

Fixing the Foundation:

An Update on Primary Health Care and Home Care Renewal in Canada

JANUARY 2008



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FOREWORD FROM THE CHAIR

If you're like most Canadians (96%), you are likely under the care of a family doctor (86%) or a regular place of care such as a clinic (10%). Perhaps you're one of the approximately 2–5% of Canadians who use home care services annually, or among the 26% of Canadians who care for a seriously ill friend or relative each year. 🍁 Primary health care and home care touch the lives of most Canadians. But both of these foundations of the health care system are stretched and in need of reforms: care is not always available when people need it, and is not always as comprehensive as it should be. Services are provided by a variety of different health professionals and organizations, and not always in a coordinated fashion. These factors can leave patients falling through the cracks.

In recent years the federal government, along with provincial and territorial governments, have made commitments to improving primary health care and home care and have invested substantial money to make it happen. The role of the Health Council of Canada is to evaluate what work is happening in health care renewal across the country. We talked to senior officials in participating jurisdictions (most of the provinces, the territories, and the federal government), and analyzed data from two recent surveys of Canadians. 🍁 We learned that there are many renewal efforts in primary health care and home care.



For example, provinces and territories are using more teams of health professionals to care for patients; there are more attempts to make family physicians available for same-day or after-hours appointments; and there are more efforts to expand home care services. These are just a few areas highlighted in this report and summarized in our conclusion (page 35). * At the same time, some changes are not moving as quickly as they could, such as the implementation of electronic health records. And there is very little information about the results of health care reform,

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an observation we have made in the past and make again in this report. Although federal, provincial, and territorial governments have vision statements to guide their renewal efforts in both primary health care and home care, few governments have set targets or have implemented strategies for measuring, monitoring, and reporting on progress. This must change in order for Canadians to know if health care reform is making a real difference. Many pilot projects show promise – but when are these strategies going to be applied more broadly? As taxpayers, we all deserve to know if the billions



of dollars spent on reforms are buying sustainable changes. ✦ Fixing the foundation requires vision, clear targets, significant resources, and determination. If we could say only one thing to the government officials and health professionals involved in primary health care and home care reform, it would be this: Keep up the good work you're doing in some areas, speed up your efforts in others, build on what's been proven to work, and set targets, evaluate, and show Canadians the results.

JEANNE BESNER, RN, PHD, CHAIR, HEALTH COUNCIL OF CANADA

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EXECUTIVE SUMMARY

In 2003, the Health Council of Canada was established to monitor and report on changes taking place in Canada's health care system. In this report, we look at primary health care and home care – two basic foundations of health care that Canadians have said are critically important to their lives.^{1,2}

The federal, provincial, and territorial governments have committed to improving primary health care and home care and have invested substantial amounts of money to make it happen.

To learn what progress has been made, we spoke with senior officials from the governments who participate in the Health Council. We asked about their visions and objectives for primary health care and home care and the activities underway, about the money that has been invested, and about their systems of measuring and evaluating progress. The jurisdictions' responses gave shape to some common themes, which we discuss throughout this report. More information on each jurisdiction's efforts appears in the appendix tables.

We also listened to what Canadians had to say about their recent experiences with the health care system. In 2007, we commissioned Statistics Canada to survey nearly 2,200 Canadians about their experiences with primary health care, and we also reviewed findings from a 2005 Statistics Canada survey of 133,000 Canadians to learn about their use of home care services. Throughout this report, we juxtapose data on Canadians' experiences with examples of health care renewal efforts that are attempting to improve their situation.

It's important to note that Canadians' experiences in recent years don't necessarily reflect the impact of changes currently underway in the health care system. It will take time before we see the effect of current reforms. However, information about their experiences paints an informative picture of some of the key challenges in primary health care and home care, and provides context for why reforms are needed. The survey results also provide a baseline against which performance can be compared in the future. Details about the surveys are provided on page 17 (primary health care) and page 32 (home care).

WHAT WE LEARNED**Primary health care renewal****ACCESS TO CARE**

Primary health care refers to community-based health professionals and programs that are the first point of contact with the health care system. In 2007, the vast majority of Canadians (96%) reported that they have a regular medical doctor (86%) or place of care (10%), although we know from other research that access to primary health care providers is not evenly distributed across the country. More than half of Canadians (55%) reported that they have had the same primary care provider for more than seven years, an indicator of good continuity of care.

However, simply having a family doctor or other regular provider is not enough. Too many Canadians who needed care told us that they had difficulty getting it for a minor health problem (24%) or for routine care (26%), and too many say they visited the emergency department for conditions that could have been treated by their primary care provider if he or she had been available. More than one-third (39%) of the 24% of Canadians who visited the emergency department in the prior year believe this was the case. Clearly, all Canadians are not getting the timely access they need to their regular primary care providers.



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One solution is around-the-clock (24/7) access to health information and health care providers, which governments have promised. Almost every jurisdiction has established some form of 24/7 access, largely through the use of telephone help lines, which are helpful but have limitations. A proportion of people who call health lines still need to be seen by doctors. And family doctors rarely learn that their patients have called 24/7 health lines or visited after-hours clinics. There should be formal systems in place to communicate this information; it's important for good continuity of care.

Some jurisdictions have implemented innovative appointment scheduling systems to improve the availability of primary health care while achieving or retaining a balanced workload for health care providers. Other strategies to improve access include after-hours clinics and shifts in physician work hours. We recommend that these types of initiatives be adopted more widely.

QUALITY OF CARE

Good quality care has many components. It means that patients are involved in their care, that health care professionals deliver well-coordinated, comprehensive care according to current recommendations, and that patients and providers are supported by information technology that helps ensure the best possible care.

Canadians give high ratings to their primary health care provider. Most (73%) say the quality of care they receive is excellent or very good. But the picture becomes less rosy when people are asked more detailed questions. Canadians have a lot to say about how their care can be improved. Too many say that not all health care providers offer the comprehensive, patient-centred care that they need: many patients don't always receive explanations about test results, the side effects of medication, or information about how to change their lifestyles to prevent illness or disease.

Across Canada, team-based care is being pursued as one way to provide more comprehensive primary health care and improve patients' health, particularly for people with chronic conditions such as diabetes. They are healthier when they're looked after by a team, which benefits everyone as these patients then generally need fewer appointments with doctors and other expensive health services such as hospital care.

Primary health teams—doctors, nurses, dietitians, pharmacists, and other health professionals who work together—have been established in a number of jurisdictions as governments promised, and more are being created. Although Canadians currently have yet to experience team-based care in any great numbers, the situation looks promising. One-third of Canadians say a nurse who works with their regular medical doctor or at their place of care is regularly involved in their care, while 17% report that other health care professionals work at their regular place of care. We recommend expanding the use of team-based care for Canadians who need it, particularly those with chronic conditions and other populations that are most likely to benefit.



Electronic information systems can also help to significantly improve quality of primary health care. For example, telehealth—the use of communication technology to care for patients—has great potential. In addition, electronic health records can improve coordination of care and reduce problems such as medication errors. But Canada lags behind other countries in its implementation of an electronic health record strategy. Some jurisdictions have made considerable investments, but to date only a small proportion of Canadians receive care from health care providers who are supported by an electronic information system. There are significant merits to investing in electronic health records and telehealth initiatives, and we encourage jurisdictions to make this a priority.

PERFORMANCE IMPROVEMENT AND REPORTING

Standardized measures—also called *health indicators*—can be used to assess health status and health system performance, as well as to determine characteristics across different populations, between jurisdictions, or over time. In 2006, a broad audience of stakeholders identified and agreed on primary health care indicators. But governments have yet to adopt, use, and publicly report using those indicators. Although most jurisdictions have described their visions for primary health care renewal, unless they use indicators to benchmark current performance and establish targets to improve access and quality, they will not be able to track or report on their progress.

In past reports we have urged jurisdictions to set targets and monitor progress, and we repeat the same recommendation here. Without sufficient performance improvement and reporting, it isn't possible to know whether the substantial money invested is buying sustainable change.

Home care renewal

When possible, many Canadians want the ability to be cared for or die at home, rather than in a hospital or institution. Providing care at home to people who are very ill or dying is not a new concept, but there is an increasing desire to have services that are more comprehensive, better coordinated, and publicly funded. The *Canada Health Act* does not require governments to provide or fund treatments given at home, although all governments committed to change this situation and now offer basic coverage for home care while some fund a broader range of services.

A 2005 survey by Statistics Canada showed that approximately 2-3% of Canadian adults used government-funded home care services; slightly more reported using home care services not funded by government (2-5%). These services are most frequently used by vulnerable populations such as seniors and adults with chronic health conditions. Unfortunately, we know very little about their views on access and quality of home care services as this type of information is not available.

When ill or disabled Canadians do not get the home support they need, there can be a significant toll on their family and friends. In a 2006 Pollara survey, one-quarter (26%) of Canadians said they had cared for a family member or close friend with a serious health problem in the last 12 months, with 22% of these people missing one or more months of work and 41% using personal savings. For these and other reasons, 80% of Canadians support the development of more home and community care programs as a means of strengthening the health care system.



Governments have committed to provide two weeks of home care services to patients who meet specific criteria (see *What governments promised*, page 13). Although this is a good first step to incorporate home care services under the umbrella of publicly funded health care delivery, it is still too modest and we urge all jurisdictions to expand their home care coverage.

As with primary health care, there are insufficient efforts to monitor and publicly report on the progress of home care renewal. This must be done so that Canadians will know whether renewal efforts are making a difference to their health and the services they receive.

CONCLUSION

There is no shortage of renewal efforts in primary health care and home care. Some jurisdictions have launched commendable new initiatives, and promising pilot projects show the potential for sustainable change.

However, it remains difficult to get a complete picture of where all this reform is taking Canadians. Jurisdictions must set targets for improvements, routinely monitor progress, and show Canadians the results. Canadians need to know that the substantial efforts and investments are creating the lasting changes to primary health care and home care that they want and need.



OUR ADVICE TO GOVERNMENTS

Primary health care

Increase opportunities to improve access to regular primary health care providers through widespread adoption of proven strategies such as innovative appointment scheduling, shifts in physicians' work hours, and after-hours clinics. Use telehealth initiatives when travel is a factor and to support 24/7 access to health information and advice.

Increase opportunities to improve continuity of care by speeding up implementation of the electronic health record. Also ensure that information about calls to telephone health lines or visits to after-hours care is communicated to the patient's regular provider.

Increase opportunities to better manage care by using more team-based care for people with chronic health conditions and other populations where it has been shown to make a difference.

Increase opportunities to learn from one another about what helps and hinders efforts in renewing primary health care.

Increase opportunities for accountability and transparency by identifying targets, monitoring your progress, and reporting this information to the public.

Home care

Increase opportunities for better home care by expanding coverage and making it a focal point of health care renewal strategies.

Increase access to home care by developing a communication strategy that lets your citizens know what services are available and how to access them.

Increase opportunities for accountability and transparency by identifying targets, monitoring your progress, and reporting this information to the public.

OUR ADVICE TO CANADIANS

Make sure the government knows that primary health care and home care renewal are important issues to you.

Expect more from your health care system and the people responsible for it.

Encourage governments and the health care community to invest now and invest heavily in strategies proven to be cost-effective at improving health care. For example, if you don't have an electronic health record, ask why this hasn't happened and when it will be in place.

Educate yourself about the home care services that are available and publicly funded, and how to access them in case you, a family member, or friend needs them.

**MORE INFORMATION IS AVAILABLE AT
WWW.HEALTHCOUNCILCANADA.CA.**

Data supplements:

- > Canadian Survey of Experiences with Primary Health Care in 2007
- > Canadians' Experiences with Chronic Illness Care in 2007

**Other recent reports relevant to primary health care
from the Health Council of Canada:**

- > Why Health Care Renewal Matters: Learning from Canadians with Chronic Health Conditions
- > Health Care Renewal in Canada: Measuring Up?
- > Why Health Care Renewal Matters: Lessons from Diabetes

SHINING A LIGHT ON HEALTH CARE RENEWAL

Three stories in this report illustrate some of the innovation underway to improve the delivery of primary health care and home care.

Booking

Patients at the Saskatoon Community Clinic love the new booking system. Known as advanced or improved access scheduling, it makes it easier to get a same-day appointment, reduces waiting-room time, and allows doctors to take on new patients. (See page 20.)

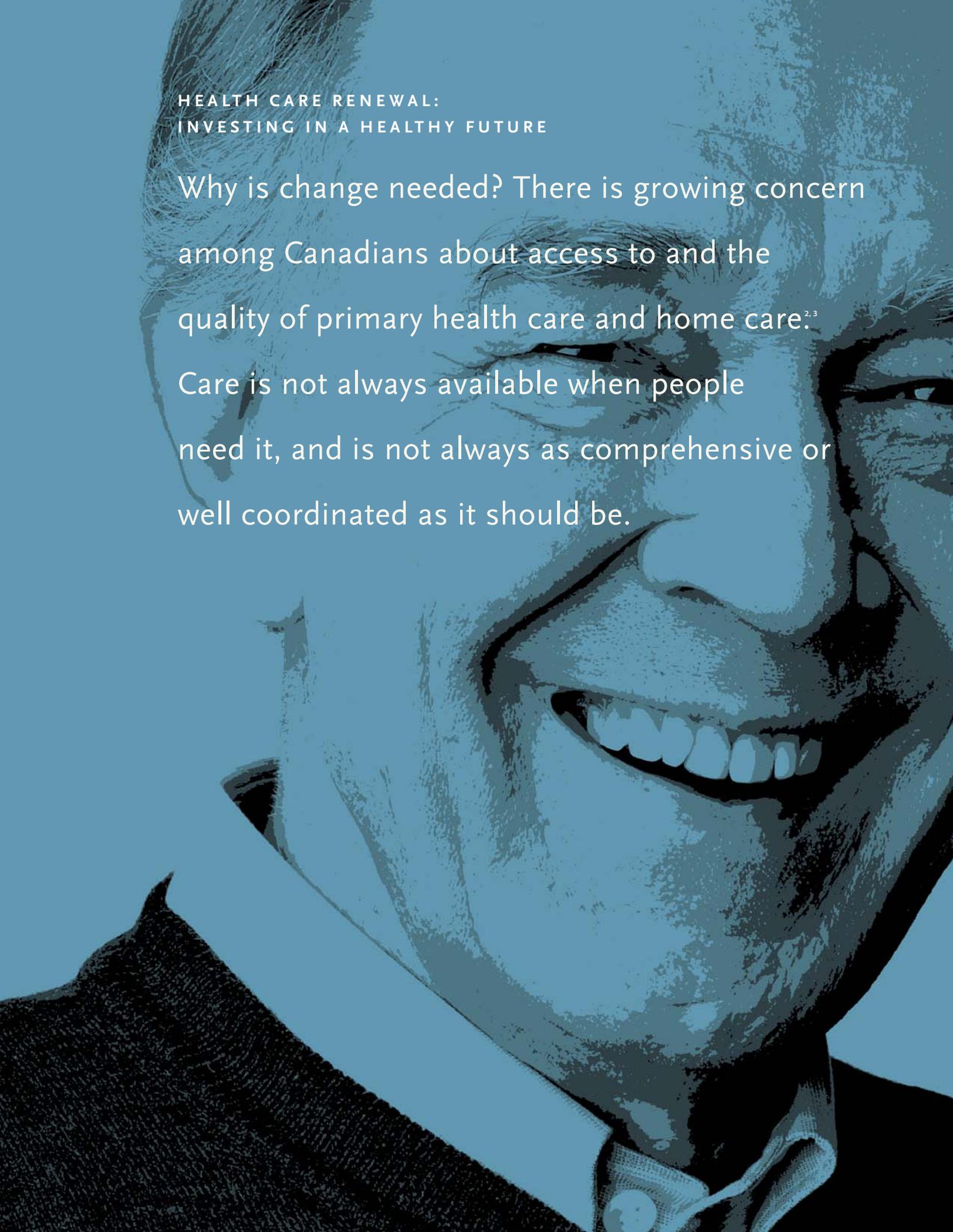
Monitoring

Conventional wisdom says that the elderly can be overwhelmed by technology, but a New Brunswick program has shown otherwise. Vulnerable patients with chronic conditions such as diabetes and heart disease received devices to monitor their own vital signs and communicate with nurses in between their home visits – with great success. Patients felt they managed better and hospital use dropped dramatically. (See page 27.)

Integrating

The National Partnership Project, sponsored by the Canadian Home Care Association, tested new ways of linking family physicians with home care services by, among other things, making a home care case manager part of each health care team. Results were so promising that the idea is now being promoted as a national model. (See page 34.)





HEALTH CARE RENEWAL:
INVESTING IN A HEALTHY FUTURE

Why is change needed? There is growing concern among Canadians about access to and the quality of primary health care and home care.^{2,3}

Care is not always available when people need it, and is not always as comprehensive or well coordinated as it should be.

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Reforms that offer more comprehensive and coordinated care in the community can improve the health of Canadians, relieve stress on the health care system by reducing the number of visits to specialists and hospitals, and save money.⁴

Creating and implementing new ways to communicate, cooperate, and deliver services will improve Canadians' experiences with care, as well as their health and well-being.

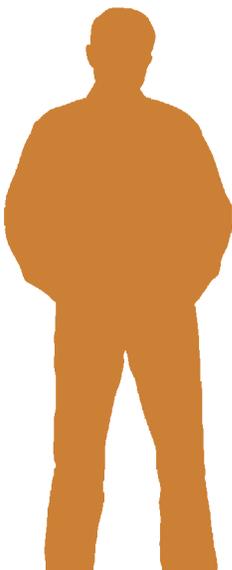
A MASSIVE INVESTMENT

Since 2000, the provinces and territories have received billions of dollars from the federal government for renewal efforts in primary health care, home care, and for catastrophic drug coverage (to help cover the costs of extremely expensive drugs used to treat certain conditions). This funding was in addition to the large sums of money that jurisdictions invest in these services. Several key funds have provided money for health care reform:

- › Between 1997 and 2001, the federal, provincial, and territorial governments administered the \$150-million Health Transition Fund. It funded 140 projects across Canada that tested and evaluated innovative ways to deliver health services, with a particular focus on primary health care and home care. These projects generated evidence that can be used by governments, health care providers, researchers, and others to make informed decisions about a more integrated health care system.

- › In 2000, the federal government committed \$800 million over five years through the Primary Health Care Transition Fund (see page 14) to kick-start system-level change and to cover the transitional costs of renewing primary health care. In particular, the money was intended to support widespread adoption of initiatives proven successful through the Health Transition Fund and other investments.
- › In 2003, the First Ministers agreed to the creation of a five-year, \$16-billion Health Reform Transfer to leverage and extend health care renewal in the areas of primary health care, home care, and catastrophic drug coverage. In 2008, when the committed funding comes to an end, money for primary health care, home care, and catastrophic drug coverage will become part of the overall federal transfer of funds to the provinces and territories for health care.
- › In 2004, the First Ministers built on this renewal and affirmed their commitment to these areas in a *10-Year Plan to Strengthen Health Care* (see *What governments promised*).

In short: A great deal of money has been allocated to primary health care and home care reform. But what progress has been made? This report attempts to answer that question.



WHAT GOVERNMENTS PROMISED: THE HEALTH ACCORDS

Primary health care

"The key to efficient, timely, quality care is primary health care reform. First Ministers agree that the core building blocks of an effective primary health care system are improved continuity and coordination of care, early detection and action, better information on needs and outcomes, and new and stronger incentives to ensure that new approaches to care are swiftly adopted and here to stay."

2003 First Ministers' Accord on Health Care Renewal

The 2003 *First Ministers' Accord on Health Care Renewal* committed governments to speed primary health care reforms so that Canadians can routinely receive needed care from an appropriate health care provider. The First Ministers agreed to the goal that by 2011, "at least 50% of residents have access to an appropriate health care provider, 24 hours a day, seven days a week."

In the 2004 *10-Year Plan to Strengthen Health Care*, this target was described a little differently: "...with the objective of 50% of Canadians having 24/7 access to multidisciplinary teams by 2011."

First Ministers agreed in 2003 to use comparable indicators on key health outcomes and to develop the necessary data infrastructure for reporting to Canadians. The 2004 plan committed governments to establish a best practices network and to continue to work with Canada Health Infoway (see page 25) to realize the vision of an electronic health record.

Home care

"Home care is an essential part of modern, integrated and patient-centred health care. Improving access to home and community care services will improve the quality of life for many Canadians by allowing them to be cared for or recover at home."

First Ministers' Meeting on Health Care, September 2004

The 2003 *First Ministers' Accord on Health Care Renewal* committed governments to determine, by September 30, 2003, the minimum "basket of services" to be provided in homes and communities. First Ministers agreed to provide first-dollar coverage for short-term acute home care, including community mental health and end-of-life care. (First-dollar coverage means that if a recipient meets the criteria, he or she pays nothing out of pocket for the defined period of home care services.) They also agreed that access to these services be based on an assessment of need, and that the services be available by 2006. The Government of Canada agreed to establish compassionate care benefits and job protection for Canadians who need to leave their jobs temporarily to care for a gravely ill or dying child, parent, or spouse.

The 2004 *10-Year Plan to Strengthen Health Care* added the following specifics about the types of home care services to be covered, based on assessed need:

- › short-term acute home care after discharge from hospital consisting of two weeks of case management, intravenous medications related to the discharge diagnosis, and nursing and personal care;
- › short-term acute community mental health home care consisting of two weeks of case management and crisis response services; and
- › end-of-life care consisting of case management, nursing, palliative-specific drugs, and personal care.

Health ministers agreed to explore the next steps to fulfilling the home care commitments described above – including plans for staged implementation and annual reporting to their citizens – and to report to First Ministers by December 31, 2006. (In January 2007, health ministers reported that all provinces and territories had taken steps toward fulfilling their commitments for home and community care services as described in the 2004 accord.)



THE PRIMARY HEALTH CARE TRANSITION FUND

Between 1997 and 2001, the \$150-million Health Transition Fund provided money for projects across Canada to test new methods of delivering primary health care. The Health Transition Fund investments spawned innovation, but there was no national vision for renewal, no policy framework to guide change, and little momentum toward changing the predominant way of providing primary health care.

In September 2000, the First Ministers agreed on a vision, principles, and action plan for health system renewal. In response, the federal government announced the Primary Health Care Transition Fund, designed to guide the investment of \$800 million over five years to support the transitional costs of implementing sustainable, large-scale, initiatives in primary health care reform. The goal was "... fundamental and sustainable change to the organization, funding, and delivery of primary health care services [in ways that] will result in improved access, accountability and integration of services".⁵

Between 2000 and 2006, the Primary Health Care Transition Fund invested in five areas: provincial-territorial, multi-jurisdictional, national, Aboriginal, and official languages minority communities. The largest of these was the provincial-territorial (75% of the fund; see table below) which provided funding directly to the provincial and territorial governments.

More details about the fund and its impact are available at www.hc-sc.gc.ca/hcs-sss/prim/phctf-fassp/index_e.html.

Primary Health Care Transition Fund investments (provincial-territorial)

PROVINCE / TERRITORY	APPROVED CONTRIBUTION
British Columbia Primary Health Care Transition Fund Initiative	\$ 74,022,488
Alberta Primary Health Care Transition Fund Initiative	\$ 54,876,073
Saskatchewan Primary Health Care Transition Fund Initiative	\$ 18,592,405
Manitoba Primary Health Care Transition Fund Initiative	\$ 20,844,059
Ontario Primary Health Care Transition Fund Initiative	\$213,170,044
Quebec Primary Health Care Transition Fund Initiative	\$133,681,689
Health Care Renewal in New Brunswick	\$ 13,689,805
Primary Health Care Renewal in Nova Scotia	\$ 17,073,265
Prince Edward Island Primary Health Care Redesign	\$ 6,526,879
Newfoundland and Labrador Primary Health Care Initiative	\$ 9,705,620
Nunavut Primary Health Care Renewal Initiative	\$ 4,508,924
Northwest Territories Primary Health Care Transition Fund Initiative	\$ 4,771,470
Yukon Primary Health Care Transition Fund Initiative	\$ 4,537,282



RENEWING PRIMARY HEALTH CARE:
PROGRESS AND CHALLENGES

Primary health care refers to the community-based health professionals and programs that are the first point of contact with the health care system. Primary health care professionals provide basic health care and manage most chronic conditions. They also promote healthy living to their patients by discussing ways to prevent diseases and injuries.

A variety of health professionals serve as primary health care providers, including family physicians, nurses, dietitians, and pharmacists.

For some time, Canadians have been asking for better access to primary health care services, better quality of care, and more health promotion and disease prevention services. In 2003 and 2004, the First Ministers committed to specific goals for renewal (see *What governments promised*, page 13).

One of the main thrusts in primary health care reform involves determining the best strategies to complement, support, or extend the work of family physicians. Although the number of medical students has increased in recent years,⁶ fewer are choosing to specialize in family medicine,⁷ and those who do choose that path want to avoid the long hours and stress that exist in the current family physician workforce.³ But Canadians still need timely access to the type of care traditionally delivered by family physicians, and they need appropriate after-hours care for urgent medical problems.

IMPROVING ACCESS TO PRIMARY HEALTH CARE

Having a regular source of primary health care is important. There is strong evidence that people who have a regular primary care provider are less likely to use emergency rooms or to be hospitalized, and receive higher levels of care.⁴ Our 2007 survey, Canadian Survey of Experiences with Primary Health Care, showed that the majority of Canadians (96%) have a regular medical doctor (86%) or place of care (10%) and have long-standing relationships with them.⁸ More than three-quarters of these people have been going to the same doctor or place of care (such as a clinic) for at least three years, while more than half (55%) have used the same provider for more than seven years. This is an indicator of good continuity of care.

However, we know from other research that access to a regular primary health care provider is not evenly distributed across the country.⁹ And having a regular provider does not necessarily mean that people have access to care when they need it. Of those survey respondents who needed immediate care for a minor health problem (29%) or routine care (35%), too many said they had trouble obtaining the care they needed (Figures 1 and 2). Commonly cited reasons were difficulty getting an appointment or waiting too long for an appointment. These findings are consistent with other research that showed Canadian wait times to see primary health care professionals were longer than in other countries (Figure 3).¹⁰

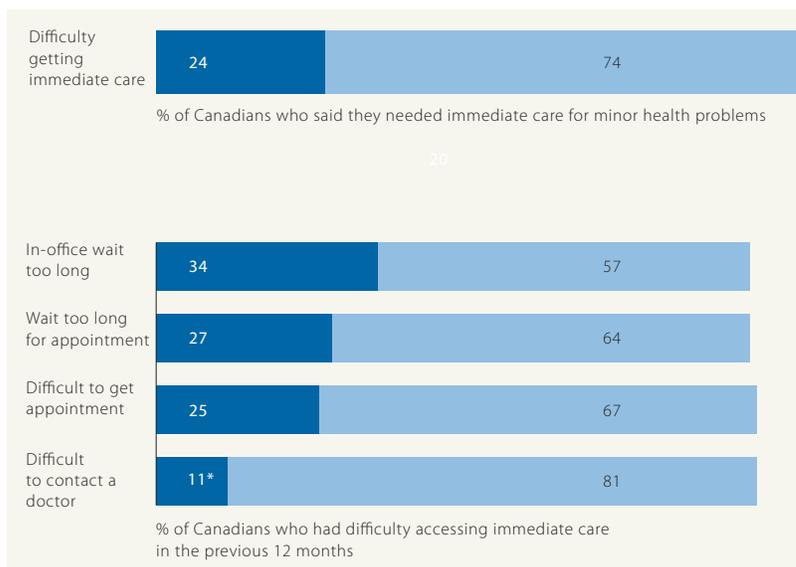


FIGURE 1
Reasons for difficulty accessing immediate care for minor health problems

Of those Canadians who needed immediate care for a minor health problem, one-quarter (24%) had trouble accessing it. Waiting too long in the office and waiting too long for an appointment were among the top reasons Canadians reported for not being able to access care.

■ Yes
■ No

Note: Percentages may not add up to 100% due to missing, refusal, and "don't know" responses.

*Interpret with caution. Data are less reliable due to small sample sizes.

Source: Statistics Canada, Canadian Survey of Experiences with Primary Health Care, 2007.

ABOUT THE PRIMARY HEALTH CARE SURVEY

The Health Council of Canada developed the Canadian Survey of Experiences with Primary Health Care to provide new information about access, use, experiences, and outcomes among the general population as well as adults who have chronic health conditions. These survey data offer the only source of pan-Canadian population-based estimates on the topic of experiences with primary health care and chronic illness care.

This cross-sectional telephone survey was conducted by Statistics Canada in January and February 2007 and administered in either French or English (depending on the preference of the survey participant). A stratified random sample of adults completed the survey (n=2,194). All participants had previously participated in Statistic Canada’s Canadian Community Health Survey (CCHS) Cycle 3.1, conducted in 2005.

Adults 18 years or older who live in private households in 10 provinces and three territories were contacted, yielding a response rate of 58%. Results are weighted to be representative of the age and gender distribution of the population. Residents of Indian Reserves and Crown land, full-time members of the Canadian Armed Forces, inmates of institutions, and residents of isolated areas were excluded. No data have been reported that would compromise individual privacy or confidentiality. Instances where small sample sizes require caution in interpreting results have been noted.

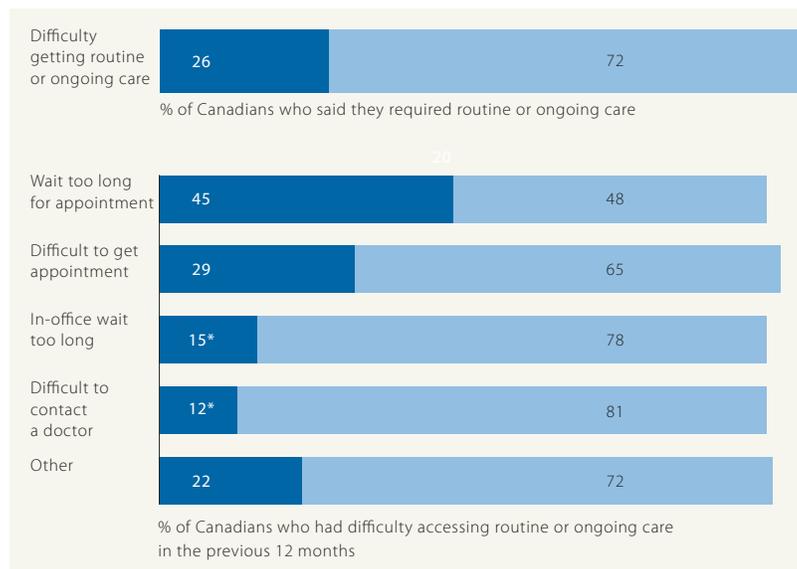


FIGURE 2
Reasons for difficulty accessing routine or ongoing care

Of those Canadians who needed routine or ongoing care, one-quarter (26%) had trouble accessing it. Waiting too long for an appointment and difficulty getting an appointment were among the top reasons Canadians reported for not being able to access care.

■ Yes
■ No

Note: Percentages may not add up to 100% due to missing, refusal, and “don’t know” responses.

*Interpret with caution. Data are less reliable due to small sample sizes.

Source: Statistics Canada, Canadian Survey of Experiences with Primary Health Care, 2007.

In addition, too many Canadians say they visited the emergency department for conditions that could have been treated by their primary care provider if he or she had been available. More than one-third (39%) of the 24% of Canadians who visited the emergency department in the prior year believe this was the case. (Figure 4).⁸

In 2003, all jurisdictions committed to ensuring that 50% of Canadians will have access to an appropriate health care provider 24/7 (24 hours a day, 7 days a week) by the year 2011. Jurisdictions also committed to establishing their own multi-year targets to achieve this goal (see Appendix, Table 1). In our February 2007 report, *Health Care Renewal in Canada: Measuring Up?*, we noted that most jurisdictions have met their 2003 commitment using a combination of after-hours care in physicians' offices, emergency rooms, and telephone lines staffed by registered nurses.

All jurisdictions continue to rely on their 24/7 telephone lines to provide timely access to health information and advice. Nurse-staffed telephone lines play an important role in providing access to health care advice and guidance for Canadians, but there are limits to what they can accomplish. As one example, Telehealth Ontario reports that although 40% of their callers are given advice on how to take care of the problem themselves, a larger proportion of callers are redirected to other medical services such as their doctor (35%) or emergency department (14%).¹¹

Telephone health lines alone cannot resolve the issue of 24/7 access to care. The key lies in a multi-strategy approach, which may include offering more after-hours access to regular primary care providers and improved same-day access to appointments.

Scheduling systems can be improved through proven techniques that balance patients' requests for immediate appointments and the ability of a practice to deliver them without increasing the physician's workload¹² (see *Changing doctors' schedules makes a difference*, page 20). Some interesting initiatives from across Canada (more in Appendix):

- › Saskatchewan has recently expanded its 24/7 telephone health line services to offer crisis support for people with mental health issues and addictions. Specially trained social workers and registered psychiatric nurses now handle crisis calls and provide referrals.
- › Nova Scotia recently established incentive payments for family physicians willing to work evenings and weekends. This initiative is intended to promote enhanced access to family physicians who have an established practice, and to offer comprehensive and ongoing care for their patients.

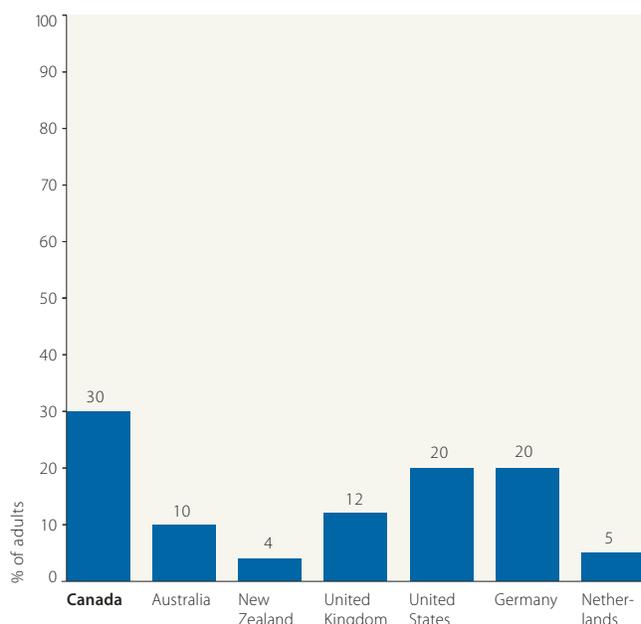


FIGURE 3

Wait time to get an appointment in 7 countries

More Canadians report waiting 6 or more days to get an appointment with a regular doctor than residents of other countries studied.

■ % of adults who waited 6+ days for an appointment to see regular medical doctor

Source: The Commonwealth Fund 2007 International Health Policy Survey of the General Public's Views of their Health Care System's Performance in Seven Countries.

19

> In British Columbia, initiatives such as the Practice Support Program offer incentives to family physicians who adopt a process called advanced or open-access scheduling that improves availability. Patients calling to schedule an appointment are offered one for that same day.

When developing after-hours strategies, jurisdictions should ensure that any information about after-hours care will be sent automatically to patients' primary care providers. We have stressed this in our previous reporting, because it is important for good continuity of care.¹³ Some jurisdictions still appear not to provide these links and have not indicated any plans or targets to put them in place.

OUR ADVICE

Although the majority of Canadians have a regular medical doctor or place of care, too many still report difficulty in accessing care for routine or immediate health problems, and too many visit emergency departments for conditions they believe could have been treated by their regular primary care provider if he or she had been available.

Most jurisdictions use telephone health lines successfully for information and advice, but these services have limitations. Jurisdictions should also improve 24/7 access to regular primary health providers through after-hours clinics, shifts in physicians' work hours, scheduling efficiencies, and other strategies beyond telephone health lines.

IMPROVING QUALITY OF PRIMARY HEALTH CARE

Quality care means that patients are engaged in their care, that health care professionals deliver coordinated, comprehensive care according to current recommendations, and that patients and providers are supported by information technology. Patient-centred care improves health outcomes, and is a key component of a high-performing health care system.¹⁴

When we asked Canadians about the quality of care they are receiving and their confidence in the health care system, the overall results were quite positive.⁸ For example:

- > Most Canadians give high ratings to the quality of primary health care they receive. Most adults (73%) who visited a family or general practitioner at least once in the previous 12 months report that the quality of care they received from the primary care provider they rely on the most was either excellent or very good.
- > Most Canadians report that their primary health care provider meets their needs. The majority of adults (91%) with a regular health care provider or place of care agree or strongly agree that their primary care provider delivers a range of services that meet most or all of their primary health care needs.

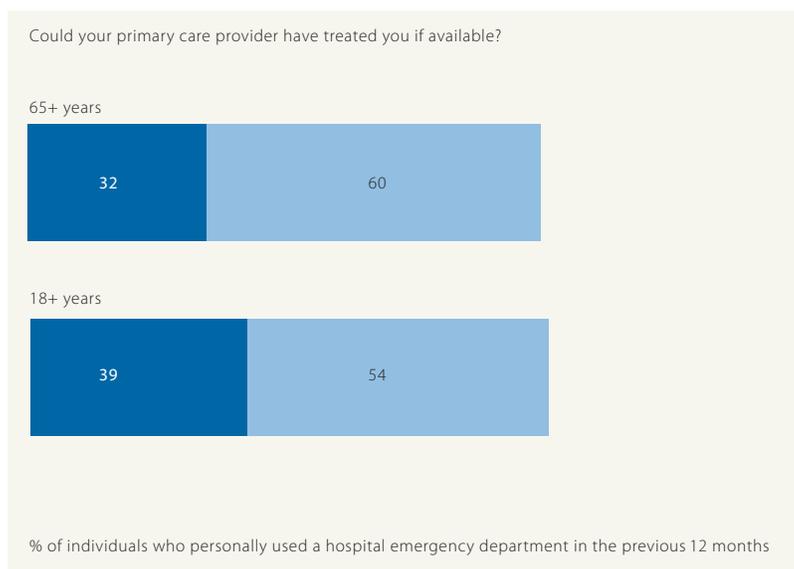


FIGURE 4

Visits to the emergency department for a condition that could have been dealt with by a primary health care provider

One-quarter (24%) of Canadians visited an emergency department at least once in the past 12 months. More than one-third (39%) of this group believe their visit to emergency was for a condition that could have been treated by their primary care provider if he or she had been available.

■ Yes
■ No

Note: Percentages may not add up to 100% due to missing, refusal, and "don't know" responses.

Source: Statistics Canada, Canadian Survey of Experiences with Primary Health Care, 2007.

Changing doctors' schedules makes a difference

Changing the way appointments are scheduled may be one simple solution to reducing the time it takes to see your doctor – and may also allow busy physicians to take on new patients.

“We all tend to think we have more patients than we can reasonably manage, but it turns out that’s not usually the case,” says Dr. Carla Eisenhauer, a family physician in Saskatoon who teaches other physicians a new approach to booking patients called *advanced* or *improved access*. She encouraged colleagues at the Saskatoon Community Clinic to try this new method several years ago after reading about some promising efforts in England.

Most family doctors in Canada have daily schedules full of prebooked appointments. When they try to accommodate patients with urgent same-day problems or need to spend longer than expected with a patient, time in the waiting room begins to soar, patients become frustrated, the workday gets longer – and it “feels like they’re always behind the eight ball,” says Dr. Eisenhauer.

When she holds workshops on improved access scheduling, Dr. Eisenhauer encourages physicians and their receptionists to track what happens in the practice, to look at what kinds of patients they serve, when and why people call for appointments, and what happens when they come in. As one example, most doctors instinctively know that Mondays are particularly hectic, with patients calling about health issues that arose over the weekend. A simple adjustment might be to keep Mondays largely free of prebooked appointments or other commitments, says Dr. Eisenhauer, so that patients who call with immediate needs can be offered appointments the same day.

Not offering this type of flexibility may lead patients to become anxious and go to the emergency department, which is neither good continuity of care nor a good use of the health care system. It also means a loss of income for physicians, who usually work on a fee-for-service basis; this means that they are paid for each treatment or the type of advice they provide to patients.

Another strategy that works is to create a scheduling system that allows patients to suggest the best day for the appointment. In her practice, says Dr. Eisenhauer, they learned to keep a portion of the day open for same-day appointments, and offered patients an appointment “today, tomorrow, or any other day.”

Most patients were accurately able to assess when their needs were urgent, and when they could comfortably wait. “It makes a difference to patient satisfaction if they choose to wait, rather than be told they have to wait,” says Dr. Eisenhauer.

The Saskatoon Community Clinic’s recent tracking statistics show that 91% of patients get an appointment on the day of their choice. Patients are thrilled, and have put their appreciation in writing: “Great new booking system.” “I love the new booking system, even though at first I had doubts about how it would work.” “I can’t believe the new booking system accommodates same-day appointments!”

Improved access scheduling looks different in every doctor’s office, says Dr. Eisenhauer, adding that determining what works is an ongoing process of tracking and adjusting. She also recommends to doctors that they invest a few months of longer hours at first, as she did, to clear up any backlog of patients waiting for annual physicals. But once the system is running smoothly, she says, “Everyone is happier.” Patients, physicians, and their receptionists embrace this new approach.

Research has shown that the option of same-day appointments improves care and reduces patients’ frustration. It also eliminates most unplanned overtime without reducing a physician’s income. And over time, improved access scheduling can allow once-swamped doctors to take on new patients – something Dr. Eisenhauer says she was recently able to do for the first time in many years.

For more information:

www.saskatooncommunityclinic.ca

While it is good news that Canadians rate their providers favourably, the picture is less rosy when they are asked more detailed questions. It appears that health care providers don't always communicate with patients as they should; not all doctors, for example, always explain test results (Figure 5) or the side effects of medications (Figure 6). Nor do all Canadians receive services intended to maintain healthy lifestyles and prevent disease (Figure 7). Only one in five adults said that their doctors always talked to them about these issues; an equal number said their doctors rarely or never did.

We also know from our prior reporting¹⁵ that many people with chronic health conditions are not receiving the level of care that experts recommend:

- › Fewer than half of adults with diabetes undergo recommended lab tests and procedures;
- › More than half of adults with diabetes have poor cardiovascular health and half do not achieve recommended levels of blood sugar;
- › Too few adults with diabetes get the help they need to avoid complications; and
- › Only half of family physicians in Canada feel their practices are well prepared to handle patients with chronic health conditions.

Emerging evidence suggests that the use of interprofessional teams may improve the care of people with chronic conditions like diabetes.¹⁶

Using interprofessional teams

When we asked jurisdictions about the barriers they face in primary health care renewal, all reported shortages of health professionals (see Appendix, Table 2).

Interprofessional teams can be a solution to the challenge of finding a family doctor or other health professionals in some communities and among certain populations. In consultations, Canadians like the idea of a team approach led by doctors, and see this as the “centrepiece of the health care system.”¹⁷ It is hoped that a supportive and coordinated team of doctors, nurses, dietitians, pharmacists, and other professionals can reduce the burden on doctors, prevent burnout, and encourage health professionals to locate and stay in rural and remote areas. A team may provide more coordinated and cost-effective care, and more opportunities to focus on wellness, prevention, and patient education.

In 2004, the jurisdictions committed to ensuring that 50% of Canadians have access to interprofessional teams by 2011. In our February 2007 report, *Health Care Renewal in Canada: Measuring Up?*, we noted that most provinces and territories do not yet have verifiable targets for the implementation of teams, and that the lack of patient registration makes it difficult to determine how many patients have access to teams.

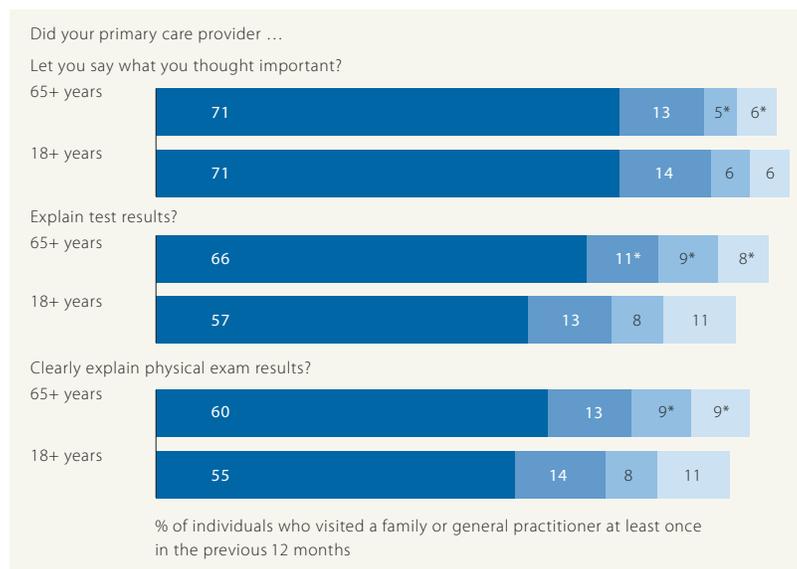


FIGURE 5
Communicating with primary care providers

Just over half of Canadians adults who had visited their doctor within the last 12 months report that when a physical exam (55%) or medical test (57%) is conducted, their primary care provider always takes time to clearly explain the results. 1 in 10 (11%) said this rarely or never occurs.

- Always
- Usually
- Sometimes
- Rarely/Never

Note: Percentages may not add up to 100% due to missing, refusal, and “don't know” responses.

*Interpret with caution. Data are less reliable due to small sample sizes.

Source: Statistics Canada, Canadian Survey of Experiences with Primary Health Care, 2007.

Most jurisdictions are now working toward a primary health care system with team-based care front and centre (see Appendix, Table 2). Whether the aim is to improve access, keep costs down, or to improve health care quality, this approach is gaining ground across the jurisdictions:

- › Ontario has announced the creation of 150 family health teams, well ahead of its initial goal of having them up and running by 2008.
- › Saskatchewan reports having 42 primary health care teams in place, serving about 20% of their population. However, the province indicates that 100% of their population will have access to teams by 2011.
- › British Columbia, Saskatchewan, and Newfoundland and Labrador have developed a number of health care collaboratives to manage chronic conditions, with promising results so far.
- › Prince Edward Island has established five family health centres. These centres have varied hours of operation, with some providing extended evening hours and others with evening walk-in clinics.
- › Newfoundland and Labrador has established 11 primary health care teams, and plans are in the works to have seven more up and running by 2008.
- › Nunavut has established a Family Practice Unit. In every community except Iqaluit, nurses are delivering front-line care.

According to our recent survey of Canadians' experiences with primary health care, 30% of adults report that a nurse works with their regular medical doctor or at their regular place of care and is regularly involved in their care, while 17% report that other health care professionals work in the same office as their regular medical doctor (Figure 8). Although Canadians have yet to experience team-based care in any great numbers, the situation looks promising. In addition, these results do not capture the care being given by off-site team members who work together but not in one location.

OUR ADVICE

Although the use of teams won't increase the number of doctors, nurses, and other health professionals, we do know that particular populations (such as those with chronic conditions) have better health outcomes when they're attended to by a team and therefore may eventually need fewer medical appointments and other more expensive health services. This "one-stop-shopping" approach to health care is better for the patient. We urge jurisdictions to focus on establishing team-based care for all Canadians who need it, but especially for those populations for which evidence has determined that it makes a significant difference to their health.

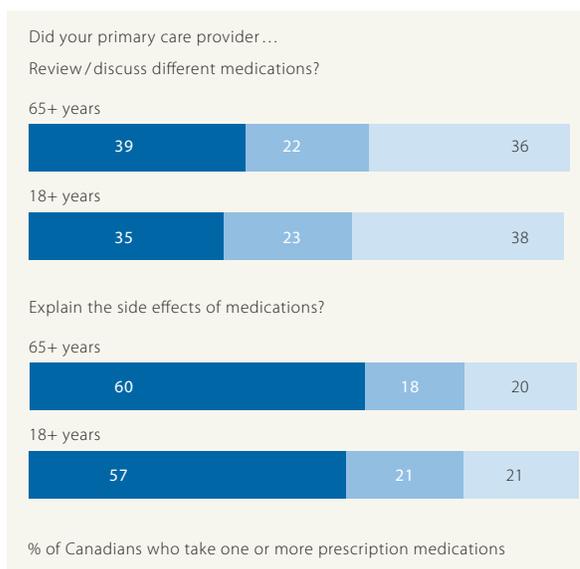


FIGURE 6

Managing prescription medications

Just over half of Canadian adults (57%) taking prescription medication report that their primary care provider always explains the side effects of medications; 1 in 5 (21%) report that this rarely or never occurs.



Note: Percentages may not add up to 100% due to missing, refusal, and "don't know" responses.

Source: Statistics Canada, Canadian Survey of Experiences with Primary Health Care, 2007.

Using information technology

As in other areas of our lives, computer technology has had an enormous impact on health care, but to date its potential has not been fully tapped. An electronic information system gives health care professionals immediate access to consistent information and the means to share it between team members and across Canada's vast geography.

Using technology to improve the efficiency and quality of primary health care is a critical part of health care renewal. As one example, information technology can help health professionals prescribe medications more effectively and efficiently (see *The benefits of e-prescribing*, page 24). In addition, information technology is being used increasingly to care for patients at a distance by gathering images and information for diagnosis and treatment.

Electronic health record

An electronic health record allows health professionals at different locations to access a patient's health history and to update the record with test results, medication information, and other details of the patient's care. The current focus of initiatives in Canada is to create records that are interoperable, meaning that they can be accessed on a variety of computer systems used by different health professionals and organizations. There are significant benefits to electronic health records: they make consistent information readily available to health professionals and can eliminate duplication of services or tests.

In 2004, First Ministers declared that 50% of Canadians would have an interoperable electronic health record by 2010. However, not all provinces and territories will meet this target (see *Timelines for electronic health records*, page 25). In our February 2007 report, *Health Care Renewal in Canada: Measuring Up?*, we called for accelerated implementation of the electronic health record, earlier than 2010. As of March 2007, only 5% of Canadians had an electronic health record despite provincial and territorial investments of \$1.176 billion.¹⁸ Clearly, much work still needs to be done.

Interoperable electronic health records result in substantial overall reductions in cost and an excellent return on investment in the long run, but the initial infrastructure is extremely costly. Despite this, in countries such as Denmark and the United Kingdom, large proportions of physicians are now using electronic health records.

To date, Canadian governments have spent approximately \$40 per person to implement the electronic health record. Estimates suggest that implementing one for each Canadian will require \$350 per person.¹⁸

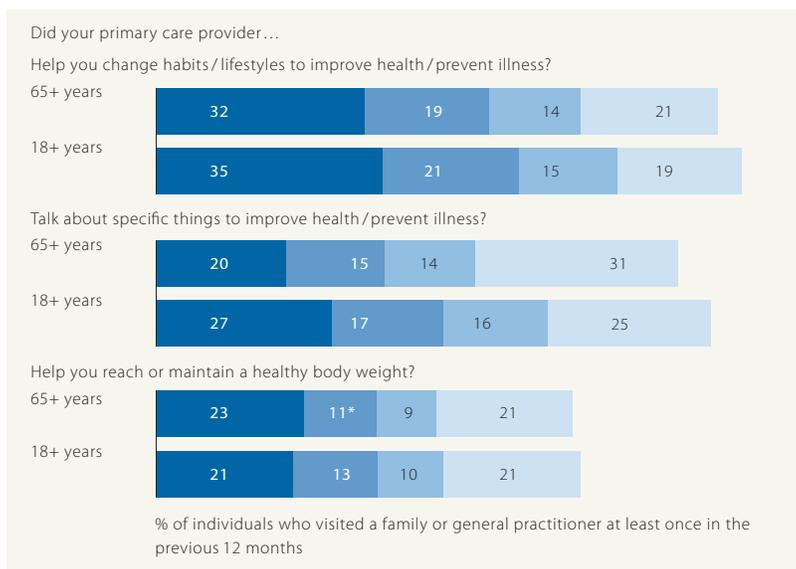


FIGURE 7
Do primary care providers promote disease prevention and healthy living?

At least 1 in 5 Canadian adults who visited their doctor within the last 12 months said their primary care provider always discussed ways to improve their health or prevent disease; an equal proportion said their provider rarely or never talked about them.

- Always
- Usually
- Sometimes
- Rarely/Never

Note: Percentages may not add up to 100% due to missing, refusal, and "don't know" responses.

*Interpret with caution. Data are less reliable due to small sample sizes.

Source: Statistics Canada, Canadian Survey of Experiences with Primary Health Care, 2007.

THE BENEFITS OF E-PRESCRIBING

Physicians and other health professionals who prescribe medication need the best possible information about their patients. When health professionals can easily access comprehensive patient records, including the patient's medication history, they can make informed decisions more quickly, more effectively, and with fewer chances of medication errors. Transmitting the prescription electronically to a pharmacy saves time and reduces the possibility of errors due to misreading handwritten prescriptions.

The Health Council hosted a symposium in June 2007 titled "Safe and Sound: Optimizing Prescribing Behaviours." The importance of electronic health records and e-prescribing was discussed. The symposium background paper, *Optimal Prescribing and Medication Use in Canada: Challenges and Opportunities*, notes some of the most important benefits of e-prescribing, including:

- › increased quality of care, because health professionals can check for drug interactions and make sure the prescriptions are accurate;

- › up to two hours less spent on the prescription process per day;
- › 30% fewer calls between pharmacists and physicians to double-check prescription instructions; and,
- › savings of approximately one hour per day for pharmacists.

(The background paper and a report on the symposium are available at www.healthcouncilcanada.ca.)

Canada lags far behind other countries in the routine use of electronic prescribing systems by primary care physicians. However, Canada has many jurisdictional initiatives underway to increase the use of e-prescribing and electronic health records, with funding for these initiatives coming in part from the federally funded Canada Health Infoway.

Physicians and others with prescribing privileges face increasingly complex demands to treat their patients with the most up-to-date medications and other treatments. Electronic health records and e-prescribing improve their ability to make good decisions.

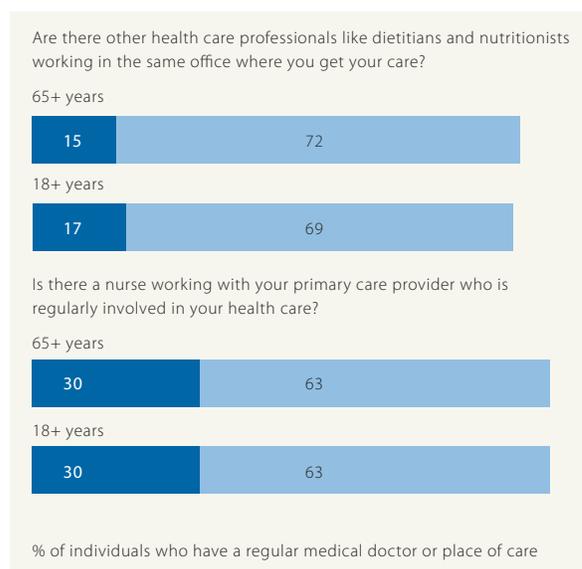


FIGURE 8

The involvement of other health professionals

One-third of Canadian adults (30%) reported that a nurse works with their doctor and is regularly involved in their care. Fewer than 1 in 5 (17%) said that other health care professionals worked in the same office as their doctor.

- Yes
- No

Note: Percentages may not add up to 100% due to missing, refusal, and "don't know" responses.

Source: Statistics Canada, Canadian Survey of Experiences with Primary Health Care, 2007.

Canada Health Infoway – created by the federal government to serve as funder and catalyst for implementation of electronic health records – has identified the lack of matched funding by jurisdictions as the main reason they may not be able to achieve their 2010 goal. Consistent with this finding, the provinces and territories have indicated that their biggest challenge to implementing a fully interoperable electronic health record is funding.

Telehealth

Expanding the use of telehealth technology has been particularly helpful in jurisdictions that face the challenge of delivering primary health care in remote areas. It is also used to monitor people with health problems in their own homes through data collection and to send information about patients (e.g. images, text) electronically to distant health care providers for assessment.

Nunavut, for example, received money under the Primary Health Care Transition Fund to expand its telehealth network. It now connects 10 communities, with savings estimated at \$1.6 million over a 21-month period as a result of reduced travel costs for medical and educational reasons and for meetings. (Not surprisingly, travel costs for medical care in the territories are substantially greater than the average for the rest of Canada: as much as 13% of health care dollars have been spent on travel in the Northwest Territories as opposed to 2% for the rest of Canada.¹⁹)

Despite demonstrable benefits, the use of technology to improve health care services and collaboration among health professionals separated by distance still has not reached its full potential. Nunavut's investments in telehealth prove that returns can be realized in both patient care and cost savings.¹⁹

OUR ADVICE

There appears to be widespread, international agreement that major quality improvement in care is possible with electronic health records. They also enhance opportunities to monitor and report on the quality of health care. Canada lags behind other countries in its implementation of an electronic health record strategy. We continue to believe in the merits of investing significantly in electronic health records and we encourage jurisdictions to make this a priority.

Telehealth has undeniable benefits, but even a modest investment in this technology is costly. Jurisdictions would benefit from sharing successful telehealth projects with other regions, and replicating them whenever possible.

TIMELINES FOR ELECTRONIC HEALTH RECORDS

Complete by 2010

Alberta
Prince Edward Island
Northwest Territories

Complete late in 2010

British Columbia
Quebec

Partial completion by 2010; need more time and resources

Saskatchewan
Manitoba
Ontario
Newfoundland and Labrador

Need more time and resources

New Brunswick
Nova Scotia
Nunavut
Yukon

Source: Canada Health Infoway,
2015: *Advancing Canada's Next Generation of Healthcare*.

DID YOU KNOW?

In Canada, 2,000 health care transactions take place every minute.

In one year there are:

- > 440 million laboratory tests
- > 382 million prescriptions
- > 322 million office-based physician visits
(94% result in handwritten paper records)
- > 35 million diagnostic images
- > 2.8 million in-patient hospitalizations

Every one of these transactions requires documentation and information exchange.²⁰

MEASURING PERFORMANCE AND REPORTING TO THE PUBLIC

There is no question that it takes time to develop, implement, and evaluate new initiatives. Canadians want accountability from their governments, and policy makers need to know that the money they are spending is buying sustainable change.

Jurisdictions have committed to improving the delivery of primary health care as well as to publicly reporting on progress. But when we asked them about targets and measures established to help monitor their progress, few reported having any (see Appendix, Table 1).

While some indicated that they are aware of primary health indicators or use them in a limited way, no jurisdiction had immediate plans to adopt this set of measures in any systematic way to monitor their progress and report to Canadians.

Health indicators

Standardized measures – also called *health indicators* – can be used to assess health status and health system performance, as well as to determine characteristics across different populations, between jurisdictions, or over time. Essentially, they provide a means to help provinces, territories, regions, and organizations track progress in the improvement and maintenance of a health system and a population's health. For example, indicators can measure performance, inform strategic planning and priority setting, support quality improvement, and can be used to gather important health information to be shared with the public. In some circumstances, indicators can also identify potential disparities in services, outcomes or health status for different populations or regions.²¹

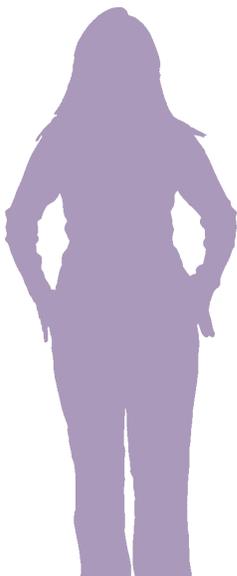
Through a consensus-building process in 2006, a broad audience of stakeholders identified and agreed upon 105 primary health care indicators.²¹ These measures can be grouped into eight categories:

- > access to primary health care through a regular provider;
- > comprehensive care, preventive health, and chronic condition management;
- > continuity through integration and coordination;
- > 24/7 access to primary health care;
- > patient-centred primary health care;
- > enhancing the orientation of care for defined populations;
- > quality in primary health care – primary prevention, secondary prevention for chronic conditions, patient safety, treatment goals, and outcomes; and
- > primary health care inputs and supports – health human resources, interdisciplinary teams, information technology, and methods of paying providers.

Without established targets to improve access and quality, and measures to monitor progress, jurisdictions can't manage improvements towards achieving their vision and goals or report on their progress.

OUR ADVICE

We continue to encourage jurisdictions to include ways to measure and report on their progress in their strategies to renew primary health care. In doing so, they will be able to demonstrate the changes they have made with the significant amount of money that has been invested in renewal.



SHINING A LIGHT ON HEALTH CARE RENEWAL

Remote monitoring a success in New Brunswick

Conventional wisdom says that the elderly can be overwhelmed by technology. But a New Brunswick program has shown otherwise, at least when it comes to health care.

New Brunswick's Extra-Mural Program is a province-wide home health care strategy that has been in place for 25 years, offering an integrated blend of primary care, home care, and rehabilitation services. Many of the patients seen by program staff are elderly and frail, coping with chronic health conditions such as diabetes and heart disease.

Three years ago, the Extra-Mural Program decided to try using medical devices in some patients' homes to monitor their conditions, reducing the need for frequent nursing visits. The program's goal has always been to help patients manage their own conditions as much as possible, says program coordinator Cheryl Hansen, and using remote monitoring offers "a way of virtually touching the patient."

A pilot project was started. Patients were taught how to monitor their vital signs such as oxygen levels, blood pressure, and weight using a small portable device with user-friendly functions. Once a day these statistics were sent to a nurse who followed up with any concerns.

When the pilot project was evaluated, the results were stunning: there were 85% fewer hospital admissions and 55% fewer emergency department visits among patients enrolled in the program. The vast majority – 93% – said that tracking in this way had helped them to better manage their conditions.

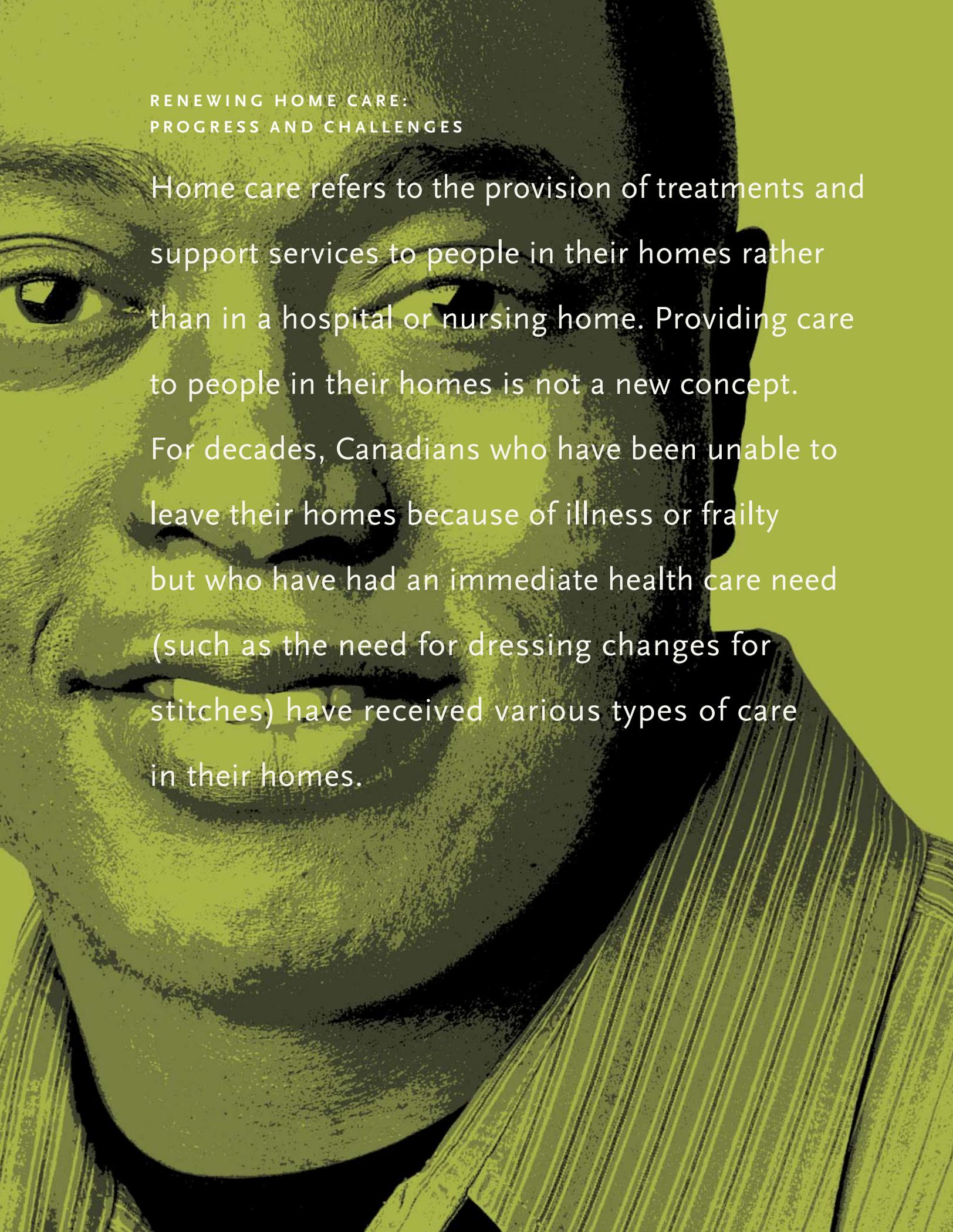
Program staff wondered whether their most vulnerable, elderly patients would be able to work successfully with the technology. "Regular self-monitoring is a very powerful learning tool," says Hansen. "Patients loved it. They could see right away if they had done something that affected their condition. And one of our biggest lessons was that this technology is not beyond anyone's abilities."

New Brunswick is currently putting together a plan to expand remote monitoring across the province.

For more information:

www.gnb.ca/0051/0384/index-e.asp

"Regular self-monitoring is a very powerful learning tool. Patients loved it. And one of our biggest lessons was that this technology is not beyond anyone's abilities."



RENEWING HOME CARE:
PROGRESS AND CHALLENGES

Home care refers to the provision of treatments and support services to people in their homes rather than in a hospital or nursing home. Providing care to people in their homes is not a new concept.

For decades, Canadians who have been unable to leave their homes because of illness or frailty but who have had an immediate health care need (such as the need for dressing changes for stitches) have received various types of care in their homes.

Increasingly, home care services are used to care for people just home from the hospital, for the mentally ill, and for people who are dying. There is a growing recognition that Canadians who are dying—and who need palliative nursing care, medication, and other support—would prefer to die at home rather than in a hospital or nursing home.²²

Home care services have not traditionally been an integral part of the publicly funded health care system because governments are not required to provide or fund treatments given at home (see *About the Canada Health Act*, below). However, there have been encouraging efforts to improve this situation (see *Primary health care and home care – a new partnership*, page 34).

There is ongoing analysis by health professionals and policy makers to determine whether providing health care in homes results in significant cost savings for the health care system overall.²³ In the meantime, Canadians have said they would rather remain at home when possible than stay in a hospital or nursing home.

Across the country, health care policy makers, managers, and providers are looking at ways to improve access to and quality of home care. The First Ministers previously agreed to provide financial coverage for two weeks of specified home care services for people who meet the criteria (see *What governments promised*, page 13).

To stay at home, many Canadians also require services that are not related to health care, such as help with cleaning, cooking, and shopping. In a 2005 survey, a significant number of Canadians (2-5%) said they used both types of home care services (Figures 9 to 13). (See *About the home care survey*, page 32.)

Canadians have spoken loudly and clearly in favour of home care.² Jurisdictions have responded by continuing to focus their efforts on making it more accessible. Some notable initiatives across the country (more in Appendix):

- › Saskatchewan is tackling the issues of providing home care to the mentally ill through the implementation of a mental health home care and crisis response program that includes case management and professional and home support without fees for up to 14 days.
- › Ontario has focused some of its efforts on expanding home care access and services in an End-of-Life Care Strategy, which includes paying for nursing and personal support services for people who want to remain in their own homes during their final days. Ontario also recently announced new funding to expand home care services for seniors. This initiative is meant to cover not only health care services but also home support services, such as housework and meal preparation.

ABOUT THE CANADA HEALTH ACT

The *Canada Health Act* ensures that provinces and territories provide universal access to publicly insured health care.

There are five criteria—often called national principles—and two provisions that provinces and territories must meet in order to receive money from the federal government for health care. The five criteria are public administration, comprehensiveness, universality, portability, and accessibility. The two provisions discourage user fees or extra-billing for insured health care services.

Under the *Canada Health Act*, insured health services include:

- › hospital services that are medically necessary to maintain health, prevent disease, or diagnose or treat an injury, illness or disability—this includes accommodation and meals, physician and nursing services, drugs, and all medical surgical equipment and supplies;
- › any medically required services rendered by medical practitioners; and
- › any medically or dentally required surgical-dental procedures which can only be properly carried out in a hospital.

Within the *Canada Health Act*, a distinction is made between insured health services and extended health care services. Extended health care services include intermediate care in nursing homes, adult residential care services, home care services, and ambulatory health care services. But these services are not subject to the five criteria or two provisions. This means that provinces and territories can charge for these services either partially or entirely, and they can choose to cover (or not) other health services that are not covered under the Act (such as optometric services, dental care, assistive devices, and prescription drugs). As a result, the range of health care services and the extent to which they are covered varies significantly by jurisdiction.

- 30 > Newfoundland and Labrador has expanded the care it provides in clients' homes through funding provided by the health accords. Previously, only those living in St. John's were able to receive intravenous therapy at home; it is now available province-wide.

Many jurisdictions told us they face the same kinds of challenges in implementing their vision for home care. Among their top concerns were recruitment and retention of home care providers and funding for home care services. Many also said that improvements in other areas of the health care system would help with home care reform. These include electronic health records, better integration of pharmaceutical management (particularly the costs of drugs delivered outside of hospitals), and better case management.

OUR ADVICE

We have said before that providing two weeks of publicly funded home care services to eligible patients is too modest an investment.²⁴ We urge jurisdictions to expand their home care coverage. Although the two weeks of care is an initial commitment to bring home care under the umbrella of Canada's universal public health care coverage, we still believe it is not enough.

In addition, few jurisdictions have considered any form of evaluation of their home care renewal efforts to date, or have any intent to monitor or report on accessibility and quality of home care. We continue to believe that renewal efforts must be coupled with a promise to monitor the progress of these efforts and report the findings to Canadians.

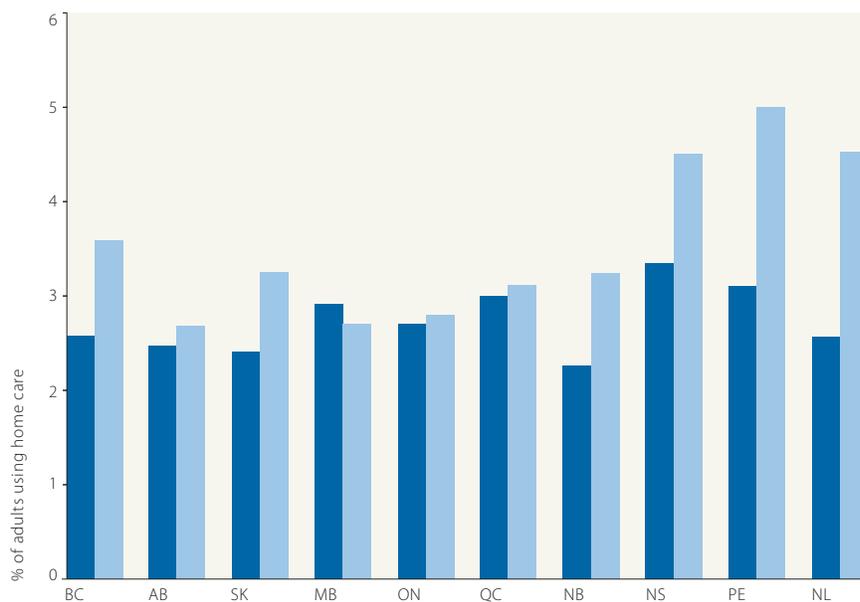


FIGURE 9

Use of home care services funded by government and not funded by government

Approximately 2-3% of Canadian adults reported using government-funded home care services; slightly more (2-5%) reported using home care services not funded by the government.

■ Funded by government
■ Not funded by government

Note: Estimates were unavailable for territories due to small sample size.

Source: Statistics Canada, Canadian Community Health Survey (Cycle 3.1), 2005.

THE TOLL ON FAMILY AND FRIENDS

In a 2006 Pollara survey,² 80% of respondents said that they supported developing more home and community care programs as a means of strengthening the health care system. Approximately one-quarter (26%) of Canadians surveyed indicated that they had needed to care for a family member or close friend with a serious health problem in the past 12 months. Of those who had provided care, 41% said that they had used personal savings to manage, and 22% had missed one or more months of work in order to provide care.

Only 9% of respondents said that they had used the federal government’s Compassionate Care Benefit program, established in 2004 under the Employment Insurance program. It was originally designed to provide employment insurance benefits to people caring for family members. All but two jurisdictions followed the federal government’s lead and enacted complementary legislation. The Health Council reported in 2005 that the program was unduly restrictive.²⁵ Since that time, the federal government and many jurisdictions have amended their program eligibility criteria to include all family members and, in most cases, close friends.

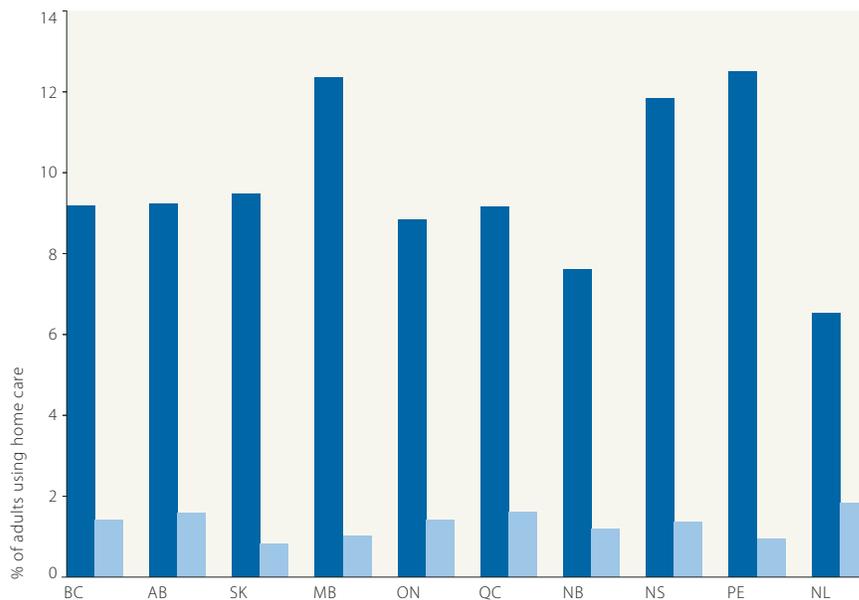


FIGURE 10
Older Canadians more likely to use government-funded home care

The percentage of Canadians using home care services varies depending on age and whether they have a chronic health condition. Canadians 65 and older were more likely to use government-funded home care services than those under 65 years of age. Between 3-4% of those 65 and older also reported needing home care services that they did not receive.

■ 65+ years
■ Under 65 years

Note: Estimates were unavailable for territories due to small sample size.

Source: Statistics Canada, Canadian Community Health Survey (Cycle 3.1), 2005

ABOUT THE HOME CARE SURVEY

Statistics Canada routinely collects data from Canadians related to health status, health care utilization, and health determinants. The information on the use of home care services contained in this report was collected in 2005 as part of their Canadian Community Health Survey. This survey is a cross-sectional survey that targets people aged 12 years and older who are living in private dwellings in the 10 provinces and the three territories. The survey covers approximately 98% of the Canadian population aged 12 and older. The survey of 133,000 is voluntary and is administered using computer-assisted interviewing.

In order to report on home care service use in Canada, the Health Council asked Statistics Canada to provide population-based estimates of those 18 years and older who indicated that they had used either non-government or government-funded home

care services or had been in need of these services within the year prior to the survey. Those who indicated that they needed or used these services were asked questions about what services they needed or used and who had provided them. They were also asked if they had difficulty getting these services.

Results presented in this report are weighted to be representative of the age and gender distribution of the Canadian population and are provided for Canadians 18 years and older, with an additional breakdown of data specific to those 65 years and older.

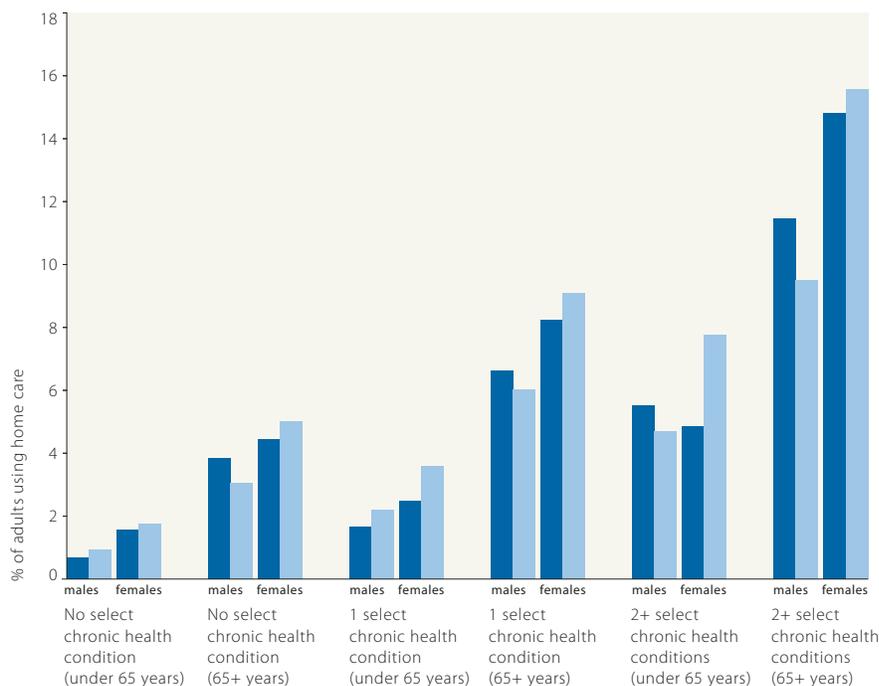


FIGURE 11

The number of chronic conditions affects demand for home care

Canadians 65 years and older who reported having 2 or more chronic conditions were most likely to use both government-funded home care services and those not funded by government.

■ Funded by government
■ Not funded by government

Note: "Select chronic health conditions" include arthritis, cancer, chronic obstructive pulmonary disease, diabetes, heart disease, high blood pressure and mood disorders. "No select chronic health condition" includes individuals who could have a different chronic condition not included in this list.

Source: Statistics Canada. Canadian Community Health Survey (Cycle 3.1), 2005.

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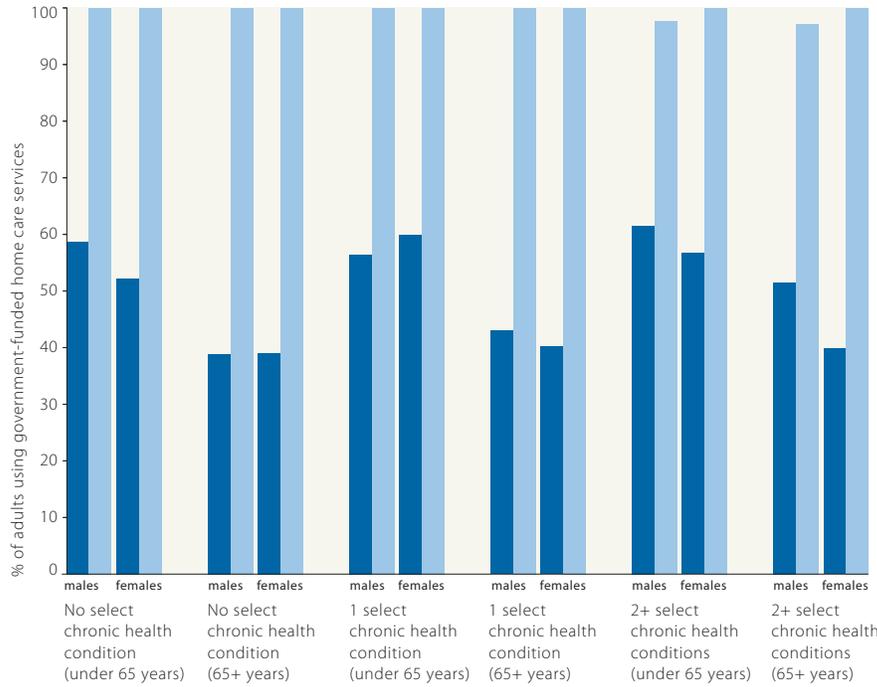


FIGURE 12
Government-funded home care used for nursing services and personal care

Nursing and personal care were the most widely used services by those receiving government-funded home care.

■ Nursing services
■ Personal care

Note: "Select chronic health conditions" include arthritis, cancer, chronic obstructive pulmonary disease, diabetes, heart disease, high blood pressure, and mood disorders. "No select chronic health condition" includes individuals who could have a different chronic condition not included in this list.

Source: Statistics Canada. Canadian Community Health Survey (Cycle 3.1), 2005.

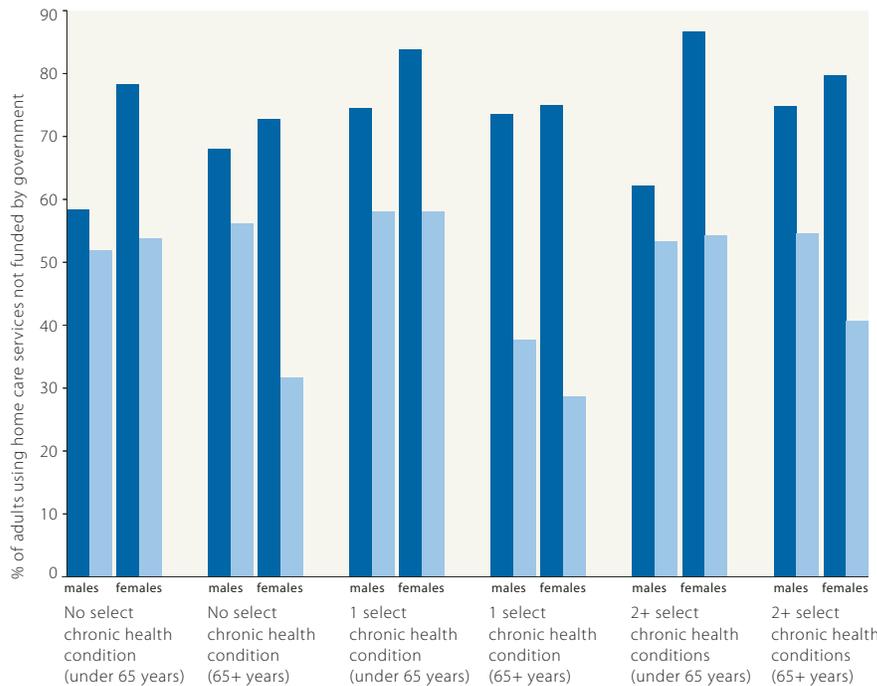


FIGURE 13
Home care needs not funded by government focus on meals and housework

Meal preparation and housework were the most commonly used services not funded by government.

■ Housework
■ Meals

Note: "Select chronic health conditions" include arthritis, cancer, chronic obstructive pulmonary disease, diabetes, heart disease, high blood pressure, and mood disorders. "No select chronic health condition" includes individuals who could have a different chronic condition not included in this list.

Source: Statistics Canada. Canadian Community Health Survey (Cycle 3.1), 2005.

Primary health care and home care – a new partnership

A demonstration project that tested new ways of linking family physicians with home care services had such promising results that it is now being promoted as a national model.

In many parts of Canada, family physicians and home care professionals don't work closely together. Patient referrals are often done by fax or phone, and there is usually limited communication. The National Partnership Project, sponsored by the Canadian Home Care Association from 2004 to 2006, involved aligning a home care case manager with each participating family physician team. The case manager then worked in partnership with the physician to assess patients' needs.

The model was tried in two locations – Calgary, Alberta, which had originated the partnership project, and Halton/Peel, Ontario – to see if it would work successfully within different provincial health care systems. (It did.)

One of the objectives of the project was to help patients with type 2 diabetes manage their condition more successfully and avoid complications. Caring for people with chronic conditions who are not house-bound was a shift in the traditional definition of home care, blurring the line between primary care and home care. In Ontario, this required revising the eligibility criteria for government-funded home care. But with the number of people with type 2 diabetes and other chronic conditions on the rise, it was important to see if home care support could make a difference.

“Patients with diabetes know that they need to change their behaviour, but knowing where to start can be daunting, which often leads to failure,” explains Allison Taylor, Primary Care Network Liaison Manager with the Calgary Health Region. “The case manager can link patients to community resources and help them problem-solve around the factors in their lives that are standing in the way of looking after their health.” Taylor adds that home care professionals often learned that a patient had a sick spouse or other stresses, and had lost the ability to manage their condition as a result. All of this information was brought back to the family physician for team discussions and joint planning of the patient's care.

“In a more traditional relationship, home care professionals respond to referrals and have limited communication with family physicians,” says Nadine Henningsen, executive director of the Canadian Home Care Association. “But in this project there were shared discussions, planning, and accountability.

Both the physicians and home care professionals developed greater understanding and respect for each other's contributions. They looked together at ways to be proactive, to keep patients healthy rather than responding to health crises.”

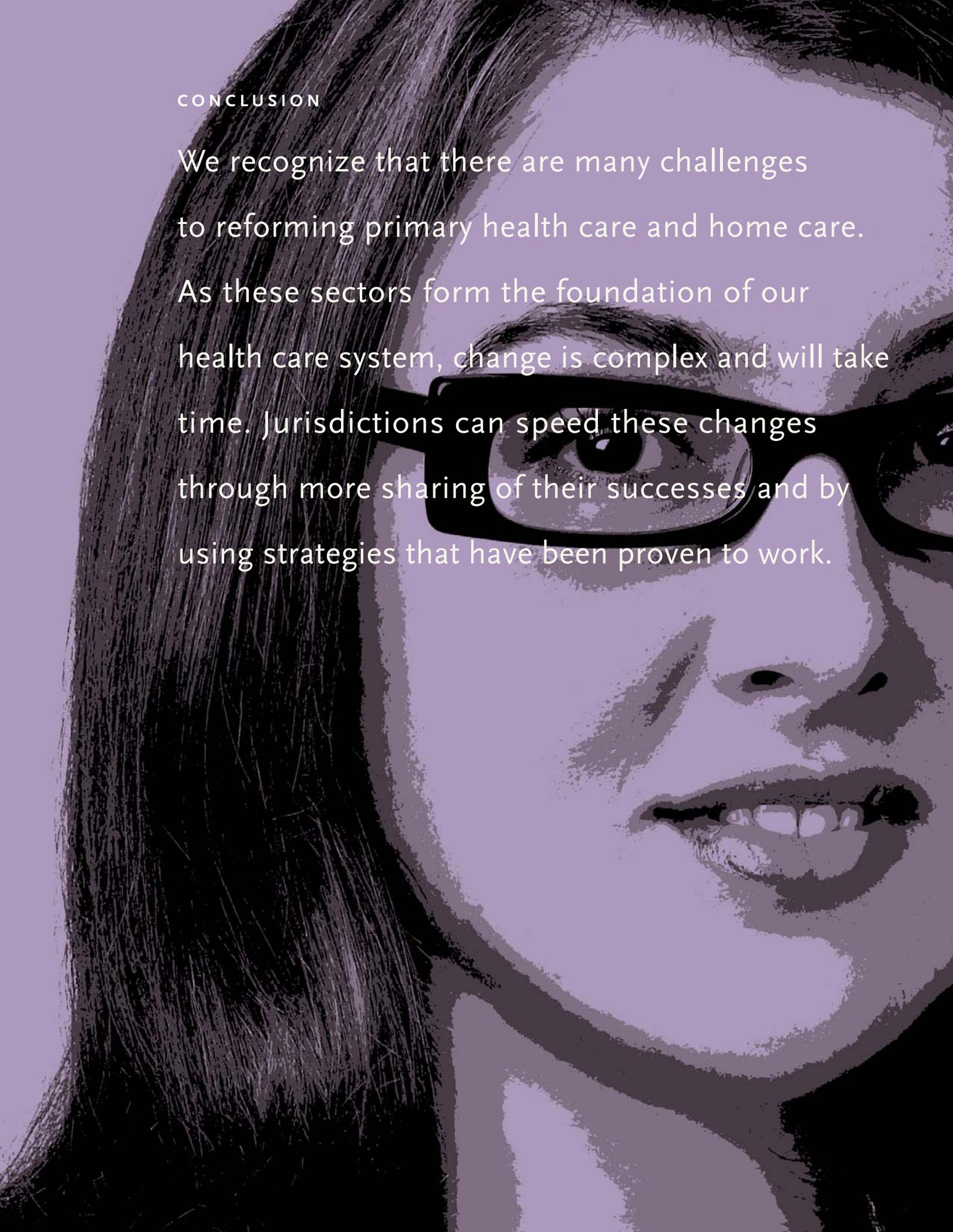
Physicians said how much they appreciated the collaboration, the joint decision-making, and the consistency of dealing with one dedicated home care case manager, rather than many.

The benefits to patients were significant. Patients said they had greater confidence in the health system and their primary health care team, and their health improved. Many of the patients with type 2 diabetes seen during the demonstration project lowered their blood pressure and cholesterol and achieved better blood sugar results, improvements that decrease the risk of health emergencies and complications.

“This partnership model works and has implications for many chronic conditions and other patient needs, including palliative care,” says Henningsen. “And it's cost-effective, since the improved health of patients reduces costs to the health care system overall.”

The National Partnership Project, which was funded by the Primary Health Care Transition Fund (see page 14), has generated significant interest across the country. With the help of tools and resources developed through the project, partnership models are currently being explored in a number of provinces and territories.

For more information:
www.cdnhomecare.ca



CONCLUSION

We recognize that there are many challenges to reforming primary health care and home care. As these sectors form the foundation of our health care system, change is complex and will take time. Jurisdictions can speed these changes through more sharing of their successes and by using strategies that have been proven to work.

Although federal, provincial, and territorial governments have vision statements to guide their renewal efforts in both primary health care and home care, few governments have set targets or have implemented strategies for measuring, monitoring, and reporting on progress. This is despite the completion of a national consensus process in 2006 that identified measures to be used to monitor quality and report on progress in primary health care. And few jurisdictions report an integrated approach to home care, suggesting that they have yet to view home care as a seamless extension of the health care system.

We also noted the following trends:

PRIMARY HEALTH CARE

- › 24/7 access to health information and health care providers has been established in almost every jurisdiction but remains reliant on telephone health lines. In addition, information about after-hours care is not always communicated to the family doctor.
- › In our survey, the vast majority of Canadians (96%) report that they have a regular medical doctor (86%) or place of care (10%) and give high ratings to the quality of their care, but they report problems with patient communication and the ability to get an appointment. In addition, too many Canadians say they visited the emergency department for conditions that could have been treated by their primary care provider if he or she had been available. More than one-third (39%) of the 24% of Canadians who visited the emergency department in the prior year believe this was the case. Clearly improvements are needed to increase timely access to regular primary health care providers.

- › Canadians have yet to experience team-based care in great numbers, but the situation looks promising. More interprofessional teams have been established to deliver primary health care and more are being implemented.
- › Some jurisdictions have made considerable investments to implement electronic health records, but to date only a small proportion of Canadians receive care from health care providers who are supported by an electronic information system to help them improve quality and efficiency.

HOME CARE

- › Each jurisdiction is making efforts to improve access to home care with some notable initiatives. Universally accessible, publicly funded home care programs have been initiated and/or expanded, but all are targeted to specific populations.
- › The majority of Canadians (80%) support the development of more home and community care programs as a means of strengthening the health care system.
- › 2-3% of Canadian adults used government-funded home care services in 2005; slightly more reported using home care services not funded by government (2-5%). Unfortunately, we know very little about people's views on access and quality of home care services as this type of information is not available in Canada.

We recommend expanding the use of team-based care for Canadians who need it, and investing significantly in electronic health records and telehealth.

37 Throughout this report, we have provided advice to improve and enhance primary health care and home care.

IN SUMMARY

- › To improve access to care, we recommend the widespread adoption of proven initiatives (such as open-access scheduling) that balance demand for services with the capacity of a practice to deliver them, without increasing the workloads of primary health care providers. We also recommend that after-hours care go hand-in-hand with a commitment to coordinate care, so that information about any after-hours care is sent to a patient's primary care provider.
- › To enhance quality, we recommend expanding the use of team-based care for Canadians who need it, particularly those with chronic health conditions.
- › We believe in the merits of significantly investing in electronic health records and telehealth initiatives and encourage jurisdictions to make this a priority.
- › We have said before that providing two weeks of publicly funded home care services to eligible patients is too modest an investment and we urge jurisdictions to expand their home care coverage.
- › Many promising strategies have been developed across the country to renew primary health care and home care. Jurisdictions are encouraged to share their experiences more broadly.

- › When jurisdictions are developing and implementing their strategies to renew primary health care and home care, we encourage them to identify targets, measure and monitor change, and report to Canadians on progress. Governments need to develop and use appropriate information systems that better support surveillance, relevant research, and public reporting in primary health care and home care. We learned that many health care policy makers, managers, and providers in Canada want this type of resource to do their work.

There is no shortage of renewal efforts in primary health care and home care. But it is now time to start applying proven strategies across the system – and it is time for jurisdictions to identify clear targets, measure their efforts, and show Canadians how their health care system is changing for the better.

We urge jurisdictions to expand their home care coverage. Two weeks of home care services following discharge from hospital is too modest.

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APPENDIX: JURISDICTIONAL TABLES ON HEALTH CARE RENEWAL

TABLE 1
Visions and targets for primary health care

TABLE 2
Improving access to primary health care: Selected activities

TABLE 3
Visions and targets for home care

TABLE 4
Expanding access to home care services: Selected activities

These tables summarize information provided and verified by the jurisdictions that participate in the Health Council of Canada. Information is accurate as of September 2007.

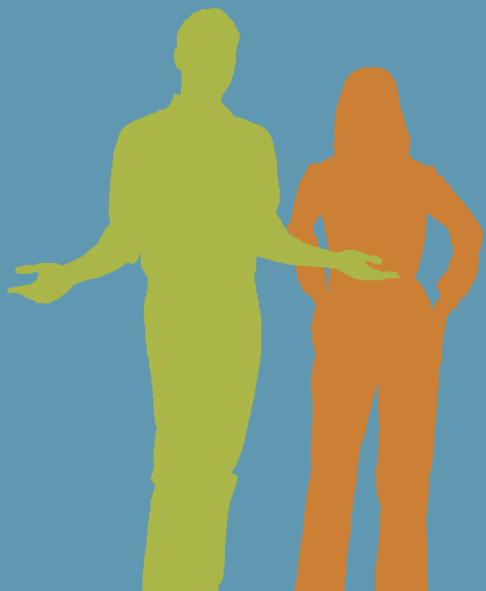


TABLE 1
Visions and targets for primary health care (PHC)

	BRITISH COLUMBIA	SASKATCHEWAN	MANITOBA	ONTARIO	NEW BRUNSWICK	PRINCE EDWARD ISLAND
VISION	<p>A primary health care system that helps British Columbians stay healthy, get better, manage chronic conditions, and die with dignity.</p> <p>Access to a PHC provider who provides continuity of care within a coordinated system that includes a variety of health professionals and health services.</p>	<p>To improve access to care and quality of care through developing and implementing primary health care teams in SK.</p>	<p>Quality primary health care is available to all Manitobans.</p> <p>Manitobans will have access to community-based, integrated and appropriate primary health care services.</p>	<p>A health system that promotes wellness and improves health outcomes through accessible, integrated, and quality services that are as close to home as possible, at every stage of life.</p>	<p>To focus on expanding and incorporating larger telehealth and e-health systems.</p>	<p>A single management structure for all diabetes programs and community mental health/addictions programs.</p>
TARGETS	<p>Not provided.</p>	<p>25% of the population to have access to PHC teams within 4 years.</p> <p>100% of the population to have access to PHC teams by 2011. Family physicians to be paid through an alternative payment method.</p>	<p>Not provided.</p>	<p>50% of residents to have access to an appropriate health care provider 24/7 by 2011.</p>	<p>Not provided.</p>	<p>Not provided.</p>
MEASURES	<p>Indicators and milestones are to be established over the coming year.</p>	<p>Currently, data measuring progress related to PHC reform and team development are being collected in each region, guided via Saskatchewan Health.</p> <p>Specific data are being collected on shadow billing for physicians and registered nurses (nurse practitioners), client satisfaction, program effectiveness, and team effectiveness.</p>	<p>Where appropriate, Canadian Institute for Health Information indicators are being used by the regional health authorities to evaluate the advancement of primary health care in the province.</p>	<p>A primary health care scorecard is to be developed. It will include results of a primary care access survey.</p>	<p>Not provided.</p>	<p>Performance indicators have been assembled, including client satisfaction and AICs specific to diabetes. Some of this information is to be gathered through surveys.</p>

TABLE 1 (CONTINUED)
Visions and targets for primary health care

	NOVA SCOTIA	NFLD AND LABRADOR	YUKON	NORTHWEST TERRITORIES
VISION	To improve the health of NS's population within 15 years, through enabling individuals, families, communities, non-governmental and governmental organizations, within and outside the health sector, to positively influence the many factors that influence health.	To have accessible primary health care available to 90% of the population.	To make steady improvement. Through an incremental approach, to achieve trust, acceptance, and sustainability of any changes made to primary health care services.	A team-based, client-focused approach to providing primary health care in the Northwest Territories, with a focus on disease prevention and health promotion. Integration of services and collaboration between different health and social services teams, which are at the core of NWT's Integrated Services Delivery Model (ISDM). The ISDM combines 3 key elements: <ul style="list-style-type: none"> • Use a primary community care approach. • Ensure all caregivers and their organizations are connected and work together. • Describe and strengthen core services.
TARGETS	A 3- to 5-year action plan for PHC renewal, including measurable targets, is under development.	50% of population to have access to PHC teams by 2010.	Continue work with BC to implement a Nurse Line for Yukon residents. Develop and implement a health human resources (HHR) strategy. Consider expanding the diabetes collaborative care initiative to include several additional chronic health challenges.	PHC objectives specifically designed to improve chronic disease management and patient and health system outcomes are contained in NWT's Action Plan 2006/2010. Target areas include: <p>Oral health In collaboration with the federal government, improve dental health services across NWT, emphasizing dental health promotion and more regular treatment services.</p> <p>Public health Establish new regional public health units (e.g. Deh Cho, Sahtu, and Tlcho); add CHR positions and integrate public health service delivery into PHC teams.</p> <p>Prevention programs and diagnosis Assure equal access to mammography for all NWT women; extend colorectal cancer screening program in the Beaufort Delta region; establish comprehensive renal program. Canada Health Infoway to invest in picture-archiving communications system for radiology.</p> <p>Nursing and midwifery Expand the use of nurse practitioners in every health centre, clinic, and emergency room; registered midwives in primary care teams in all regions; and licensed practical nurses (LPN). Also offer a revised LPN training program.</p> <p>Surgical wait times Undertake initiatives to increase availability of operating room time. Continue to increase volume of cases from existing ORs and invest strategically in surgical tools, equipment, and prosthetics.</p> <p>Call centre Tele-Care NWT provides residents with 24/7 access to registered nurses for symptom triage, health and family support information, and advice. The call centre is in its 3rd year of operation.</p> <p>Electronic health records (EHR) Critically important to our strategy: develop electronic health records and other information systems over the next 4 years. EHRs will be rolled out in NWT starting February 2008. For successful EHR rollout, address privacy and capacity issues.</p>
MEASURES	NS mapped the evolving set of Canadian Institute for Health Information indicators to provincial evaluation questions. Where it appeared there were gaps, indicators unique to the Nova Scotia context were identified. Of the 130 indicators so identified, only 22 could be calculated using existing data sources. Three data collection tools were adapted, pilot-tested and revised: a community survey, a survey of PHC teams, and a primary health care organization survey. These new instruments (along with data from the Primary Healthcare Information Management System and other sources) form a strong data collection structure for evaluating change in NS's PHC system.	As of March 2007, 27% of population has access to PHC teams.	Various steps have been taken to implement a Nurse Line. It is not yet in place. Various HHR strategy elements are in place or announced. Collaborative care activities for diabetes have been implemented over the past year. Some planning elements have been formulated for the possible expansion of this model to other areas.	Not provided.

TABLE 1 (CONTINUED)

Visions and targets for primary health care

	NUNAVUT	CANADIAN FORCES	HEALTH CANADA
VISION	To strengthen and enhance existing programs (such as the family practice unit) and use of nurse practitioners.	To create patient-centred clinics, focused on the long-term health of the Canadian Forces members and community, using a collaborative, interdisciplinary team of health care providers.	<p>To improve alignment and (where possible) integration of services on-reserve with those of the jurisdictions, in the federal government's provision of PHC services to predominantly rural or remote First Nations and Inuit communities that would not otherwise have access to provincial PHC services.</p> <p>To achieve this vision through collaborative processes such as the Tripartite First Nations Health Plan, signed on June 11, 2007 by Health Canada, the Province of British Columbia, and the BC First Nations Leadership Council. This agreement seeks to improve coordination and integration of health services, enhance First Nations control and accountability, and improve overall access and quality of health services for First Nations.</p> <p>To achieve the vision through the Aboriginal Health Transition Fund (AHTF). The AHTF is designed to benefit all Aboriginal peoples and is intended to:</p> <ul style="list-style-type: none"> • improve integration of, and access to, health services; • make health programs and services that are better suited to Aboriginal peoples; and • increase the participation of Aboriginal peoples in the design, delivery, and evaluation of health programs and services.
TARGETS	Not provided.	<p>Conversion of 38 sites into patient-centred clinics, to be complete by 2010.</p> <p>A renewal initiative is currently underway at DND/Canadian Forces Health Services to better coordinate various PHC practitioners into defined, collaborative, interdisciplinary teams.</p>	<p>Look beyond project-based targets and focus on health sector transformation for First Nations and Inuit.</p> <p>Work with other willing provinces and First Nations towards signing tripartite health agreements across the country, and continue efforts at health service integration and adaptation through the AHTF.</p>
MEASURES	Not provided.	<p>Attempts are being made to rationalize many Canadian Institute for Health Information indicators to a Canadian Forces setting.</p> <p>Performance indicators primarily being focused on are effectiveness and efficiency. Specifically included are:</p> <ul style="list-style-type: none"> • wait-time parameters (time between triage and clinician assessments); • sick parade cycle time; • per cent of no-show patients; • total number of patients seen by each member of the collaborative team; • proportion of sick parade/walk-in visits to number of scheduled appointments; • availability of military personnel for delivery of patient care; • number of patient encounters where collaboration between disciplines is documented. 	<p>Efforts to improve health information are ongoing, with the goal of building a comprehensive health information system, in collaboration with First Nations and jurisdictions. These efforts respect First Nation concerns around privacy and control, and seek to track First Nations clients across multiple data sets.</p> <p>Performance measurement, indicators, and accountabilities are to be key components of tripartite health service agreements. In the BC agreement, key indicators include the measurement of new and improved health governance, management, and service delivery relationships.</p> <p>A national evaluation framework and set of indicators for the AHTF are being developed. Indicators will be used to assess integration, adaptation, and access to health services as well as the increased participation by Aboriginal people in health services design, delivery, and evaluation.</p> <p>Health Canada financially supports the First Nations Regional Longitudinal Health Survey which focuses in part on access and uptake of PHC services.</p>

TABLE 2
Improving access to primary health care (PHC): Selected activities

	BRITISH COLUMBIA	SASKATCHEWAN	MANITOBA
OBJECTIVES	<p>To take action on general access to primary health care, specifically:</p> <ul style="list-style-type: none"> • access to maternity care; • chronic disease prevention and management; • management of co-morbidities; • improved care for the frail elderly; • enhanced end-of-life care. 	<p>To improve access to care and quality of care through developing and implementing primary health care teams.</p>	<p>To support RHAs and physicians in delivering quality primary care to all Manitobans, through work on integration, interface, innovation, and indicators. Specific objectives for the future are:</p> <ul style="list-style-type: none"> • Improve access to primary care services; • Implement collaborative teams; • Work with RHAs to connect systems of care across the continuum; • Build capacity in RHAs to manage change and promote innovation and quality improvement; • Develop an intradepartmental planning network; • Explore a PHC intersectoral network; • Promote skill development and competency in community building across RHAs.
SELECTED ACTIVITIES	<p>To attract and retain additional family physicians in group practices in areas with demonstrated need, a \$10-million initiative has been undertaken.</p> <p>To improve availability of same-day access to service, practice support program teams offer family physicians change packages and support in adopting advanced or open-access scheduling.</p> <p>For patients living with two or more chronic conditions, the family physician incentive for complex care needs to be implemented and evaluated; it is to have an annual budget of \$25 million.</p>	<p>Teams to be established in all 13 regions:</p> <ul style="list-style-type: none"> • to provide coordination, services, and case management; • to strengthen the roles of providers at other entry points such as home care, mental health and public health. <p>An intersectoral approach will be adopted; services are to be provided by a range of professionals:</p> <ul style="list-style-type: none"> • physicians to be linked to regional health authorities (RHA); • Registered nurses (RN)/nurse practitioners (NP) to work in expanded nursing roles; • programs and services to be targeted to high-risk populations. <p>Access to 24/7 health care is provided:</p> <ul style="list-style-type: none"> • in urban centres, after hours via emergency departments; • in rural areas, via community health centres designated as 24/7 service providers; RNs provide service. <p>Access to health information and advice provided by the HealthLine:</p> <ul style="list-style-type: none"> • 24-hour access services are provided by RNs; • specific information/advice is given regarding crystal methamphetamine use; • as of December 2006, mental health and addictions crisis support expanded to 24/7; • to supplement and support existing services, specially trained social workers and registered psychiatric nurses are now available to handle crisis calls and provide referrals. <p>HealthLine Online, a complementary SK Health website, provides basic health information in "living room" language as of June 2006:</p> <ul style="list-style-type: none"> • descriptions of common medical conditions; • common treatments; • direction on when to seek medical advice. <p>SK intends to develop critical care paths back to PHC teams where appropriate.</p>	<p>A major expansion to Health Links-Info Santé, MB's provincial call centre, has been undertaken as part of the Primary Health Care Transition Fund. Two broad goals of the expanded call centre are:</p> <ul style="list-style-type: none"> • to provide timely, multilingual, 24/7 PHC information and referral services to all Manitobans; • to have a database of community-based referral agencies and resources accessible via the desktop. <p>The call centre is foundational in that it affords all regions within the province the opportunity to build future initiatives on these core services.</p>
CHALLENGES	<p>Current system supports passive patients rather than patients as partners in their own care.</p> <p>Challenges include:</p> <ul style="list-style-type: none"> • health care inequities; • aging health care workforce; • how to recruit and retain family physicians; • lack of information technology in PHC practices. 	<p>Increase availability of RNs, NPs, physicians and other health professionals.</p> <p>How to change health care needs and expectations:</p> <ul style="list-style-type: none"> • from management of acute illness and injury to support of chronic disease; • an expectation that services would be available 24/7. <p>Limited evidence on how organization of services will help to achieve improved health outcomes with existing resources.</p>	<p>MB's Primary Health Care Branch is in the midst of a strategic planning exercise.</p> <p>Comprehensive planning and early involvement of key stakeholders will help the Branch to anticipate potential impediments.</p>

TABLE 2 (CONTINUED)

Improving access to primary health care: Selected activities

	ONTARIO	NEW BRUNSWICK	PRINCE EDWARD ISLAND	NOVA SCOTIA
OBJECTIVES	<p>Improve:</p> <ul style="list-style-type: none"> access to primary health care; quality and continuity of primary health care. <p>Increase:</p> <ul style="list-style-type: none"> patient and provider satisfaction; cost-effectiveness of PHC services. <p>Provide:</p> <ul style="list-style-type: none"> interdisciplinary team-based care – the right service by the right provider; around-the-clock care – via extended hours, telephone health advisory service; coordinated system access and navigation – e.g. hospitals, long-term care services, diagnostic services, specialist referrals; health promotion, disease prevention, and chronic disease management; guided by local population health indicators; active support for patients' self-care responsibilities; better management and increased accountability for funds spent and services delivered. 	<p>To increase 24/7 access in all communities via developing:</p> <ul style="list-style-type: none"> outbound calling for telecare; an initiative to maintain PHC services as close to the community as possible, in rural areas; communities desire a range of clinic services in such areas as diabetes, well baby, mental health, and addiction; Building a Better Tomorrow – initiative for training and interdisciplinary integration and promoting synthesis, transfer and exchange; a framework for chronic disease prevention and management, applicable to any condition. 	<p>Acute-care information systems currently linked to family health centres including pharmacy and radiology; laboratory in process.</p> <p>Standardized common booking and scheduling system implemented.</p> <p>Family health centres have varied hours of operation; some provide extended evening hours while others offer evening walk-in clinics.</p> <p>Ongoing quality improvement process leading to accreditation by the Canadian Council on Health Services Accreditation. A quality team comprising all the family health centres across the Island will track the indicators.</p>	<p>To make PHC services more responsive and accessible, and encompass a wider range of services in the community.</p> <p>To strengthen PHC information management and technology.</p> <p>To improve chronic disease management so as to achieve better health outcomes for Nova Scotians.</p>
SELECTED ACTIVITIES	<p>Peterborough Networked Family Health Teams Created by the physicians of Peterborough, these teams have addressed systemic crises in local health care:</p> <ul style="list-style-type: none"> too many patients without a regular primary care provider; growing strain on outpatient services; a rising incidence of chronic disease. <p>The teams have reinvigorated primary care practice by:</p> <ul style="list-style-type: none"> integrating NPs, mental health practitioners, and dietitians; setting up local and health-system partnerships; creating a roster-based payment model for family physicians. <p>Together, these innovations have provided care to more than 8,200 patients who did not previously have a regular primary care provider, and brought three new physicians into community practice. Evening clinic and telehealth service have been combined with the benefits of primary care, eliminating 10,000 unnecessary emergency department visits in the first 18 months of the teams' operation.</p> <p>Dryden Area Family Health Team This team designed "It's Your Health!" – a program with several components, including:</p> <ul style="list-style-type: none"> Healthy Living – a health promotion and disease prevention service; Manage Your Health – supporting management of chronic diseases, including mental health; Your Health Toolkit – based on a care plan determined by the patient's family health team assessment, the toolkit identifies individual appointments with the appropriate provider. 	<p>Initiatives in place:</p> <ul style="list-style-type: none"> e-health – tele-psychology mental health, tele-oncology, and tele-cardiology already in use; a 4-year research project on disease management to prevent diabetic complications; involves electronic health records (EHR) and collaboration between a nephrologist and general practitioners; pre-diabetes screening project led by endocrinologist; teams working in community health centres coordinated to meet each community's particular needs; enhanced role of NPs in PHC areas such as mental health and addictions. <p>Initiative needed/being developed for:</p> <ul style="list-style-type: none"> outbound calling for telecare. 	<p>Five family health centres are currently operating with another partially operational. Three family health centres have a walk-in clinic. Two centres have NPs and additional sites have submitted proposals to add NPs.</p> <p>Single management structure for all the diabetes programs, community mental health and addictions, and family health centres.</p>	<p>In its first year, 27% of the province's PHC physicians joined the Primary Healthcare Information Management program (PHIM) and started using the electronic patient record to maintain their patients' health records. PHIM includes interfaces with all provincial acute care hospitals as well as laboratory and diagnostic imaging results.</p> <p>Since January 2007, an incentive payment is available to PHC physicians for evening and weekend office visits.</p> <p>A remote on-call stipend is available to PHC physicians located more than 72 km (45 mi.) from an emergency department who provide after-hours service.</p> <p>Currently, 27 NP positions are funded by NS's Department of Health. To meet community needs, other disciplines will also be funded.</p> <p>Chronic disease management was identified as a health-system-wide priority in the 2006/07 NS Department of Health business plan.</p>
CHALLENGES	<p>A main challenge is HR shortages in many health care professions.</p> <p>Regarding family physicians specifically, this shortage is complicated by several factors, including:</p> <ul style="list-style-type: none"> average age of 50 among current family physicians; decreased interest in family medicine among medical students choosing a career; relatively high turnover of physicians in some rural areas; sub-specialization/focused practice of family physicians; increased opportunities for family physicians in hospital settings; changing expectations of the new generation of family physicians. 	<p>Increase availability of physicians, including physicians to work in community health centres.</p> <p>Overcome information technology challenges; difficult for health care and technology professionals to find time to meet and work on IT projects.</p> <p>Current remuneration models do not support interdisciplinary collaboration.</p>	<p>Increase physician recruitment.</p> <p>Take time for team building – encourage collaboration; build relationships, trust, and respect for skill sets.</p> <p>Create time for health care team planning, given difficulties posed by existing demands for service.</p>	<p>Access Work with the changing demographics of the medical workforces:</p> <ul style="list-style-type: none"> Worklife issues and family commitments influence the need for part-time work or shorter work hours. Reports of a move towards specialized rather than comprehensive care could also have an impact on access. In collaboration with physicians, NPs have been able to free up demand on physicians by assuming certain defined medical functions. However, some funded NP positions have been difficult to fill. <p>Chronic disease management The challenge is to develop and implement a comprehensive chronic disease management program for the benefit of all Nova Scotians. Currently, more than two-thirds (68.1%) of Nova Scotians aged 12 years and over report having a chronic medical condition.</p>

TABLE 2 (CONTINUED)
Improving access to primary health care: Selected activities

	NFLD AND LABRADOR	YUKON	NORTHWEST TERRITORIES	NUNAVUT	CANADIAN FORCES	HEALTH CANADA
OBJECTIVES	To increase access to PHC: <ul style="list-style-type: none"> • 50% of population to have access to PHC by 2010; • 90% of population to have access to PHC (no time frame). 	To achieve trust, acceptance, and sustainability of any changes made to PHC services. To increase 24/7 access to health care.	To improve chronic disease management and patient and health system outcomes. Specific PHC objectives are included in NWT's Action Plan 2006/2010. Target areas include: oral and public health; prevention programs and diagnosis; nursing and midwifery; surgical wait times; call centre; and EHRs.	The objectives of the primary care initiative have been met, including the innovative introduction of nurse practitioners. As a priority, to advance the use of EHRs in the health centres, for referral purposes within NU and for connections to southern jurisdictions.	The Canadian Forces is enhancing access to care by establishing care delivery units (CDUs) to deliver PHC in a patient-centred, interdisciplinary environment.	Health Canada will continue to work with Aboriginal and provincial/territorial partners to improve access and integration/adaptation of primary health services for First Nations and Inuit peoples.
SELECTED ACTIVITIES	Establish 18 PHC teams by 2008. Eleven are up and running; the remainder are in the proposal stage.	Foster increased collaboration and improve the flow of information. In rural and remote communities, community NPs provide 24/7 service through the health centres. In Whitehorse, 24/7 access is maintained by the Whitehorse General Hospital's emergency department. Access to a Nurse Line will also contribute to ensuring 24/7 care. Under consideration is an expanded diabetes collaborative care initiative; to include several additional chronic health challenges.	Planned deliverables include: <ul style="list-style-type: none"> • mammography screening managed as a territorial program with equal access for all NWT women; • system-wide plans underway for the introduction of NPs and midwives; • pilot EHR program. 	NU is proud of the family practice unit. In every community except Iqaluit, nurses deliver front-line care. This situation enables NU to consider additional ways of supporting the patient population. With support, those patients who previously sought physician services can have their health issues addressed through nursing and the NP-supported model. This will be explored further. A new acute care hospital will open soon. The delivery model will provide opportunities to consider how to integrate primary and secondary care, out-patient care, physician office practice, and physician care family practice – a transformation from current practices. NU is working towards having digital imagery and an integrated information system.	The Canadian Forces provides direct access to PHC through direct access to physicians, NPs, physician assistants, primary care nurses, primary psycho-social service workers (mental health nurses, social workers, addiction counsellors), pharmacists, physiotherapists, ophthalmologists, and medical technicians. CDUs – the nucleus of the primary care model – are composed of an interdisciplinary team of Canadian Forces and civilian health care providers. The Canadian Forces is automating and replacing the paper health record system with an EHR system. The effort is currently in the second phase of a three-phase program.	Health Canada provides 24/7 access in over 75 primary care nursing stations located on remote and isolated First Nations reserves. The non-insured health benefits program provides medical transportation, assisting eligible recipients to access medically required health services that cannot be obtained on the reserve or in the community of residence. Health Canada also provides e-health and telehealth services to enhance access to care within First Nations and Inuit communities. The Aboriginal Health Transition Fund is designed to benefit all First Nations, Inuit, and Métis peoples, and is intended to: <ul style="list-style-type: none"> • improve the integration of health services funded by different levels of government; • improve access to health services; • make available health programs and services that are better suited to First Nations, Inuit, and Métis peoples; • increase the participation of First Nations, Inuit, and Métis peoples in the design, delivery, and evaluation of health programs and services. To improve coordination, integration, and access to quality health services for First Nations, Health Canada will also be working to develop regional tripartite agreements with provincial governments and First Nations.
CHALLENGES	Increase recruitment and retention, particularly of physicians. Increase permanent positions for nurses.	Lack of availability of health care professionals is a continuing challenge.	NWT faces the same challenges as the rest of Canada in recruiting professional staff and retaining existing staff. The competition to hire and retain health professionals is intense and requires a focused and determined effort.	HHR challenges include: <ul style="list-style-type: none"> • unfilled, difficult-to-recruit positions, such as nursing positions, have a bigger impact for NU than for larger jurisdictions; • high staff turnover is a challenge to achieving collaboration. Technological challenges include: <ul style="list-style-type: none"> • not all communities run on the same server systems; • many challenges exist without the appropriate communication technologies to support the type of electronic information required; • staff are needed to develop and implement the technology. 	Like the civilian health care sector, the Department of National Defence faces challenges in the form of infrastructure barriers, shortages in health care professionals, change management, and long-term budgetary constraints combined with an increased operational tempo. To staff our CDUs in accordance with the collaborative practice model has been one of our greatest challenges.	Recruitment and retention of health human resources is an ongoing challenge in primary care for First Nations and Inuit. As in other health systems, nursing shortages have had a considerable impact. A further challenge is attracting and retaining qualified Aboriginal health professionals and allied health workers. Ongoing work through the Aboriginal Health Human Resources Initiative (AHHRI) has increased the number of opportunities for Aboriginal peoples seeking health careers and educational/skills training opportunities. AHHRI has been able to fund a six-fold increase in the amount of bursary and scholarship funds available for First Nations, Inuit, and Métis health career students, with over \$3 million now available annually.

TABLE 3
Visions and targets for home care

	BRITISH COLUMBIA	SASKATCHEWAN	MANITOBA	ONTARIO
VISION	To provide individuals with the support and health services they need to live fully and independently or interdependently as valued members of their community. BC's home and community care services system will respect, recognize, and support clients, their caregivers, and their service providers.	Home care is an integral part of a continuum including community as well as institutional services; both are seen as necessary to ensure the best possible quality of life for people with varying degrees of short- and long-term illnesses.	To ensure provision of effective, reliable, and responsive home health care services to Manitobans so as to support independent living in the community. To ensure coordination of admission to facility care when living in the community is not a viable alternative. RHAs are developing community living alternatives, which delay the need for facility care.	To help people stay healthy, support their personal responsibility, and provide effective, accessible, quality care where and when needed, through health care policies and standards developed by the Health Program Policy and Standards Branch, as part of the Health System Strategy Division. Such policies and standards are seen as part of a sustainable, publicly funded system.
TARGETS	Target to be determined for home care rate. Performance targets relating to deaths out of hospital for end-of life (EOL) measures: <ul style="list-style-type: none"> • Provincial long-term target is 60%. • Provincial benchmark is 50%. 	SK's current level of home care services continues to exceed the First Ministers' commitment in the 10-year plan of 2004. SK continues to be committed to maintaining a high level of home care services.	Each RHA is targeting development based on identified needs.	Establish clear directives for providing access to services in targeted sectors (program designs, standards, policies, regulations, legislation). Increase effectiveness of policies for accessing health care services by sector. Improve quality of health care programs designs, policies, and standards. Increase integration and alignment between program policy change initiatives.
MEASURES	Health System Performance Improvement Measure for 2007/2008: Age-standardized client count rate per 1,000 population for assisted living, adult day programs, home support/Choice in Supports for Independent Living, and direct care service types, clients aged 65+. In the health authorities' 2005/06-2007/08 Performance Agreement, the Ministry of Health included two new performance measures for EOL care, focused on the percentage of natural deaths occurring in settings outside hospitals within each health authority: <ul style="list-style-type: none"> • Percentage of deaths from cancer increased from 45.3% in 2005 to 49.7% in 2006. • Percentage of non-cancer deaths increased from 45.9% in 2005 to 47.3% in 2006. 	Regional health authorities (RHA) are asked to report on the delivery, development, and enhancement of services as part of accountability requirements for SK Health.	Performance indicators are established for each of the goals/objectives of the Manitoba home care program.	Develop program performance measures and monitor and evaluate mechanisms for application across the province.

TABLE 3 (CONTINUED)
Visions and targets for home care

	NEW BRUNSWICK	PRINCE EDWARD ISLAND	NOVA SCOTIA	NEWFOUNDLAND AND LABRADOR	YUKON
VISION	To integrate all services and bring them closer to people in their homes, including enhancing the Extra-Mural Program. Telehealth and e-health to figure prominently in this goal. NB is also currently developing a new provincial health plan.	To continue providing a wide range of services in home care, with focus on greater attention to exploring service delivery models. Additional resources would be required to make the vision fully operational.	To provide safe, quality care in the home, allowing people to stay in their own home for as long as is beneficial to their health.	To achieve a consistent approach to home care delivery throughout the province, supporting individuals and families and empowering them to achieve their optimal functioning, health, and well-being in the setting of their choice.	To support people's diverse needs for quality of life and living independently. YK Home Care supplements other community supports and is linked to a continuity of health care services.
TARGETS	<p>Family and Community Services is currently developing a 10-year strategy for long-term care services. Strong commitment with NB's Extra-Mural Program to remain innovative in meeting the needs for home health care now and in the future.</p> <p>Continue to improve the remote monitoring program to integrate with the clinical information system.</p>	Following a restructuring of the Department of Health, a strategic plan has been developed but has not yet been approved.	<p>Enhance palliative care services.</p> <p>Increase budget allotment for home adaptation and repair programs.</p> <p>Where possible, shift mental health services to be home-based rather than hospital-based.</p>	Identify core services of home care and minimize discrepancies between service delivery areas.	<p>Enhance data collection at the point of care.</p> <p>Develop and implement electronic health records (EHR) to support delivery of home care service.</p> <p>Apply interRAI tools to assist with focused individual care planning processes.</p> <p>Enhance supports for delivery of services in rural and remote locations.</p>
MEASURES	Home care programs are increasingly accumulating the required data to satisfy demands for evidence-based decision-making.	Work is in progress.	First phase of palliative care entitlements has been completed; services can be accessed from anywhere in the province at first-dollar coverage during the last 3 months of life.	<p>Quarterly reports began on April 1, 2007. Reports to contain indicators of service delivery.</p> <p>Continued enhanced usage of the client referral management system (CRMS).</p> <p>Continue working with Canadian Institute for Health Information (CIHI) and interRAI projects to develop the minimum data set.</p>	<p>YK is currently the only jurisdiction that feeds live data to CIHI's Home Care Reporting System.</p> <p>EHR is in place, and is audited semi-annually.</p> <p>interRAI data is reported quarterly to CIHI.</p> <p>Needs assessment conducted in 3 YK communities annually.</p>

TABLE 3 (CONTINUED)

Visions and targets for home care

	NORTHWEST TERRITORIES	NUNAVUT	CANADIAN FORCES	HEALTH CANADA
VISION	To meet individual needs in the least intrusive manner, promoting the greatest opportunity for lasting wellness and functional independence.	To maintain and increase capacity to support people in their own communities and homes for as long as possible, resulting in less dependence on facility-based acute care.	To assist clients to remain healthy and independent and in their own homes and communities, through Veterans Affairs Canada's (VAC) national home care program. The program includes services such as housekeeping, groundskeeping, and personal care. A programs-of-choice component provides benefits such as special equipment and therapeutic services, to ensure that equipment and services continue to be appropriate for clients' needs.	To provide basic home and community care services that are comprehensive, culturally sensitive, accessible, effective, and equitable and that respond to the unique health and social needs of First Nations and Inuit peoples, through the First Nations and Inuit Home and Community Care Program. The program is a coordinated system of home- and community care-based health-related services that enable people with disabilities, chronic or acute illnesses, and the elderly to receive the care they need in their home communities.
TARGETS	Every resident of NWT to have access to increased quantity and quality of services provided by highly skilled and certified employees.	No further specific targets since meeting Accord commitments. Enhance additional therapies (e.g. occupational therapy, physiotherapy, language therapy) to strengthen the home care program.	Continue regular reviews of its comprehensive home care program, Veterans Independence Program (VIP), and add new benefits or modify existing programs as necessary. Any new therapies or other interventions proposed for inclusion must be supported by independent medical research.	Not provided
MEASURES	In order to better measure progress on home care, NWT is looking at enhancing its data-gathering system through such methods as collecting data similar to the interRAI project. Such things as adverse-event reporting and the system of indicator development exhibited by the interRAI project are being considered for adoption into YK's continuing care strategy.	Diagnostic data are focused primarily on acute and chronic disease management. Hours of service by type of patient are monitored. Overall service utilization is monitored and analyzed regionally, locally, and across the territory.	The VAC home care program is regularly evaluated. The last 5 years have seen a renewed emphasis on quality assurance and improvement. As a fundamental component of the case-management process, clients receiving services under the national VIP are closely monitored and regularly reassessed to ensure that health, functional status, and overall well-being remain at an optimum.	Communities are required to submit monthly program delivery statistics. The data, including non-identifying patient demographic information as well as the type and hours of service provided, are collected electronically. First Nations communities are encouraged to follow the direction of their P/T counterparts with regard to developing IT strategies. As communities move towards an electronic medical record they will be encouraged to implement home care assessment tools, as per their P/T counterparts.

TABLE 4
Expanding access to home care services: Selected activities

	BRITISH COLUMBIA	SASKATCHEWAN	MANITOBA
OBJECTIVES	<p>To optimize the health of persons with functional impairment due to aging, illness, or disability by expanding and redesigning the home and community care system to improve access to, and choice within, an enhanced range of community support options.</p>	<p>Home care is a key component of primary health care (PHC) renewal. As an example, home care professionals are part of PHC teams. The goal is for 100% of SK residents to have access to these teams by 2011.</p> <p>Mental health home care and crisis response have been implemented and require monitoring and review.</p>	<p>To ensure assessment of client care needs and eligibility for home care services.</p> <p>To ensure support of clients and their family caregivers so they may remain independent and in the community as long as possible.</p> <p>To ensure provision of services in the home (or an alternative community setting) instead of a care facility, where appropriate.</p> <p>To ensure collaboration with care facilities in effective discharge planning.</p> <p>To ensure coordination of placement in a care facility.</p> <p>To ensure collaboration with communities to develop services to meet changing client needs.</p> <p>To evaluate the impact of the Manitoba Home Care Program on target populations and on other health care delivery systems.</p>
SELECTED ACTIVITIES	<p>The Vancouver Island Health Authority (VIHA) has initiated a pharmacy medication assessment and administration project at 3 pilot sites, and intends to expand the project across the health authority by spring of 2008. The primary goal is to improve VIHA home and community care clients' safety and health outcomes related to medication use. A standardized, evidence-based approach (including tools, processes, and guidelines) to medication assessment and administration is to be developed throughout VIHA. The process involves collaboration with community pharmacists who participate in identification of risks and care planning.</p> <p>A late-life depression pilot project has been developed by the home health and mental health programs in Abbotsford and Mission, acting as partners, to evaluate the effectiveness of providing primary care treatment to community-dwelling older adults experiencing depression.</p> <p>The ministry is reviewing the need for possible legislative, regulatory, and policy changes to support end-of-life (EOL) care in areas such as hospice care and advance care planning. In addition, the ministry is supporting research, identifying opportunities to enhance education for professionals, caregivers, and the general public, and working with the BC Medical Association, through the General Practitioners Services Committee, on remuneration issues related to palliative care.</p> <p>In February 2007, the ministry issued a revised Joint Protocol for Expected/Planned Home Deaths. The protocol outlines procedures for managing anticipated natural home deaths resulting from terminal illness and the roles of the family, various health professionals, and the agencies involved. First developed in 1996, the protocol has been well received and successful in directing families, first responders, and health care providers in planning for home deaths and in responding appropriately at the time of death.</p> <p>The BC NurseLine has provided enhanced training to all its nurses on responding to EOL care issues. Under a project initiated with the Fraser Health Authority (FHA) in 2004, BC NurseLine also now makes direct referrals after hours (9:00 p.m. to 8:00 a.m.) to FHA's on-call palliative providers. Based on an evaluation of its success, other health authorities are now looking to implement a similar service. In June 2006, this innovative palliative tele-nursing service won the Tommy Douglas 2006 Protection of Medicare award.</p>	<p>In 2006/07, SK Health invested and annualized \$2.9 million provincially for the enhancement of acute home care services.</p> <p>This initiative includes:</p> <ul style="list-style-type: none"> • increased capacity for short-term acute and end-of-life care; • elimination of personal care fees for short-term acute care for up to 14 days; • increased case management, home support services, and crisis response for clients with mental illness. <p>Through community-based service, the initiative also facilitates early hospital discharge, avoids or prevents re-admission, and avoids or prevents imminent admission.</p> <p>SK Health worked with regional health authorities (RHA) to facilitate developing, implementing and delivering acute community mental health home care. This would include case management, professional and home support, without fees, for up to 14 days.</p> <p>In addition, the province contracted SK HealthLine to develop, implement, and deliver a provincial mental health and addictions crisis response service. The service was introduced in December 2006.</p>	<p>MB Health's method of program data collation was revised using current technology and human resources.</p> <p>A long-term care strategy, Aging in Place, addresses the need for affordable housing options. The strategy includes building on supports which could reduce inappropriate use of acute care.</p> <p>Provincial networks and other ongoing mechanisms facilitate sharing and collaboration across the province.</p> <p>RHAs are reviewing HR trends and needs.</p>
CHALLENGES	<p>Too often hospital care is being used as a substitute for home care rather than the other way around.</p> <p>Ensuring provision of a wide range of services across the province, including in rural and remote areas, remains a challenge.</p> <p>Other challenges include:</p> <ul style="list-style-type: none"> • aging workforce; • introduction of new technology; • lack of comprehensive, integrated information systems in the community sector; • integration with other health sectors. 	<p>Recruiting/retaining health professional staff and workers in both urban and rural/remote areas presents challenges in the delivery of home care.</p> <p>Working Together: Saskatchewan's Health Workforce Action Plan sets a direction for more integrated workforce and includes initiatives and innovations to improve health workplaces and to address issues affecting key health professionals.</p>	<p>Sustaining human resources including staff recruitment, training, and retention.</p> <p>Increasing complexity of clients' care needs.</p> <p>Expanding use of in-home medical technology and resulting HR and training requirements.</p> <p>Access of all RHAs to electronic assessment tools to further facilitate quality decision-making.</p> <p>Improving community attitudes towards care providers and towards living in alternative community environments.</p>

TABLE 4 (CONTINUED)

Expanding access to home care services: Selected activities

	ONTARIO	NEW BRUNSWICK	PRINCE EDWARD ISLAND	NOVA SCOTIA
OBJECTIVES	<p>To support individuals to remain and age in their home and community, and to relieve pressures on hospitals, the Health Program, Policy, and Standards Branch (HPPSB) continues to demonstrate and pursue the benefits of community care over higher-cost institutional care.</p> <p>By the end of 2007/08, Community Care Access Centres (CCAC) are expected to achieve their client targets. From 2003/04 through the end of 2007/08, enhancements to home care funding delivered through CCACs will have provided an additional 95,700 Ontarians with short-term acute care in their homes, and EOL care to another 6,000 clients.</p>	<p>Any door should be the right door when it comes to patients' enquiries about their health, and patients should be able to access the same information throughout the health system.</p>	<p>To plan for a province-wide delivery of home care services, so that consistency of available services is ensured and provided.</p>	<p>To achieve greater development of regional management.</p> <p>As the Department of Health does not provide services directly, it must provide for an array of services that are consistent across the province and that meet policy requirements. It must evaluate practices and ensure that standards and procedures are being followed by contracted agencies.</p>
SELECTED ACTIVITIES	<p>Funding is being targeted at two key strategies, acute hospital replacement and EOL care, thus supporting the government's commitment to strengthening the home care sector.</p> <p>End-of-Life Care Strategy For people in the last stages of their lives, this strategy shifts care from hospitals to home or another appropriate setting of the client's choice. The strategy also aims to enhance an interdisciplinary team approach to care in the community, and is working towards better coordination and integration of local services.</p> <p>Funding to support nursing and personal support services in residential hospices in more than 30 communities by 2007/08 is also included. Residential hospices offer care, compassion, and dignity to those who are in their last stages of life, while providing needed support to their families.</p> <p>Aging at Home Strategy The strategy is intended to help seniors stay healthy and to live more independently in their own homes, by providing seniors and their caregivers with an integrated continuum of community-based services. The strategy was announced on August 28, 2007 by the Ministry of Health and Long-Term Care, with \$702 million in new funding over the next 3 years. Funding is to be directed at traditional services including:</p> <ul style="list-style-type: none"> • community support services; • home care; • assistive devices; • supportive housing services; • long-term care beds; • EOL care. <p>As well, the strategy works to link the above services and providers with new and innovative approaches to service and non-traditional providers.</p> <p>In addition, the government announced funding of \$13.7 million on February 16, 2007, intended to alleviate pressures in hospitals by building the capacity of community-based health care providers. A portion of this is for CCACs.</p> <p>Announced on October 27, 2006, a 3-point action plan to relieve pressure on emergency departments (total investment of \$142 million) included:</p> <ul style="list-style-type: none"> • \$30 million – one-time funding in 2006/07 for CCACs to better serve the needs of their clients, and provide services that appropriately meet their needs and allow people to remain safely, comfortably, and independently in their homes for longer. • \$5.3 million – for community services as part of a multi-year strategy to address pressures in 10 communities; some of this funding was to be allocated to CCACs. 	<p>The Extra-Mural Program (EMP) has recently been enhanced by the recent NB Self-Sufficiency Task Force, with a particular focus on bringing services closer to people in their own homes.</p> <p>Self-management and appropriate levels of self-reliance are being promoted in all aspects of home care, including mental health.</p>	<p>The palliative care program is the best example of integrated practice that the provincial home care program has been able to implement and sustain.</p>	<p>The Continuing Care Branch has been working with the Department of Community Services on housing and home adaptation programs, and district network committees have been working with the District Health Authorities, with the goal of wrapping services around the clients so that they are not intrusive, and to manage clients in supportive environments.</p>
CHALLENGES	<p>To provide increasing support for an aging population.</p> <p>To relieve pressures in hospitals and long-term care homes.</p> <p>To provide the right services, in the right place, and at the right time to ensure seniors are cared for with the best support possible.</p>	<p>NB's home care plan reflects the reality that the health care system does not have the capacity to provide home nursing care 24 hours a day, 7 days a week. Acknowledging the idea that empowering patients' health self-management is not new, the plan has a strong focus on client service with clients actively involved in their own care decisions. This move away from health professionals dictating health goals to patients taking a more active role in their own care represents a continuing, fundamental change in focus.</p>	<p>Allocation of scarce financial resources.</p> <p>Multiple agendas within the health care system.</p>	<p>Human resources may be a factor in rural and remote areas. Recruitment and retention are both significant issues. The Department of Health works with contracted agencies to develop HR strategies throughout the sector.</p>

TABLE 4 (CONTINUED)
Expanding access to home care services: Selected activities

	NEWFOUNDLAND AND LABRADOR	YUKON	NORTHWEST TERRITORIES	NUNAVUT	CANADIAN FORCES	HEALTH CANADA
OBJECTIVES	<p>To achieve consistency in assessment and delivery of home care, regardless of the RHA delivering services.</p> <p>To develop new mandates for core services (e.g. nursing care or long-term care components) to better integrate the components.</p> <p>The provincial home care division has identified home care as an integral component of primary health care.</p>	<p>To support clients' diverse needs towards quality of life and living independently.</p> <p>Home care is intended to supplement other community supports and is linked to a continuity of health care services.</p>	<p>A needs assessment of current clients accessing home and community care will be completed by March 2008. From there a plan will be developed, to include short-term and long-term goals for home and community care that will integrate with the Continuing Care Strategy and Action Plan currently in development.</p> <p>NWT is committed to expanding access to social respite care under the umbrella of continuing care through the home and community care stream. A successful pilot respite program in Yellowknife will be expanded in the future to other communities.</p>	<p>Specific new initiatives include training programs such as one for training home and continuing-care workers. Efforts are being made to design a curriculum that would work for staff in both a facility environment and in the community. The focus is on capacity building.</p>	<p>To provide a wide range of services and programs based on eligibility and need to eligible veterans. Clients are regularly screened, assessed, and monitored in order to identify care and service requirements.</p>	<p>To foster better integration at the community level, with community PHC services as well as with the assisted living program funded by Indian and Northern Affairs Canada, home and community care funding has been moved into a cluster with PHC. This approach will support clients' better access to a more comprehensive continuum of care.</p>
SELECTED ACTIVITIES	<p>All funding allocated under the Accord for home care nursing went into client services. The funding was directed to the regions based on their own needs assessments.</p> <p>Prior to the new funding, only those clients living in St. John's had access to home intravenous therapy. Now, that service is available across the province, delivered by community health nurses.</p> <p>A 4-week EOL home care program means that, should clients choose to die in their own homes, their families would not bear the financial burden for the clients' pain medication or home support. This is viewed as a significant support to the families.</p>	<p>Current developments in home care include implementing electronic health records (EHR) and applying interRAI tools to assist with focused, individual care planning processes.</p> <p>YK is currently the only jurisdiction that feeds live data to the Canadian Institute for Health Information's home care reporting system.</p>	<p>The action plan also includes objectives for enhancing continuing care, including:</p> <ul style="list-style-type: none"> • services for adults and the elderly, through enhancing home and community care positions; • completing renovations of several long-term care facilities; • support planning for a dementia facility in 2007/08. <p>To enhance supported living options for adults with disabilities or mental illnesses, a plan is to be completed in 2008.</p>	<p>NU has been successful in implementing a home care program, and in creating and training a home care group workforce.</p> <p>Work continues to progress towards integrating home care with other dimensions of primary health care.</p> <p>Case management and the enhancement of additional therapies – such as occupational therapy, physiotherapy, and language therapy – have been targeted for future development.</p>	<p>The Veterans Independence Program (VIP), a comprehensive national home care program, has been offered to eligible veterans for over 20 years.</p> <p>VIP services may include grounds maintenance, house-keeping, and personal care services such as assistance with bathing, dressing, and eating. These services make a tremendous impact on an individual's ability to remain at home.</p>	<p>Not provided.</p>
CHALLENGES	<p>Recruitment and retention of health professionals, including nurses, occupational therapists and other professionals, is a challenge.</p>	<p>YK is experiencing an ongoing and growing need for long-term supports for younger people with medically complex and chronic conditions.</p> <p>Communications and transportation challenges are a significant part of the potentially high cost associated with extending access to home care to all Yukoners.</p>	<p>Not provided.</p>	<p>Recruiting and retaining home care nurses is a challenge, as is retaining home support workers and recruiting individuals with formal training. Frequently, not enough candidates have formal training, so on-the-job training is provided as an interim step before individuals get formal training.</p>	<p>The capacity of clients to access services may vary with marketplace conditions in the provinces or health regions. Provincial programming may vary in terms of what is offered and the time frames relating to accessing services. VAC works in close collaboration with other jurisdictions so that veterans may receive required services in a timely manner.</p>	<p>Wage disparities, isolation, nursing shortages, and lack of professional support are often cited as deterrents for service providers. Lack of educational preparedness is a major barrier to recruitment.</p>

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Canada's First Ministers established the Health Council of Canada in the 2003 *Accord on Health Care Renewal* and enhanced our role in the 2004 *10-Year Plan to Strengthen Health Care*. We report on the progress of health care renewal, on the health status of Canadians, and on the health outcomes of our system. Our goal is to provide a system-wide perspective on health care reform for the Canadian public, with particular attention to accountability and transparency.

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An informed and healthy Canadian public, confident in the effectiveness, sustainability and capacity of the Canadian health care system to promote their health and meet their health care needs.

The Council's mission

The Health Council of Canada fosters accountability and transparency by assessing progress in improving the quality, effectiveness and sustainability of the health care system. Through insightful monitoring, public reporting and facilitating informed discussion, the Council shines a light on what helps or hinders health care renewal and the well-being of Canadians.

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