Task Force calls for action to produce a "gradual but persistent reallocation of resources from health systems to social systems" without providing details on how this is to be achieved.

Of the 57 calls to action, only 12 are found in the chapters discussing the SDH, which amount to 49 pages of the 255-page report. The chapter outlining what the SDH are and why they matter is only 5 pages long and is self-described as "not complete." The proposed actions are disappointingly thin and vague. For example, increased "awareness and understanding" of social determinants (Action 6.1); embedding the SDH into all health-related decisions (Action 6.2); addressing the growing climate emergency (Action 6.4); and creating "a provincial Pathway for inclusion shaping an inclusive health system within an inclusive society" (Action 6.5). Two proposals concern children and youth—creating a "continuum of education, learning and socializing, and care for children and youth" (Action 7.2) and creating an "integrated model of care for children and youth at risk" (Action 7.2). Several other proposals involve broadly outlined programs to enhance care for seniors—a "comprehensive provincial frail elderly program" (Action 8.1); and an "integrated continuum of care" for older adults (Action 8.2). The only proposal in this group that recommends a specific policy initiative is the suggestion of a guaranteed basic income for families with children which would support their health and well-being (Action 7.3). This proposal, which has received the most media attention, is described in sparse detail and is accompanied by an acknowledgment that such a program would require input and leadership from Ottawa. The combination of heavy rhetorical emphasis on "why SDH matter" and the brevity and vagueness of most of the related set of proposals is, to say the least, puzzling. It is also interesting that none of the 12 SDH-related calls to action is included in the list of 30 actions that the authors of the report deem to be "Actions That Can Start in the Short Term" (p. 136). So, paradoxically, despite being the preconditions for improved population and individual health and a necessary accompaniment of effective health system rebalancing,' the SDH are not, apparently, amenable to improvement in the short run.

The report describes its goals very modestly as a rebalancing of the province's health care system. In fact, what is being proposed is a massive transformation of the system through a significant number of major innovations. Many of the calls to action do, indeed, involve shifting the balance and focus of the province's health system but even these involve substantial change. Action 9.2 proposes "improved coordination of care across the health and social systems" while Action 9.3 proposes "greater emphasis on health promotion and well-being" rather than on downstream care. Action 9.4 proposes "improving appropriateness of medication use," while Action 9.5 proposes a reorganization of hospital and health services to better "reflect population needs."

Many of the other calls to action in this section of the report are considerably more

audacious. Probably the most significant is Action 9.1 which involves a reconfiguration of the province's primary health care institutions by creating 35 community health teams, each of which would bring together a wide range of health professionals to provide care for 7,000 to 8,000 residents "and upwards" with "special arrangements" for more isolated communities. No details are provided about how this much-needed restructuring of the province's fragmented system of primary care would be designed, how these teams will be constituted, how patients will be linked to them (beyond a suggestion about rostering), who will lead them, how staff will be paid (other than a suggestion that fee for service would need to be supplanted by "a blended capitation model" for family physician payment) or how the province's well-organized and conservative medical profession will be persuaded to participate. No details are provided as to how improved after-hours access will be supported and what action will be taken to "connect community teams with patients/clients, families, school and community organizations." A patient navigator in each community team is seen as helping provide enhanced coordination and communication.

Various new units and programs are proposed. An occupational health clinic is to be created (Action 9.6) with linkages to the community teams and to the SafetyNet research centre at Memorial University. To improve recruitment and retention of family physicians and other health professionals, a Provincial Health and Social Workforce Planning Strategy will be developed. The report recommends that all of the province's 13 hospitals should be retained (Action 9.7) but be organized into a better-integrated network with services based on population needs. The province's three regional hospitals each needs a "centre of excellence for geriatrics," and the province's drastic need for geriatricians (there are currently only two in the province with Canada's oldest and most rapidly aging population) will be remediated. Women's health will be added to the mandate of the Janeway Children's Hospital (Action 9.9). A provincial stroke unit will be created and so will a formal Frail Elderly Program, providing "integrated, interprofessional care for children and youth with complex needs" (Action 9.9); a plan for improvement in mortality rates for cancer, cardiac disease and stroke (Action 9.14); and an "explicit statement" of standards of care for acute care services (Action 9.12). An integrated, publicly operated road and air ambulance system with a single medical dispatch system is urgently required. The province's fragmented and heterogeneous system of laboratory and pathology services should be transformed into a "provincial networked service" with a single test formulary, a modernized specimen transport system, and a provincial management structure (Action 9.10). Substantial changes are also needed to "modernize" the province's information technology systems, replacing the current Meditech system based on 1984 technology, and creating a personal e-health record as part of an effective e-health system, although nothing is said about where the NL Centre for Health Information, which manages the current IT system, will fit into this complex venture.

On top of these specific policy and program changes, Chapter 11 of the report calls for a total overhaul of the way the province's health system is governed. The four Regional Health Authorities are to be replaced by, or perhaps transformed into, four to six Regional Health Councils and four to six Regional Social and Health Networks with most of their

current authority over the design and delivery of health services being taken over by a single Provincial Health Authority led by its own CEO as well as a new deputy-minister-level "senior executive" in the province's Cabinet Secretariat. How these new leaders will be chosen, or how they will interact with the Deputy Minister of Health or the Deputy Minister of Children, Seniors and Social Development is not explained but may come in the 'blueprint.' There will also be a provincial Council for Health Quality and Performance with permanent links to the Quality of Care NL unit that is currently led by one of the report's co-chairs, Patrick Parfrey.

Taken together, the 57 actions proposed by the Task Force amount to a menu for massive and complex change. The report includes a discussion of change management techniques (Actions 10.14-16) as well as a set of recommended steps for their adoption and implementation (Action 11.10 including the creation of an interim CEO and interim council for the new Provincial Health Authority). Even the least audacious of these calls to action involve changes that the province's health system has long resisted or avoided. In addition, many of them will require, as the authors concede, new and innovative leaders and considerable investment at least in the short and medium terms.

With only the visioning report available, without detail about what steps will be involved, who will undertake them, how they will be sequenced, nor how much they will cost, it is hard to anticipate the likelihood of successful implementation of some, many, or all the proposed reforms. Meanwhile, health systems researchers in Newfoundland and other provinces must await the release of 'the blueprint' and 'the evidence library' to learn which experts and decision makers from outside the province have been consulted or how changes like those being proposed have been implemented in other jurisdictions, either in Canada or elsewhere, and what evidence exists about their impacts. Releasing the 'final report' before the second and third components are ready may have been a clever strategy in that it has put the general outline of the Task Force's findings into play but made it hard for government or the media or public opinion to respond in any substantive way. The Premier has simply acknowledged receipt of the report and released it to the public. Discussion in the mainstream and social media has been limited with a focus on the proposal for a basic guaranteed income. Real discussion of the proposed reforms is likely to emerge only after the next two volumes, and especially the second, are released.

At this point, all we can do is speculate about the shape of that upcoming discussion. It is hard to foresee much disagreement with the bulk of the report's assessment of the current system, although various groups such as alternative health groups and wellness advocates will portray it as too narrow while others may complain about its excessive breadth and lack of focus. Among health systems researchers, the proposal to eliminate Regional Health Authorities and replace them with a single, province-wide authority as was done in Alberta with mixed results is likely to spark debate, as will the proposal to create a potentially confusing array of new provincial and regional bodies whose roles and interrelationships have not yet been clearly delineated. Given the province's dire economic and fiscal situation, the blueprint will probably seek to keep cost projections as modest

as possible, to provide optimistic projections for savings to be generated by many of the health system reforms, and to emphasize the cost of doing nothing. Even if the government decides, as is likely, to implement the reforms in staggered fashion over several years, any costs will have to be incurred well before projected savings are realized. Governments tend to be reluctant to spend now in order to (possibly) save later. In this regard, it is worth noting that the report's 5-year implementation period is longer than the current government's life expectancy. Accordingly, even if the Premier and the Cabinet end up endorsing the full report and promising to implement all or most of its proposals, they are likely to choose a gradual, step-by-step implementation process focused on the least costly of the proposed reforms and especially those that involve more consultations and the development of frameworks and plans rather than concrete changes. This cherry-picking approach would violate the Task Force's ardently expressed wish that its proposed program be "understood as a single, integrated, holistic, comprehensive approach (p. 6)." The decision by the Task Force to 'go big' by proposing such a huge array of calls to action and objectives may have been a mistake if it is taken as a non-negotiable demand for full adoption and comprehensive implementation. It is also possible to see it as a pragmatic bargaining strategy that will allow the government freedom of manoeuvre while giving the leaders of the Task Force input into the process by embedding them and their allies in the bodies that will oversee its rollout and evaluate its impacts.

2 REFERENCES

Bornstein S, Abbott J, Maddalena V, Letto A, Sullivan M, Navarro P. 2021. *Newfoundland and Labrador: a health system profile.* University of Toronto Press.

Fierlbeck K. 2018. *Nova Scotia: a health system profile.* University of Toronto Press.

Government of Newfoundland and Labrador (Executive Council). 2020. Press Release: Premier Furey and Minister Haggie appoint co-chairs for Health Accord NL. 5 November. https://www.gov.nl.ca/releases/2020/exec/1105n03/

Health Accord NL. 2022. Our province. Our health. Our future. A 10-year health transformation. https://healthaccordnl.ca/final-reports/.

Marchildon GP. 2005. Health systems in transition—Canada. European Observatory.

Marchildon GP, O'Fee K. 2007. *Health care in Saskatchewan: an analytic profile.* University of Regina Press.

Marchildon GP, Torgerson R. 2013. *Nunavut: a health system profile.* McGill-Queen's Press.