

Effecting Change in Equity and Access – the Canadian Experience

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“Cheshire-puss, would you tell me please
which way I ought to go from here?”

“That depends a good deal on where you
want to get to.”

- Lewis Carroll, Alice in Wonderland

Key facts

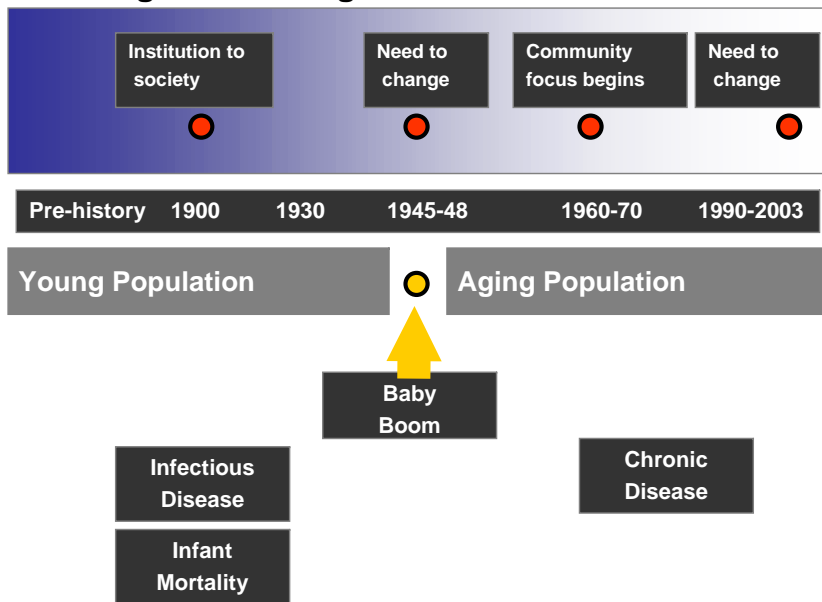
	Canada	Ireland
Size (sq. km)	9,976,140	70,280
Population (millions)	32.2	3.9
Population per sq. km	3.2	55.8
GDP/capita (€ PPP)	25,389	26,339
Services (% of GDP)	71.2	49
Industry (% of GDP)	26.5	46
Agriculture (% of GDP)	2.3	5

Health facts

	Canada	Ireland
Births/1,000	10.99	14.63
Deaths/1,000	7.61	7.94
Life expectancy	79.83	74.5
Population 60+ (%)	16.9	15.3
Infant mortality/1,000	4.88	5.34
HIV/AIDS prevalence (%)	0.3	0.1
Health spending (% GDP)	9.1	6.7
Health level performance (WHO)	35	32
Health system performance (WHO)	30	19

Where have we come from?

Paradigms of Change



Pre-history of Canadian health

- First hospitals based on, and similar to, European institutions – founded by religious orders or charities
- Hôtel Dieu established by 3 nuns in Québec City in 1639
- Toronto General created in 1797 in 'Upper Canada' as a clearing house for immigrants
- Choice between private hospitals and 'bedlam'



First paradigm shift

- From externally imposed 'institution' to organically developed 'society' with intrinsic values
- Community-based
 - Myrnam, Saskatchewan builds its own hospital funded by public donations. "There is no need to go hungry for medical attention or hospitalization, whether you are rich or poor. This has been achieved because of the people, who have at heart the welfare, not only of their own, but that of their fellow citizens as well."
- Often with a specific mandate (e.g. Jewish community, women's health)

Mount Sinai Hospital

- Founded 1922 in a small house by a charitable Jewish women's group
- Served Jewish residents of the city
- Provided practice opportunities for Jewish doctors who were discriminated against
- All 40 of Toronto's Jewish doctors were in practice here



Women's College Hospital

- 7 bed facility founded by Canada's first woman doctor, Emily Stowe, in 1898 to "provide for women, medical and surgical care by physicians of their own sex"



Drivers for this shift

- Initial focus
 - Infectious disease and epidemic prevention (among poor and immigrants)
 - Infant mortality
- Funding instability (Toronto General closed for a year in 1867 due to lack of funds)
- Care gaps for specific populations



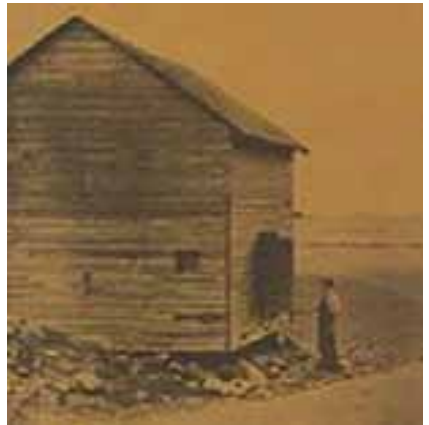
Second paradigm shift

- 'Social conscience,' Saskatchewan-style
- Socialist government of Tommy Douglas
- Vision of universal health care
- Extends community focus of first paradigm shift to encompass all citizens
 - 1947 Saskatchewan hospital coverage
 - 1958 national hospital coverage
 - 1962 Saskatchewan medical coverage
 - 1968 national medical coverage



Drivers for this shift

- Rural and small town Depression experiences “losing the farm”
- Inequitable access
 - Private, doctor-sponsored plans (purchased by individuals or through employers) varied in coverage
 - Charity cases for uninsured



Legacies of change

- National culture of entitlement to universal and accessible health care
- Systemic manifestations of this culture in program and policy development
- Hospital and diagnostics focused system
 - The expensive parts – machinery and buildings
- Fee-for-service (private delivery of publicly funded care)
- Independent mindset of physicians (cf. Saskatchewan doctors' strike)

Where are we now?

Snapshot of Ontario

- 21,000 physicians
 - Almost 50/50 GP/specialist split
- 83,000 nurses active, 113,000 registered
- 540 nurse practitioners
- Range of other providers
- 150+ hospitals
- 1,000 'independent health facilities'
- Several primary care delivery models

Challenges

- 12 million people spread over a million sq. km
 - 80% within 300 km of US border
- 203,000 aboriginal people
- North-south divide
- Urban-rural divide



Canada Health Act

- Introduced in 1984
- Builds on earlier principles and legislation
- 5 governing principles
 - **Public administration** – not for profit basis by public authority
 - **Comprehensiveness** – all medically necessary hospital and physician services covered
 - **Universality** – all insured persons covered
 - **Portability** – applicable throughout Canada
 - **Accessibility** – ‘reasonable’ access unimpeded by financial or other barriers

What do access and equity mean?

- Access - both a principle of health care and a process or outcome. Access includes:
 - the availability of a continuum of health services close to where people lives and work
 - the ability to move easily from one service to another
 - the ability to understand and navigate the system
 - having choice
 - universal availability of services that defines a public system
- Equity - ethical dimension of access
 - public system is defined by fair and universal availability



Determinants of health

- Gender
- Aboriginal status
 - On reservation and dislocated urban
 - At risk for: diabetes, alcoholism, drug abuse, suicide, mental illness
- Geography
 - MD:population ratios vary - 1:705 for North, 1:375 for Toronto
 - Access to diagnostics and specialists impaired
 - Remote populations more likely to suffer complications from chronic diseases and have increased hospitalization rates
- Poverty
 - urban and rural
 - “can’t pay, won’t pay” barrier to access (drugs, dental)
 - Poor more likely to suffer complications from diseases like diabetes



Why change?

- Significant care gaps still exist
 - Exacerbated by aging population
- Determinants of health must be faced head on
- Health human resources challenges
- Growing financial pressures
 - 43% of provincial budget spent on health
 - New drugs and technologies
- Hospital focused system not the answer

Where are we going?

Think globally, act locally

Third paradigm shift?

- Balances system view with local needs
- Continues organic development of health structures and services through
 - Community and population health approaches
 - Integrated services approach



Changing relationships

- Think systemically, not linearly
- Specialist, GP, other provider interaction
- Components are inter-connected and patients may enter at any point and navigate system in different ways
 - Acute care
 - Primary care models
 - Public health
 - Mental Health
 - Long term care

Responses

- Equitable access to all programs
 - Chronic disease management
 - Drugs
 - Nutrition
 - Disease prevention
 - Public health
 - Long term and palliative care



Emphasizing primary care

- More responsive than hospital-based care
 - Hospitals expensive to build and operate; capital more effectively used elsewhere
- Opportunities to integrate other providers and create interdisciplinary teams
- Acknowledges role of GPs in chronic care
 - Endocrinologist to population - 0.01:1,000
 - 75% of diabetics managed by their GP
- Can be community based and focused
 - Addresses specific health challenges

What will be different?

Benefits

- Cohesion throughout system
- Sensitivity to local needs
- Connectivity of all parts
- Access to appropriate care in the appropriate setting by the appropriate provider

Lessons learned

- Equity and access come from -
 - Greater community integration (largely through the community's interaction with primary care models and government understanding of community needs – listen!)
 - Organic, tailored, rather than imposed solutions
 - Needed shift from acute care focus to primary care focus
 - Solutions that take into account health human resources issues
 - Technology can be used to overcome barriers (eCHN)
- Public/private systems inhibit equity
 - Deep attachment to the idea of a single tier system began early in Canada and is a strong current (viz. Romanow Commission)
 - Private hospitals are part of the 'pre-history' of Canadian, socialized medicine

Looking ahead

- October 2nd – change in government in Ontario (the Liberal party)
- Commitment to primary care – vision of ‘family health teams’ that are interdisciplinary
- Recognizes access as key health issue
- Ideologically opposed to privatization of health delivery – campaigned against ‘two tier medicine’

