Making the most of Commitments made to Canada's Health System

Pre-Budget Consultations in Advance of the 2024 Federal Budget

Submitted August 4, 2023

Canadian Cardiovascular Society
Leadership. Knowledge. Community.

Recommendation:

1. That the Canadian federal government support recovery from COVID-19 of health systems in Canada, by defining targets for screening, diagnosis, and management of cardiovascular disease. The development of these targets should begin with management of heart failure as a priority as quickly and comprehensively as possible. Targets for additional chronic cardiac conditions, and other non-cardiac chronic disease, could follow, thereby improving benchmarking, measurement of health service delivery, and ultimately patient outcomes for Canadians living with chronic disease. The initial work to set target for heart failure care requires an investment of $3 million in funding over three years.
2. The CCS urges immediate climate action: implement 2030 emissions plan, end fossil fuel subsidies, and support transition policies for a healthier future.

Heart disease is a leading cause of death, premature death and disability among Canadians. There is a steady increase in the health burden of heart disease on individuals, and in the cost to taxpayers in Canada. Before the COVID-19 pandemic, the economic burden was expected to reach $28.3 billion annually, including more than $2.8 billion (or 1% of GDP) related to heart failure (HF).

Heart failure (HF) is a chronic, progressive condition that requires ongoing management.[1] It occurs when the heart is not able to properly circulate blood throughout the body following heart damage or because of a weak heart. One in three Canadian are affected by HF, either directly or through a loved one. It is one of the top 3 causes of hospital admission in Canada, requiring lifelong treatment.

In February 2023, federal, provincial and territorial (FPT) governments agreed on a new health funding arrangement. The federal government will invest $196 billion in health care over 10 years, including $19 billion in new funding through the Canada Health Transfer and $25 billion for bilateral health agreements. Bilateral agreements will be focused on four defined priorities and requires reporting on progress. This approach echoes the success of previous governments who reported wait times against medically acceptable benchmarks and worked closely with the Canadian Cardiovascular Society, other medical speciality societies and the Canadian Medical Association. The buy-in of health care providers, governments and patients must be embedded into metrics for meaningful improvements in care. Specific cardiovascular metrics have not yet been defined.

In the past, policy makers have learned about the causes of high wait times and the variety of strategies that can be employed to address them. Much of the attention has focused on the hospital component. While hospital-based efforts to improve patient flow, they represent improvements to only one part of the system, and do not fully address the range of contributing problems from the perspective of patients. Quality improvement efforts by health care providers to prevent, screen for and treat illness are implemented daily. But these individual efforts cannot be effective within a system that is not designed to support health care in 2024 and beyond.

Acute care hospitals operate at high capacity because there are large numbers of patients requiring a vast spectrum care who have nowhere else to go. For example, heart failure patients awaiting a transfer home with home care support block the admission of additional patients into the hospital while they wait for homecare care to be available. Patients who cannot afford medications see worsening of their heart condition and end up with repeated unplanned readmissions through emergency departments. The interconnectedness of all the sectors in health care has been underappreciated, and poor communication and siloed funding has inhibited the real integration that could improve care. There are insufficient health care providers, many of whom are not able to practice to their full scope; limited operating room time; limited machines for advanced imaging; and other shortages of human and material resources that contribute to growing wait lists. Wait times for specialist care and diagnostic imaging, in turn, increase the burden placed on family doctors through a greater number of patient visits while patients wait, and their conditions deteriorate. There is enormous administrative burden on health providers

[1] Ensuring Canadian heart failure patients receive optimal care. Canadian Cardiovascular Society. August 16, 2022.

and decreases time for of patient care. In implementing solutions, targets must be known at the outset to determine if change measures have been successful. We have not, as a nation embraced the notion that we need to measure and publicly report wait times beyond the few procedures identified by the Minsters in 2004. Notably, some provinces have reported on wait times for some areas of care, but there are not yet national benchmarks and no accountability to achieving acceptable wait times in Canada.

For example, the province of Saskatchewan focused on reducing wait times by defining targets, adding resources, introducing innovative practices and tools, and enabling care providers to work to their full scope of practice. This is making a difference. While this is an encouraging anecdote, Canadians can and should expect more. Health care delivery in Canada compares so poorly to that of other developed nations partly because we have not implemented a consistent and wholistic nation-wide strategy to address the problems within the health system.

Therefore, provinces, territories, and the federal government (for Canadians whose care is provided through federally-run programs) must publicly report on a range of metrics describing health system performance to, thereby, make it clear where change has been effective in improving outcomes, and where improvements remain to be made.

Canada should define national wait times that are accepted by provincial and territorial governments, health care providers, and patients.

A Focus on Heart Failure will Support Canada's Economic Recovery

A pan-Canadian approach can support Canada's post-pandemic recovery by the efficient use of funds, seizing cost savings, and applying additional tax revenue. We must reduce the burden of chronic disease, like heart failure, on individuals and their families. The economic impact of heart failure in Canada is significant – to individuals, our health care system, and our economy. In the workforce, heart failure results in early departure from the workforce due to disease-related disability, and lost productivity due to absenteeism, early mortality and exclusion from the workplace to take care of sick family members.

With a mandate and federal funding, the CCS will immediately update and establish wait time benchmarks for heart failure care. With this as the priority, we will then expand our focus to defining wait time benchmarks for all cardiovascular conditions, including those requiring surgery, non-invasive procedures, and access to referral rehabilitative services. The CCS is well positioned to build consensus by convening its expert members and consulting with its 14 affiliate sub-specialty societies, to establish benchmarks that will guide improvements of the health systems.

Based on prior experience with this work, to define, monitor and report on cardiovascular benchmarks, starting with heart failure, the federal government is asked to fund a task force for 3 years at a cost of $3 million. The mandate of this task force would be to first collaborate with heart failure health care providers, patients living with heart failure, and consult with provincial/territorial governments and non-governmental organizations to agree on and implement an approach to the reporting of heart failure wait times in Canada.

Given that HF is common, and progressive disease means that wait times must include all aspects of care such as diagnostic testing (echocardiogram and access to NTpro-BNP testing), access to specialist care, multi-disciplinary management programs, and newer areas of specialties/procedures such as TAVI.

Table 1
Estimated budget of proposed Cardiovascular Benchmark Task Force

Year	Budget
2024	$ 750,000
2025	$ 1 250,000
2026	$ 1 000,000

To define national benchmarks for heart failure care, and then follow with benchmarks for all cardiovascular conditions, the CCS will:

1. Work collaboratively with stakeholders to establish evidence-based HF wait times for Canada. This will include convening a national consensus conference of experts and people with lived experience.
2. Conduct a thorough assessment of the current HF wait times available with current data sources and make recommendations for enhanced data and reporting,
3. Consult with government officials and seek input about heart failure related wait times and additional data required.
4. Identify bottlenecks and priority areas of improvement.
5. Publicly report HF wait time benchmarks.
6. Evaluate the process and expand the work to additional cardiovascular conditions to define wait time benchmarks.

The CCS recognizes that First Nations, Métis and Inuit communities have unique challenges related to colonization, trauma, and living conditions. Over-crowded and poor-quality housing, water quality, lack of access to affordable food, jurisdictional issues and in some cases, remoteness, all affect their access to diagnosis and care. Many Indigenous Peoples of Canada do not trust the health system to treat them fairly and do not wish to enter into the system. We could not begin to justly describe the need for equity of access to care by defining wait times alone. We do pledge to work with Indigenous groups to define a path for improving access to care that is described and led by Indigenous Peoples.

Patient Engagement – The CCS supports patient-centred care. This means more than an individual right to make decisions for one's own health care and lifestyle choices. It also includes the involvement of patients in policy development and at the program planning, implementation,

and evaluation. The eight headline indicators identified in the new health agreements are excellent measures of patients' experience with health care. The CCS would extend this effort by developing additional indicators to better track improvements in cardiovascular care. These indicators would be developed with patients, or members of the family.

Reducing the impact of human behavior on climate change

There is an irrefutable link between the implications of climate change and the effect on the cardiovascular health due to extreme temperatures and poor air quality.16 We know that more than 20% of all cardiovascular disease deaths are caused by air pollution, and we expect these numbers will continue to rise without climate action. There is also an association between increased climate change-related heat exposure and an increase in cardiac events.

For these reasons, the CCS recommends that the federal government make policy and funding decisions that will mitigate the climate crisis and benefit cardiovascular health.
Specifically:

A. Fully implementing Canada's 2030 Emissions Reduction Plan and increasing ambition in the near term. The CCS supports Canada's 2030 Emission Reduction Plan – reducing GHG emissions 40% below 2005 levels by 2005 and net-zero emissions by 2050. There is a high likelihood that global temperatures will surpass the lower target of the Paris Agreement – limiting global warming to 1.5°C.1At this level, we can expect the impact of climate change to be increasingly harmful for human health.
B. Ending public financing to oil and gas companies.
   According to the International Institution for Sustainable Development (IISD), $1.91 billion was spent on fossil fuel subsidies in 2020 by the Canadian government and this may not capture everything based on insufficient data. Eliminating subsidies was one of the Liberal Party's commitments in the 2021 federal election, we are supportive of this commitment and rapid implementation.
C. Enacting "just transition" legislation and investing funds to help Canadian workers and communities succeed in a low-carbon economy. CCS recommends that funds be directed towards transitioning communities from economies that depend on fossil fuels to ones that depend on low/net-zero carbon. The Stockholm Environment Institute defines "just transition" broadly as the way in which equity issues associated with structural change are considered and properly managed.

Conclusion

As a significant provider of healthcare funds to the provinces and territories, the federal government has an interest in establishing accountability for the health services provided by the province and territories and by its own programs. Leadership from the federal government is needed to help define relevant and current national benchmarks , beginning with cardiovascular disease.

The CCS recommends that the Government of Canada upholds its commitment to climate actions that will benefit the health of Canadians and the planet.