NORTHERN POLICY INSTITUTE | INSTITUT DES POLITIQUES DU NORD

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Access to Care for All Northern Ontarians as a Means to Optimizing Health

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About Northern Policy Institute

Northern Policy Institute is Northern Ontario's independent think tank. We perform research, collect and disseminate evidence, and identify policy opportunities to support the growth of sustainable Northern Communities. Our operations are located in Thunder Bay and Sudbury. We seek to enhance Northern Ontario's capacity to take the lead position on socio-economic policy that impacts Northern Ontario, Ontario, and Canada as a whole.

Vision

A growing, sustainable, and self-sufficient Northern Ontario. One with the ability to not only identify opportunities but to pursue them, either on its own or through intelligent partnerships. A Northern Ontario that contributes both to its own success and to the success of others.

Mission

Northern Policy Institute is an independent policy institute. We exist for the purposes of:

- The development and promotion of proactive, evidence based and purpose driven policy options that deepen understanding about the unique challenges of Northern Ontario and ensure the sustainable development and long-term economic prosperity of Northern Ontario;
- The research and analysis of:
  - » Existing and emerging policies relevant to Northern Ontario;
  - » Economic, technological and social trends which affect Northern Ontario;
- The formulation and advocacy of policies that benefit all Northern Ontario communities that include Aboriginal, Francophone, remote/rural communities, and urban centres; and,
- Other complementary purposes not inconsistent with these objectives.

Values

Objectivity: Northern Policy Institute is a non-partisan, not-for-profit incorporated body providing fair, balanced and objective assessments of policy issues in a pan-Northern Ontario context;

Relevance: Northern Policy Institute will support practical and applied research on current or emerging issues and implications relevant to Northern Ontario now and in the future in keeping with the themes and objectives of the Growth Plan for Northern Ontario, 2011;

Collaboration: Northern Policy Institute recognizes the value of multi-stakeholder, multi-disciplinary, and multicultural contributions to the collective advancement of Northern Ontario and works in a collaborative and inclusive approach to provide a full range of policy options for decision makers;

Coordination: Northern Policy Institute will complement the existing research efforts of Northern Ontario's post-secondary institutions and non government organizations and explore opportunities for coordinated efforts that contribute to the mandate of Northern Policy Institute; and

Accessibility: The work of Northern Policy Institute will be publicly accessible to stimulate public engagement and dialogue, promoting view points on the interests of Northern Ontario and its people.

About the Authors

The co-authors of this briefing note are doctoral candidates at the School of Rural and Northern Health at Laurentian University. Northern Policy Institute is pleased to provide an opportunity for our next generation of thinkers to express their views to a public audience.

Emily Donato

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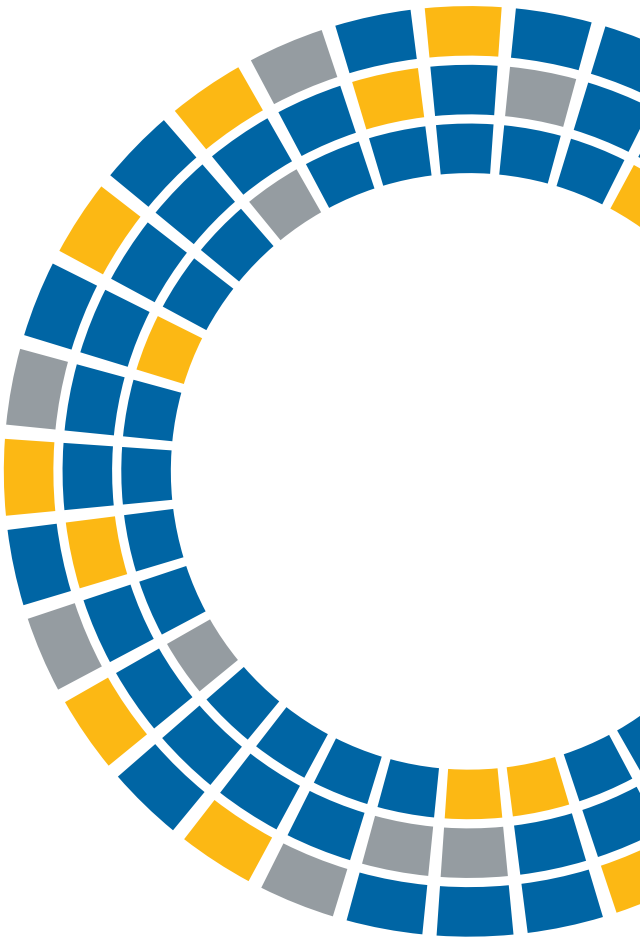
John M. MacDonald

John M Macdonald, M.P.H., M.A., is an epidemiological consultant and a doctoral student in the Rural and Northern Health program at Laurentian University. He has conducted various health projects for the North East Local Health Integration Network, Health Sciences North, and a number of primary care physicians in Northeastern Ontario. Areas of research interest include: improving delivery of care for seniors, as well as those afflicted with dementia residing in long-term care homes; prevention of infectious/communicable diseases; pediatric traumatic brain injuries; improving coordination and delivery of public health and public health emergency preparedness; with particular attention about challenges unique to rural and northern contexts.



Purpose

Healthcare spending is the single largest expenditure of the Ontario government, accounting for approximately 44 percent of the total provincial budget, or $44.77 billion in 2011. Despite the amount of resources spent, why do residents of Northern Ontario continue to experience disproportionate rates of ill-health compared to the provincial averages? The purpose of this briefing note is to identify the top three health priorities for Northern Ontario (LHIN's 13 & 14) over the next three to five years. This briefing note will outline the root causes contributing to the disproportionate health outcomes for three of Northern Ontario's most health-marginalized populations, as well as provide recommendations aimed at alleviating these disparities.

Background

Health Canada's 2013-2014 priorities report (Health Canada, 2013) and two Ontario Ministry of Health and Long Term Care (MOHLTC) documents (MOHLTC, 2010, 2012) reveal the current health priorities for Northern Ontario. From Health Canada's 2013-2014 priorities report, the area of greatest importance for Northern Ontario is the commitment to strengthening First Nations and Inuit health programming, including mental health and addiction services (Health Canada, 2013). The most important areas according to the MOHLTCs' *Action Plan for Health Care* were the commitment to establish links to family health care, faster access, house calls for frail elderly, local integration of family health care including quality improvement, and ensuring patients receive timely and appropriate care in the right place (MOHLTC, 2012). These initiatives were of particular importance for the improvement of two exponentially increasing health-sector populations in Northern Ontario, seniors (aged 65 and over) and those suffering from mental health and addiction disorders. The *Ontario's Action Plan for Health Care - Year Two Progress Report* released in 2014 indicated that steps had been taken toward increasing funding for mental health and addictions programs, moving toward local integration and increased quality in family health care, faster access to care, including house calls to seniors, funding for several seniors initiatives, expanded scope of practice for RNs and RPNs, moving procedures into the community and establishing processes to implement high quality care (MOHLTC, 2014). These provincial health priorities are echoed in the MOHLTC's *Rural and Northern Health Care Framework/Plan* (MOHLTC, 2010), where factors such as the interplay of geography and demographics have further emphasized deleterious health outcomes. Some of the issues outlined in the *Rural and Northern Health Care Framework/Plan* include lowered life expectancy, increases in most chronic health conditions (circulatory diseases, cancers, diabetes), an exponentially higher First Nation population, a higher proportion of seniors within the population and increased complexity of care due to comorbidity, access to care with respect to home care, quality family care, and higher rates of mental health and addiction disorders (NELHIN, 2013).

Northern Ontario, encompassed by LHINs 13 & 14, accounts for 79.71 percent of Ontario's landmass (858,010 km2) and has a unique and diverse patient population (NELHIN, 2013; NWLHIN, 2013). There are 784,091 residents living in Northern Ontario (according to the 2011 census), with more than 53 percent residing in rural and small communities, 18 percent (NE) and 16 percent (NW) of the population are seniors (65 plus) (compared to 13 percent in ON), 9.5 percent (NE) and 19.2 percent (NW) of the population is First Nation (compared to 2 percent in ON), and 22 percent (NE) and 3.4 percent (NW) are Francophone (compared to 4.1 percent in ON) (NELHIN, 2013; NWLHIN, 2013).

Analysis

Despite assurances presented in the MOHLTC *2014 Progress Report*, residents of Northern Ontario are 26 percent more likely to experience premature death resulting in lower life expectancies for both men and women across this region, have disproportionately higher rates of cardiovascular/circulatory diseases including strokes, most cancers, rates of neurocognitive disease (NCD-dementia), and report less access to a regular physician (NELHIN, 2013; NWLHIN, 2013). Considering the national and provincial priorities, and the unique patient demographics of Northern Ontario, the three main Northern health priorities for the next three to five years should be: First Nations' health, seniors' health, and mental health and addiction disorders.

The First Nation populations within Northern Ontario range between ~10 percent (NE) to ~20 percent (NW) of the total population, compared to the provincial average of 2 percent. In 2000, life expectancy for male First Nations' people was ~7.4 years lower than the Ontario life expectancy (68.9 vs. 76.3) and is 5.2 years lower than the provincial life expectancy for women (76.6 vs. 81.8). The First Nation population also experiences 16 times the provincial rate of infant mortality (H. Canada, 2009; NELHIN, 2013; NWLHIN, 2013). Additionally, First Nations' people experience a disproportionate mortality rate due to injury, with ~22 percent of all deaths attributable to injury (H. Canada, 2009). Motor vehicle accidents were the leading cause of unintentional death, however; suicide and self-injury were responsible for 22 percent of deaths in the 10-19 age cohort, and 16 percent of deaths within the 20-44 age cohort (2009). Additionally, First Nation populations experience disproportionately higher rates of Type II diabetes, Tuberculosis, HIV and infectious diseases compared to the Ontario population due largely to social determinants of health. Compounding these findings, First Nations' people have an inequitable access to quality and culturally appropriate healthcare services, with access to healthcare decreasing as the remoteness of the community increases (MOHLTC, 2010).

In Canada the population of seniors will continue to grow with trends predicting the population to increase within Ontario to ~22 percent by 2031 (Borrie, 2008; Statistics Canada, 2012). As Ontario's senior population continues to age, the proportion of residents occupying beds within LTC facilities increases as well. Presently, there are more than 100,000 residents in LTC facilities (MOHLTC, 2013). The risk of developing a NCD (dementia) increases with age for males and females (371 per 1,000 for the population aged 85 and over), which contributes to the overall burden of mental health illness within Ontario (Lindsay & Anderson, 2004). NCD is also a risk factor for other mental health illnesses (depression, anxiety, isolation), falls and injuries (Krueger, Brazil, & Lohfeld, 2001), behavioural episodes (including violence and aggression) (Greenwood et al., 2005), and mortality (Lindsay & Anderson, 2004). Co-morbidity within this population is estimated to account for approximately 60 percent of all healthcare-related spending involving multiple specialists and multiple medications. These unique chronic health concerns, the increase in NCDs, and the increasing trend to move away from homecare to LTC facilities, provides clear evidence that traditional care models will no longer continue to work with this population. Approximately 20 percent of Ontarians (1 in 5) experience a mental health or addiction problem each year (CAMH, 2012). Of this population, approximately 20 percent of those afflicted with a mental health condition also have a co-occurring substance addiction (2012). The age cohort between 15-24 years of age are most at risk for

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experiencing mental illness and/or substance addiction and those in lower socioeconomic groups are three to four times more likely to experience mental health and substance addiction. CAMH estimates that the total economic burden (direct and indirect costs) of mental illness and addictions is ~$51 billion annually, with approximately 500,000 Canadians missing work every week due to these afflictions (2012). Moreover, in Ontario it is estimated that the total disease burden of mental illness and addictions is 1.5 times greater than all forms of cancer combined. CAMH also report that despite mental health and addictions comprising ~15 percent of the disease burden in Canada, this sector of healthcare receives less than 6 percent of healthcare funding (2012). Additionally, one out of three patients requiring mental health and addictions services in Canada report that their needs were not met, or only partially met, while 60 percent of primary care physicians indicated that their ability to refer a patient to a psychiatrist was 'fair to poor' (2012).

Recommendation

Despite a significant influx of funding and resources from the Federal and Provincial governments, and reports attesting to the progress being made in Northern Ontario, there still exists a disproportionate need for healthcare resources and access to be diverted to First Nations' care, seniors' care, and mental health and addictions care. Although the three areas identified have unique circumstances, access to timely and appropriate care, inclusive of cultural background and the developmental lifespan of Northern Ontario, requires immediate attention given the complex needs of the entire population. By providing the right care, at the right time, and in the right place as suggested by *Ontario's Action Plan for Health Care* (2012), the real issue of health service provision for First Nations people, seniors, and mental health and addictions care will serve to maintain and promote health and prevent further morbidity in Northern Ontario. As has been repeatedly demonstrated, "quality care can only be optimized when patients have access to the system," (MOHLTC, 2010). Significant effort, resources and funding must be focused on addressing the unique patient populations within Northeastern Ontario, utilizing and maximizing existing resources, overcoming geographical barriers, and allowing local input into the problem solving process to increase buy-in. Only when 'access to quality care' for all Ontarians is properly addressed, will the health disparities of marginalized populations in Northeastern Ontario begin to decrease.

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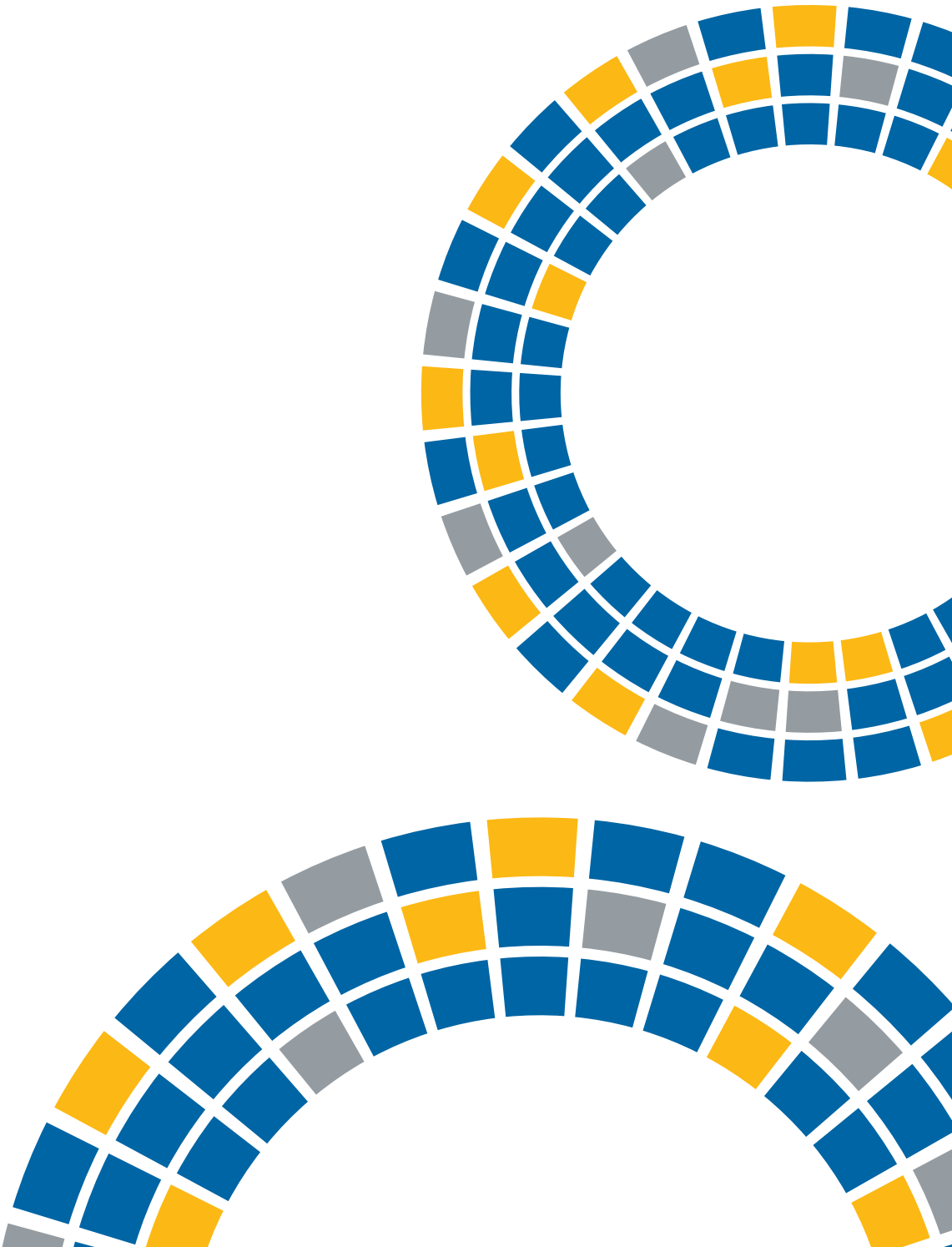


Who We Are

Internally, Northern Policy Institute seeks to be as "flat" as possible with much of the work contracted out to experts in the fields under consideration. This approach avoids the risks associated with large bureaucratic organizations. It also allows Northern Policy Institute to flexibly respond across a wide range of issues while also building up in house and regional expertise by matching bright young minds on temporary placements and project specific work with talented experts who can supply guidance and coaching.

Some of the key players in this model, and their roles, are as follows:

Board: The Board of Directors sets strategic direction for Northern Policy Institute. Directors serve on operational committees dealing with finance, fundraising and governance, and collectively the Board holds the CEO accountable for achieving our Strategic Plan goals. The Board's principal responsibility is to protect and promote the interests, reputation, and stature of Northern Policy Institute.

CEO: Recommends strategic direction, develops plans and processes, and secures and allocates resources to achieve it.

Advisory Council: A group of committed individuals interested in supporting, but not directing, the work of Northern Policy Institute. Leaders in their fields, they provide advice on potential researchers or points of contact in the wider community.

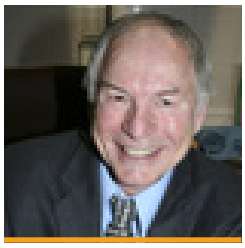
Research Advisory Board: A group of academic researchers who provide guidance and input on potential research directions, potential authors, and draft studies and commentaries. They are Northern Policy Institute's formal link to the academic community.

Peer Reviewers: Ensure specific papers are factual, relevant and publishable.

Authors and Research Fellows: Provide independent expertise on specific policy areas as and when needed.

Standing engagement tools (general public, government stakeholders, community stakeholders): Ensure Northern Policy Institute remains responsive to the community and reflects THEIR priorities and concerns in project selection.

Board of Directors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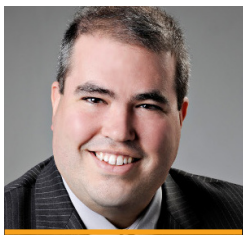
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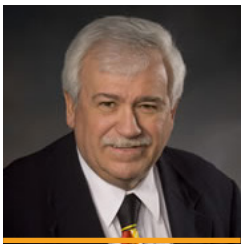
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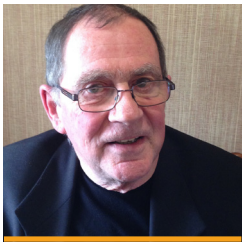
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