Report Summary

Some Interesting Factoids…

A recent report in Ontario found that rates of 38 chronic diseases were highest among people on social assistance

(Community Social Planning Council of Toronto, University of Toronto's Social Assistance in the New Economy Project, & Wellesley Institute, 2009).

The most common chronic diseases, such as cardiovascular conditions, cancer, respiratory conditions, and type 2 diabetes, account for 60 per cent of all deaths and 44 per cent of premature deaths worldwide

(Coleman, Austin, Brach, & Wagner, 2009; Daar et al., 2007; Ebrahim, 2008; Yach, Hawkes, Gould, & Hofman, 2004)

In 2002, there were over 2 million caregivers aged 45 years and older

Hollander, Liu, & Chappell, 2009).

When asked, 51 per cent of Canadian adults with a chronic condition described a relationship that included knowledge of their medical history, easy phone access, and help in coordinating care

(Schoen et al., 2007)

Transforming Care for Canadians with Chronic Health Conditions:

Put People First, Expect the Best, Manage for Results

An estimated 16 million Canadians live with some chronic condition. These Canadians and the families and friends who care for them need a healthcare system that meets all of their needs. Some people's needs are relatively simple, involving the management of a single chronic condition, while other people's needs are increasingly complex, requiring the management of several chronic conditions concurrently. At the same time, there are huge concurrent demands that challenge the sustainability of our healthcare system.

The Canadian Academy of Health Sciences appointed an international Expert Panel of leading thinkers and researchers who volunteered their time to conduct an 18-month review, assessing the needs of people with chronic conditions, examining existing evidence and the state of the Canadian healthcare system, and contributing their expert opinions on emerging ideas about the appropriate care and support for these people. This comprehensive process led them to a consensus on a vision:

> ***All Canadians with chronic health conditions have access to healthcare that recognizes and treats them as people with specific needs; where their unique conditions and circumstances are known and accommodated by all of their healthcare providers; and where they are able to act as partners in their own care.***

When the vision is achieved, Canada's healthcare system will be integrated, person-focused, and population-based, with primary care practices as the hub for coordination and continuity of care with specialty and acute care and community-based services. This integrated healthcare system will:

- have primary care practices that are responsible for a defined population;
- be person focused (and family or friend-caregiver-focused);
- provide comprehensive services through interprofessional teams;
- link with other sectors in health and social care; and
- be accountable for outcomes.

Plans for implementation must begin immediately and can occur concurrently—across all recommendations and at local, regional, provincial, and pan-Canadian levels. Figure 1 illustrates how people with chronic conditions and their family and friend caregivers are at the centre of this strategy and will be supported by a healthcare system with three core directions: put people first, expect the best, and manage for results. Throughout the healthcare system there will be movement with concurrent connected activity related to the Expert Panel's recommendations.

Stakeholders are connected and engaged and work in collaboration to ensure the full strategy is implemented.

Enhancing the Canadian health-care system through low-cost and feasible actions is best achieved by building on, linking, and learning from existing innovations. There are many existing innovations at a local, regional, provincial or territorial and pan Canadian or national level that can be used as prototypes, strengthened, and drawn on to expand their impact.

This report provides a comprehensive assessment of the needs of people with chronic health conditions, the best research evidence, emerging ideas about the appropriate care and support for these people, and an analysis of the state of the Canadian healthcare system. Implementation of the recommendations in this report will lead to the changes needed to ensure people living with chronic conditions receive the healthcare they need and deserve.

The burden of chronic conditions is growing: people with chronic conditions are suffering; the healthcare system and providers are stretched beyond capacity. It is time to challenge the status quo in the interest of improving outcomes for people with chronic conditions in Canada.

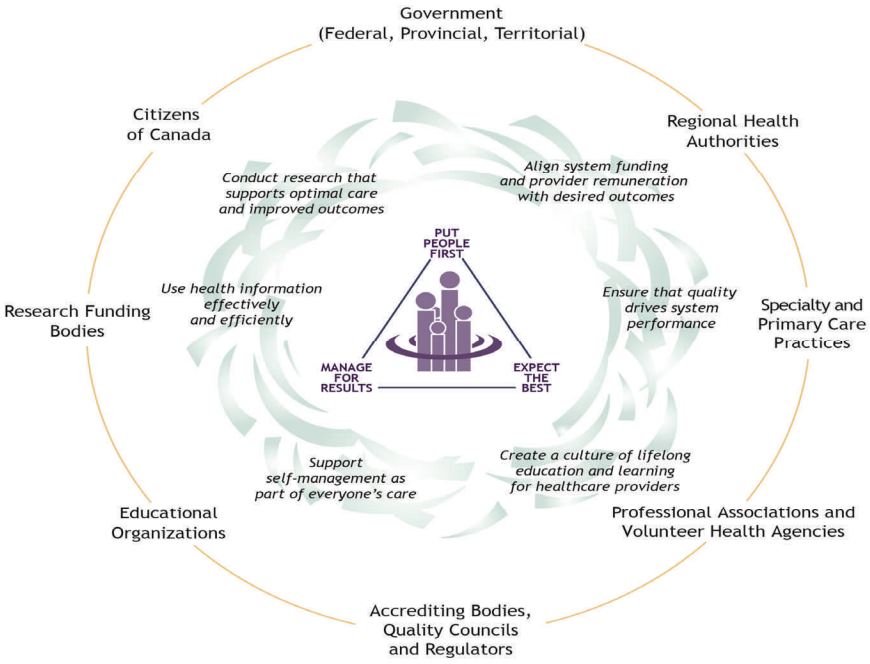

Figure 1: Strategy for transforming care for Canadians with chronic health conditions.

Case Study

Mr. E recently celebrated his 80th birthday at home with his wife. Over the years he has been diagnosed with hypertension, diabetes, arthritis, and most recently Alzheimer's. His long-time family doctor retired, and since then he has been unable to find a replacement. Mrs. E is becoming increasingly overwhelmed with the mounting responsibilities, including needing to sort through the advice from the many health professionals they see and to make healthcare decisions on her husband's behalf.

Variations on Mr. E's situation affect Canadians of all ages across the country. Canadians are living longer, often with severe chronic conditions, and some with diseases diagnosed in their infancy. As more people are diagnosed with multiple chronic conditions, it has become increasingly clear that the Canadian healthcare system does not meet their needs and must be transformed.

Recommendations

The Expert Panel appointed by the Canadian Academy of Health Sciences identified the following overarching recommendation that will be enacted through six enabling recommendations and an implementation recommendation. All are equally essential and require actions that need to be integrated.

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 by:

- *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; and*
- *conducting research that supports optimal care and improved outcomes.*

Federal, provincial, and territorial ministers of health should review these recommendations with a view to making them part of the 2014 renewal of the federal-provincial-territorial accord on healthcare.

To read the full report of the Canadian Academy of Health Sciences' Expert Panel, go to: www.cahs-acss.ca/e/publications/

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