NORTHERN POLICY INSTITUTE | INSTITUT DES POLITIQUES DU NORD

Briefing Note | March 2015

Setting Priorities for Northern Ontario's Health Policy Agenda

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northernpolicy.ca

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Published by Northern Policy Institute
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This report was made possible through the support of our partners Lakehead University, Laurentian University and Northern Ontario Heritage Fund Corporation. Northern Policy Institute expresses great appreciation for their generous support but emphasizes the following:

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Contents

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  - » Economic, technological and social trends which affect Northern Ontario;
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About the Authors

The three co-authors of this briefing note are doctoral candidates at the School of Rural and Northern Health at Laurentian University. This briefing note was prepared as part of their course work under the supervision of Northern Policy Institute Fellow in Rural and Northern Health, Dr. Elizabeth Wenghofer. Northern Policy Institute is pleased to provide an opportunity for our new generation of thinkers to express their views to a public audience.

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Purpose

The purpose of the briefing note is to identify the top priorities for Northern Ontario's health policy agenda over the next three to five years.

Background

Improving the health of Canadians has become a national and provincial priority in recent years (Drummond, Girioux, Pigott, & Stephenson, 2012; Romanow, 2002), leading to legislative change (Ministry of Health and Long-Term Care [MOHLTC], 2012a) and policy realignment (MOHLTC, 2012b). As a result, the province of Ontario has adopted a "Right Care, Right Time, Right Place" approach (Ministry of Finance, 2012; MOHLTC, 2012b), which is committed to patient centered, community-based coordinated care.

Although there is evidence to suggest that Ontario's health care system is ranked better than other provinces (Drummond et al., 2012; Hutchison, Lévesque, Strumpf, & Coyle, 2011), the indicators used to make such comparisons are typically based on southern and heavily urbanized areas of Ontario. Northern Ontario, being a periphery region, has a vastly different economic, social and environmental landscape, and is not necessarily represented by provincially- or southern-based indicators. Northern Ontario is home to a large portion of First Nations, Francophone, and rural populations, all of which present regionally unique challenges for addressing proper access to health care than the rest of the province (DesMeules et al., 2006; Wenghofer, Timony, & Pong, 2011).

Mental health: 'Ready to respond, but not to prevent'

Unmet mental health needs have been documented in rural and remote regions internationally (Welch & Welch, 2007), as well as in rural and Northern Ontario (Cheng, deRuiter, Howlett, Hanson, & Dewa, 2013; Kirby & Keon, 2006). Mental health policy-making has a long history of attempting to shift care from hospital and physician-based settings to a coordinated care system with an emphasis on community-based care (Hartford, Schrecker, Wiktorowicz, Hoch, & Sharp, 2003; Mulvale, Abelson, & Goering, 2007). Northern Ontario residents suffering from mental health conditions have limited options for treatment, and they are often required to travel to urban centers in southern regions of the province (Canadian Mental Health Association [CMHA], 2007).

Furthermore, it has been suggested that the current health care system focuses excessively on physicians and hospital based care and obstructs the coordination of care between other health care professionals, including mental health providers, as well as across other jurisdictions (Hutchison, Abelson, & Lavis, 2001). The result is a fragmented system in which care is delivered in uncoordinated "silos." Consequently, many complex cases – for example, those with comorbidities or psychosocial problems (Oyewumi, Odejide, & Kazarian, 1992; Vingilis, Wade, & Seeley, 2007) – do not fit squarely into one silo end up falling through the cracks, remain untreated, and eventually become more costly to the health care system (Drummond et al., 2012).

Care for the elderly: 'Aging in the community'

The aging population is one of the major drivers of the increasing cost of Ontario's health care system (Drummond et al., 2012). Costs related to the aging population will continue to rise as the relative number of elderly increases (Drummond et al., 2012; Healthy Aging and Wellness Working Group [HAWWG], 2006). The majority of older adults have complex health issues and require more resources (Canadian Institute for Health Information [CIHI], 2009; Sinha, 2012).

Additionally, Ontario has the highest alternate level of care (ALC) rates in Canada (CIHI, 2009; Sinha, 2012). In the absence of alternative care settings – that is, rehabilitation, behavioural, or palliative care services – hospitals often become inundated with ALC patients. This is common problem in small rural hospitals (Walker, 2011). Furthermore, challenges in caring for the aging population (Kuluski, Berta, Williams, & Laporte, 2012; Skinner, Hanlon, & Hasleth, 2011) will be compounded by an aging healthcare workforce (Carstairs, Keon, 2009; Ontario Association of Community Care Access Centres [OACCAC], 2013a).

Primary health care (PHC) models: Changing delivery to improve access

Universal health care has become a "sacred trust," (Canada, House of Commons Debates, 1983; Minister of Justice, 2012) one that can be maintained by PHC providers delivering first contact services such as, family physicians, nurse practitioners, pharmacists, and telephone advice lines (Health Canada, 2012). However, the current healthcare system is financially unsustainable, due to its fragmented nature, a focus on treatment over prevention, an aging population with growing health care needs, and other challenges (Drummond, 2012; Canadian Institute of Actuaries, 2013). Exacerbating these issues is a shortage (Pong, 2008; Cheng et el., 2013) and overall maldistribution of primary health care providers (Koren, Mian, & Rukholm, 2010; Wenghofer et al., 2011). Given the dispersed nature of the northern population and the disparity of providers, it is clear that PHC strategies, which work in the southern parts of the province, will not necessarily be viable in the north.

Analysis

Mental health

Mental health services, which are not publicly funded, can be quite expensive to rural Northerners who must travel to receive them (Oyewumi et al., 1992). As such, many who are financially constrained remain severely underserviced (Durbin, Bondy, & Durbin, 2012; MOHLTC, 2012c). Individuals with unmet mental health needs are also no longer easily identifiable (Jansson, Sonnander, & Wiesel, 2003; Nelson & Park, 2006), especially in smaller regions where access to services is limited. There is a need for local accessibility to services and supports, integration, early intervention, and a community-based rural approach to service delivery (MOHLTC, 2012c).[1]

Training non-medical personnel to identify and refer individuals experiencing mental health issues may improve service utilization. Such services could be provided by teachers, youth group leaders, and mental health professionals (e.g., licensed counselors, therapists, clinical social workers), who are typically the first point of contact in rural and remote areas (Cheng, et al., 2013; Minore, Boone, Katt, Kinch, & Birch, 2004). Supporters, such as the public, Ontario Health Insurance Plan (MOHLTC, 2013), and community-based organizations (Centre for Addiction and Mental Health [CAMH], 2012; CMHA, 2014) agree that an increase in access to community-based mental health services will provide better care for people in Northern Ontario, and that there is a unique opportunity to use resources that are readily available (e.g., between visit telephone or e-mail support, multidisciplinary outreach programs).

There may be, however, some divided professional interest over a change in the way mental health services are delivered. For example, psychiatric nurses, treatment service providers, psychiatrists, and psychologists may perceive this change as a boundary issue and diminished professional autonomy. In addition, while there remains a clear need for community-based mental health care, small community size contributes to a lack of anonymity and concerns regarding stigma associated with mental illness (Boydell et al., 2006; Roberts, Battaglia, & Epstein, 1999).

Care for the elderly

Current policy (MOHLTC, 2012b)[2] suggests that a shift towards home and community-based care for the aging population is warranted, a position supported by the elderly (OACCAC, 2013a) and their providers (Registered Nurses Association of Ontario, 2011). Many ALC patients within a hospital share the same urgency and complexity of needs as those individuals receiving care at home (The Change Foundation, 2011), yet cost the system considerably more (OACCAC, 2013a; OACCAC, 2013b). Options need to be available for patients to receive high quality care, in a timely manner, and within the comforts of home (MOHLTC, 2012b; Walker, 2011; OACCAC, 2013b).

Enhanced coordination of services could also facilitate the comprehensive care required for complex patients (Carstairs & Keon, 2009) within the community to support their independence and enhance their quality of life (HAWWG, 2006; Walker, 2011). Additional support needs to be maintained or potentially increased to facilitate home or community-based care (Ontario Home Care Association, 2014).[3] However, privately owned long-term care facilities may oppose a reallocation of funds to support home based care (Walker, 2011).

Primary care models

Canadian and international researchers have demonstrated that a 'one size fits all' model of PHC does not exist (Humphreys et al., 2008; Hutchison et al., 2011; Lamarche et al., 2003). Various innovative PHC models have been suggested in the literature and implemented to varying degrees.[4] However, given the diversity and dispersion of the Northern population (Ontario Tourism Marketing Partnership, 2013), recommending one model over another would be unsound.

PHC models should be tailored to respond to the health needs, resource limitations (e.g., funding and availability of health professionals), and degrees of rurality of each community (Humphreys & Wakerman, 2008). Such models may range from team-based practices in more densely populated areas, to hub-and-spoke, and telemedicine models in more remote communities (Humphreys et al., 2008) all of which would benefit from collaborative, multidisciplinary teams (Drummond, 2012).

In order to be successful, selecting and implementing a PHC model requires public intervention though collaborative consultations with local health authorities

1 See also: Boydell et al. (2006), McEwan & Goldner (2001), and North East Local Health Integration Network (LHIN) (2013), North West LHIN (2013).

2 See also: HAWWG (2006), MOHLTC (2012d), Ministry of Finance (2012), North East LHIN (2013), OACCAC (2013a), Ontario Seniors' Secretariat (2013), Sinha (2012) and Walker (2011).

3 See also: Ministry of Finance (2012), OACCAC (2013a), and Walker (2011).

4 See, for example, Drummond (2012), Hutchison et al. (2001), Marriott and Mable (2000), Lamarche (2003), and Romanow (2002).

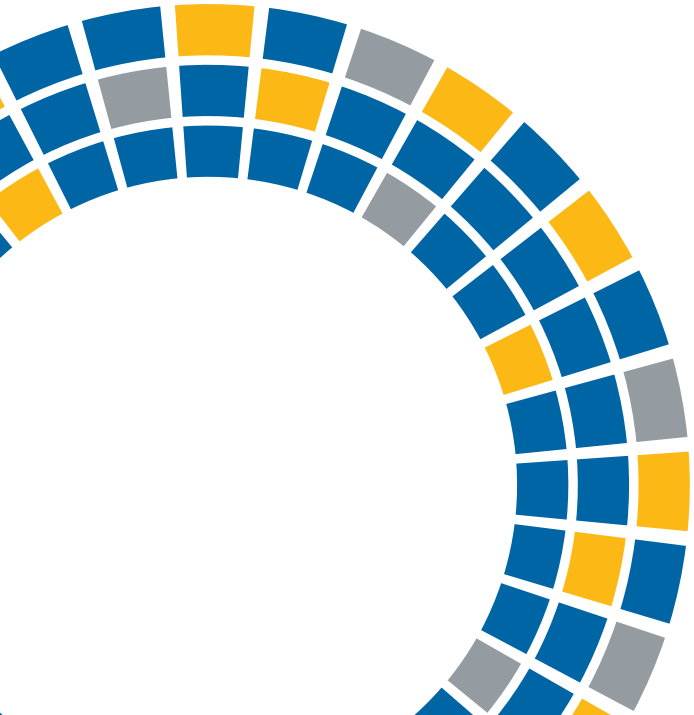
(the LHINs) and the community (MOHLTC, 2010). Such reform strategies are consistent with current provincial priorities[5] and are strongly supported by healthcare providers and patient groups (Health Policy Monitor, 2008).

Early signs of such changes have begun to emerge (Hutchison et al., 2011); however, training and orientation is needed to ensure a successful collaborative practice (Bailey, Jones, & Way, 2006) and to allow providers to expand their scope of practice, professional autonomy, and knowledge of northern issues (Strasser et al., 2013).[6]

Despite the current trend of healthcare reform, change has been incremental at best (Russell et al., 2007) and may be opposed from various sources. Until recently (Health Services Research Fund, 2013), funding for PHC research in Canada has been scarce (Russell et al., 2007), giving the government very little evidence on which to base funding decisions. Further opposition may arise from the Canadian Medical Association who advocate for physicians as the central provider and may be concerned with PHC models that place primary care in the hands of non-physicians, thus standing in contrast to such organizations as the Canadian Nurses Association who advocate for a broader definition of primary care (Canadian Medical Association, 2012; Health Policy Monitor, 2008).

5 See, for example, Health Policy Monitor (2008), Ministry of Finance (2012), MOHLTC (2010), and Ministry of Infrastructure and MNDM (2011).

6 See also: MOHLTC (2012b), MOHLTC (2010), Ministry of Infrastructure and MNDM (2011).



Reimagining the way health care professionals work collaboratively in the north is a wide-ranging goal. The approach includes strategic training (Strasser et al., 2013) and recruitment of providers to work in underserviced areas with increased integration and an expanded scope of practice.

Recommendations

The recommended policy option identified above addresses the shortage of primary care options through the expanded use PHC models. This prioritization strategy addresses the physicians' shortage (Pong, 2008) in Northern Ontario and represents a comprehensive solution to address the critical shortages identified in other areas (an aging population [Kuluski et al., 2012; Skinner et al., 2011] and increased mental health support [MOHLTC, 2012c; Boydell, 2006; North East LHIN, 2013]).

Reimagining the way health care professionals work collaboratively in the north is a wide-ranging goal. The approach includes strategic training (Strasser et al., 2013) and recruitment of providers to work in underserviced areas with increased integration and an expanded scope of practice. At the same time, the overall healthcare system will operate more efficiently through the use of foresight and planning in terms of the role of multidisciplinary teams. By encouraging collaboration between health care professionals, gaps in the system can be overcome.

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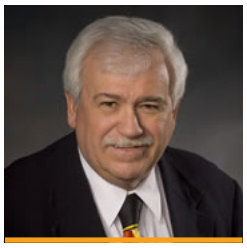
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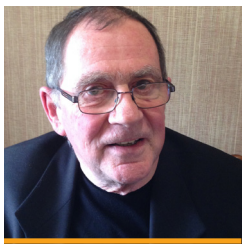
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