Health Accord
for Newfoundland & Labrador

A Call to Action to Transform Health

Interim Report • April 16, 2021

In responding to its mandate to develop a 10-year Health Accord for the people of Newfoundland and Labrador, the Task Force established a three-phase process to ensure that the Accord would be developed in a thorough, inclusive, holistic, and integrated manner. The first phase of that process, the setting of the overall vision and direction for the Accord, has been completed. The outcomes are outlined in this Interim Report.

The overall vision and direction were decided after five months of extensive engagement with a broadly representative group of people from the public, stakeholder organizations, key informants, and officials from the provincial government and the four regional health authorities. The direction responds to a compelling case for change rooted in the serious health inequity experienced by Newfoundlanders and Labradorians. Pursuing the vision and the direction as outlined will mean a significant culture shift for the health system, for other social systems, and for government.

Having outlined the direction in which it is going, the Task Force now begins the second phase of its work: the identification of the key calls to action which will take the Health Accord into this new direction. As this phase of the work unfolds, the Task Force will be mindful of the fiscal envelope within which the plan must function. As in phase one, the Task Force will engage with all who have a vested interest in the outcome of this work before calling forth the actions needed.

Once this second phase is complete (by the end of September 2021), the Task Force will move to the third phase of its work, the final confirmation that the direction and calls to action constitute the Health Accord to which government, stakeholder organizations and the people of the province will make a firm and sustained commitment over the next 10 years. The final report will be delivered to government by December 31, 2021.

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Executive Summary

"Please try to be brave. Our only limitation is our lack of imagination, initiative, and courage."

Town Hall Participant, Series 2, Survey

Newfoundlanders and Labradorians have the right to health. As there are indicators of worse health in the province in comparison to other provinces in Canada and among groups within the province, steps must be taken to address this inequity. The Government of Newfoundland and Labrador has chosen to explore such steps by appointing a Task Force on Health in November 2020.

Task Force Objective:

To use evidence, strategies, and public engagement to create a plan for a 10-year Health Accord that will improve health in Newfoundland and Labrador, and to do so within the fiscal envelope of the province.

This objective, to be completed by December 2021, will be carried out in two phases: setting the direction and developing an implementation plan. This document summarizes the results of the first phase.

A Compelling Case:

Health outcomes in the province are among the worst in Canada, with the lives of Newfoundlanders and Labradorians shorter by 2.6 years compared to other Canadians. The lives of Canadian Indigenous people are shorter by a further 4.7 years. The province has among the highest rates of chronic disease as well as death from cancer, heart disease and stroke in Canada, even when adjusted for the older age of the population.

The province's health system was structured over 50 years ago at a time when there were 200,000 children (under the age of 15 years) and 30,000 seniors (over the age of 65 years). Today, in the province, there are 70,000 children and 120,000 seniors.

The poor health care system performance is a result of systemic challenges and does not reflect the competence, the compassion, the dedication, and the hard work of all those who work in the system. Confidence that it is possible to bring about a culture shift in the approach to health and health care comes from knowing that those who work in the system will provide the wisdom, the leadership, and the energy to make it happen.

Engaging to Lead Change:

The Task Force, appointed by the Premier and Minister of Health and Community Services, has 25 members including people from stakeholder groups and the broader community. Six strategy committees, broadly representative of the health and social systems and the community, have been meeting for the past four months. Evolving strategies include those related to the social determinants of health, the aging population, community care, hospital services, quality health care, and digital technology.

There have been two rounds of engagement with 21 public town halls, ten special interest town halls, and more than 75 stakeholder group meetings. The same high level of engagement will continue as the Task Force moves into the implementation phase. The Task Force and Committees have heard from and will continue to engage with multiple key informants through a variety of communication processes.

What We Have Heard:

There was strong agreement on two themes: first, the social determinants of health comprise the biggest factor that affects health, and second, the ways in which regular care from providers is received needs to change.

Three major areas of concern were identified. There was a focus on social determinants of health including early childhood development, poverty, housing insecurity, food insecurity, and disabilities.

Health system access was another major area of concern with priorities relating to access to primary and specialist care, care for older people, a better integrated hub and spoke structure, and medical transportation.

The third major area of concern was the performance of the health system with priorities focused on better team-based care, digital communication, a better health system structure, providers working to the full scope of their practice, and seniors' care.

A Vision Emerges:

The vision of Health Accord NL is improved health and health outcomes for Newfoundlanders and Labradorians through acceptance of and interventions in social determinants of health and a higher quality health system that balances community, hospital, and long-term care services. We will improve the health of the people by:

- addressing specific areas of concern relating to social, economic and environmental factors
- empowering people to transition seamlessly through age-related health changes
- balancing the health system with accessible team-based networks of community, hospital, and long-term care services

- ensuring high quality care in social and health systems
- creatively using digital technology to connect systems and people as well as health and social systems

The realization of this vision will require a holistic and integrated approach to change.

Pathways to Success:

Interwoven across these strategies are pathways to ensure the success of the plan by:

- a new approach to governance and oversight, and to engaging community groups
- a cross-sectoral approach to health literacy
- strengthened human resource planning and education for those who work within health and social systems
- an awareness of interdependence which demands commitments to work with provincial, federal, and Indigenous governments, municipalities and communities, and to build on existing government initiatives

A Call to Action:

Based on the compelling case for change and the convergence of ideas arising from both public engagement and the strategy committees, we call on the public, the stakeholders and the political system to engage in the creation of a Health Accord. This will be an agreement about how we together can improve health and health equity, with implementation within five years. Such engagement is essential if our objective of a transformation in health outcomes in Newfoundland and Labrador over the next 10 years can be achieved.

Introduction

"The cultural shift needed in health care must include changing the nature of the care relationship between providers and people from provider as expert to provider as partner with people in their care journey. Both citizens and providers will need education and coaching to transition to a patient centric partnership model of care."

Town Hall Participant, Series 1, Survey

On November 5, 2020, Premier Andrew Furey and the Honourable John Haggie, Minister of Health and Community Services, announced a Task Force on Health Care with Co-Chairs, Dr. Patrick Parfrey and Sister Elizabeth Davis. Six strategy committees were established to carry out the work of the Task Force which is focusing on creating a Health Accord for Newfoundland and Labrador (NL). Health Accord NL will be dedicated to improving health outcomes and achieving health equity for Newfoundlanders and Labradorians by understanding and intervening in social, economic, and environmental factors which influence health, and by reimagining a higher quality health system that balances community, hospital, and long-term care services. The Health Accord will be an agreement among Government, organizations, and the people of the province.

In the context of the Health Accord in agreement with the World Health Organization, the Task Force considers health to be **"a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."**

Members of the Task Force and six committees were selected based on their knowledge, experience, and perspective. Efforts were made to have as broad a representation as possible, giving consideration to:

- gender
- rural/urban
- Island/Labrador
- age groups
- experience from health and from other sectors
- those who work in health and social systems
- members of Indigenous communities (with the support of Indigenous governments)

In total, there are 90 individual members of the Task Force or Task Force Committees. Members have taken on this responsibility in addition to their regular job responsibilities both within and outside the health care system. Additionally, many retired health care and other sector leaders are volunteering their time because they are committed to this important change process. The members of the Task Force and six strategy committees are listed in Appendix A. The Terms of Reference of Health Accord NL is included in Appendix B.

The Task Force has adopted the following vision:

Our Vision is improved health and health outcomes of Newfoundlanders and Labradorians through acceptance of and interventions in social determinants of health, and a higher quality health system that balances community, hospital, and long-term care services.

To achieve this vision, the Task Force has set the following objective:

Use evidence, strategies, and public engagement to create a 10-year Health Accord that will improve health in Newfoundland and Labrador and do so within the fiscal envelope of the province.

All Task Force work is guided by the following principles:

- We believe that social, economic, and environmental factors, together with personal characteristics (biology, genetics, gender and personal behaviours) and health systems, help determine health outcomes for individuals and communities.
- We believe that only by attending to all these factors together will we find the culture change needed to ensure better health outcomes, while helping people become and stay healthy, find well-being, and thrive economically.
- We believe that people and communities will decide how best to address these factors in ways that reflect their values, their perspectives, and their preferences — therefore, public engagement is key in bringing about healthy culture change.
- We believe that partnerships across all sectors are essential in transforming health outcomes and coming closer to health equity in this province over the next 10 years.
- We believe that digital technology and funding consistent with our priorities are important resources in reorienting and rebalancing our health system.

Although the Health Accord itself will take 10 years to bring about the transformation needed to improve health and health outcomes and to move closer to health equity, the work of the Task Force will be completed by December 2021. It is expected that the calls to action on which the Task Force is built will take up to five years to implement. Evaluation will take place along the 10-year period to ensure that the calls to action are being implemented and are achieving the anticipated outcomes.

Phase One

The first phase of the Task Force's work is centered on creating the directions at each of the six strategic levels and for the Health Accord itself. This interim report describes these directions. Three supplements to the report (Engagement, Evidence, and Social Determinants of Health) will provide more detail related to these areas.

Phase Two

The second phase of the Task Force's work will begin in April 2021 and will outline the calls to action needed to achieve the named directions as well as the choices essential to responding to these calls to action.

A Compelling Case

"I think that the presentation of the FACTS I watched prior to this Town Hall should be on the front page of every existing community and city newspaper, radio, TV, social media, and the subject of VERY public discussion."

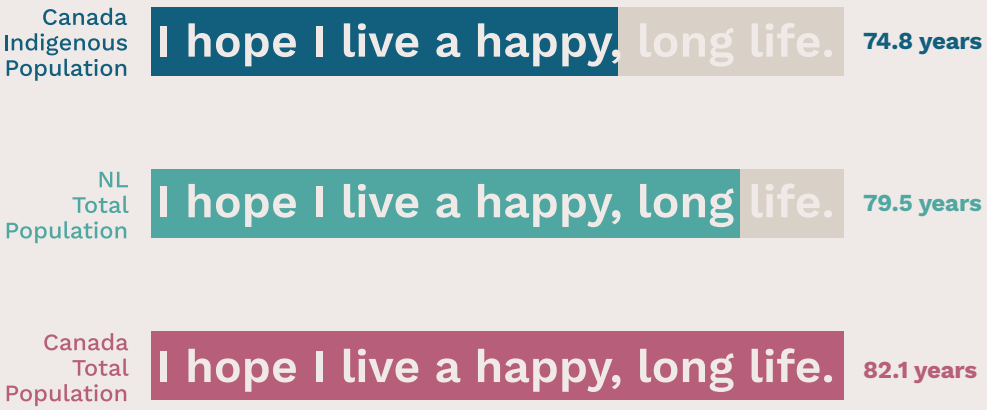
Town Hall Participant, Series 2, Survey

A Compelling Case

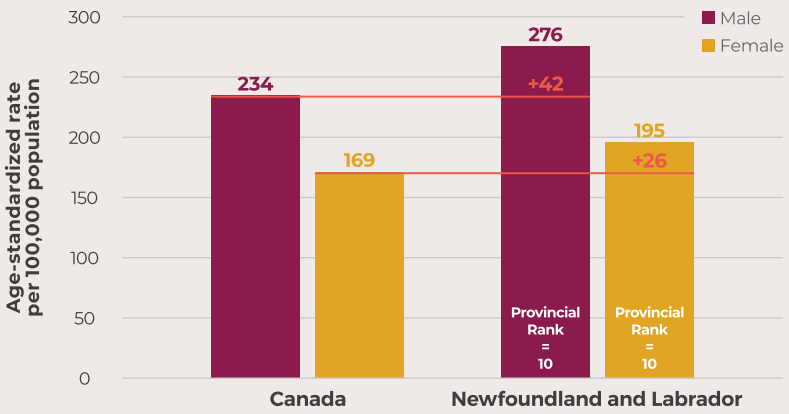
The Task Force was created in response to a gathered body of evidence which identified six stark facts that describe the unacceptable health inequity experienced by the people of Newfoundland and Labrador (see Practice Points Special Edition, November 2020).

The following six facts provide a compelling case for change:

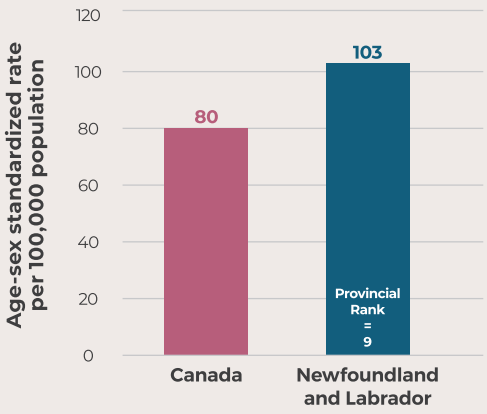
1. The people of Newfoundland and Labrador, on average, have the **worst life expectancy**, **highest death rates for cancer, cardiac disease and stroke**, and **highest rate of chronic disease** compared with the people of other provinces in Canada.



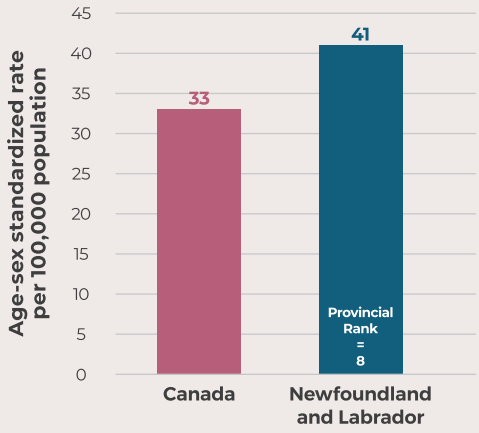
The life expectancy of Newfoundlanders and Labradorians is **2.6 years less** than the life expectancy of Canadians (Statistics Canada 2016). The lives of Canadian Indigenous people are substantially shorter, **72.5 years for males and 77 years for females** (Statistics Canada 2011).



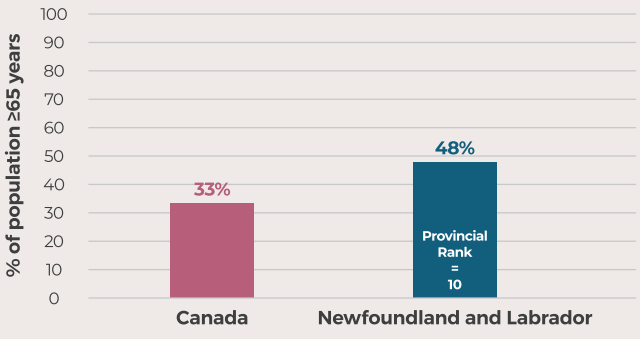
Cancer mortality



Cardiac disease mortality



Stroke mortality



Seniors with three or more chronic conditions*

*Chronic Diseases/Conditions are diseases that are long lasting and generally progress slowly, which can be treated but not cured. These can include hypertension or high blood pressure; heart disease including heart attack; diabetes; asthma or chronic lung disease such as chronic bronchitis, emphysema, or chronic obstructive pulmonary disease (COPD); depression, anxiety, or other mental health problems; cancer; joint pain or arthritis; and stroke.

2. Since 1981, there has been a **6% increase in social spending** (despite the social factors underlying chronic illnesses noted in Fact #1) while there has been a **232% increase in health care spending**.

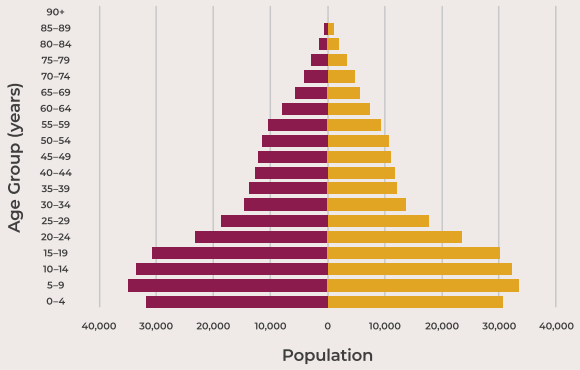
3. Studies show that Newfoundland and Labrador has the **worst health system performance** across the Canadian provinces.

4. Newfoundland and Labrador has the **highest level of per capita spending on health care** compared with other provinces in Canada. Facts #3 and #4 suggest that this province provides the **worst value for spending in health care in Canada**.

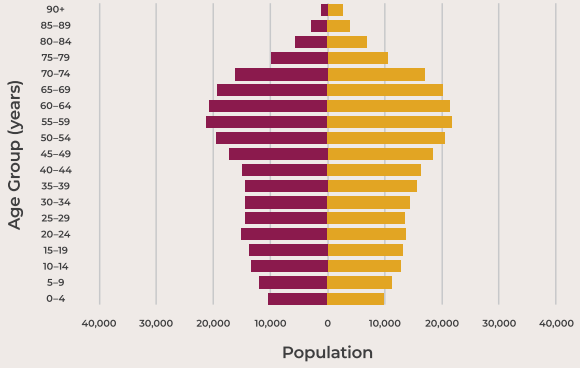
5. There has been a **dramatic population shift in Newfoundland and Labrador** in the past 50 years with a decreasing number of people under 15 years of age (from 200,000 in 1971 to 70,000 in 2021), an increasing number of people over 65 years of age (from 30,000 in 1971 to 120,000 in 2021), and a significant migration from rural communities to urban communities.

6. The health system, developed more than 50 years ago for the population of that time, is **no longer suitable for today's population**. There is an **imbalance between community, hospital, and long-term care services**.

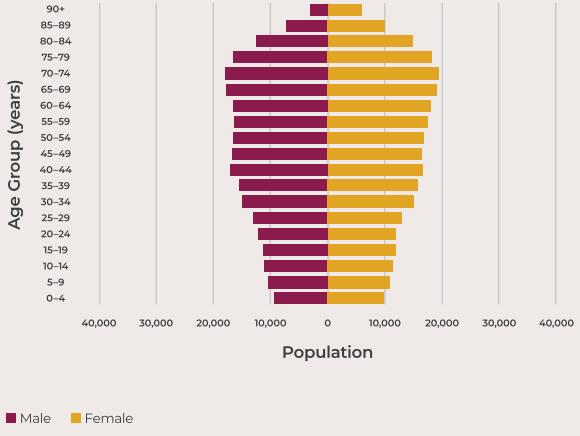
NL Population 1971



NL Population 2020



NL Population 2040



In response to this reality, it was determined that six strategic areas would provide the focus of the Task Force's work: social determinants of health, community care (broadened from the initial primary health care), hospital services, aging population, quality health care, and digital technology. Committees were established for each of these strategic areas, each with its Chair, a broadly represented membership, and a small secretariat (to assist with administration, operations, policy, and data support).

Each committee works separately, focuses on one specific area of the Health Accord, and meets with members of the public, stakeholders, and key informants. However, each committee is aware that its focus is integrally connected to and influenced by the work of the other five committees. Therefore, the work of all six committees is being integrated to ensure that one overall vision will guide the Health Accord that is being imagined. The integration across committees is achieved through regular meetings of the six committee Chairs with the two Co-Chairs, members of the committee secretariats who serve on all committees, attendance of the two Co-Chairs at occasional committee meetings and regular reporting from the committees to the Task Force itself.

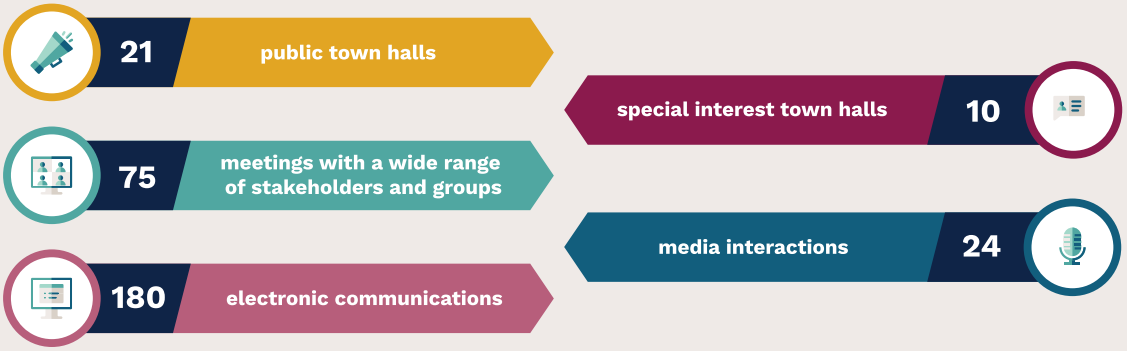
Engaging to Lead Change

"Municipalities can play a critical role. If we are going to look at better health outcomes in 10 years — living longer; lower BMI [Body Mass Index]; decreased admissions for acute and mental health — then there is a role for communities to play."

Municipalities Town Hall Participant

Your Health. Your Province. Your Say. is the title of the public town halls which were held during November/December 2020 and February/March 2021. The first series centered on introducing the Health Accord process, and the second series sought advice on strengthening the draft directions for the Accord. This title reflects the need for strong engagement that listens to and learns from the people of the province. Simply said, the Health Accord cannot be created, nor can it be implemented, without the will, the wisdom, the commitment, and the voice of the people. A compelling case for transformation is essential, but it is not enough. Evidence provides the basis for change; engagement ensures that change will happen. Regular, consistent, and transparent engagement with all stakeholders is essential for the creation and the implementation of the Health Accord.

In addition to the 21 virtual public town halls, there have been extensive media coverage, one-on-one meetings with Task Force Co-Chairs and key stakeholders, and a series of symposiums and town halls aimed at receiving input from specific groups of stakeholders. To date, Health Accord NL has been influenced by approximately 906 attendees at various engagement events and received 180 email communications (as of April 9, 2021).



A communication network with over 15 organizations has been created and will remain in place through the life of the Heath Accord process. This network includes regional health authorities, Newfoundland and Labrador Centre for Health Information, health sector unions, and others, and is a method of distributing information and inviting public feedback.

Health Accord NL Co-Chairs have participated in 24 media events. Dr. Patrick Parfrey and Sister Elizabeth Davis have been quoted in The Telegram and presented live on radio and television including, NTV, VOCM Open Line, CBC Cross Talk and CBC Labrador Morning.

The Health Accord NL website accepts submissions and emails from the public as well as stakeholders. Health Accord NL has social media accounts including Twitter, Facebook, Instagram, and YouTube to communicate and engage with the public.

Informing the work of the committees are key informant groups including members of the five Indigenous communities, many groups within the community sector and an Engagement Group. Not all these stakeholders hold a place within the formal Task Force or committee structure. They may be engaged by the Task Force or by the individual committees in varied ways. They all have an important role in informing the work of the committees and the Task Force as the Health Accord begins to take shape.

What We Heard

"The best approach is the combined best of modern medicine and traditional healing methods."

Qalipu First Nation Town Hall Participant

Since beginning the work in November 2020, the Task Force and committees have sought input and advice in two separate stages of engagement, one from November 2020 to January 2021 and the second from February 2021 to March 2021.

Engagement Series One – What the Stakeholders Said

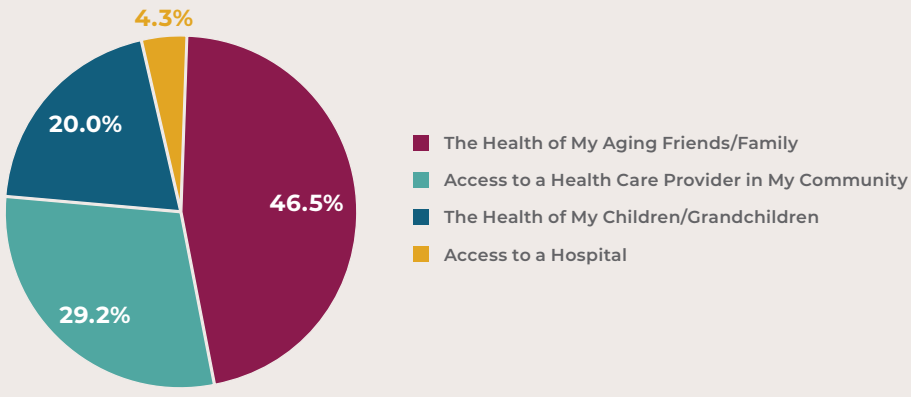
"There is ageism in that people could stay in their home; there is no focus on prevention, and access is normally much too late. Great to have availability of a variety of services — meals on wheels, social contact, checking on seniors, shopping and transport services, day cares for seniors."

—Town Hall, Series 1, Comment

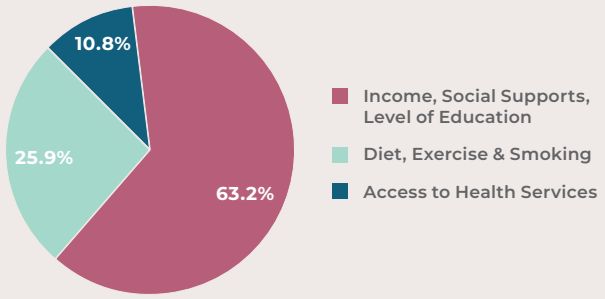
In the first series of virtual town hall meetings, 320 participants gave input through completion of a poll and a survey and through comments and questions during the meetings. Below are examples of the input received. A more detailed summary is contained in the Engagement Supplement.

The following two figures come from the Poll Questions asked at the beginning of each town hall session.

Which of the Following Is Your Top Concern Around Health? (N=185)



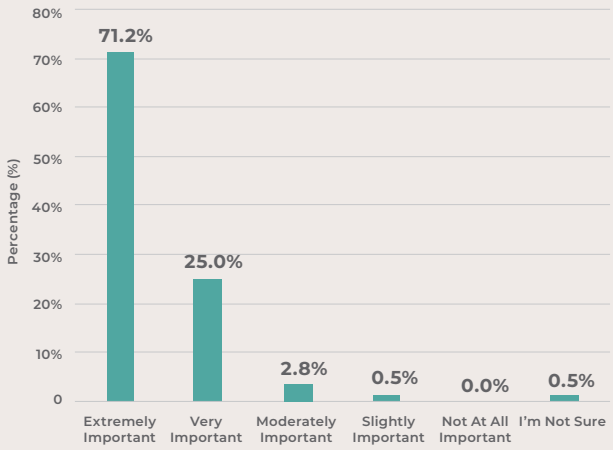
What Is the Biggest Factor That Affects Health? (N=185)



According to respondents the biggest factor that affects health is related to the social determinants of health and to a lesser extent personal behaviours. This is a response consistent with evidence that these factors contribute far more to adverse health outcomes than health services do.

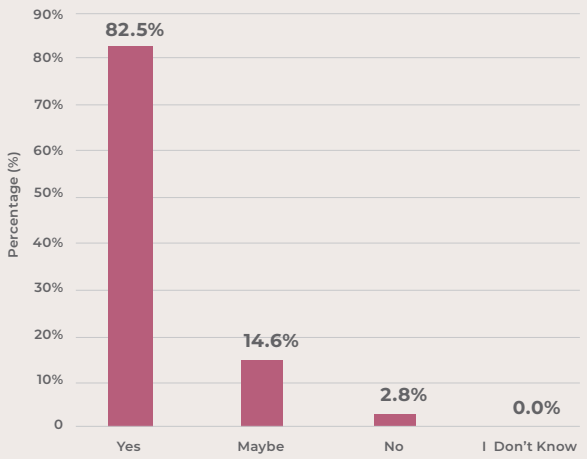
The next two graphs show the answers to two quantitative questions asked in the town hall survey.

Is It Important to Provide Solutions to Social Factors That Affect Our Health Like Level of Education, Employment, Our Social Circumstances, Culture, Race, Etc.? (N=212)



In the survey, 96% of respondents answered that it was extremely or very important to provide solutions to social factors that influence health.

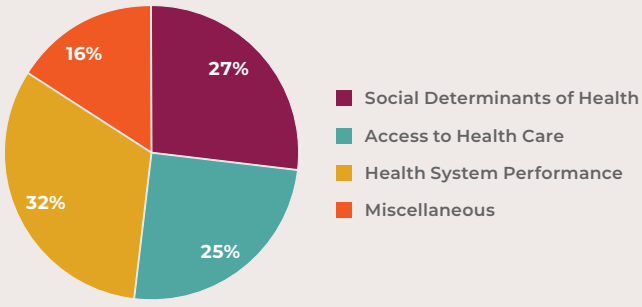
Do You Believe That the Way We Receive Regular Care From Doctors, Nurses, or Other Providers Needs To Change? (N=212)



In the survey, 83% answered that the way we receive regular health care from providers needs to change.

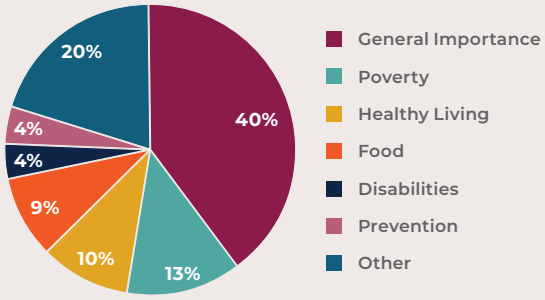
The next four diagrams summarize the qualitative analysis of the questions asked and comments made on the surveys at the virtual town halls.

Relative Contribution of Social and Health Themes Arising From Questions and Comments From Town Halls (Responses = 618)



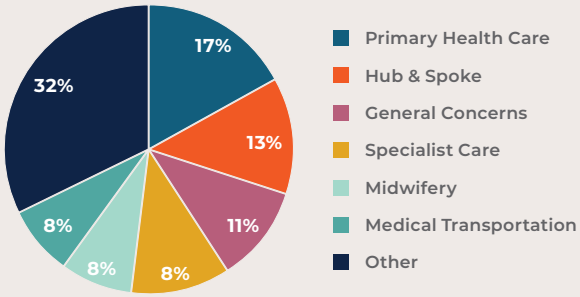
The proportion of comments was nearly equally distributed across themes related to social determinants of health, access to the health system, and performance of the health system.

The Top Six Themes Arising From Both Questions and Comments Concerning the Social Determinants of Health (Responses = 167)



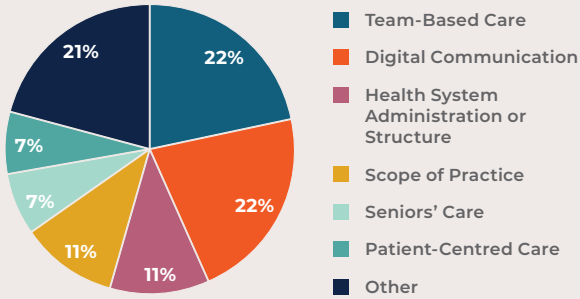
Specific sub-themes identified in the **social determinants of health** included poverty, healthy living, food insecurity, and disabilities.

The Top Six Themes Arising From Both Questions and Comments Concerning Health System Access (Responses = 157)



Specific sub-themes identified in **access to the health system** were access to primary care, a better hub and spoke model, access to specialist care, midwifery, and medical transportation.

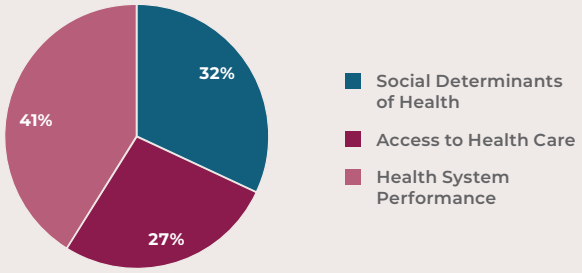
The Top Six Themes Arising From Both Questions and Comments Concerning Health System Peformance (Responses = 196)



Specific sub-themes identified in **performance of the health system** were team-based care, digital communication, system structure, providers working to the full scope of their practice, and seniors' care.

The next graph illustrates the relative contribution of social and health themes identified from email and website contributions.

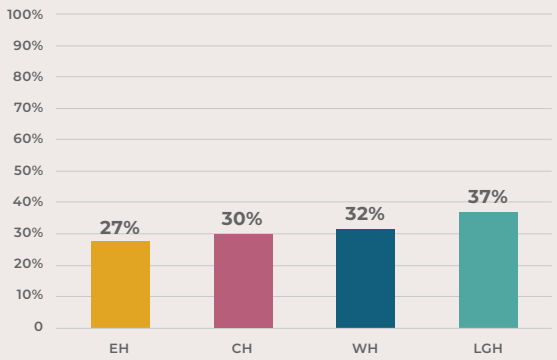
The Relative Contribution of Social and Health Themes Arising From Electronic Communication With the Public (Responses = 76)



The proportion of comments was almost equally distributed across themes related to social determinants of health, access to the health system, and performance of the health system.

In 2019–20, Regional Health Authorities (RHA) completed Community Health Assessment Surveys to aid the 2020 to 2023 strategic planning cycle. A total of 7,255 surveys were completed by members of the public. Eastern Health (EH), Western Health (WH), and Central Health (CH) used a similar survey and report similarly by region; Labrador-Grenfell Health (LGH) did not report for the full region but reported for each of the six sub-regions as each sub-region is very different from a socioeconomic standpoint. The following charts show some conclusions from these reports.

Percentage of Respondents Unable to Access Health Care Services in the Past 12 Months



The percent of respondents unable to access health care services in the past 12 months ranged from 27% in Eastern Health to 37% in Labrador-Grenfell Health.

Top 10 Issues/Areas of Concern in the Community in EH, CH, and WH

	EH (%)	CH (%)	WH (%)
Addictions	57	58	51
Mental health	56	62	46
Cost of living	55	46	46
Road quality	54	50	51
Chronic disease	53	53	46
Distracted driving	44	36	42
Bullying	36	36	39
Unemployment	35	27	27
Seniors resources	34	36	26
Food insecurity	56	62	46

The top two issues of concern were addictions and mental health. The percentages for the top 10 areas of concern differed little by RHA.

Of the top six areas of concern in LGH, five were similar to the RHAs in the rest of the province, and the sixth related to language and culture.

Taking into consideration all the input and advice, each Committee drafted key directions. These key directions were shared with stakeholders including the public and community and health specific groups in order to receive further advice on the drafts. Considering this input, each Committee drafted its direction statement.

These six direction statements, integrated together with the vision, show where Health Accord NL is going and what it will look like when it gets there. As further engagement happens on the plan going forward, there may be further refinements to the wording of the statements, but there will not be major adjustments to the overall way forward.

Engagement Series Two – What the Stakeholders Said

"If economic considerations are to be considered in the social determinants of health, is there space to make a recommendation to government to introduce rent control in the province so that the cost of housing doesn't take the lion's share of someone's income?"

—Town Hall, Series 2, Comment

"Has any consideration been given to pharmacare and the importance of people being able to afford and properly take the prescriptions they are given? "

—Town Hall, Series 2, Directions Survey

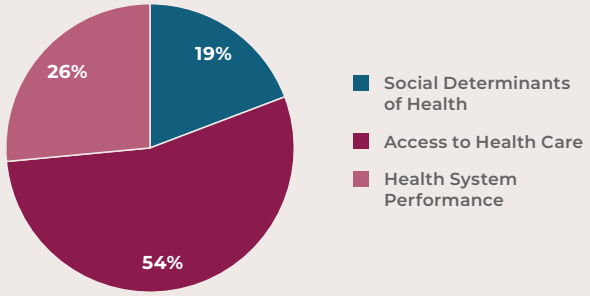
Engagement Series Two occurred from February to March 2021, centered around the six direction statements drafted by the Committees. The purpose was to bring the drafted statements to the attention of the public and to determine if the directions were supported, required refinement, or needed major change. With these key directions as the focus of engagement, the Task Force continued one-on-one engagement meetings between Task Force Co-Chairs and key stakeholders.

Eleven public virtual town hall sessions were held during February/March 2021 with 358 participants covering all areas of the province. Participants were invited to complete a survey related to the direction statements.

This second engagement series offered several new opportunities and methods of engagement for the public and health system stakeholders. An engagement guide was created and posted on the website. New opportunities included two website surveys for both the general public and organizations to complete: (i) a general survey, and (ii) a survey related to the vision statement and the six committee direction statements.

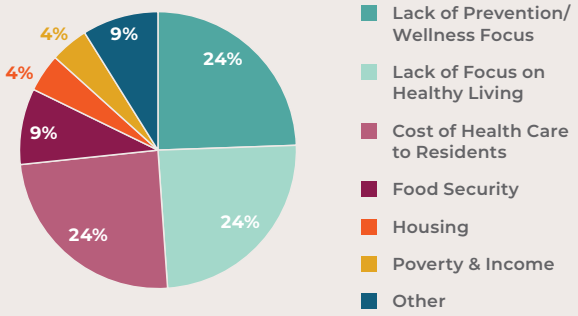
The themes arising from the comments made in the general survey on the question “Overall what aspects of health and wellness are you dissatisfied with?” are provided in the next four graphs.

Major themes identified from comments on “Overall what aspects of health and wellness are you dissatisfied with?” (Responses = 234)



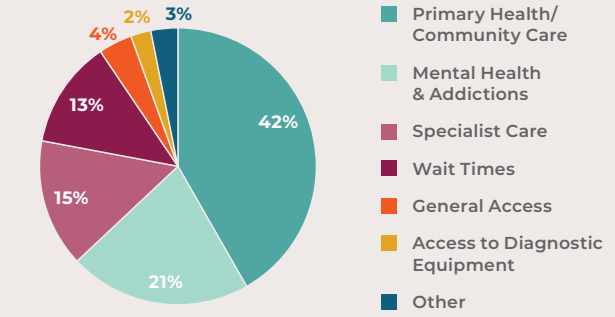
The majority of comments concerned access to health care.

Specific sub-themes associated with the social determinants of health theme identified from comments on “Overall what aspects of health and wellness are you dissatisfied with?” (Responses = 45)



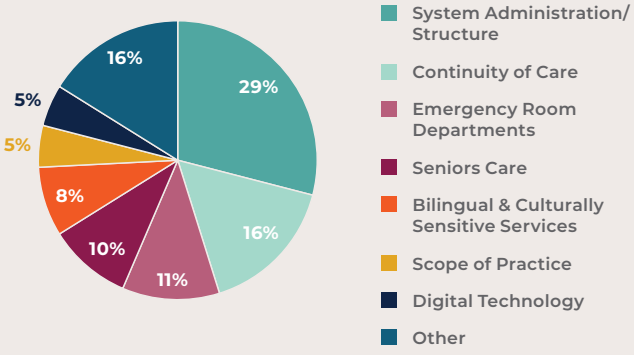
The top three sub-themes associated with the **social determinants of health** were prevention, healthy living and cost of health care to residents.

Specific sub-themes associated with the access to the health system theme identified from comments on "Overall what aspects of health and wellness are you dissatisfied with?" (Responses = 127)



The top four sub-themes associated with **access to the health system** were access to primary health care, access to mental health and addictions services, access to specialist care, and long wait times.

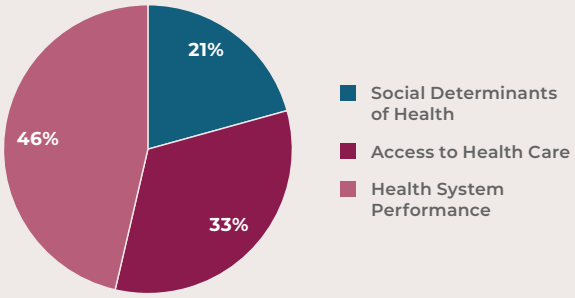
Specific sub-themes associated with the performance of the health system theme arising from comments on "Overall what aspects of health and wellness are you dissatisfied with?" (Responses = 62)



The top three sub-themes associated with the **performance of the health system** were system structure, continuity of care, and emergency departments.

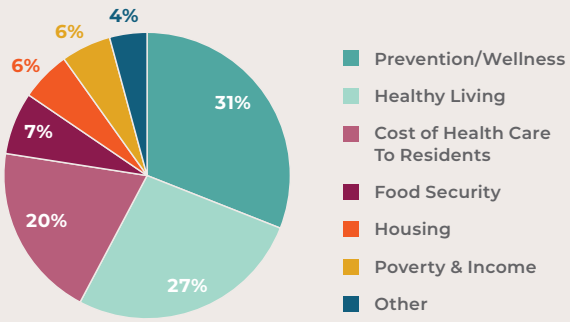
The themes arising from comments made in the general survey on the question "In your opinion what are the top three things that the province should do over the next 5-10 years to improve health care and service delivery?" are provided in the next four graphs.

The major themes arising from comments on "What are the top 3 things the province should do over the next 5-10 years to improve health care and service delivery?" (Responses = 343)



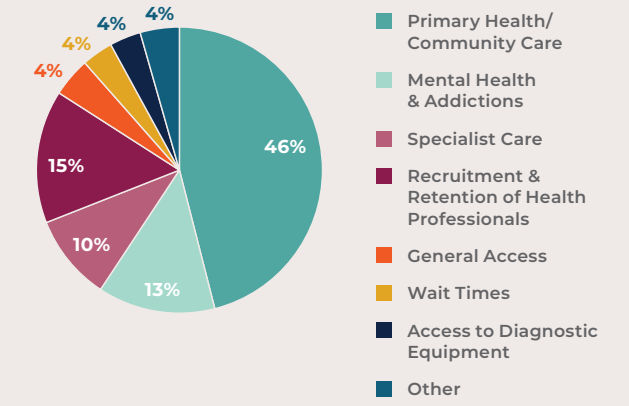
Forty-six per cent of respondents felt that the performance of the health system needed to improve, followed by improvement in access to the health system and the social determinants of health.

Major sub-themes associated with the social determinants of health theme identified from comments on "What are the top 3 things the province should do over the next 5-10 years to improve health care and service delivery?" (Responses = 71)



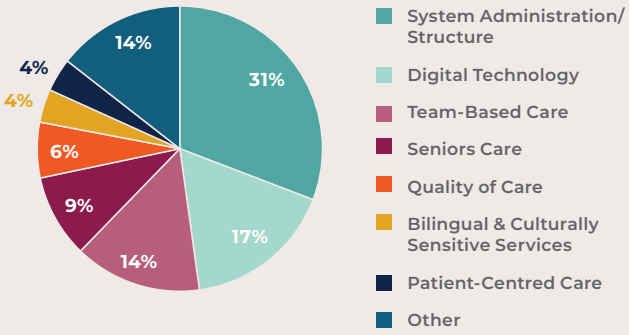
The three major sub-themes associated with the **social determinants of health** were prevention, healthy living, and cost of health care.

Major sub-themes associated with the access to the health system theme identified from comments on "What are the top 3 things the province should do over the next 5-10 years to improve health care and service delivery?" (Responses = 113)



The three major sub-themes associated with **access to the health system** were access to primary care, access to mental health and addictions services, and recruitment of health professionals.

Major sub-themes associated with the performance of the health system theme identified from comments on "What are the top 3 things the province should do over the next 5-10 years to improve health care and service delivery?" (Responses = 159)



The three major sub-themes associated with **performance of the health system** were improvement in system structure, use of digital technology, and team-based care.

A second round of public virtual town halls occurred between February 22 and March 11, 2021. There were 356 attendees at 11 town halls.

Health advocacy organizations and health professional associations were invited to present their priorities to the Task Force virtually.

Other special interest town halls included:

- seniors' groups hosted by the Aging Population Committee
- community groups hosted by the Community Care Committee
- key players in the air and road ambulance system hosted by the Hospital Services Committee
- appropriate drug use hosted by the Quality Health Care Committee
- food security hosted by the Social Determinants of Health Committee
- Municipalities NL and its members
- patient advisory groups from around the province
- Community Sector Council of NL network
- Qalipu First Nation

Additionally, the Task Force supported any key stakeholders wishing to use focus groups to gain insight from their members. There were five media events: four on radio and one newspaper article.

The level of support for the drafted direction statements was high. There were suggestions for re-wording to strengthen clarity in some of the statements. Based on advice from the public and stakeholders about missing elements, the Task Force also created four pathway statements which were interwoven across all strategy areas of the six Committees.

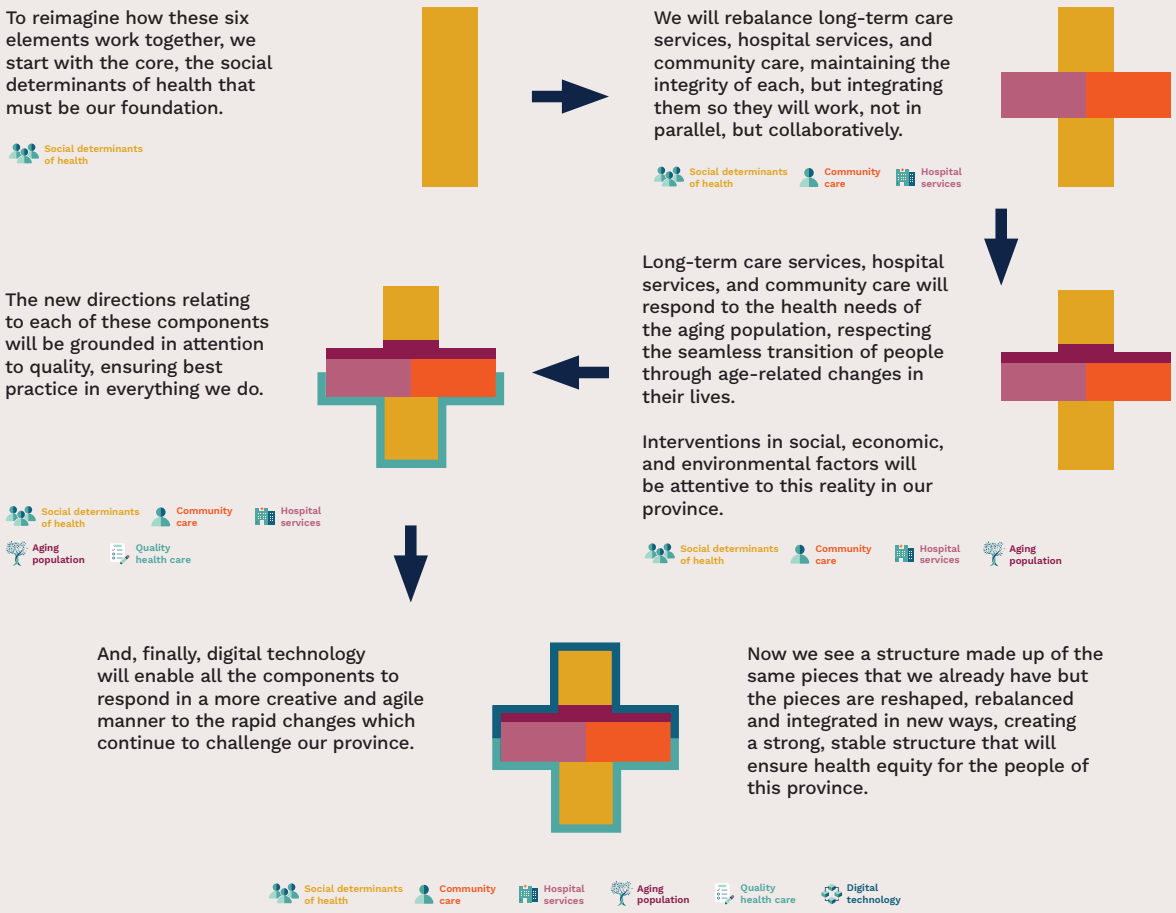
A Vision Emerges

"Healthy communities mean more than just caring for people after they have already become ill. We need to address poverty and food security by strengthening the social fabric of our communities and ensuring that people have access to affordable healthy food, warmth, and shelter."

Town Hall Series 1, Survey Response

During the first phase of the work of the Task Force, the committees were asked to concentrate on the key directions for their strategic areas. As noted above, these key directions were presented to the public via the virtual town halls and to other key stakeholders via special town halls, symposiums, focus groups, and meetings. Input was gathered and synthesized. The final statements of key directions were reaffirmed or shaped accordingly. This work has resulted in the following six direction statements that will form the basis of Task Force work going forward.

In phase one, we remain focused on the six key strategies with their individual directions. But to bring about health and health equity, these six strategies must be integrated and together create a holistic approach.



The animated version of this graphic can be found at healthaccordnl.ca

Direction Statements from Six Strategy Committees

Social Determinants of Health

We will continue to seek a clearer understanding of the **social**, **economic**, and **environmental factors** which have led to continuing health inequity in NL. We will **engage** communities in identifying and addressing specific areas of concern.

We will challenge the health care system to strengthen its role in promoting **health equity**.

We will champion the "**Health in All Policies**" approach by provincial and municipal governments and encourage its expansion to include public, community and private organizations.

We will **build on our strengths** and existing initiatives to bring about a **cross-sectoral approach**, essential to improving the health of Newfoundlanders and Labradorians.

Community Care

Every person in Newfoundland and Labrador will have **timely access** to social and health services, and to **continuous care** centered in the community as part of a well-connected network.

This structure will be enabled and strengthened by **interdisciplinary teams working collaboratively** with individuals and their families and focusing on all aspects of health and wellness.

Hospital Services

Quality hospital services will be delivered through better integrated **hub-and-spoke team-based care** where all practitioners will be able to fully utilize their skills.

The care model will be delivered in **collaboration with community services** to provide **sustainable**, **appropriate**, **equitable** and **person-focused** care that supports the needs of the patients in their communities.

Patient travel will be minimized by the utilization of **virtual technology**. When travel is necessary, patients will access a **better transportation** system.

Aging Population

The people of Newfoundland and Labrador will be **enabled** and **empowered** to **transition** seamlessly through age and health-related changes with **dignity** and **autonomy**.

This will be rooted in **family** and **community supports**, strengthened by a commitment to **aging-in-place** in **age-friendly communities**, and supported by **home support** and **long-term care** in which **quality of care** and **quality of life** are fundamentally linked.

Quality Health Care

We will improve individual and population health, as well as the performance of our social and health systems.

All people of the province will receive **high value**, **timely** services in a way which matches actual practice with **best practice**.

Accountability, **oversight**, **research**, and **beneficial innovation** will ensure optimal quality of care.

Digital Technology

Digital technology will improve health and health outcomes in the province by empowering people with **information**, **access**, and **choice**.

By embracing digital technologies, we will connect people and systems, we will **integrate** systems, and we will **link** health and social factors.

Using an **agile**, **iterative**, and **evidence-based** approach, we will spur **leading innovation** and a **culture of exploration**, which will become a driving force for **inclusion**.

"What I have seen thus far is definitely a step in the right direction — especially community care, hospital services and digital technologies. All of this will only be possible if you have 'buy-in' from those who provide health care."

—Town Hall, Series 2, Comment

"The use of technology in communication with individuals throughout our province is being recognized as an important strategy in diagnosis, treatment, and in health promotion and prevention. One of the barriers is the distribution of WIFI and cell service. Will the Health Accord look at the distribution of technology infrastructure?"

—Town Hall, Series 1, Comment

"I am hopeful we can do this if we are vigilant in clearly detailing the foundational statements of the vision and the principles that underpin it."

—Town Hall, Series 2, Survey

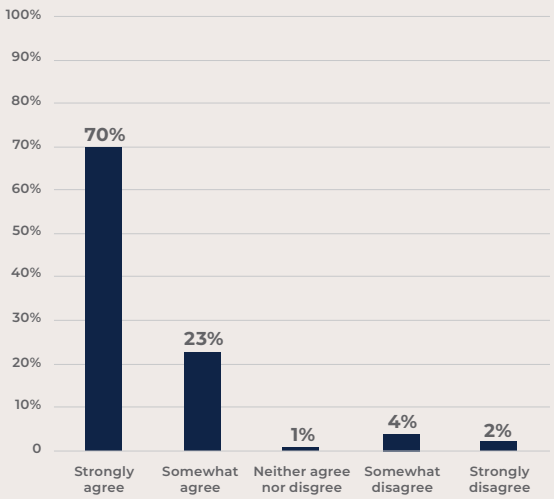
"I fully support the Vision and Direction Statement as articulated...Over the years, our healthcare system has been studied and debated to death with little or no advancement or improvement. For the first time, I am hearing something new and substantial coming from individuals with expertise, insight, objectivity, and empathy. What I have heard and read so far is real, innovative, exciting, and hopeful."

—Town Hall, Series 2, Survey

The following figures contain the data which came from the general survey and show the extent of support or not for the vision and each of the six direction statements.

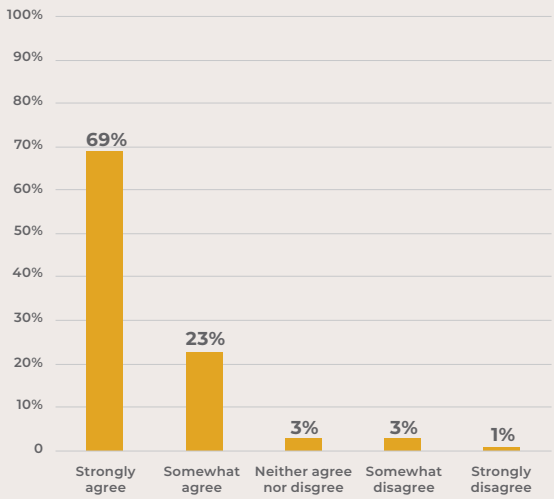
Vision

Do you agree or disagree with the draft Vision Statement? (N=223)



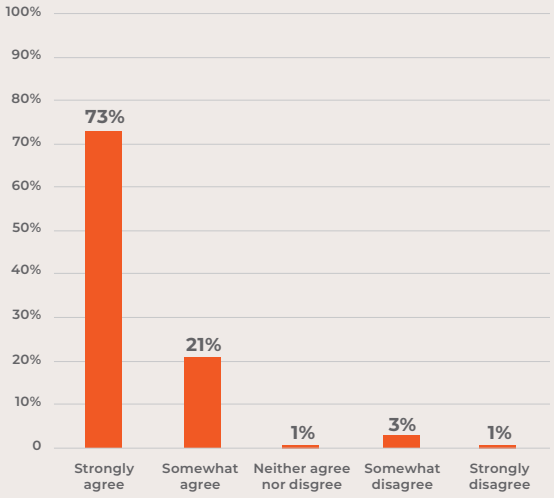
Social Determinants of Health

Do you agree or disagree with the direction statement for Social Determinants of Health? (N=206)



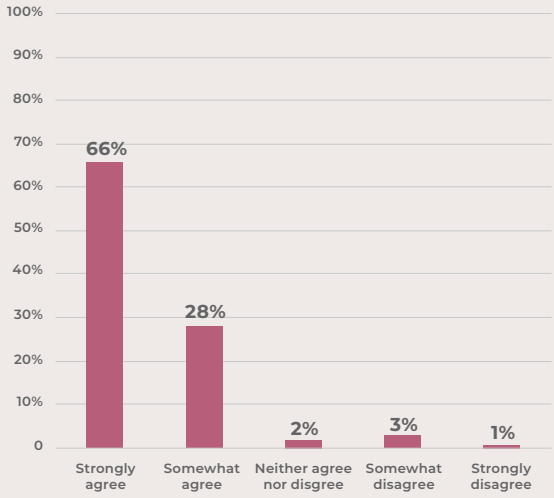
Community Care

Do you agree or disagree with the direction statement for Community Care? (N=201)



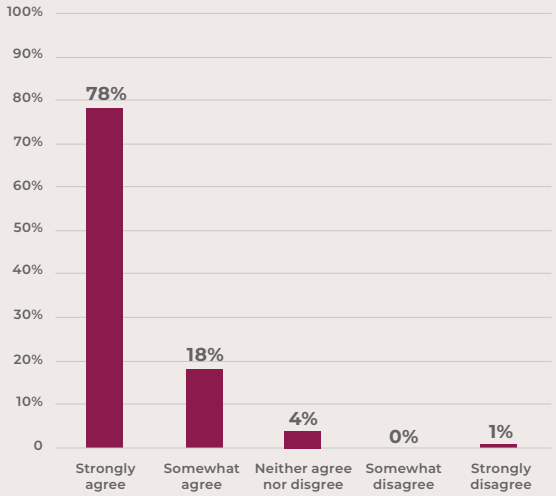
Hospital Services

Do you agree or disagree with the direction statement for Hospital Services? (N=195)



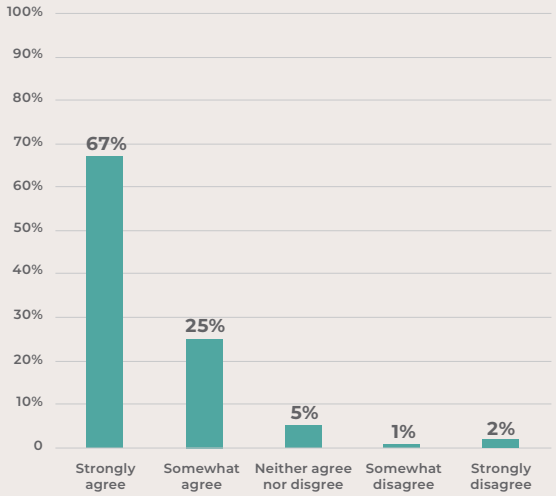
Aging Population

Do you agree or disagree with the direction statement for Aging Population? (N=197)



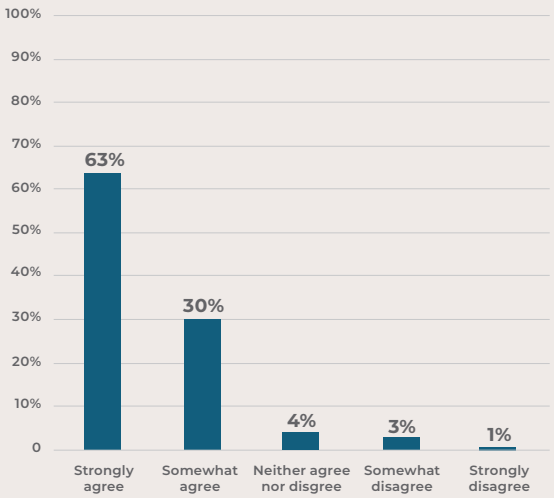
Quality Health Care

Do you agree or disagree with the direction statement for Quality Health Care? (N=194)



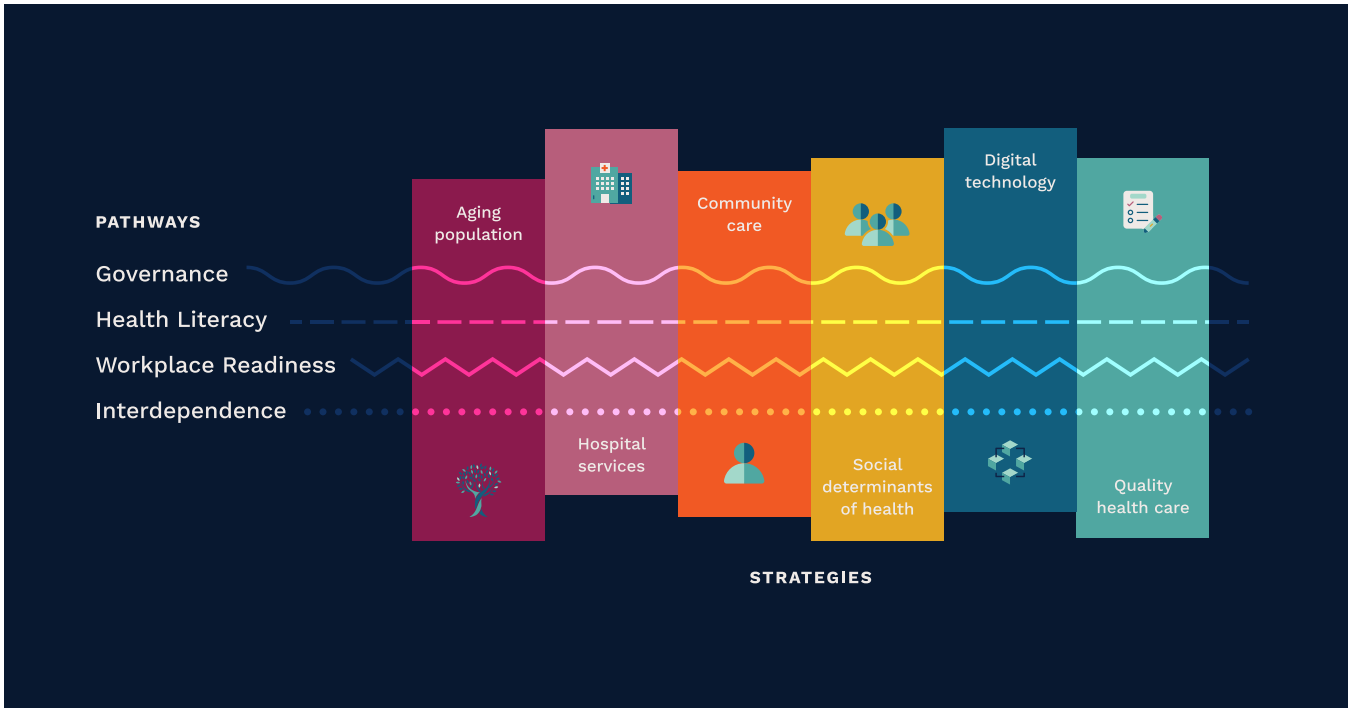
Digital Technology

Do you agree or disagree with the direction statement for Digital Technology? (N=193)



Pathways Interwoven Through Direction Statements

During Engagement Series Two, input not only further helped shape the key directions but identified four pathways that are interwoven and have an impact on all key directions. Forward movement and recommendations on these pathways will be required to form a strong foundation for the future health and social sector of Newfoundland and Labrador. The pathways are as follows:



Governance

We will develop an approach to governance that **integrates social and health systems**, **engages** communities, and **ensures oversight** for the implementation of the Health Accord.

We will find new ways to engage the **energy**, the **flexibility**, and the **diversity** of community groups in improving our health and social systems.

Health Literacy

We will explore how a better understanding of the impact of social factors on **health-related behaviours** can help facilitate **health-promoting** behaviours and better health outcomes.

We will encourage efforts to strengthen the **ability of people of all ages** to find, understand, and use information as a way to **promote**, **maintain**, and **improve health** in a variety of settings for themselves and others.

Workplace Readiness

We will ensure that human resource **planning** is directed towards the appropriate **number**, **distribution** and **mix** of **people** that work in the **rebalanced** social and health systems.

We will advocate for their **education** in a manner consistent with the directions of the Health Accord, with a focus on **leadership**, strengthening **health equity**, collaborating across **social and health systems**, working in **team-based care**, and improving **health outcomes**.

Interdependence

We will approach change in social and health systems in a way that recognizes the **interdependence** of the **provincial**, **federal**, and **Indigenous** governments, **municipalities**, and **communities**.

To enhance **health equity**, we will work with existing government initiatives, such as those relating to **mental health**, **education**, and **poverty reduction**.

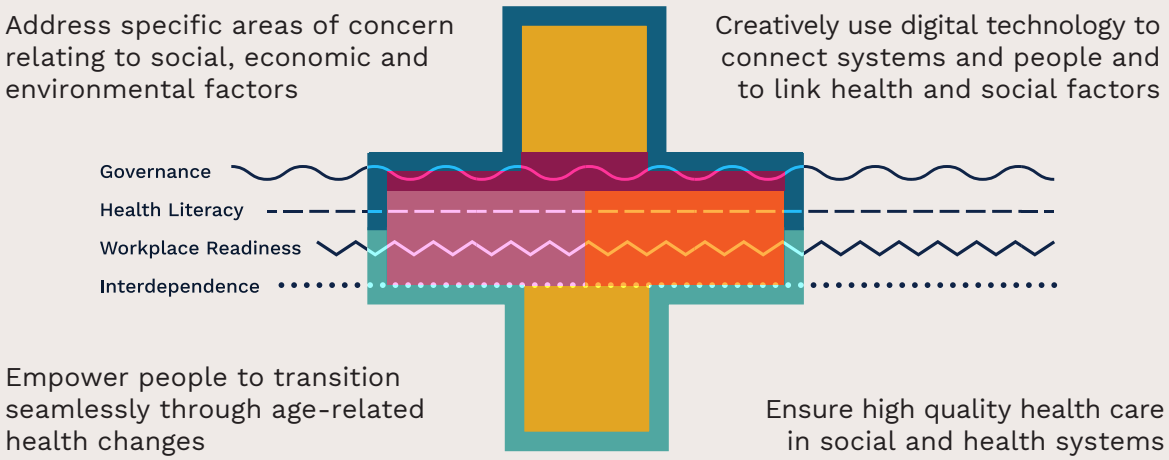
A Call To Action

"I look forward to continued engagement with this process and hope you will utilize the knowledge and wisdom of the citizens as you proceed. Citizens, communities, Government, and professionals must work together."

Town Hall, Series 2, Survey

Five months into the Health Accord 13-month process, there appears to be strong alignment among all health system stakeholders, the public, and research both in the urgent need to transform the Newfoundland and Labrador health system and in the key directions and pathways forward outlining how this should be accomplished.

We will improve the health of Newfoundlanders and Labradorians



The next step in the process of shaping the Health Accord will be moving the vision and strategic directions to reality by developing calls for action related to implementation. Concern has been expressed about making major change when the financial situation of the province is uncertain. The Task Force is taking time to develop, implement and evaluate a Health Accord that is built through engagement among Government, stakeholders, and the people of the province. The creation of the Health Accord in this way better prepares Government to make certain that any fiscal decisions they make will not lead to worse health outcomes or greater health inequity but, in fact, will lead to better outcomes while reducing health inequity.

Next steps will include throwing out even further the net of engagement, ensuring that many more voices are heard and that many more lived experiences are understood. If difficult choices are to be made, the diverse voices and experience will ensure that the wisest choices are made.

The need for the Health Accord has never been greater; the timing and the approach are consistent with a commitment to a stronger Newfoundland and Labrador despite the challenges and uncertainties of today. Based on the compelling case for change and the convergence of ideas arising from both public engagement and the work of the committees, we will be calling on the public, the stakeholders, and the political system to do the hard work needed to create this Health Accord.

What will Newfoundland and Labrador look like when the Health Accord is fully implemented? As the calls for action are developed, we can imagine the following framework emerging. The person and the family are at the center. The community is that space in which people are born, live, learn, work, play, and age. Attention to social, economic, and environmental conditions positively influences the health and health equity of people, families, and communities. The health and social systems, based in the community and with higher quality and better access, bring about improved health outcomes. As the Health Accord is further developed by calls to action outlined in the second phase of our work together, we will see more clearly what must be held in each circle if the vision is to become real.

If the transformation of the health and health outcomes of Newfoundlanders and Labradorians is to happen and if inclusion and health equity are to mark the way of life in this province, the people, community groups, the private sector, and the various governments must come together in an agreement to do what is needed to bring the Health Accord to life. The people of Newfoundland and Labrador deserve no less.

Health Accord
for Newfoundland & Labrador

Appendices

Appendix A

Health Accord NL Membership

Health Accord NL Task Force Members

Task Force	
Task Force Co-Chair & Committee Chair: Quality Health Care	**Dr. Patrick Parfrey** (Clinical Lead, Quality of Care NL; John Lewis Paton Distinguished University Professor)
Task Force Co-Chair & Committee Chair: Social Determinants of Health	**Elizabeth M. Davis, rsm** (Congregational Leader, Sisters of Mercy of NL)
Committee Chair: Community Care	**Dr. Shanda Slipp** (Family Physician, Western Health)
Committee Chair: Aging Population	**Joan Marie Aylward** (Community Champion; Former Provincial Politician; Former NLNU President; Former Executive Director of St. Patrick's Mercy Home)
Committee Chair: Digital Technology	**Paul Preston** (CEO, techNL)
Committee Chair: Hospital Services	**Dr. Sean Connors** (Associate Professor of Medicine-Cardiology. Head of Cardiology, Eastern Health)
Eastern Health	**David Diamond** (CEO)
Central Health	**Andrée Robichaud** (CEO)
Western Health	**Michelle House** (Interim CEO)
Labrador-Grenfell Health	**Heather Brown** (CEO)
NL Centre for Health Information	**Steve Clark** (CEO)
Department of Health & Community Services, Government of NL	**Karen Stone** (Deputy Minister)
NAPE	**Jerry Earle** (President)
CUPE	**Sherry Hillier** (President)
Newfoundland & Labrador Medical Association	**Robert Thompson** (Executive Director)
Registered Nurses' Union NL	**Yvette Coffey** (President)
Association of Allied Health Professionals	**Pamela Toope** (Executive Director)
Faculty of Medicine, Memorial University	**Dr. Margaret Steele** (Dean)
Community Member	**Bud Davidge**
Community Member	**Linda Oldford**
Community Member	**Michael O'Keefe**

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Nunatsiavut Government Member	**Anthony Anderson**
Task Force Member appointed by Liberal Party of NL	**Dr. Jeff Marshall** (Chiropractor)
Task Force Member appointed by NL New Democratic Party	**Joshua Smee** (CEO, Food First NL)
Task Force Member appointed by Progressive Conservative Party of NL	**TBD**
Engagement Advisor	**Dr. Stephen Tomblin** (Retired Professor of Political Science)
Support	
Secretariat	**Lynn Taylor** (Manager, Quality of Care NL)
Senior Policy Advisor – Health	**Heather Hanrahan** (Assistant Deputy Minister, Government of NL)
Senior Policy Advisory – Interdepartmental	**Tanya Noseworthy** (Assistant Deputy Minister, Government of NL)
Epidemiologist	**Dr. John Harnett** (Retired Professor of Medicine)
Implementation Advisor	**Cassie Chisholm** (Director, Cardiac & Critical Care, Eastern Health)
Communications	**Melissa Ennis** (Communications Lead, Quality of Care NL)

Health Accord NL Task Force Committee Members

	Social Determinants of Health	Community Care	Hospital Services	Aging Population	Quality Health Care	Digital Technology
Chair	**Elizabeth M. Davis, rsm** (Congregational Leader, Sisters of Mercy of NL)	**Dr. Shanda Slipp** (Family Physician, Western Health)	**Dr. Sean Connors** (Associate Professor of Medicine-Cardiology; Head of Cardiology, Eastern Health)	**Joan Marie Aylward** (Community Champion; Former Provincial Politician; Former NLNU President; Former ED, St. Patrick's Mercy Home)	**Dr. Patrick Parfrey** (Clinical Lead, Quality of Care NL; John Lewis Paton Distinguished University Professor)	**Paul Preston** (CEO, techNL)
Community Leader	**Penelope Rowe** (CEO, Community Sector Council NL)	**John Norman** (Mayor, Bonavista)	**Dorothy Senior** (Patient Partner)	**Dr. Rick Singleton, PhD** (Ethicist & Theologian)	**Dr. John Jeddore** (Medical Resident)	**Josh Quinton** (Investment Advisor, CIBC Wood Gundy & Board Director)
Health Professional	**Dr. Steve Darcy** (Family Physician, Eastern Health)	**Lynn Power** (Executive Director, College of Registered Nurses NL)	**Dr. Greg Browne** (Chief of Surgery, Eastern Health; Clinical Assistant Professor of Surgery, Memorial University)	**Dr. Kim Babb** (Geriatrician, Eastern Health)	**Dr. Melissa Skanes** (Chief of Interventional Radiology, Eastern Health; Clinical Assistant Professor of Radiology, Memorial University)	**Dr. Brendan Barrett** (Internist, Eastern Health)
Regional Health Authority Leader	**Michelle House** (Interim CEO, Western Health)	**Judy O'Keefe** (Vice President, Clinical Services, Eastern Health)	**Dr. Gabe Woollam** (Vice President, Medical Services, Diagnostics & Pharmacy, Labrador-Grenfell Health)	**Kelli O'Brien** (Vice President, People, Quality & Safety, Western Health)	**Antionette Cabot** (Vice President, Clinical Services, Labrador-Grenfell Health)	**Ron Johnson** (Vice President, Innovation and Rural Health, Eastern Health)

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Content Experts	**Dr. Thomas Piggott** (Medical Officer of Health, Labrador-Grenfell Health)	**Dr. Nicole Stockley** (Family Physician, Eastern Health; Director of Engagement, NL College of Family Physicians)	**Tina Edmonds** (Project Lead, Integrated Capacity Management, Western Health)	**Dr. Roger Butler** (Family Physician, Geriatric Researcher, Eastern Health)	**Dr. Ed Randell, PhD** (Clinical Chief Laboratory Medicine, Eastern Health; Professor, Division of Laboratory Medicine, Faculty of Medicine, Memorial University)	**Dr. Randy Giffen** (Family Physician, Programmer)
	Dr. Brenda Wilson (Professor & Associate Dean, Community Health & Humanities, Faculty of Medicine, Memorial University)	**Ada Roberts** (Nurse Practitioner, Central Health)	**Dr. Dave Carroll** (Internist, Central Health)	**Dr. Suzanne Brake, PhD** (Provincial Seniors' Advocate)	**Dr. Debbie Kelly, PhD** (Associate Professor & Special Advisor of Practice Innovation, School of Pharmacy, Memorial University)	**Blair White** (Vice President, Corporate Services, NL Centre for Health Information)
	Pablo Navarro (Senior Research Officer, NL Centre for Applied Health Research)	**Dr. Michael Jong** (Retired Family Physician; Former Regional Health Authority Executive, Labrador-Grenfell Health)	**Dr. Larry Alteen** (Retired Regional Health Authority Executive)	**Sharron Callahan** (Chair, NL Seniors & Pensioners Coalition; President of CARP NL; Chair of the Seniors Advisory Committee for St. John's)	**Dr. Jared Butler** (Family Physician; Shalloway FPN, Central Health)	**Dr. Chandra Kavanagh, PhD** (Director, Bounce Health Innovation)
	Dr. Bob Williams (Retired Physician; Former Regional Health Authority Executive; Former Deputy Minister, Health & Community Services)					
	Dr. John Harnett (Epidemiologist; Retired Professor of Medicine; Retired Nephrologist)	**Dr. Carmel Casey** (Family Physician, Central Health)	**Jeannine Herritt** (Director, Regional Medicine Program, Eastern Health)	**Nancy Healey-Dove** (Nurse Practitioner, Central Health)	**Dr. Kris Aubrey-Bassler** (Family Physician; Director, Primary Health Research Unit, Memorial University)	**Niki Legge** (Director, Mental Health & Addictions, Health & Community Services)

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Support						
	Social Determinants of Health	**Community Care**	**Hospital Services**	**Aging Population**	**Quality Health Care**	**Digital Technology**
Secretariat (Quality of Care NL)	**Kathleen Mather** (Knowledge Translation Lead)	**Cheryl Etchegary** (Health Policy Analyst)	**Dr. Karen Dickson, PhD** (Health Policy Analyst)	**Dr. Robert Wilson, PhD** (Research Associate)	**Dr. Susan Stuckless, PhD** (Research Associate)	**Owen Parfrey** (Project Coordinator)
Senior Policy Advisor (Government of NL)	**Maggie O'Toole** (Policy Consultant, Health & Community Services)	**Monica Bull** (Senior Manager, Primary Health Care, Health & Community Services)	**Annette Bridgeman** (Director, Regional Services, Health & Community Services)	**Henry Kielley** (Director, Seniors & Aging, Children, Seniors & Social Development)	**John McGrath** (Assistant Deputy Minister, Corporate Services, Health & Community Services)	**Andrea McKenna** (Assistant Deputy Minister, Policy and Planning, Health & Community Services)
Digital Technology Support (NL Centre for Health Information)	**Dr. Don MacDonald, PhD** (Vice President, Data & Information Services)	**Cynthia Clarke** (Director, eHealth)	**Pat Hepditch** (Chief Information Officer)	**Nicole Gill** (Director, Evaluation & Performance Improvement)	**Dr. Donna Roche, PhD** (Director, Analytics & Data Access)	**Gillian Sweeney** (Vice President, Clinical Information Programs & Change Leadership)

Appendix B

Mandate and Terms of Reference

PURPOSE

Health Accord NL, the provincial Task Force on health (the Task Force), is responsible for developing a 10-Year Health Accord for Newfoundland and Labrador that comprises actions and recommendations in strategic areas of health and health care to be implemented throughout the life of the Health Accord.

MANDATE

The Task Force has the mandate to:

- Work with the Minister of the Department of Health and Community Services to assist in the delivery of the Task Force mandate.
- Work with the Task Force Committees to review Committee work plans, provide strategic direction, ensure connection and continuity between each Committee, and build consensus amongst stakeholders for Committee actions and recommendations.
- Work with the Engagement Group to implement strategies to ensure opportunities for two-way engagement and communication with all stakeholders, particularly the public, including opportunities to provide feedback to and connect with Task Force and Committee representatives.
- Work with Key Informant Groups, the Indigenous Community Circle, and the Community Sector Circle to garner advice and counsel as needed, as well as to build consensus for actions and recommendations.

MEMBERSHIP

Task Force Members:

- Co-Chairs, Task Force (2 positions)
- Chair, Social Determinants of Health Committee
- Chair, Community Care Committee
- Chair, Hospital Services Committee
- Chair, Aging Population Committee
- Chair, Quality Health Care Committee
- Chair, Digital Technology Committee
- Chief Executive Officers, Regional Health Authorities (4 positions)
- Chief Executive Officer, NL Centre for Health Information
- Deputy Minister, Health and Community Services

Task Force Members (continued):

- President (or designate), NAPE
- President (or designate), CUPE
- Executive Director (or designate), NL Medical Association
- Executive Director (or designate), Registered Nurses' Union of NL
- Executive Director (or designate), Association of Allied Health Professionals
- Dean, Faculty of Medicine, Memorial University
- Community Members (3 positions)
- Indigenous Member (1 position or as advised by Indigenous Communities)
- Liberal Party Appointment (1 position)
- Progressive Conservative Party Appointment (1 position)
- New Democratic Party Appointment (1 position)
- Engagement Advisor (1 position)
- Other representatives as invited or required by the Task Force

Support

- Secretariat
- Senior Policy Advisor-Health
- Senior Policy Advisor-Interdepartmental
- Epidemiology Advisor
- Implementation Advisor
- Other representatives as invited or required by the Task Force

RULES OF PROCEDURE

Meetings

- The Task Force will meet the first Thursday of every month.
- The Secretariat will support the Task Force and will distribute a draft agenda with relevant documents for the meeting no later than five days before an agreed meeting date.
- The Task Force will strive to work by consensus in drafting its advice and recommendations.
- A record of each meeting will be kept and will be circulated to The Task Force after each meeting.

Accountability

- The Task Force is accountable to the Premier and the Minister of Health and Community Services.

Members

- Attend meetings on a regular basis.
- Review all necessary meeting material and be prepared to speak to the items on the agenda.

Review

These terms of reference will be reviewed as needed.

April 2021

Health Accord
for Newfoundland & Labrador

Supplements

Supplement 1

Evidence

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Introduction

As outlined in the main body of this report, the six facts depicted in Figure 1 regarding the Newfoundland and Labrador (NL) health and social systems provide a compelling case for change.

This supplement provides further evidence regarding these six facts.

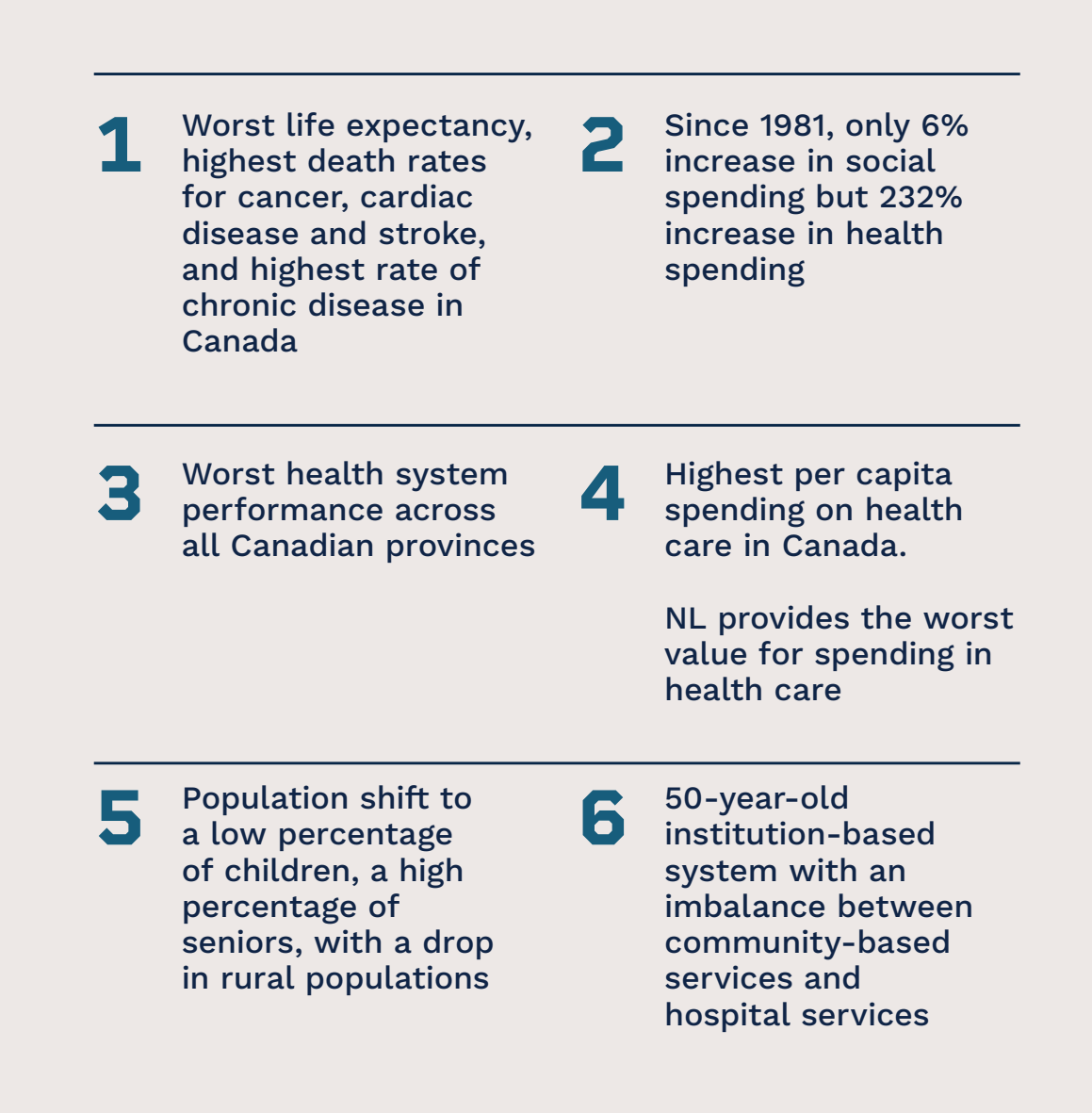

Figure 1: Six Facts Regarding Newfoundland and Labrador's Health Care System

1 Newfoundland and Labrador has the worst life expectancy, highest death rates for cancer, cardiac disease and stroke, and highest rate of chronic disease in Canada

As outlined in Table 1, life expectancy from birth is lower than the Canadian average for both males and females. In addition, Table 1 shows that at age 65, the life expectancy of Newfoundlanders and Labradorians is 2.1 years less than that for Canadians – the lowest life expectancy amongst the ten Canadian provinces.

Not only is health inequity evident in Newfoundland and Labrador when compared to other provinces, but it is evident in particular groups in the province, particularly the Indigenous communities. Life expectancy in Labrador-Grenfell Health (LGH) is 1.6 years less than that in the province; 33% of the population in the LGH region is Indigenous. According to Statistics Canada, in 2011 the life expectancy for Indigenous people in Canada was 9.3 years less than that for non-Indigenous Canadians.

Table 1: Life Expectancy (in Years) and Mortality Rate per 100,000 Population in Canada and NL, and Provincial Rank of NL

		CAN	NL	NL Rank
Life expectancy	At birth	82.1	79.5	10
	At age 65	21.0	18.9	10
All causes mortality	Crude rate	766.4	993.0	9
	Age-standardized rate	671.8	839.8	10
Avoidable deaths	Overall	195	238	9
	From preventable causes	128	149	7
	From treatable causes	67	90	10

Table 1 demonstrates that the age-standardized all causes mortality rate is the highest amongst the Canadian provinces. In particular, mortality rates in Newfoundland and Labrador are the highest in Canada for cancer, cardiac disease, cerebrovascular disease, diabetes, and kidney disease (Table 2).

Table 2: Age-standardized Mortality Rates per 100,000 Population for Canada and NL and Provincial Rank of NL for the Most Common Natural Causes of Death in Canada

	CAN	NL	NL Rank
Malignant neoplasms	190.0	222.3	10
Diseases of the heart	123.6	167.8	10
Cerebrovascular diseases	31.4	44.2	10
Chronic lower respiratory diseases	30.4	40.9	8
Influenza and pneumonia	19.5	25.9	9
Diabetes mellitus	16.1	34.1	10
Alzheimer's disease	14.6	10.8	5
Nephritis, nephrotic syndrome, and nephrosis	8.4	16.6	10

Table 3 shows the age-standardized cancer mortality rate per 100,000 population for men and women and that of the ten Canadian provinces, NL has the highest rates.

Table 3: Age-standardized Cancer Mortality Rate per 100,000 Population Analyzed by Gender

Gender	CAN	NL	NL Rank
Male	234	276	10
Female	169	195	10

2 Since 1981, there has only been a 6% increase in social spending, but a 232% increase in health spending in Newfoundland and Labrador

Since 1981, adjusted for constant dollars, health spending in Newfoundland and Labrador has increased by 232% and social spending by 6% (Figure 2). This information comes from the Government of Newfoundland and Labrador public accounts. Health spending is defined as expenditures of the Department of Health and Community Services. Social spending is defined as expenditures of the Department of Children, Seniors and Social Development which includes, but is not limited to, Child Protection Services, Adult Protection Services, Adoption, Disability Policy, Seniors and Aging Policy, Poverty Reduction, Youth Corrections Program, plus the Newfoundland and Labrador Housing Corporation and Income Support from the Department of Immigration, Skills and Labour. Social spending does not include spending on the education system.

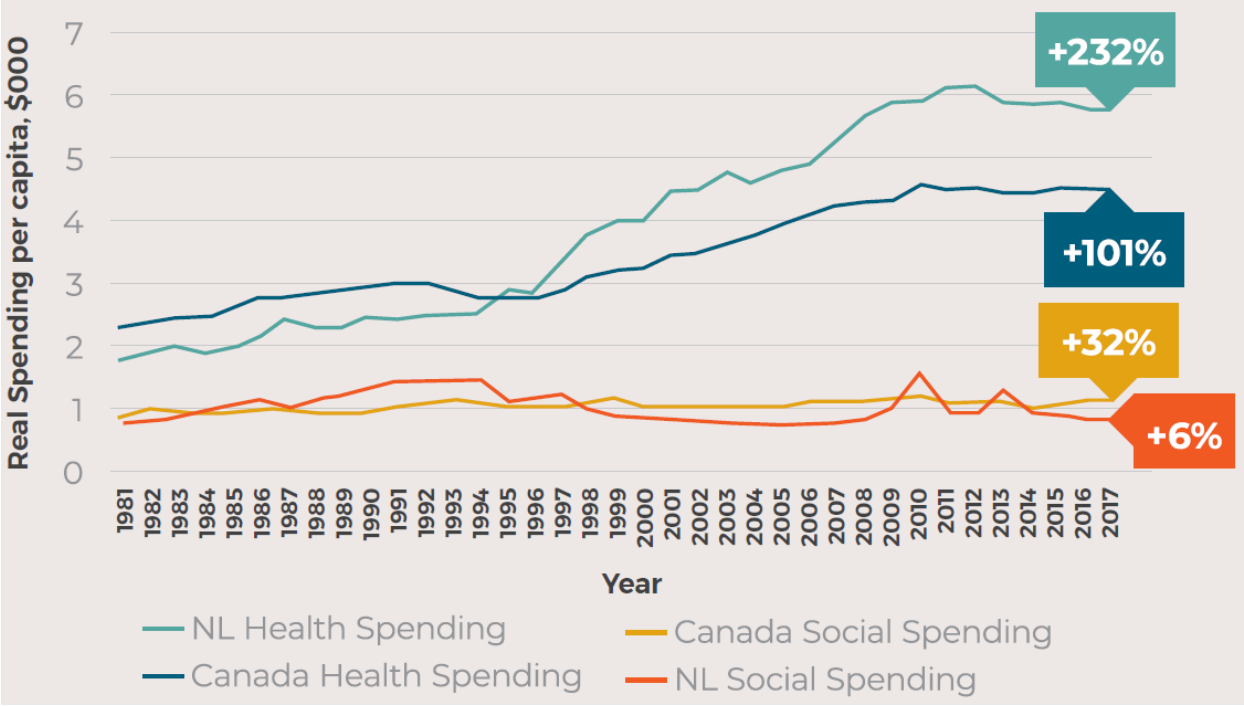

Figure 2: Real Per Capita Social Spending Versus Health Spending in Newfoundland and Labrador and Canada; 1981 to 2017 (D. Dutton, Dalhousie)

Dutton et al indicated that by spending one more cent on social services for every dollar spent on health, life expectancy would increase by 5%.[1] This means population-level health outcomes could benefit from a reallocation of government dollars from health to social spending, even if total government spending was left unchanged. This result is consistent with other findings from Canada and the United States.

The discrepancy between social spending and health spending and the failure to achieve optimum health outcomes, even with high levels of health spending, are strong indicators that a new direction is needed. Life expectancy, prevalence of chronic disease, and incidence of cancer and vascular disease in Newfoundland and Labrador are the worst in Canada, all of which are strongly influenced by non-medical determinants such as unemployment, education, income, diet, physical activity, smoking, and alcohol use. Table 4 provides an overview of key non-medical and social determinants of health in Newfoundland and Labrador compared to Canada. This table indicates Newfoundland and Labrador has the lowest provincial ranking for many of the non-medical determinants of health in Canada.

Table 4: Non-medical and Social Determinants of Health in Newfoundland and Labrador Compared to Canada, 2017–18

Social Determinants of Health		CAN	NL	NL Rank
Healthy Eating	Fruit consumption at least once per day	66.5%	56.3%	10
	Vegetable consumption at least once per day	55.9%	34.1%	10
	Fruit or vegetable consumption 5+ times per day	28.6%	18.3%	10
Physical Activity	Adults (age 18+): 150 minutes per week	56.0%	49.4%	10
	Youth (age 12-17): 60 minutes per day	57.8%	51.0%	9
Alcohol Use	Heavy drinker	19.3%	26.7%	10
	Consumption (litres per capita)	8.2	9.1	10
Current Smoker	Daily or occasional	16.0%	20.8%	10
	Daily	11.3%	16.7%	10

continued on next page

[1]Daniel J. Dutton, Pierre-Gerlier Forest, Ronald D. Kneebone, Jennifer D. Zwicker, "Effect of provincial spending on social services and heath care on health outcomes in Canada: an observational longitudinal study", CMAJ, 2018, 190 (3), E66-E71.

Table 4 continued

Social Determinants of Health		CAN	NL	NL Rank
Breastfeeding	Initiation	91.0%	70.6%	10
	Exclusive, at least 6 months	34.5%	20.6%	10
Employment	Unemployment rate	6.0%	14.8%	10
Income	Living on low income	8.7%	9.7%	9
Education	Tertiary education	58.0%	49.0%	9
	Bachelor's level or above	32.0%	20.0%	10
Family	Children living in lone-parent family	19.2%	23.2%	8
	Children living in a family without their parents	1.4%	2.0%	8
Stress	Most days quite a bit or extremely stressful	21.4%	14.9%	1
Belonging	Somewhat or very strong sense of belonging	68.9%	77.8%	1
Life Satisfaction	Satisfied or very satisfied	93.2%	92.6%	7

3 Newfoundland and Labrador has the worst health system performance across all Canadian provinces

According to the Commonwealth Fund analysis, Newfoundland and Labrador has the worst health system performance among the ten provinces in Canada based on the integration of multiple metrics. Canada itself performs below the international average in comparison to 11 other OECD (Organization for Economic Co-operation and Development) countries such as Australia and the United Kingdom (Figure 3).

The potential exists for improvement in this ranking because of the quality of people working in the health system and the desire for change in health system structure.

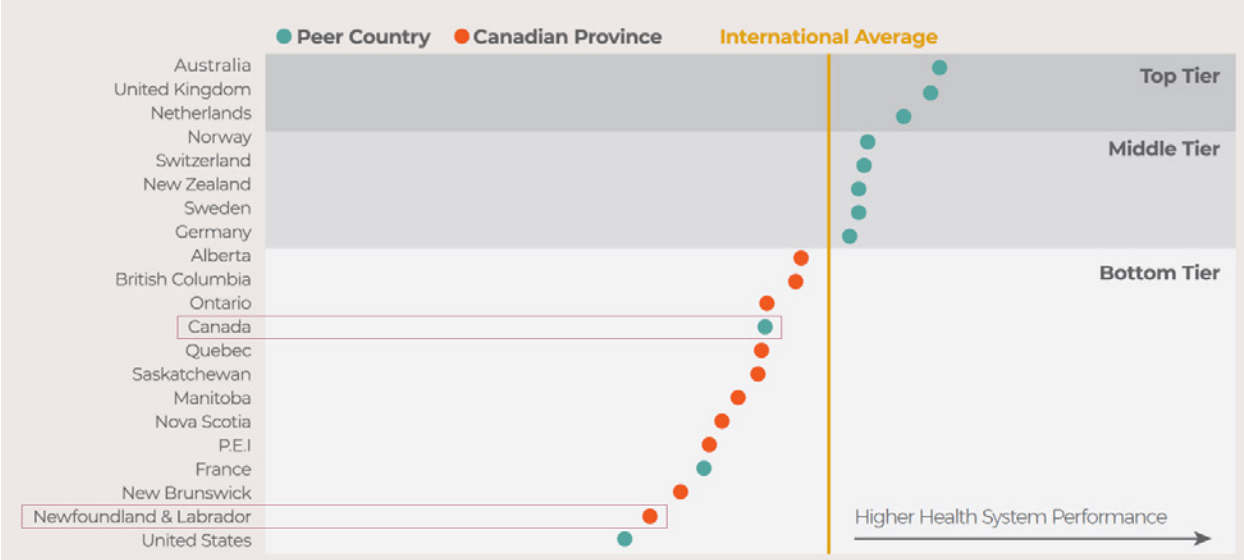

Figure 3: Ranking of Health System Performance in 11 OECD Countries and ten Canadian Provinces (source: C.D. Howe Institute analysis of Commonwealth Fund data)

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4 Newfoundland and Labrador has the highest per capita spending on health care in Canada

Newfoundland and Labrador has the highest health spend per capita among Canadian provinces. As detailed in Figure 4 below, according to the Canadian Institute of Health Information (CIHI), for 2018-19, Provincial/ Territorial Government-sector health spend for NL was $5,945 per capita versus the Canadian average of $4,476.

Some, but not all, of this variance can be explained by (1) the rural and remote nature of the province; (2) a large land mass and low population density which make Labrador more like a territory than a province where the cost of health care delivery is much higher; (3) the fact there has been a significant drop in the size of the population since the early 1990s without a corresponding drop in health spending; and (4) the aging of the population and the high rate of chronic disease in the population.

Given the above noted factors, it may not be reasonable to expect the Newfoundland and Labrador expenditure per capita to be at the Canadian average. It may however be reasonable to expect that a different allocation of these expenditures could result in better health outcomes for the population.

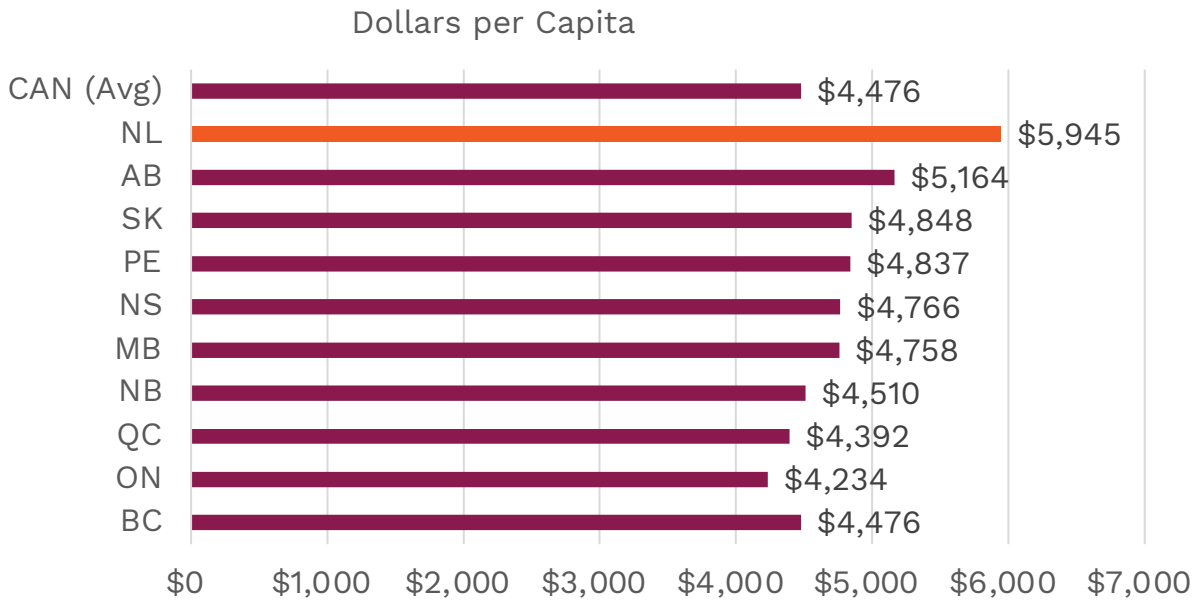

Figure 4: Provincial Government per Capita Health Expenditure, 2018-2019

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Using definitions of types of facilities and data from CIHI, three categories of spend account for most of the variance in NL compared to Canada (Table 5):

- **Hospitals** account for $395.20M higher spend in Newfoundland and Labrador as compared to the Canadian average (39.4% variance). Hospitals are defined as those providing acute care, extended and chronic care, rehabilitation and convalescent care, and psychiatric care, as well as nursing stations or outpost hospitals.

  Public health has been included in this category because in Newfoundland and Labrador public health is part of the regional health authority (RHA) system.

  Total spending in this category ($1,414M) is comprised of hospitals ($1,290M) and public health ($124M).

- **Other institutions** account for $193.50M higher spend in Newfoundland and Labrador as compared to the Canadian average (69.67% variance). As defined by CIHI, these institutions include residential care types of facilities (for the chronically ill or disabled, who reside at the institution more or less permanently), approved, funded or licensed by provincial or territorial departments of health and/or social services. Residential care facilities include homes for the aged (such as nursing homes) and facilities for adults and children with varying supports needs. In these facilities, a mix of health and social services is provided; health services are largely at the level of nursing care, in combination with personal care services. The medical components of care are much less intensive than those provided in hospitals. Further detail on the definitions for this type of facility-based care can be found at https://www.cihi.ca/en.

  Total spending in this category ($477M) is comprised of long-term care ($389M), residential including personal care homes ($75M), and four in-patient addictions treatment centres ($13M).

- **Other health spend** accounts for $189.50M higher spend in Newfoundland and Labrador as compared to the Canadian average (87.7% variance). This category includes expenditures on health research, home and community care, medical transportation (ambulances), hearing aids, other appliances and prostheses, and miscellaneous health care.

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Total spending in this area ($410.9M) [excluding medical school ($59.6M)] is comprised of home support and home care ($285M), special assistance program ($10M), autism therapy ($4M), CIHI membership fees ($0.4M), Newfoundland and Labrador Centre for Health Information (NLCHI) ($28.5M), and air and road ambulance ($83M).

- Other main categories of spend including physicians, other professionals, drugs, capital and administration are closer to the national average in per capita spend, or the magnitude of spend is much smaller, so overall the impact is less.

Table 5: Newfoundland and Labrador Health Spending Compared to Canada, 2018

Categories:	Canada Per Capita Health Expenditure ($)	NL Per Capita Health Expenditure ($)*	Per Capita Variance from Canadian Avg. ($)	Increase (Decrease) in $ (in millions) required to be at Canadian Avg.
Hospitals and Public Health**	1,930.57	2,690.99	(760.42)	(395.20)
Other Institutions	534.43	906.78	(372.35)	(193.50)
Physicians	994.80	951.36	43.44	22.60
Other Professionals	58.81	24.63	34.18	17.80
Drugs	324.71	282.63	42.08	21.90
Capital	173.07	135.29	37.78	19.60
Administration (DHCS)	44.10	58.37	(14.27)	(7.40)
Other Health Spending less Faculty of Medicine***	415.85	780.40	(364.55)	(189.50)
Total	4,476.34	5,830.45	(1,354.11)	(703.70)

Source: CIHI and Department of Health and Community Services, Teledata System
*Based on population of Newfoundland and Labrador in 2016 - 519,716.
**Public Health cost is included with hospitals because in Newfoundland and Labrador Public Health is part of the regional health authority structure. There is no standalone public health structure as in some other provinces. Public Health spending taken alone is $25.5M below Canada, but this does not account for all the administrative and support structures provided by regional health authorities.
***Cost of Faculty of Medicine, Memorial University, $114.60 per capita or $59.6M removed from health spending for comparison purposes as Faculties of Medicine are not funded by the Department of Health and Community Services in other Canadian jurisdictions. This explains why $5,830.45 in Table 5 is lower than $5,945 in Figure 4.

Institutional health spending in Newfoundland and Labrador is the highest in Canada. Using data from CIHI, cost per hospital stay in Newfoundland and Labrador in 2018/19 was $6,248 per stay versus $6,162 for Canada. There is, however, a wide variation in cost per stay by facility ($4,757 to $11,644). The high hospital cost can be explained by the following indicators: (1) for 2018, the rate of hospital beds per 1,000 population is 25% higher than in Canada; (2) the age-sex standardized hospitalization rate per 100,000 people for 2018/19 in NL is 9% higher than in Canada (8,604 versus 7,883); (3) the age-standardized length of stay in NL for 2018/19 is 13% higher than in Canada (7.8 days versus 6.9 days); and (4) the percentage of patients requiring an alternate level of care in NL hospitals for 2019/20 is 30% higher than in Canada (21.5% versus 16.6%).

5 Demography of Newfoundland and Labrador's population has radically changed to a low proportion of children, a high proportion of seniors, and departure from rural areas

The number of children under 15 has fallen from 194,585 in 1971 to 70,715 in 2020 and is anticipated to fall further to 55,000 in 2040. Conversely, the number of people 65 years and over has increased from 32,075 in 1971 to 117,905 in 2020 and is anticipated to increase further to 162,000 by 2040, with the overall population remaining relatively the same in these particular years.

As depicted in Figure 5, not only is the population aging, but there has been, and continues to be, a transition from rural to urban areas within the island portion of the province. In the past 20 years, there has been a 91% increase in people aged 65 years and over in St. John's, 79% increase on the rest of the island, and 168% increase in Labrador. For the next 20 years, further increase is predicted.

These factors impact the demand for health care, the type of health care needed, and the location of care.

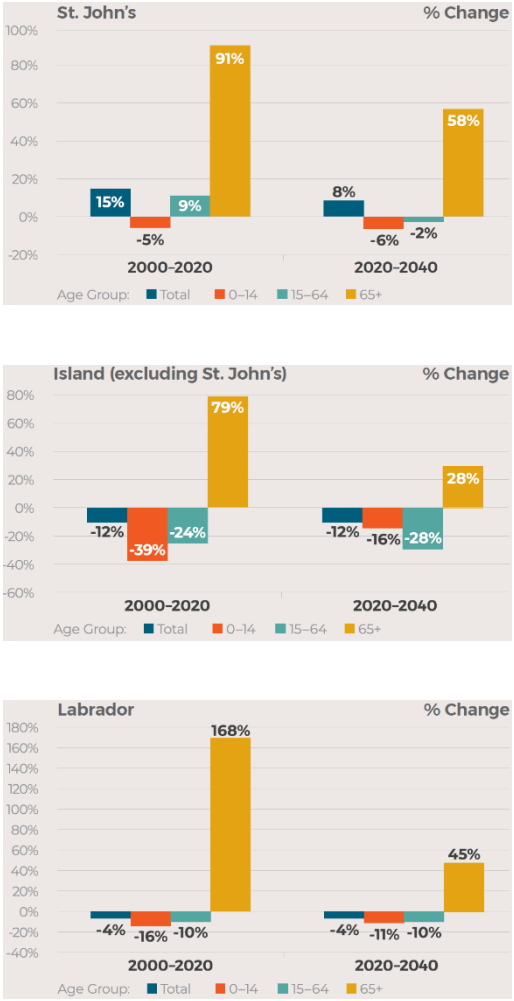


Figure 5: Demographic Change in Three Regions of Newfoundland and Labrador from 2000 to 2020 and Predicted Change from 2020 to 2040

6 Newfoundland and Labrador has a 50-year-old institution-based system with an imbalance between community-based services and hospital services

Medicare is over 60 years old in Canada. Its initial focus was provision of hospital care and physicians with universal access to citizens with services paid for by the taxpayer. Since then, health care practice has changed with more specialized care provided by multi-disciplinary teams, higher demand for primary care (health care provider that is the first point of contact for the patient), and a higher need for long-term care, especially for the frail elderly.

The structure of the institutional health system outside of St. John's in not optimal as there is an excess of acute medical beds and a deficit of long-term care beds (Figure 6).

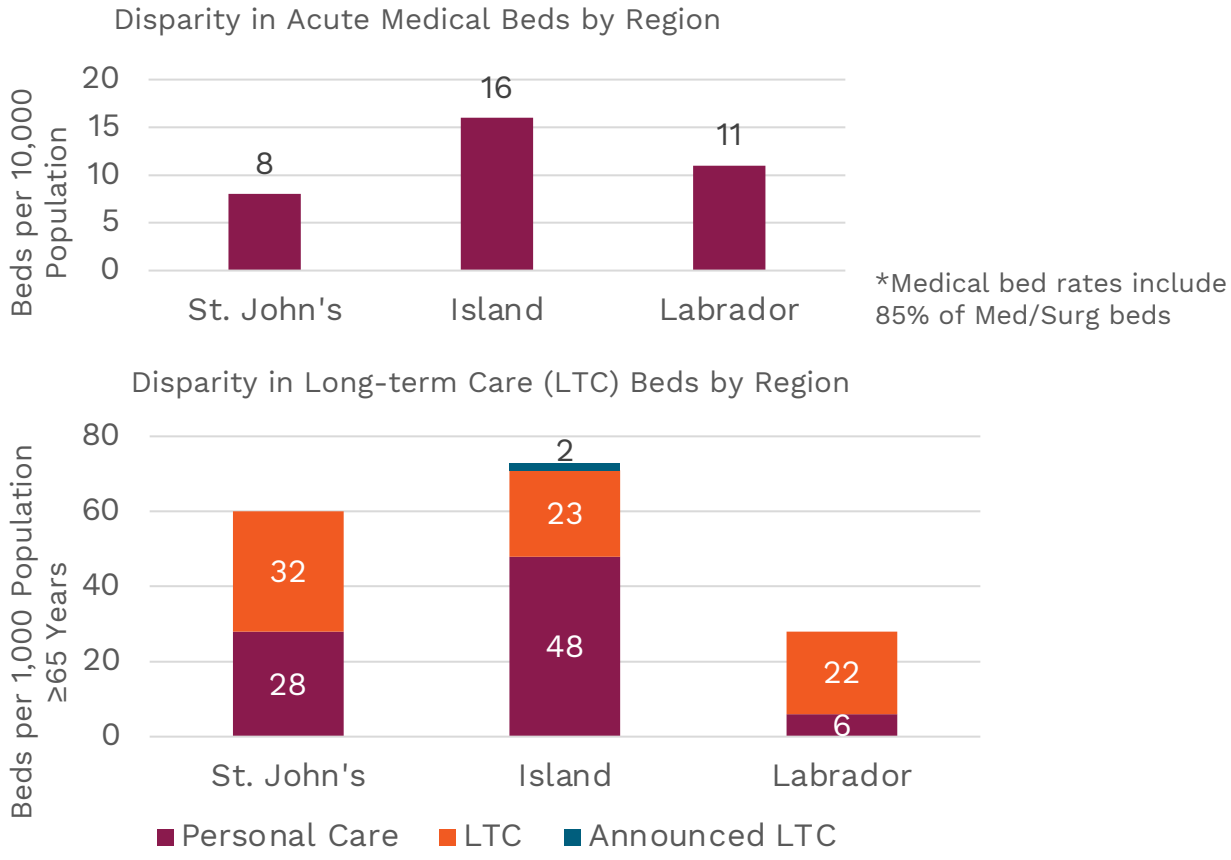
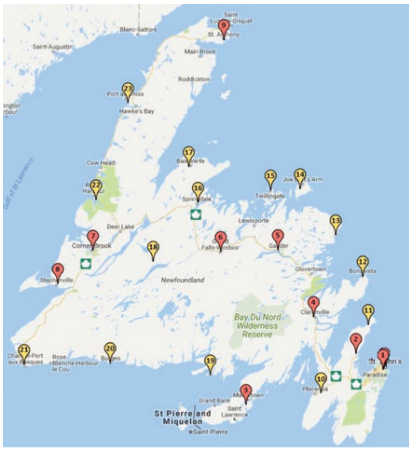


Figure 6: Regional Rates of Acute Medicine and Residential Care Beds

There are 520 acute medicine beds and 130 medicine/surgery beds in 12 hospitals and 14 health centres on the Island portion of the province (Figure 7). In the health centres, bed occupancy is 75%, and 43% of beds are used for patients who require an alternative level of care.



*

ALC = Alternate Level of Care

Hospitals Newfoundland

1. St. John's (Health Sciences Centre)
Beds: 92; Occupancy: 96%; ALC: 11%

St. John's (St. Clare's)
Beds: 76; Occupancy: 89%; ALC: 21%

2. Carbonear
Beds: 48; Occupancy: 83%; ALC: 15%

3. Burin
Beds: 22; Med/Surg; Occupancy: 69%; ALC: 16%

4. Clarenville
Beds: 28; Med/Surg; Occupancy: 87%; ALC: 16%

5. Gander
Beds: 27; Occupancy: 110%; ALC: 27%

6. Grand Falls- Windsor
Beds: 52; Occupancy: 108%; ALC: 38%

7. Corner Brook
Beds: 91; Occupancy: 94%; ALC: 37%

8. Stephenville
Beds: 25 + 16; Med/Surg; Occupancy: 94%; ALC: 22%

9. St. Anthony
Beds: 24; Med/Surg; Occupancy: 86%; ALC: 29%

Labrador

Happy Valley-Goose Bay
Beds: 25; Med/Surg; Occupancy: 97%; ALC: 21%

Labrador City
Beds: 15; Med/Surg; Occupancy: 84%; ALC: 16%

Health Centres

Overall
Occupancy: 75%; ALC: 42%

10. Placentia
Beds: 10; Occupancy: 42%; ALC: 13%

11. Old Perlican
Beds: 4; Occupancy: 37%; ALC: 4%

12. Bonavista
Beds: 10; Occupancy: 64%; ALC: 26%

13. New-Wes-Valley
Beds: 12; Occupancy: 76%; ALC: 36%

14. Fogo
Beds: 5; Occupancy: 70%; ALC: 49%

15. Twillingate
Beds: 12; Occupancy: 115%; ALC: 50%

16. Springdale
Beds: 9; Occupancy: 95%; ALC: 52%

17. Baie Verte
Beds: 7; Occupancy: 78%; ALC: 42%

18. Buchans
Beds: 3; Occupancy: 51%; ALC: 0%

19. Harbour Breton
Beds: 5; Occupancy: 64%; ALC: 63%

20. Burgeo
Beds: 3; Occupancy: 63%; ALC: 45%

21. Port Aux Basques
Beds: 14; Occupancy: 85%; ALC: 45%

22. Norris Point
Beds: 8; Occupancy: 77%; ALC: 66%

23. Port Saunders
Beds: 7; Occupancy: 46%; ALC: 16%

Figure 7: Geographic Distribution and Utilization of Acute Medicine Beds on the Island of Newfoundland

Although the community sector has grown, except for a few unique examples of integration such as the primary health care team in Bonavista, primary care is siloed and lacking integration. Primary care by family physicians is separate from the community services provided by regional health authorities (RHAs).

These RHA community-based services (public health, continuing care nursing services, health promotion, community support services, mental health and addictions services and others) and primary care by family physicians are not well integrated and therefore do not always work together.

Primary Care Providers

There is indication from family physicians and others who are proposing team-based models that they are ready for change. A January 2021 advertisement in The Telegram by the Newfoundland and Labrador Medical Association (NLMA), the Registered Nurses' Union of NL, the Association of Allied Health Professionals, and ten other groups calling for primary health care reform is signaling the climate is ripe for change. The NLMA indicates from its research that there are 90,000 people in NL with no family physician and proposes a team-based, primary health care approach as a solution to this problem.

According to CIHI data from 2017-18 presented in Table 6 below, Newfoundland and Labrador has more people linked to a regular health care provider than the national average. However, there are significant disparities within and between regions. Western, Central, and Eastern Health regions are above the national average, while the Labrador-Grenfell Health region falls significantly below.

Table 6: Percentage of Population With a Regular Health Care Provider (CIHI: 2017-2018)

Jurisdiction	Percentage with regular provider	Percentage without a regular provider	Population 2016 census	Number of people without regular provider
Canada	84.9	15.1	35,151,728	5,307,910
Eastern Health	89.6	10.4	313,380	32,592
Central Health	87.4	12.4	92,525	9,623
Western Health	89.8	10.2	77,330	7,888
Labrador-Grenfell Health	53.4	46.6	36,475	16,997
NL	87.1	12.9	519,710	67,100

In addition, as detailed above, Newfoundland and Labrador's population demography has changed substantially with a decrease in the number of children and an increase in the number of seniors, indicating the need to provide more care for chronic diseases and for the frail elderly.

The provincial rate of avoidable death, both from preventable causes and from treatable causes, indicates the potential for health system improvements that can improve mortality rates (Table 1).

Based on CIHI data, another explanation for the high use of hospitals in Newfoundland and Labrador is the high rate of hospitalization for ambulatory sensitive conditions. The Canadian rate for 2019/20 is 316 per 100,000 people versus 415 for Newfoundland and Labrador, making Newfoundland and Labrador eighth of out 11 jurisdictions reporting. This indicator is a measure of acute care hospitalization rate in conditions that can be prevented/reduced if appropriate ambulatory care is provided. This points to the need to strengthen primary care in the community.

Primary Care Safety

Extensive prescribing of medications contrary to Choosing Wisely Canada recommendations occurs with the highest frequency in Newfoundland and Labrador (Table 7). It is important to note five of the eight indicators below are related to adults 65 years or older. Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care.

Table 7: Patient Safety in Primary Care

CAN	NL	NL Rank
% of adults ≥65 years taking ≥5 medications		
31.1	39.2	10
Antibiotics dispensed in the community (DDD/1,000 inhabitant days)		
17.9	29.1	10
Antibiotics dispensed in the community (Prescriptions/1,000 inhabitant days)		
--	970	10

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Table 7 continued

CAN	NL	NL Rank
Chronic use of benzodiazepines in adults ≥65 years per 1,000 population ≥65 years		
14.6	53.6	9
Use of long acting benzodiazepines in adults ≥65 years per 1,000 population ≥65 years		
10.6	32.1	10
Age-sex standardized rate of antipsychotic use per 1,000 population ≥65 years		
54.0	59.1	9
% of adults ≥65 years whose health provider reviewed medications during the past 12 months		
80.9	55.9	10
% of primary care providers who review prescribing practices at least yearly		
26.5	23.5	4

Long-Term Care

The Canadian Institute for Health Information found that in 2018–2019, about 1 in 9 (11 per cent) newly admitted residents in long-term care (LTC) facilities potentially could have been cared for at home. This represents more than 5,000 long-term care spaces in reporting provinces and territories.

Using Quality of Care NL data, in this province in 2019/20, 80 per cent of long-term care facility residents had extensive/total dependence for the activities of daily living, 45% had severe/very severe cognitive impairment, and 84% had either one or the other or both disabilities. Whether the remaining 16% of residents, 491 people, could be cared for in other settings requires further investigation.

Table 8 details one indicator impacting all seniors and two indicators related to seniors in long-term care where Newfoundland and Labrador has a low ranking compared to other jurisdictions.

Table 8: Indicators Impacting All Seniors and Those Living in Long-term Care (LTC)

Indicator	CAN	NL	NL Rank
Potentially inappropriate medication prescribed to seniors	44.3%	65.0%	10 of 10
Restraint use in LTC	4.6%	11.1%	5 of 5
Experiencing worsened pain in LTC	6.3%	15.3%	4 of 5

End-of-Life Care for Adults ≥ 65

Advance health directives are a way of making sure that the wishes and values of the person are respected in important health care decisions made when the person is no longer able to make such decisions. It ensures that those making decisions on behalf of the other person have the appropriate guidance to do so. Yet fewer than 50% of seniors in NL today have discussed end-of-life care or prepared a written plan on desired care, including identifying a person to make treatment decisions if they themselves are incapacitated (Table 9 and Figure 8).

Table 9: End-of-Life Care for Adults ≥65 Years

CAN	NL	NL Rank
% who had discussion with family, a close friend or health professional about what health care is wanted if incapacitated		
65.6	49.7	10
% who have written a plan or document on health care wanted at end of life		
43.0	22.3	10
% who have a written document that names someone else to make treatment decisions if incapacitated		
62.6	42.8	10

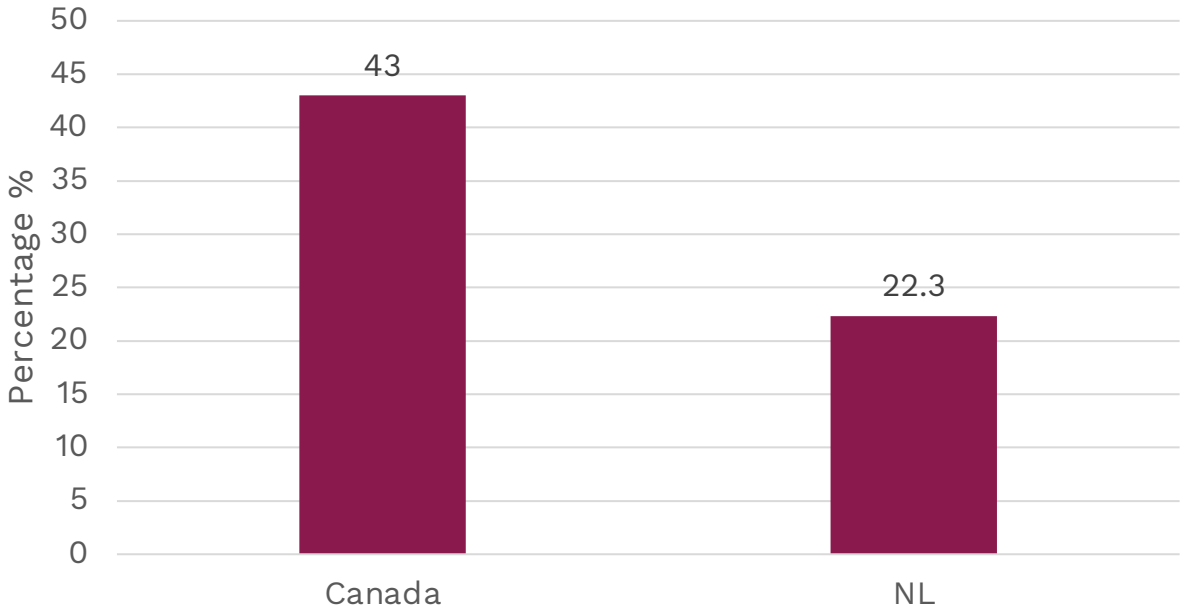

Figure 8: Percent Who Have Written a Plan or Document on Health Care Wanted at End of Life

Conclusion

Sources for this document and further evidence on health system performance can be obtained from:

- *Practice Points Special Edition – November 2020: Evidence and Strategies to Inform a 10-Year Health Accord in Newfoundland and Labrador*
- *Practice Points Volume 7 – Jan-Jun 2020*

(www.qualityofcarenl.ca/practice-points)

Supplement 2

Engagement

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Engaging Stakeholders

Open communication and meaningful engagement with the people of Newfoundland and Labrador are essential to the creation of Health Accord NL.

Throughout the Accord development process to date, there have been a number of initiatives designed to engage with both the general public and with the key stakeholder organizations in the province. Stakeholder organizations, for the purpose of the Accord, have been broadly divided into 19 different categories (Annex A).

The engagement framework has included one-on-one meetings with Health Accord NL Co-Chairs, Dr. Patrick Parfrey and Sister Elizabeth Davis, presentations to the Task Force and Committees, virtual town halls, online surveys, online submissions, digital communication via email and social media, and focus groups.

As indicated in the Interim Report, there have been two distinct engagement series completed to date: Series 1: November to December 2020 and Series 2: February to March 2021. Two more engagement series are planned for June and September 2021.

This document provides additional information on these engagement activities and is supplemental to the data included in the Interim Report.

Engagement Series One

Overview

The first engagement series included several one-on-one engagement meetings with Task Force Co-Chairs and key stakeholders. These meetings have been used to build rapport with key groups, seek input, and answer questions regarding the Task Force process.

A communication network with over 15 organizations has been created and will remain in place through the life of the Heath Accord process. This network includes regional health authorities, Newfoundland and Labrador Centre for Health Information, health sector unions, and others, and is a method of distributing information and inviting public feedback.

In the first engagement series there were 19 media events. The Co-Chairs are the public face of the Task Force. They have been quoted in print (The Telegram and The Gazette) and presented live on radio and television including NTV, VOCM Open Line, and CBC's Cross Talk and Labrador Morning (see Annex B for List of Media Coverage).

Health Accord NL's website accepts submissions from the public as well as stakeholders. Health Accord NL has social media accounts including Twitter, Facebook, Instagram, and YouTube to communicate and engage with the public.

The six task force committees have had local, national, and international experts provide presentations that helped inform the key directions coming from each committee and will, in time, inform the creation of short-, medium-, and long-term recommendations.

The ten virtual town hall sessions covering all areas of the province occurred from November 30 to December 16, 2020 with 345 participants. These sessions commenced with poll questions, followed by a presentation on the origin of Health Accord NL titled *A 10-Year Health Transformation*, and finally a question-and-answer period. After the session participants were invited to compete a survey. A total of 218 completed surveys were received. The following sections provide an overview of the information collected through the town halls and the related survey.

Town Hall Poll Questions

Three poll questions were asked at the beginning of the town hall sessions. As shown in Figure 1, almost 62% of respondents receive most of their health care services in health centres in their community.

Information is included in the Interim Report on poll questions about participants' top concerns regarding health as well as the biggest factor that they believe affects health.

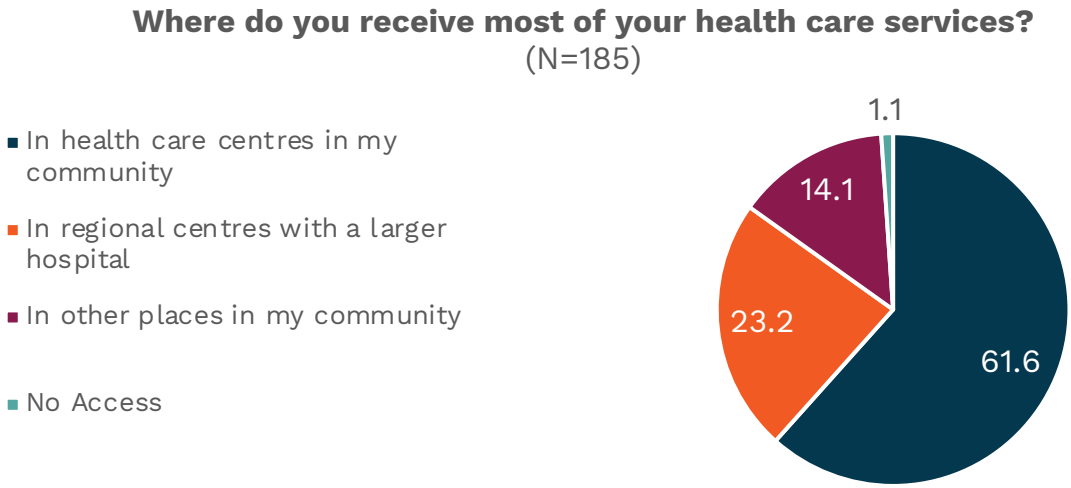
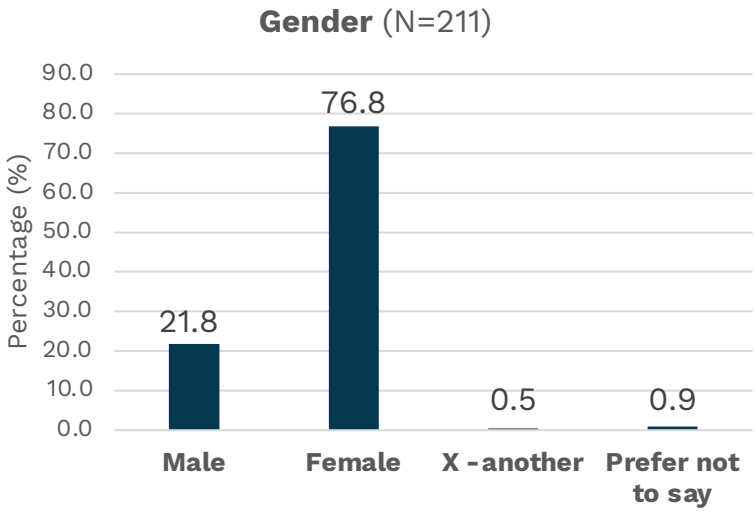


Figure 1: Town Hall Poll Question – Where Health Care is Received

Survey Information

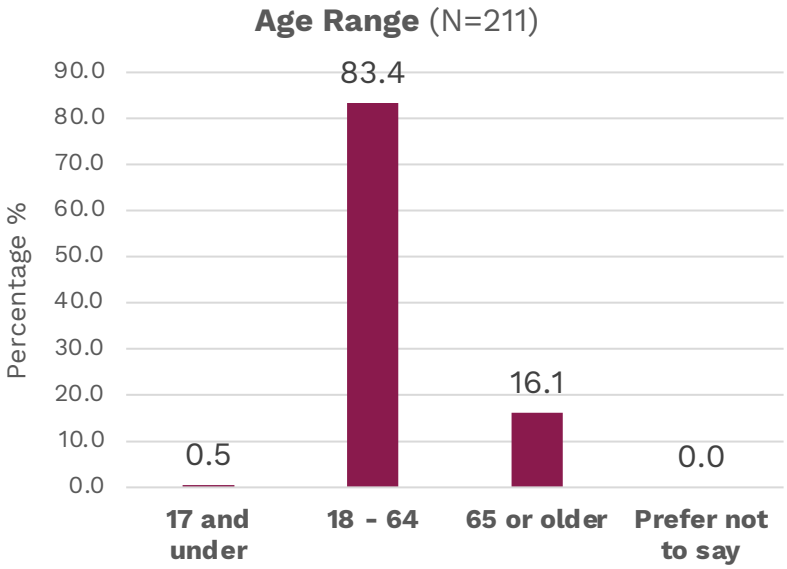
Following each town hall session, participants were provided with a link to complete a survey. A reminder email containing the link was also sent to each participant on the day following the town hall. The following sections provide an overview of data received from the survey. It should be noted that survey respondents were not required to answer all questions, thus response numbers vary by question. For clarity, the number of respondents for each question is provided in each chart, denoted as N.

Demographics of Survey Respondents



Overall, 76.8% of respondents were female and 21.8% were male.

Figure 2: Gender of Survey Respondents



The vast majority of respondents, 83.4%, were in the 18–64-year-old range. An additional 16.1% were 65 years of age or older.

Figure 3: Age of Survey Respondents

Survey Questions

Participants were asked **Is it important to provide solutions to social factors that affect our health like level of education, employment, our social circumstances, culture, race, etc.?** and **Do you believe that the way we receive regular care from doctors, nurses, or other providers needs to change?** Results from these questions are included in the Interim Report.

Comments

During the question-and-answer period of each town hall, notes were kept and compiled into categories, and subsequently into themes, by frequency. Survey comments were compiled in a similar manner.

Four broad themes arose from the question-and-answer periods and the survey comments: 1) social determinants of health; 2) health system access; 3) health system performance; and 4) a miscellaneous category primarily supporting the need for change, the importance of the Health Accord work, and questions on the Health Accord process. Information on these main themes, as well as the sub-themes that emerged for each, is presented in the Interim Report. A total of 618 comments or phrases were assessed.

Other Electronic Information

A total of 95 comments were received via email, social media and the website. The main themes identified for email and website feedback are included in the Interim Report. The breakdown of sub-themes for each are provided in the following three tables.

Table 1: Sub-themes Identified Through Email, Website and Social Media for Social Determinants of Health

Social Determinants of Health	
Theme	**Total**
General Comments	8
Poverty and Income	3
Food Insecurity	13
Healthy Living	8
Housing	1
Cost of Health Care to Residents	1
Disability	1

The major sub-themes were food insecurity, healthy living and poverty.

Table 2: Sub-themes Identified Through Email, Website and Social Media for Health System Access

Health System Access	
Theme	**Total**
General Access	**1**
Primary Health Care	**9**
Access to Diagnostic Equipment	**3**
Seniors' Care	**2**
Mental Health and Addictions	**1**
Remote Location	**1**
Specialist Care	**4**
Digital Communication Impacting Health Delivery	**7**

The major sub-themes were access to primary care, digital communication and access to specialist care.

Table 3: Sub-themes Identified Through Email, Website and Social Media for Health System Performance

Health System Performance	
Theme	**Total**
Health System Administration or Structure	**10**
Team-Based Cared	**2**
Scope of Practice	**4**
Quality of Care	**9**
Patient-Centred Care	**4**
Seniors	**3**

The major sub-themes were system structure, quality of care, providers working to the full scope of their practice, and patient-centered care.

Engagement Series Two

Overview

Engagement Series 2 offered several new opportunities and methods of engagement for the public and stakeholders. An engagement guide was created and posted on the website. New opportunities included two surveys for the general public and organizations to complete: 1) general survey, and 2) survey related to the vision statement and the six committee direction statements. A website form was created for information/ document submissions. People were also advised how to submit feedback by telephone, digital recording, or mail.

A second round of public virtual town halls occurred between February 22 and March 11, 2021. There were 356 attendees at 11 public town halls.

Health advocacy organizations and health professional associations were invited to present their priorities to the Task Force virtually.

Other special interest town halls included:

- ten seniors' groups hosted by the Aging Population Committee
- 20 community groups hosted by the Community Care Committee
- key players in the air and road ambulance system hosted by the Hospital Services Committee
- appropriate drug use hosted by the Quality Health Care Committee
- food security hosted by the Social Determinants of Health Committee
- Municipalities NL and its members (76 participants)
- patient advisory groups from around the province (32 participants)
- Community Sector Council of NL network (82 participants)
- Qalipu First Nation (15 participants)

Additionally, the Task Force has begun the process of supporting focus groups for any key stakeholder wishing to conduct them with their members. For example, the Newfoundland and Labrador Medical Association (NLMA) conducted extensive consultations with their members in February/March 2021, including focus groups, and submitted to Health Accord NL a high-level summary of the views of its membership.

Engagement Series 2 included many one-on-one engagement meetings with Task Force Co-Chairs and key stakeholders. These meetings have continued to build rapport with key groups, seek input, and answer questions regarding the Task Force process.

There were five media events during Series 2: four on the radio and one print article. Dr. Patrick Parfrey and Sister Elizabeth Davis, as Co-Chairs for the Task Force, continued as the public face of the Task Force (see Annex B for List of Media Coverage).

Health Accord NL continued to accept submissions and emails from the public and stakeholders and remained active on social media.

The six Task Force committees have continued to have local, national, and international experts present on various topics to help inform the work of each committee.

Figure 4: Tweet Sent by Health Accord NL to Engage Followers

The tweet in Figure 4 resulted in 43,429 impressions (number of times people saw the tweet), 594 engagements (number of times people interacted with the tweet), and approximately 72 responses as of April 5, 2021.

Directions Survey Information

Demographics of Survey Respondents

Table 4: Top Demographic Characteristics of Directions Survey Respondents

Demographic	Percentage of Respondents
Female	73%
18-64 Years of Age	78%
Completed a Bachelors, Professional or Graduate Degree	80%
Household Income Greater than $75,000	62%
Employed Full-Time	66%
Retired From Paid Work	25%
Living in Eastern Region	73%

Directions Survey Questions

The survey included several questions related to the draft vision statement and the direction statement for each of the six committees. The following table shows the level of agreement with each of the statements. The full responses for each statement are provided in the Interim Report.

Table 5: Level of Agreement with Vision Statement and Each Direction Statement

Statement	Strongly Agree	Somewhat Agree	Number of Respondents
Vision	70%	23%	223
Social Determinants of Health	69%	23%	206
Community Care	73%	21%	201
Hospital Services	66%	28%	195
Aging Population	78%	18%	197
Quality Health Care	67%	25%	194
Digital Technology	63%	30%	193

Directions Survey Comments

After each direction statement in the survey, respondents were given the opportunity to comment on what they liked about the statement, what they did not like about the statement, and what they believed may have been missing. Respondents were not required to complete every question in the survey and thus the number of comments made for each question varied. These statements were analyzed using qualitative analysis software. Over 900 comments were grouped by statement and provided to the relevant committee for review and consideration as they move through the next stages of their work.

A sample of the comments provided for each statement is included in Table 6.

Table 6: Level of Agreement with Vision Statement and Each Direction Statement

Statement	Sample Comment(s)
Vision Statement	"I love the focus on the social determinants of health and the idea of a balance between community-based & hospital services. This is a much-needed new focus." "I would like to see a reference to a culture of health. We have on the whole an unhealthy culture with so much potential given our geography, clean air, and proximity to and relationship with nature."
Social Determinants of Health Direction Statement	"Championing the 'Health in All Policies' approach. This is absolutely vital in order to have the social determinants of health used to increase our health and health outcomes. This is one of (if not the most) important factor in order to have the Health Accord work" "The statement is missing a focus on the opportunity to empower others to improve their health. It reads like the only answer is for the formal health care system to fix things rather than to support communities and individuals to tackle their own challenges."
Community Care Direction Statement	"Just the very delineation of 'community-based care' as a concept and the placing of it as an important and integral component of our health. This new focus is important if we are to change the archaic view that 'hospital care is the apex of our health care'." "only going to work if interdisciplinary teams are utilized in true sense. ie: the lead DOES NOT have to be a doctor--the lead in a community/region should be the professional who is best for that community/region ie: could be the NP, Pharmacist etc."

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Table 6 continued

Statement	Sample Comment(s)
Hospital Services Direction Statement	"Acknowledgement that emergency/stabilization care is local but that bigger services will have to be in centers. There shouldn't be surgeons in St. Anthony. Health care cannot support hospitals in every small community - many should be emergency care clinics. Money could then be centered in community supports such as meals on wheels, home care etc. collaboration with community services - great to see this" "Care should be planned also in collaboration with the patient. Too often a plan of care is agreed upon and a patient is hustled out of hospital because the plan in theory *should* work."
Aging Population Direction Statement	"empowers citizens to transition - empowerment really needs to be improved. I do believe we are missing some options for aging individuals who are experiencing difficulties with independent living and maintaining their own homes but do not want (or feel they need) to move to residential care." "I believe this statement should reference social services as well as health services. There are some of these that are directly linked to aging in place, in some cases the first intervention of any type in a household."
Quality Health Care Direction Statement	"Accountability, oversight and beneficial innovation will ensure optimal quality of care. This is critical to the success of healthcare sustainability." "When I read the second sentence of the statement, I am left wondering how timely access can be guaranteed, especially in rural areas where specialists and even general practitioners can be in short supply."

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Table 6 continued

Statement	Sample Comment(s)
Digital Technology Direction Statement	"We need more technology in healthcare. If GP and NP could use this to communicate and do appointments over the phone there would be less wait times and more money saved by everyone." "There is no questioning the importance and benefits of digital technology, but we are still faced with the problems of providing it, including enabling people of low income to afford the equipment and internet costs necessary to purchase and avail of digital technology."

General Survey Information

As indicated, the Task Force is committed to ensuring that all people have an opportunity to provide feedback about the current health and wellness resources in the province. To do this, a general survey was developed along the lines of the community health assessment surveys used by the regional health authorities (RHA). The RHA survey results included input from 7,255 respondents and the data, obtained in 2019, is available to the Task Force.

The Task Force's general survey included a demographics section, a series of fixed answer questions about use of health and wellness resources and three open-ended questions. The following sections provide an overview of the input received to date. The survey will remain on the website throughout all engagement phases of the Health Accord.

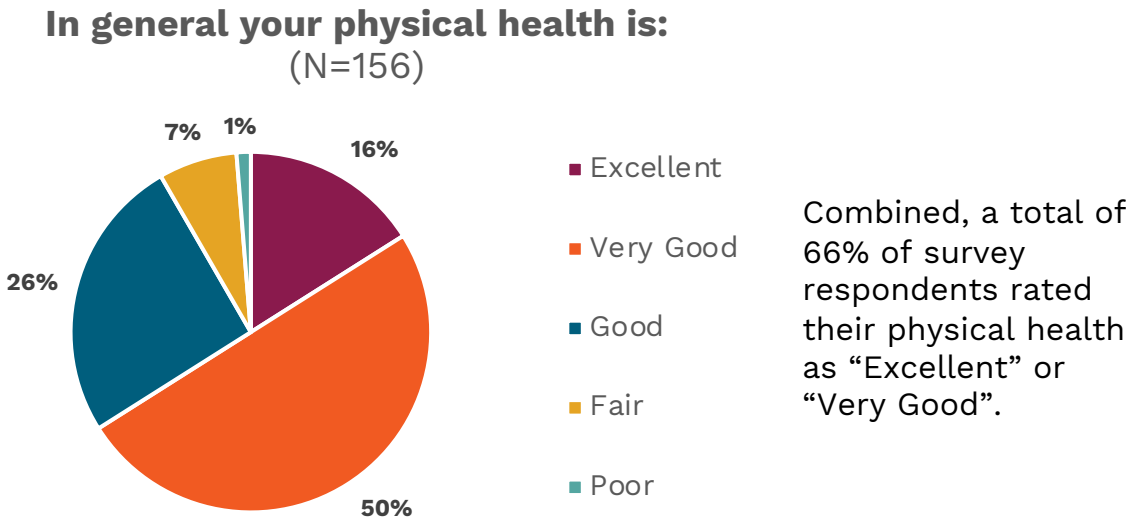
Demographics of Survey Respondents

Table 7: Demographic Characteristics of General Survey Respondents

Demographics	Percentage of Respondents
Female	75%
18-64 Years of Age	90%
Completed a Bachelors, Professional or Graduate Degree	80%
Household Income Greater than $75,000	68%
Employed Full-Time	70%
Retired From Paid Work	14%
Living in Eastern Region	70%
Living in St. John's Metropolitan Area	55%

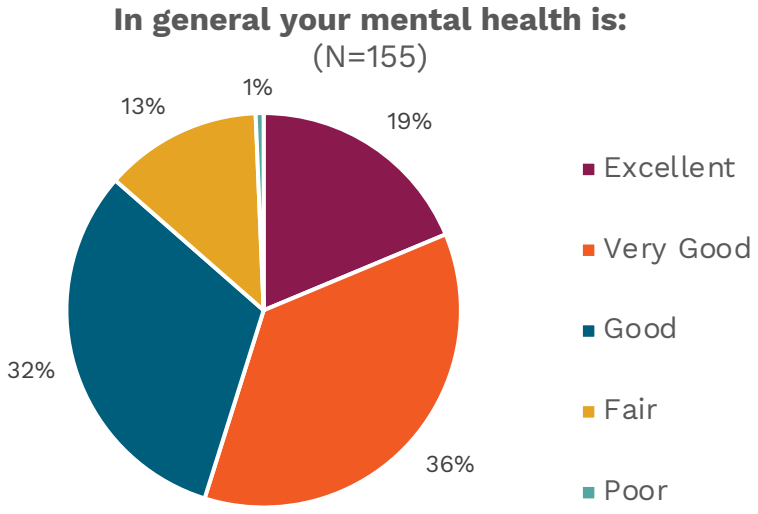
Survey Fixed Answer Questions

The following charts summarize the responses of survey participants to fixed answer questions related to their health and wellness, and their use of health and wellness resources in their communities.



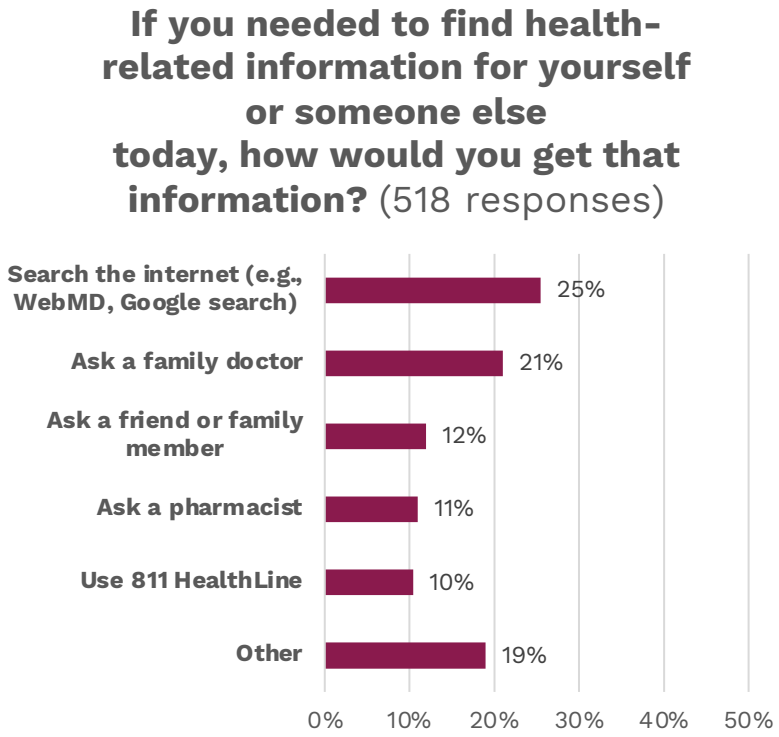
Combined, a total of 66% of survey respondents rated their physical health as “Excellent” or “Very Good”.

Figure 5: Perceived Physical Health of General Survey Respondents



55% of respondents indicated that their mental health was “Excellent” or “Very Good”.

Figure 6: Perceived Mental Health of General Survey Respondents



The top source of health-related information for respondents was the internet (25%), followed by a family doctor (21%).

Figure 7: Seeking Health-Related Information – General Survey Respondents

Combined, a total of 72% were either “Extremely Satisfied” or “Satisfied” with their family doctor or nurse practitioner. 5% of respondents indicated they did not have a family doctor or nurse practitioner.

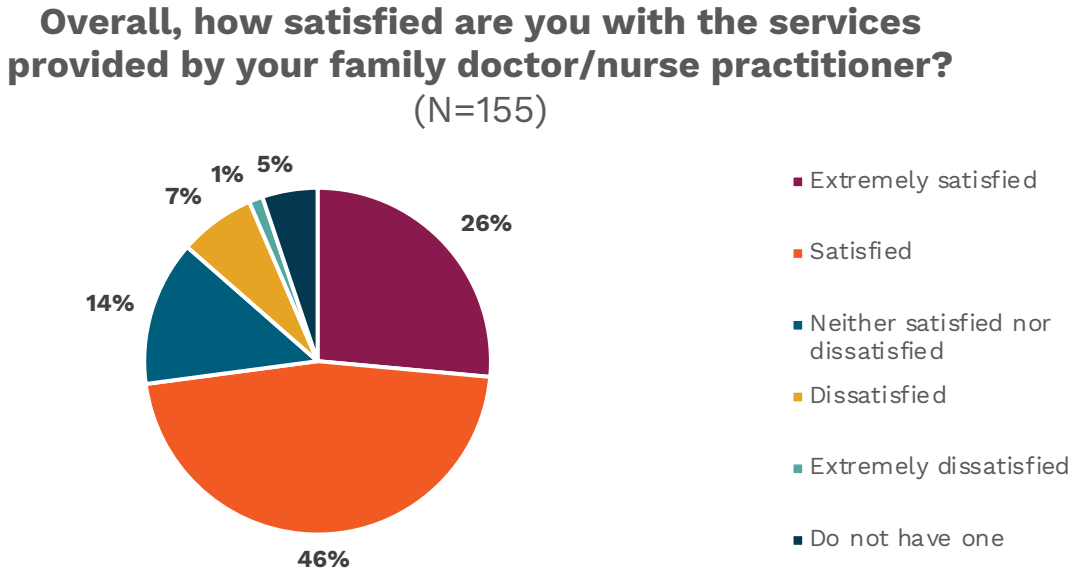


Figure 8: Satisfaction with Family Doctor/Nurse Practitioner

For those who were not satisfied with their family doctor or nurse practitioner, the top two reasons were wait lists for appointment (24%) and lack of trust or confidence in their provider (15%).

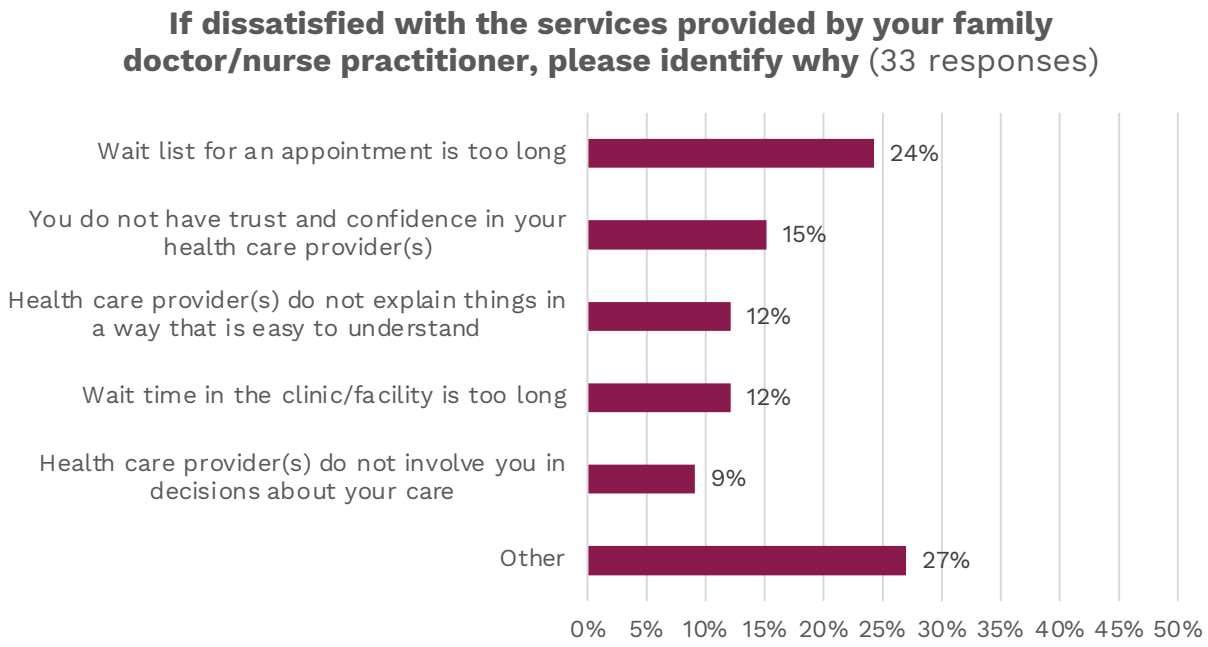


Figure 9: Nature of Dissatisfaction with Family Doctor/Nurse Practitioner

66% of respondents were either “Very Satisfied” or “Satisfied” with the health care services that they used during the past 12 months.

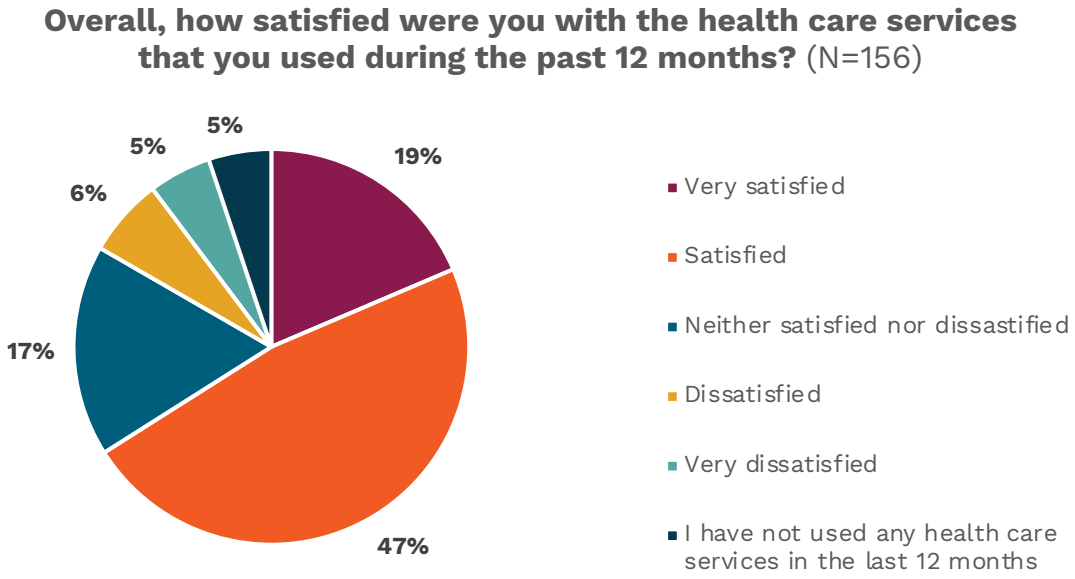


Figure 10: Satisfaction with Health Care Services

For respondents who were dissatisfied with health care services, the top two reasons were “Wait list for appointment was too long” (19%) and the “Health system was difficult to navigate” (13%).

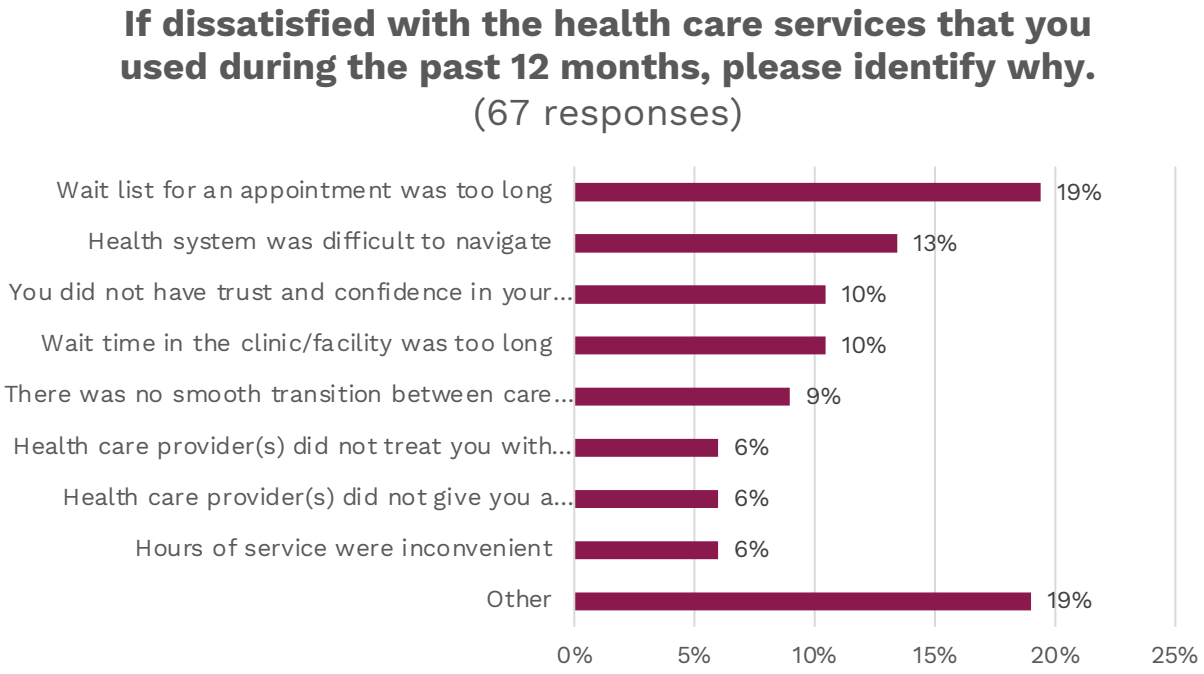
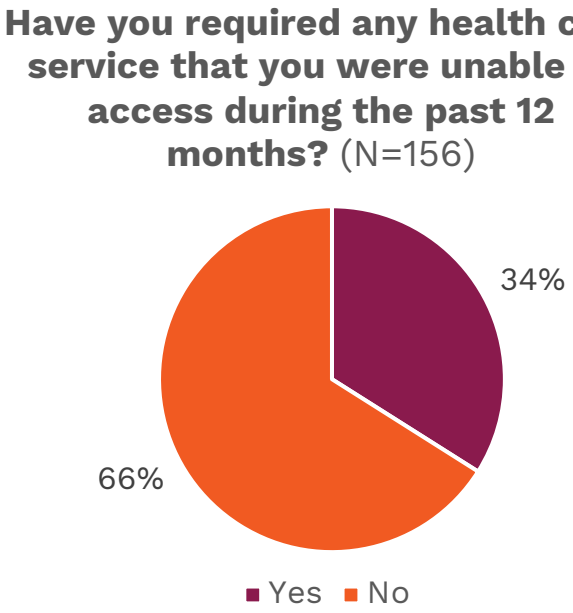


Figure 11: Source of Dissatisfaction with Health Care Services



34% of respondents required a health care service in the past 12 months that they were unable to access.

Figure 12: Access to Health Care Services

Of the responses received, 29% identified wait time as the reason why they were unable to access services. A further 20% indicated that the service was not available.

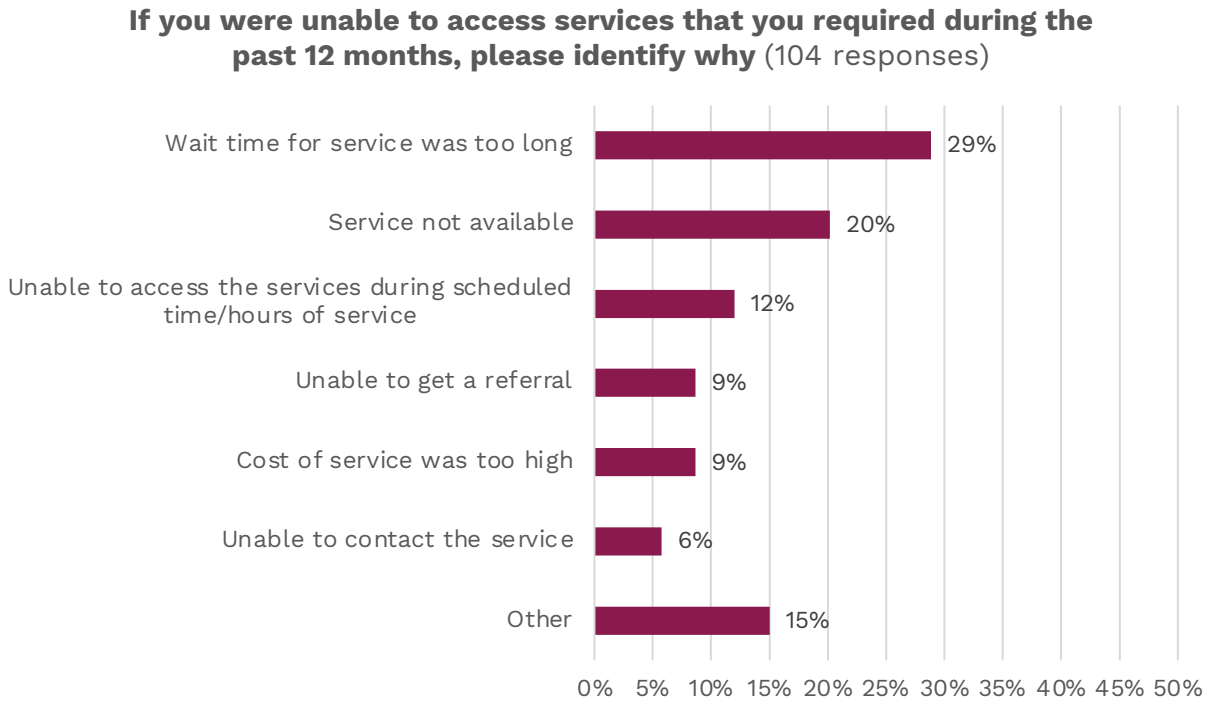
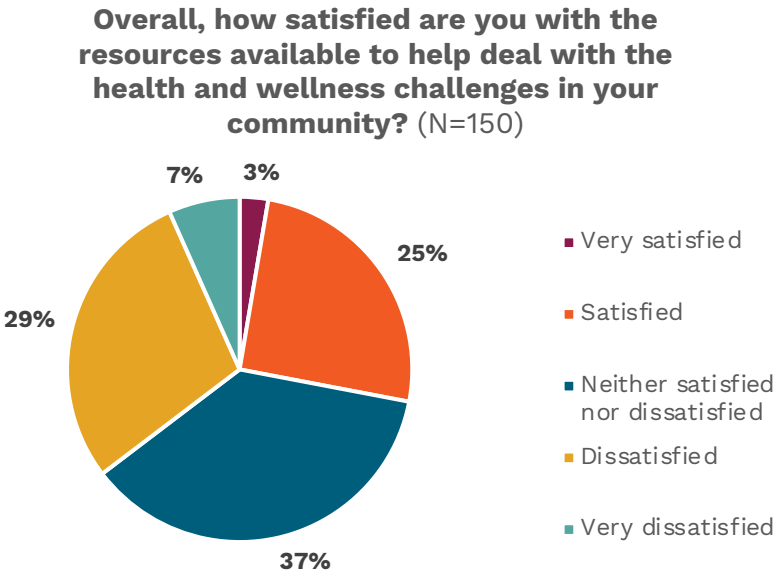


Figure 13: Reasons for Inability to Access Health Care Services



A combined 28% of respondents were "Very Satisfied" or "Satisfied" with the resources available to deal with health and wellness challenges in their community.

Figure 14: Satisfaction with Resources Available

Table 8: Top Areas/Issues of Concern in Region (Top Responses Provided, Total Responses=1738)

Answer (note: respondents could select more than one)	Number of Times Selected	Percentage of Respondents
Mental health of residents	106	64%
Chronic diseases (e.g., prevalence of diabetes, high blood pressure, cancer, etc.)	111	67%
Addictions (e.g., alcohol and/or drug abuse, gambling)	82	49%
Physical health of residents	83	50%
Access to a family physician or other primary care provider	90	54%
Social isolation and lack of community involvement	64	39%
Food security (access to sufficient, affordable, nutritious food)	74	45%
Cost of living	76	46%
Childcare (including affordability, lack of accessibility)	45	27%
Violence in the home (e.g., child abuse/neglect, domestic)	46	28%
Homelessness (including couch surfing)	48	29%
Quality of community care (e.g., care that is delivered in private homes, retirement communities, residential or long-term care homes and community clinics)	53	32%
Unemployment	54	33%
Poverty	55	33%
Seniors' resources/programs	55	33%
Quality of care in a hospital	55	33%
Resources for people with disabilities (e.g., accessible buildings)	57	34%

Information from Open-ended Survey Questions

Individuals who completed the survey were also given the opportunity to answer three open-ended questions:

1. **Overall, what aspects of health and wellness are you most satisfied with?**
2. **Overall, what aspects of health and wellness resources are you dissatisfied with?**
3. **In your opinion, what are the top three things the province should do over the next 5-10 years to improve health care and service delivery?**

The answers provided by the respondents were again analyzed using qualitative analysis software and were coded into main themes. The sub-themes identified for question 1 are provided in Table 9. The themes and sub-themes identified for questions 2 and 3 are included in detail in the Interim Report. In total, there were 715 comments/phrases coded in response to the three questions.

Table 9: Sub-themes from the Question "Overall, what aspects of health and wellness are you most satisfied with?"

Theme	Count	%
Primary Health Care – Access to Family Doctor	43	33%
Access to Health Services	11	8%
Quality of Care Received	10	8%
Acute/Hospital Care	10	8%
Satisfied General	7	5%
Specialist Care	6	5%
Digital Technology & Telehealth	6	5%
Community & Support Services	6	5%
Pharmacists	5	4%
Access to Wellness Activities	4	3%

continued on next page

Table 9 continued

Theme	Count	%
Nurse Practitioners	4	3%
Private Services (Massage, OT, PT, etc.)	4	3%
Awareness of Mental Health	4	3%
Care During COVID-19	4	3%
Awareness of Importance of Social Determinants	3	2%
Miscellaneous	2	2%
Total	**129**	**100%**

Other Electronic Information

Similar to Engagement Series 1, comments have been received via website, email, and social media. The following table provides an overview of the number of submissions received during this series of engagement.

These submissions are downloaded on a regular basis. Formal reports or research received via these means are provided to the appropriate committee(s) for review. General input with respect to the Health Accord process is analyzed using qualitative analysis software. This analysis is ongoing.

Table 10: Electronic Submissions Received in Engagement Series 2 (as of April 6, 2021)

Format	Number Received
Email	73
Twitter	112
Facebook	1
Website	32
Total	**218**

Conclusion

Engagement activities are ongoing and will be expanded as the Task Force moves into its next phase. The process of engagement is constantly evolving. Health Accord NL is committed to increasing awareness of the Task Force and providing many opportunities and multiple methods of engagement. The people of Newfoundland and Labrador must be involved in this process and have their voices heard.

Visit www.healthaccordnl.ca/get-involved for more information.

Annex A – Health and Social Sector Stakeholder Groups

- General public
- Five Indigenous communities
- Municipalities
- Community organizations with health/social focus
- Health advocacy organizations
- Post-secondary health education
- Health research units
- Individual experts (local, national and international)
- Professional self-regulatory bodies
- Health professional associations
- Health care unions
- Private health care providers
- Sector associations
- Religious organizations
- Regional health authorities
- newfoundland and Labrador Centre for Health Information
- Patient, family, and resident representatives from the regional health authorities, NL SUPPORT and Quality of Care NL, and the Newfoundland and Labrador Centre for Applied Health Research
- Region specific community and wellness organizations
- Provincial Government departments and relevant provincial agencies, boards, commissions

Annex B – List of Media Coverage

Date	Outlet	Type	Headline
5-Nov-20	Gov NL	News Release	Premier Furey and Minister Haggie Appoint Co-Chairs for Health Accord NL
5-Nov-20	NTV	TV	Premier launches task force to reimagine health care system
6-Nov-20	VOCM	Article	Chair of Economic Recovery Team Speaks on Healthcare
6-Nov-20	CBC NL	Article	The road to economic recovery in N.L. is paved with hard questions, Moya Greene says
6-Nov-20	VOCM	Article	Government Appoints 2 Leaders in Healthcare for New Task Force
6-Nov-20	NTV	Video	Task force leaders seek public input for new health accord
6-Nov-20	The Telegram	Article	Newfoundland and Labrador task force chairs say the culture of health care has to change
7-Nov-20	CBC NL	Article	Waste and health care: What to watch for as a new task force gets to work
7-Nov-20	VOCM	Poll	Question of the Day-Do you agree with setting up a task force to look at health care in NL?
10-Nov-20	The Telegram	Article	Newfoundland and Labrador doctors say they're in sync with new task force
12-Nov-20	Gov NL	News Release	Six Committees Established for Health Accord NL
20-Nov-20	VOCM	Radio	Open Line
23-Nov-20	Health Accord NL	News Release	Health Accord NL focused on meaningful conversations with residents of NL
24-Nov-20	CBC NL	Radio	Cross Talk - What changes would you make here so that we were all healthier?
2-Dec-20	CBC NL	Radio	Labrador Morning with Janice Goudie
7-Dec-20	VOCM	Radio	Dr. Pat Parfrey Co-Chair Of Health Accord NL - Current State Of Provincial Healthcare Consultations
11-Dec-20	The Gazette	Article	Health care task force with Memorial ties to develop 10-year plan
3-Dec-20	NTV	TV	Issues & Answers - start at 8:09
14-Dec-20	VOCM	Article	Health Accord NL Seeking Public Engagement on Improving Health of Province

Annex B – List of Media Coverage (continued)

Date	Outlet	Type	Headline
4-Feb-21	CBC Newfoundland Morning	Radio	Update on the provincial health accord task force
9-Feb-21	CBC Labrador Morning	Radio	Health Accord NL Task Force Check-In
15-Feb-21	VOCM	Radio	Open Line
18-Feb-21	CBC St. John's Morning Show	Radio	Healthcare Deep-Dive
22-Feb-21	The Telegram	Article	Health of Newfoundland and Labrador is about more than hospitals

Supplement 3

Social Determinants of Health

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Introduction

The World Health Organization describes the social determinants of health as the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries or groups of people.

In 1977, the World Health Assembly set as a goal "the attainment of all people of the world by the year 2000 a level of health that would permit them to lead a socially and economically productive life." This statement led to the **Global Strategy for Health for All by the Year 2000** and the "Health for All" movement.

In 1978 the **Declaration of Alma-Ata** reiterated the definition of "health" outlined in the WHO's constitution as:

> a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

The Declaration was a major milestone for public health and primary health care. It is here that the roots of social determinants of health are found. Another major milestone in this field, with its roots in Canada, was the **Ottawa Charter for Health Promotion** in 1986. It built on the work of the Declaration, outlining prerequisites for health and further stated that:

> Health promotion goes beyond health care – and puts health on the agenda of policy-makers in all sectors and all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

In parallel to the new public health movements emerging globally, Canada was also a leader in promoting an understanding of the importance of the determinants of health. In addition to the **Ottawa Charter**, other recognizable Canadian reports in the field included:

- ✓ **A New Perspective on the Health of Canadians** (1974) – "health is related not only to health care but also to human biology, the environment, and lifestyle"
- ✓ **Achieving Health for All: A Framework for Health Promotion** (1986)

- ✓ **A Healthy, Productive Canada: A Determinant of Health Approach**, Senate of Canada (2009) – "Success will require leadership from our prime minister and first ministers, from our mayors, municipal leaders, community leaders, and the leaders of our Aboriginal peoples. A whole-of-government approach is required with intersectoral action embracing business, volunteers, and community organizations"
- ✓ **Stepping it Up: Moving the Focus from Health Care in Canada to a Healthier Canada**, Health Council of Canada (2010) – "Messaging to the public, including media support, about the importance of dealing with population health and reducing health inequities through action on the determinants of health"
- ✓ Many contributions by the **National Collaborating Centres on the Determinants of Health** (www.nccdh.ca) and **Healthy Public Policy** (http://www.ncchpp.ca).

While progress has been made over the past fifty years, much work remains within Canada and globally to achieving the WHO's vision for health. As Health Accord NL begins its work, these underlying visions and goals are foundational. In the words of another WHO document, "Socioeconomic development and health systems development are mutually reinforcing; addressing determinants of health alongside clinical services leads to greater sustainability of results."[1] The vision of Health Accord NL endorses that call:

Our Vision is improved health and health outcomes of Newfoundlanders and Labradorians through acceptance of and interventions in social determinants of health, and a higher quality health system that balances community, hospital and long-term care services.

[1]Erik Blas, Nathalie Roebbel, Dheepa Rajan and Nicole Valentine, Intersectoral planning for health and health equity, chapter 12, in G. Schmets, D Rajan, S Kadandale, editors, Strategizing national health in the 21st century: a handbook (Geneva: World Health Organization, 2016), 8.

Social Determinants of Health

Dahlgren and Whitehead in 1991 developed one of the most widely used diagrams showing the social determinants of health. The diagram shows the individual and the progressive layers influencing health, from individual factors through to the broadest social, economic, cultural, and environmental conditions.

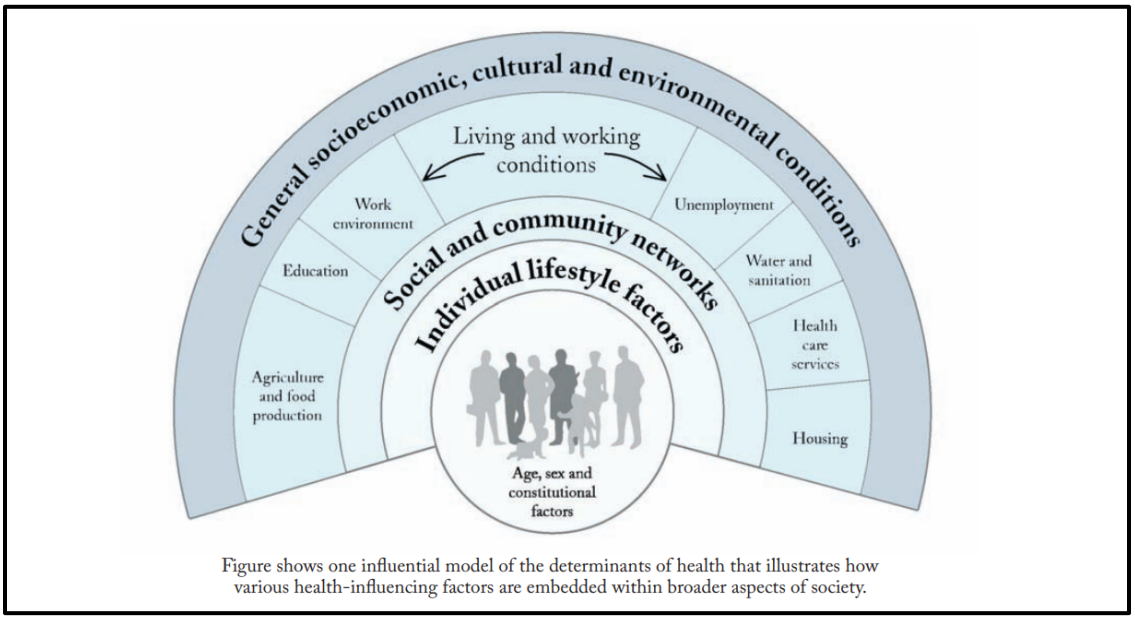

Figure 1: Dahlgren and Whitehead, Model of the Determinants of Health[2]

There are many lists of determinants to draw from, and they vary. However, consistently, most include what some call structural dimensions and intermediary dimensions (see Figure 2) and what others call social location and resources which society makes available to its members. A widely cited Canadian expert in the field of social determinants gives the following listing:

> These resources include, but are not limited to, conditions of childhood, income, education, employment security and working conditions, food and housing security, and availability of health and social services. Social locations such as Indigenous descent, social class, dis/ability, gender, race, and immigrant and refugee status are also SDH, as they specify which individuals have access to these resources.[3]

[2]Source: Dahlgren G. and Whitehead, M (1991), *Policies and Strategies to Promote Social Equity in Health* (Stockholm: Institute for Futures Studies, 1991).

[3]Dennis Raphael, The Social Determinants of Health of Under-Served Populations in Canada, chapter 2, in Thomas Piggott and Akshaya Neil Arya, Under-Served (CSP Books Inc., 2018), 23.

There is not agreement on the extent of impact that the social determinants of health have on population health. However, there is agreement that the impact is significantly higher than that of the health care system or of factors such as biology, genetics, or personal behaviours. The following figure shows a generally accepted approximation of the degree of impact with social, economic, and environmental factors having 60% of the impact:

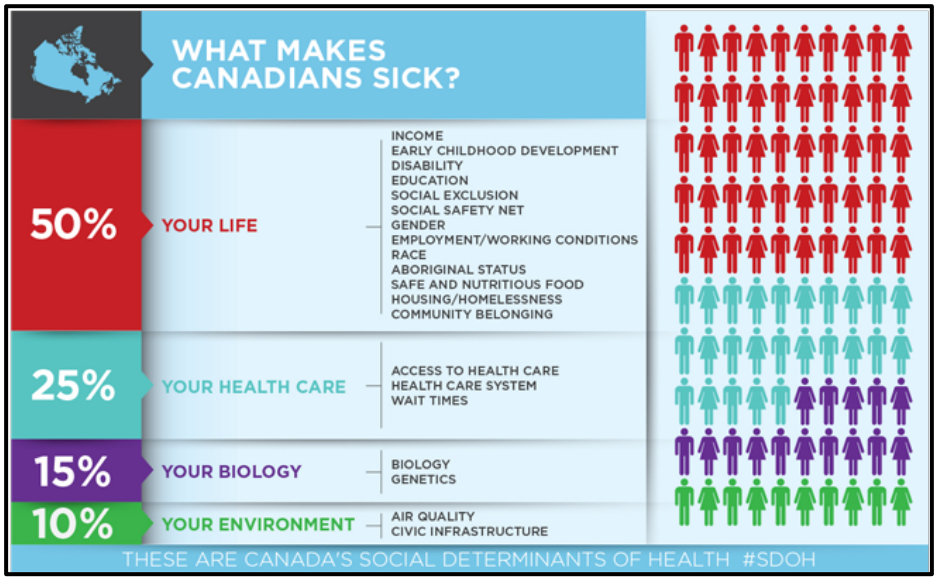

Figure 2: Impact of Social, Economic and Environmental Factors on Health[4]

Health Equity

Given that "living and working conditions—not biomedical factors or health-related behaviours—are the primary contributors to health and illness,"[5] it follows that the determinants have a direct impact on health equity. The WHO defines health equity as the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically, or geographically. Health inequities are health differences that are socially produced, systematic in their distribution across the population, and unfair. In other words, health inequity is something that a country or a province can change.

There is substantial evidence that the health of the people of Newfoundland and Labrador is worse, on average, than the health of the people in other provinces in Canada. As well, there is substantial evidence that the health of some groups within the province, for example members of the five Indigenous communities, is worse than the health of other groups. The Supplement on Evidence to the Interim Report gives indications of this evidence.

[4]Source: Canadian Medical Association, 2017, "Health equity and the social determinants of health," (Canadian Medical Association Journal, 2017).
[5]Raphael, 23-24.

Institutional Racism and Discrimination in the Health System

Of particular concern and with need for attention is the assessment of the experience of clients in the health system, and the ways in which the health system may be continuing to support, in the delivery of health services, racism and other discrimination reflected in society. This discrimination may manifest in ways as explicit as the racism of health care providers or fellow clients that goes unaddressed. It may show itself through clinical care received by patients due to implicit bias of providers, e.g., the differential treatment of pain,[6] language barriers or inadequacies of health education or communication across cultures.

Tragically, we know that racism is present in particular against Indigenous patients in the Canadian health care system through high profile cases including the deaths of Brian Sinclair in Winnipeg, Manitoba in 2008, who was ignored waiting for emergency treatment, or Joyce Echaquan, in Saint-Charles-Borromée, Quebec in 2020, who was abused in her dying moments. The everyday experience of Indigenous patients and other patients experiencing discrimination may amount to more trauma and may push the very patients who need care the most away from accessing it. Addressing this tragedy and under-service is a complex problem and will require thoughtful and meaningful engagement with Indigenous partners.[7]

Response Needed

If health inequities are "socially produced, systematic in their distribution across the population, and unfair," any attempt to improve the health of a population must focus on the social determinants of health. Health Accord NL recognizes this reality and has sought advice on how to develop a response. What is the wisdom from Canadian and global sources?

Perhaps the most detailed and influential work in the past decade on this matter has been The Commission on Social Determinants of Health (CSDH), a global network of policy makers, researchers and civil society organizations brought together by the World Health Organization to give support in addressing the social causes of health inequities. The framework which came from this Commission delineates the layers in structural and intermediary dimensions, illustrating where interventions are possible and can be targeted.

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[6]Ngozi Iroanyah and Madi Cyr, "Navigating systemic racism in Canadian healthcare," in Healthy Debate, July 13, 2021, accessed at https://healthydebate.ca/2020/07/topic/navigating-systemic-racism/.

[7]See the following book reference and websites for more detailed information: Paul Tomascik, Thomas Dignan, and Barry Lavallée, "Intergenerational Trauma and Indigenous Health in Canada: How Racism Affects the Health of the Indigenous Patient," chapter 4, in Thomas Piggott and Akshaya Neil Arya, Under-Served (CSP Books Inc., 2018), 57-66.
https://www.ohchr.org/Documents/Issues/IPeoples/EMRIP/Health/UniversityManitoba.pdf
https://portal.cfpc.ca/ResourcesDocs/uploadedFiles/Resources/_PDFs/SystemicRacism_ENG.pdf
https://www.royalcollege.ca/rcsite/documents/health-policy/indigenous-health-primer-e.pdf

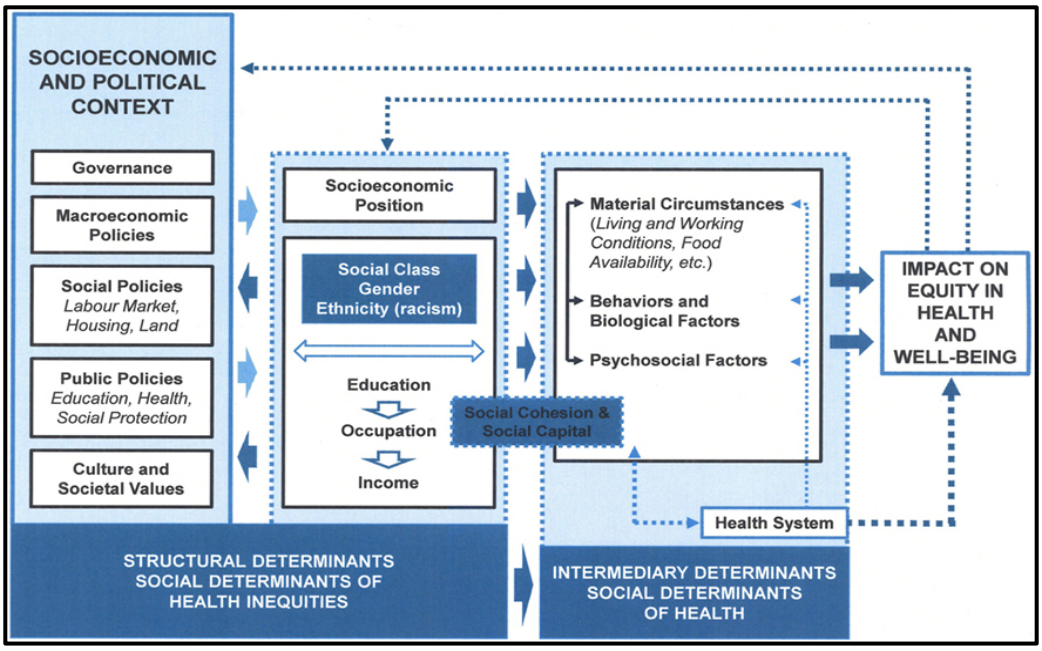

Figure 3: CSDH Conceptual Framework for Action on the Social Determinants of Health[8]

That Commission recommended three domains of action:

1. ***Improve the conditions of daily life*** – the circumstances in which people are born, grow, live, work, and age.
2. ***Tackle the inequitable distribution of power, money, and resources*** – the structural drivers of those conditions of daily life – globally, nationally, and locally.
3. ***Measure the problem***, evaluate action, expand the knowledge base, develop a work-force that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

The actions that the Commission identified (and summarized in the figure above) focus in four areas:

- ✓ context-specific strategies to tackle both structural and intermediary determinants
- ✓ intersectoral action
- ✓ participation of civil society and the empowerment of affected communities to become active protagonists in shaping their own health
- ✓ more collaborative, responsive modes of governance

[8]Source: Conceptual framework in O. Solar and A. Irwin, "A conceptual framework for action on the social determinants of health," Social Determinants of Health Discussion Paper 2 (World Health Organization, 2010), 6.

Specific elements of collaboration in governance include “sharing resources (including staff and budgets), working to craft joint decisions, engaging the opposition in creative solutions to shared problems, and building new relationships as needs and problems arise.”

The two Canadian reports from ten years ago give good advice in terms of possible approaches to enter these domains of action. The Senate report in 2009 referenced as a key Canadian report set out the following pathway:

1. a more integrated set of actions across Canada aimed at revitalizing the national health goals and matching these goals with indicators and targets for health disparities;
2. a reinvigorated approach to fund and encourage health impact assessment within all governments to assess their policies for their potential impact on health;
3. conducting research that identifies which public policy interventions work and how to do the research, followed by the dissemination of this information about what works best. More specifically, there need to be methods to advance the collection and sharing of best or promising practices around whole-of-government and intersectoral approaches;
4. providing a database infrastructure to ensure the collection, monitoring, analysis, and sharing of health equity and population health indicators, at national, regional, and local levels;
5. increasing the Canadian public’s understanding of the determinants of health and the economic costs to society of not acting on these determinants; and
6. enabling and supporting communities to manage situations locally.[9]

[9]A Healthy, Productive Canada: A Determinant of Health Approach, Senate of Canada (2009). Accessed at https://sencanada/content/sen/Committee/402/pop/rep/rephealth1jun09-e.pdf (sencanada.ca).

The Health Council of Canada report referenced as a key Canadian report from 2010 listed conditions for the success of such a venture:

1. Strong political and bureaucratic leadership
2. A strong and compelling case for support, accompanied by clear, bold numerical goals and targets
3. Appropriate government structures to facilitate the initiative and support action
4. More public engagement
5. Work at the community level
6. Policy entrepreneurs or champions

That Health Council Report provides a good checklist for an intersectoral approach.[10]

In the "Foreword" to *Under-Served*, David Butler-Jones lists six elements of a framework for response:

- ***Partner:*** Who else can we work with, to do it better together? Joining with others rather than duplicating or creating anew. The editors, as one form of partnership have brought together a broad group of individuals interested in improving the health of under-served populations from across the health sector and beyond to other allied sectors.
- ***Advocate:*** What needs to be done at a policy, program, or legislative level? Can we bring both evidence and workable solutions, rather than just point out problems for others?
- ***Cheerlead:*** Encouraging others and not being a barrier to progress or undermining others' good efforts because they aren't ours.
- ***Enable:*** What we do directly to change or influence the determinants. How we work effectively with others. Adopting reconciliation approaches. Ensuring services are accessible to those who need them most.
- ***Mitigate:*** Reducing the risks of adverse outcomes. For example, harm reduction, clinical care, or immunization to prevent diseases like hepatitis A, which we know is a result of overcrowding and sanitation issues. Working to minimize or mitigate the harms, while not ignoring that the real solutions are determinant based.[11]

[10]Stepping it Up: Moving the Focus from Health Care in Canada to a Healthier Canada, Health Council of Canada (2010), 25. Accessed at https://healthcouncilcanada.ca/files/2.40-HCCpromoDec2010.pdf (healthcouncilcanada.ca).
[11]David Butler-Jones, "Foreword," in Thomas Piggott and Akshaya Neil Arya, Under-Served (CSP Books Inc., 2018), xii-xiv.

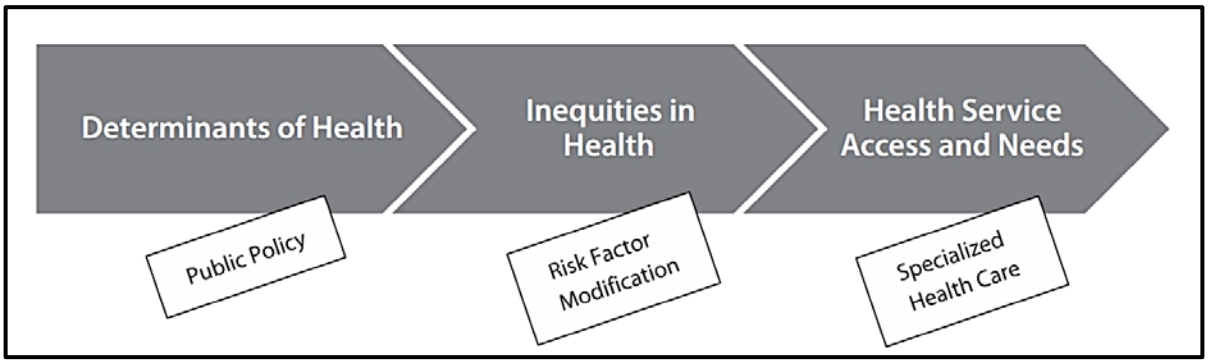

Figure 4: Differences in the Health of Special Populations and Interventions[12]

In that same book, Piggott and Arya illustrate differing focuses on action on various factors influencing the health of special populations. They conclude, "The determinants of health are socioeconomic and political and therefore require attention at a political or public policy level."[13]

They caution about labelling and note their use of the word "under-served". "Whereas vulnerable or marginalized identify the problem within the individual, under-served points to a system failure that leaves a group of individuals with an unmet need. Under-served also creates an avenue for rectifying this unmet need, by way of bridging the gap between needs and services by creating more appropriate or adequate services."[14] Health systems that do not explicitly consider equity and care for under-served populations may further entrench societal inequities through differential access to services. Examples of this could include not providing access to translation services for Indigenous people whose first language is not English, gender-normative approaches to cancer screening that may neglect the needs of a trans person, or institutional racism in service delivery that may marginalize people most in need of care.

In their cautioning about labelling, they also recognize the breadth of "special" populations with their reminder of "intersectionality" (the overlapping characteristics of populations requiring special attention) and their non-comprehensive listing of special populations: children, individuals with low education levels, individuals with non-normative gender identities, individuals with inadequate or precarious housing, immigrants, Indigenous populations, those living in low-income countries, visible minorities, people with mental and physical disabilities, pregnant women, prisoners, racialized individuals, refugees, people suffering from serious illness, people who identify as LGBTQ, asexual individuals, those who are socially isolated, people with low socioeconomic status, the unemployed, and, more broadly, women.[15]

[12]Thomas Piggott and Aaron Orkin, "Deconstructing the Concept of Special Populations for Health Care, Research, and Policy," chapter 1, in Thomas Piggott and Akshaya Neil Arya, Under-Served (CSP Books Inc., 2018), 17.
[13]Piggott and Arya, 17.
[14]Piggott and Arya, 14.
[15]Piggott and Arya, 14-15.

While recognizing complex interplay between under-served populations, the Health Accord also recognizes that all inequities are not equal. In particular Indigenous NL residents, and those who have been disenfranchised due to intergenerational racism or poverty, bear a disproportionate burden of ill health effects today. They are under-served by our current health system. It is with a keen attention to health inequities that our health system must be re-envisioned.

Health in All Policies

From public policy on health to population health to health for all to health in all policies (HiAP), there has been a progression of phrases all centered on social determinants of health. In its Joint statement of the UN Platform on Social Determinants of Health entitled *Health in the post-2015 development agenda: need for a social determinants of health approach*, the United Nations supports the work of the World Health Organization in this field. It also highlights the strengths of the HiAP approach:

> A "health in all policies" approach is one in which the actions are taken in a coordinated manner to improve the impact or accountability of public policies across sectors on population health, health equity, health-related human rights and health systems. It highlights the important links between health and broader economic and social goals in modern societies and considers the effects of policies on social determinants as well as the beneficial impact of improvements in health on the goals of other sectors. It assists leaders and policy-makers to integrate considerations of health, well-being and equity during the development, implementation and evaluation of policies and services.

Building upon the WHO work on social determinants of health referred to in the first section, a series of WHO statements on HiAP were made in the last decade including the *2010 Adelaide Statement*, the *2013 Helsinki Statement*, and in 2017, the second *Adelaide Statement on Health in All Policies*.

In 2015, the Government of Newfoundland and Labrador commissioned a report which made recommendations for designing and implementing HiAP. That report was entitled *Health in All Policies: Description of tools and practices with recommendations for the Government of Newfoundland and Labrador*. One of its key recommendations, in supporting the design and implementation for HiAP for the province, was to legislate a public health act. In 2018, the *Public Health Protection and Promotion Act* was promulgated.

The purpose of this Act was outlined in section 5:

a) promote the health and well-being of individuals and communities;

b) protect individuals and communities from risks to the health of the population;

c) prevent disease, injury and disability;

d) provide a healthy environment for individuals and communities;

e) provide measures for the early detection and management of risks to the health of the population, including monitoring of a disease or health condition of significance;

f) improve the health of the population and of vulnerable groups; and

g) promote health equity within the population by addressing the social determinants of health.

Section 6 of the Act, entitled "Health in all Policies," reads:

> The minister shall be responsible for facilitating the consideration of the health of the population in the development of laws, policies and measures among government departments, agencies, boards and commissions in accordance with the regulations, including the consideration of those social determinants of health that have an impact on the health of the population.

Since 2017, HiAP activities within Government have focused on building capacity within departments to understand their influence on health and population health outcomes; leveraging opportunities to incorporate HiAP into the education sector and other children and youth serving departments, and government departments responsible for municipalities and environment; and learning from other jurisdictions' experiences with HiAP, including approaches to governance, implementation, and monitoring and evaluation.

A Global Network for HiAP has been established with the mission to work with various stakeholders to address the determinants of health by strengthening the HiAP approach, with an aim to support the implementation of the United Nations' Sustainable Development Goals and universal health coverage. In a recent document entitled "A partnership for integrated SDG action," the Network illustrates an intersectoral model to connect the social determinants of health, the Sustainable Development Goals, HiAP and health equity (see Figure 5).[16]

[16]Global Network for Health in All Policies, "All for Equity: Convening SDH actors to reach the SDGs," accessed at https://actionsdg.ctb.ku.edu/sdh-hiap-sdgs.

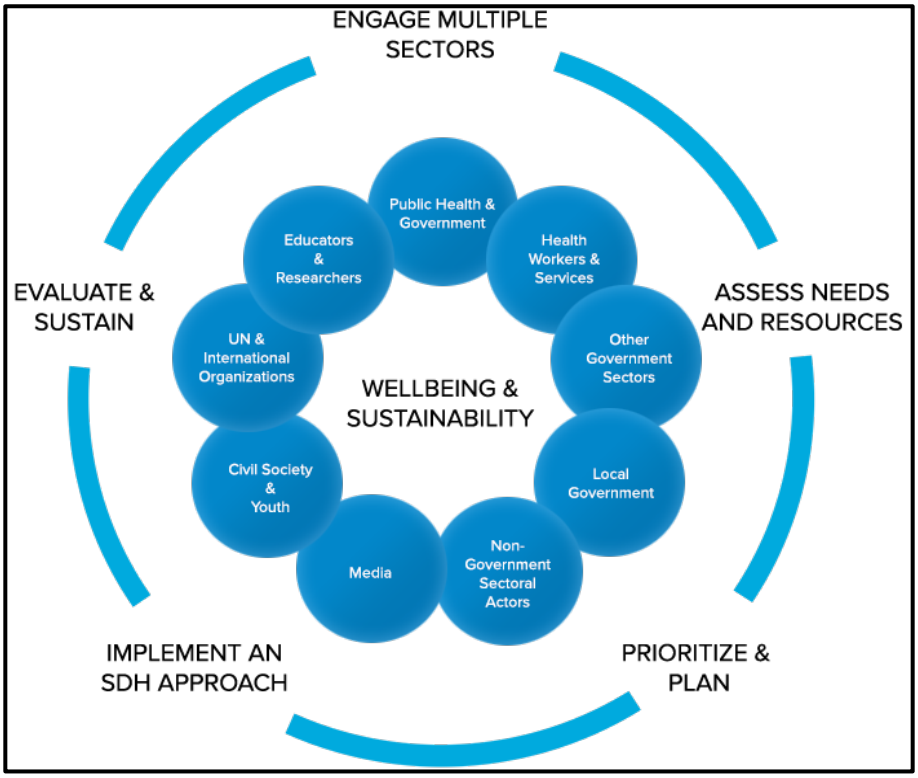

Figure 5: Intersectoral Model for a Partnership for Integrated SDG Action[17]

Conclusion

Health Accord NL can and must build on this foundation if the people of Newfoundland and Labrador are to find health equity within our own province and with the people of other provinces. As we stated earlier in this supplement, "Socioeconomic development and health systems development are mutually reinforcing; addressing determinants of health alongside clinical services leads to greater sustainability of results."[18]

The vision of Health Accord NL embraces both social determinants of health and the health system. It is built on the confidence that all the people of this province will come together to find the way that makes that health equity real among us. It will require delving more carefully into complex and difficult conversations around the deeper determinants of health and the unfair barriers, through racism, discrimination and class divide, that mean all residents of NL do not have the same opportunities to attain health. It trusts that the leaders in all sectors of the province – government, academia, Indigenous communities, municipalities, businesses, community groups and organizations, and the health system – will call all of us to action to make this happen.

[17]Source: Global Network for Health in All Policies, accessed at https://actionsdg.ctb.ku.edu/sdh-hiap-sdgs.
[18]Blas, Roebbel, Rajan and Valentine, 8.

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