



Equity: Chronic Health Conditions & Primary Care

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Fundamental Concepts

1. Horizontal and Vertical Equity

- People with same needs do have same access
- People with greater needs do not have access to greater resources

2. Disease vs patient-centred care

3. Co-morbidity and multimorbidity

- Burden of illness
- Populations at risk

Context: The Canadian Health System & Chronic Disease



- The basic premise: that the health system needs transformation to better meet the needs of the millions of Canadians who have one or more chronic diseases.
 - **Morbidity:** 16M Cdns live with chronic disease
 - **Health of Communities and Quality of Life:** especially for poorest Canadians
 - **Inefficiencies:** 60% of hospitalizations are due to chronic disease.
 - **Access to Care:** 76% of people with breast cancer, versus 45% of people with diabetes receive the recommended care



Challenge

What **strategic investments** are needed to shift health care delivery in Canada from a number of “islands of innovation” to a system-wide transformation that will ensure that all Canadians with chronic health conditions receive appropriate care to achieve improved health outcomes?

Tensions: Canadian Health Care System

- Half of physicians work in primary care, where most visits relate to CD  Resources of system focused on acute care & specific diseases
- Regionalization of health services in most parts of the country, enabling population need based planning  Health system primarily reactive to patient crisis, not proactive to population needs.
- Universal access to health services =shared value  People in poor communities have higher CD and lower life expectancy
- Innovations in primary care are underway in a number of jurisdictions across Canada.  No universal EHR to support integration.



Tensions: Canadian Health Care System

- Multiple statutory roles with responsibility for quality of care and protecting public interest



Weak accountability for health outcomes of patients living with chronic illness.

- Canada internationally recognized as a leader in tobacco control and other health promotion initiatives.



Rate of daily tobacco smoking among aboriginal populations is more than double that of the general population.

- Increasing move to collaborative practice and inter-professional education



Health system largely siloed—health disciplines and single diseases/organs



“If we were building a health care system today from scratch, it would be structured much differently from the one we now have and might be less expensive. The system would rely less on hospitals and doctors and would provide a broader range of community-based services, delivered by multidisciplinary teams with a much stronger emphasis on prevention. We would also have much better information linking interventions and health outcomes.”

(National Forum on Health, 1997)



“Islands of Innovation” ?

Inter and Intraprofessional Models

- Family Health Teams in Ontario
- RACE in BC
- Expanded scope of practice for pharmacists

“Islands of Innovation” ?

Quality Improvement

- Saskatchewan Health Quality Council
- Quality Improvement and Innovation Partnership (QIP) in Ontario

“Islands of Innovation” ?

Education

- IPE initiatives across the country
- EHPIC and IP-CLS (CPD)

“Islands of Innovation” ?

Self-Management

- MyOscar
- Chronic Disease Self-Management Program

“Islands of Innovation” ?

Health Information

- Drug Information Systems
- Alberta – provincial initiative

“Islands of Innovation” ?

Research

- Bridgepoint Collaboratory for Research and Innovation in Complex Chronic Disease
- Canadian Strategy on Patient Oriented Research

Now What?

We know where we are still lagging behind.....

We have good models to build on.....

How can we make these “mainstream”?

Overarching Recommendation

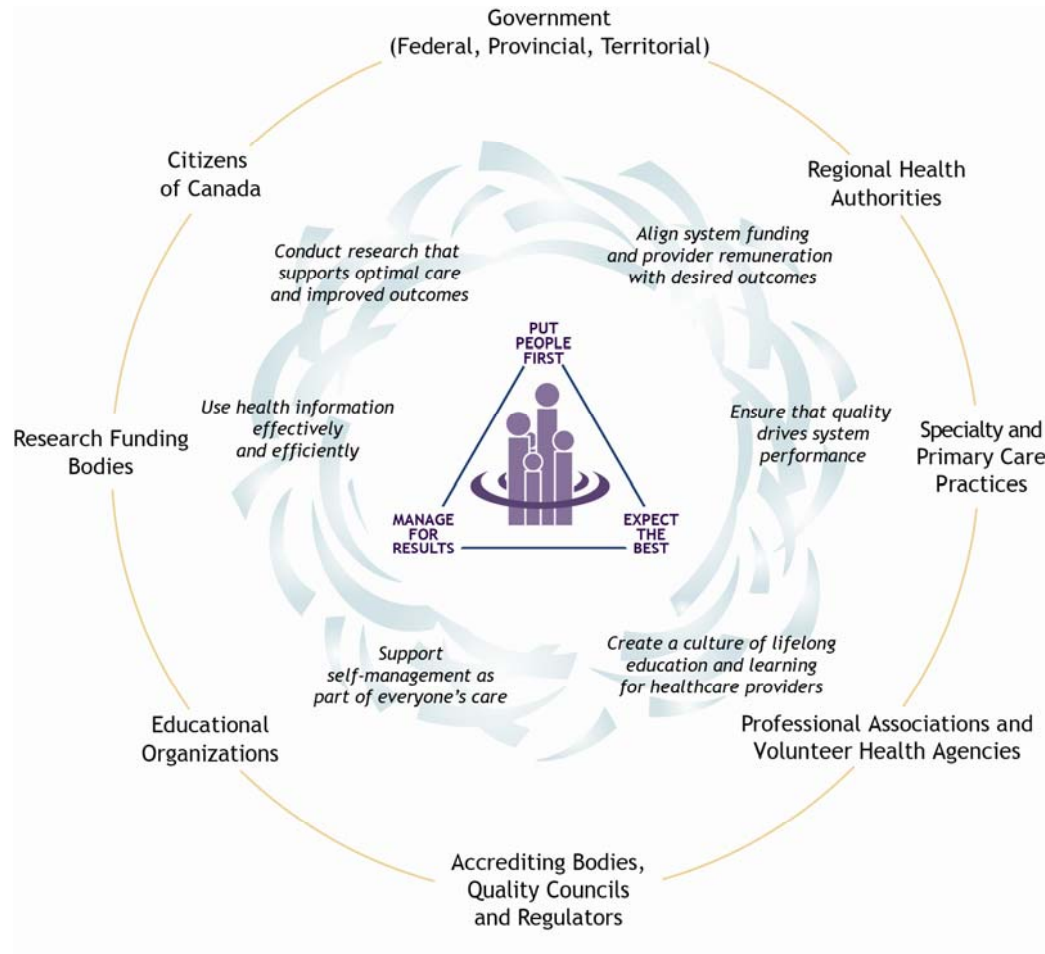
What needs to happen?

Enable all people with chronic health conditions to have access to a system of care with a specific clinician or team of clinicians who are responsible for providing their primary care and for coordinating care with acute, specialty, and community services throughout their life spans

Recommendations

- Aligning system funding and provider remuneration with desired health outcomes;
- Ensuring that quality drives system performance;
- Creating a culture of lifelong education and learning for healthcare providers;
- Supporting self-management as part of everyone's care;
- Using health information effectively and efficiently;
- Conducting research that supports optimal care and improved outcomes.

Strategy for Transforming Care for Canadians with Chronic Health Conditions



Investment.....

Interprofessional Primary Care Teams:

- linked by functioning EHR
- access to data; used for CQI
- patient not disease-focused
- serve as educational hubs
- serve as research hubs for “complex” patients, “complex” care (multimorbidity)

Core direction for healthcare system transformation in Canada

Put people first

- We need system-wide changes to focus on and to further engage people and their family or friend caregivers who want and need to be partners in their care. Clinicians need to be involved in changing and continuously improving the system.

Expect the best

- We know what is needed. Many examples of innovative services and systems already exist. We need to learn from and, where possible, to build on these pockets of excellence so that all areas in Canada can expect the best health services.

Manage for results

- We need to consistently monitor what we are doing so that we know what to change. We need to learn from our mistakes and near misses as well as from our successes.