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Spinning Our Wheels? Chronic Disease Management as a Health Policy Priority for Northern Ontario

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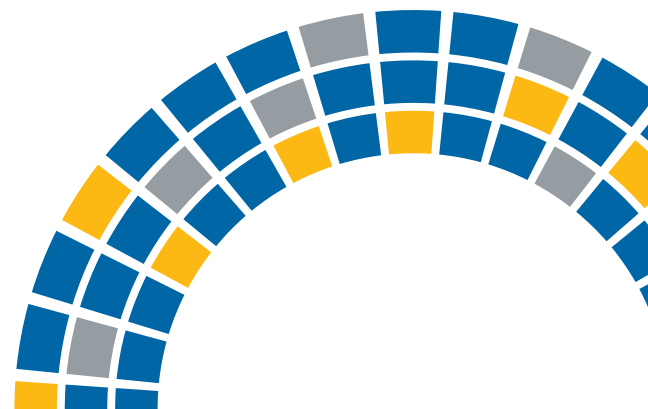


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Executive Summary

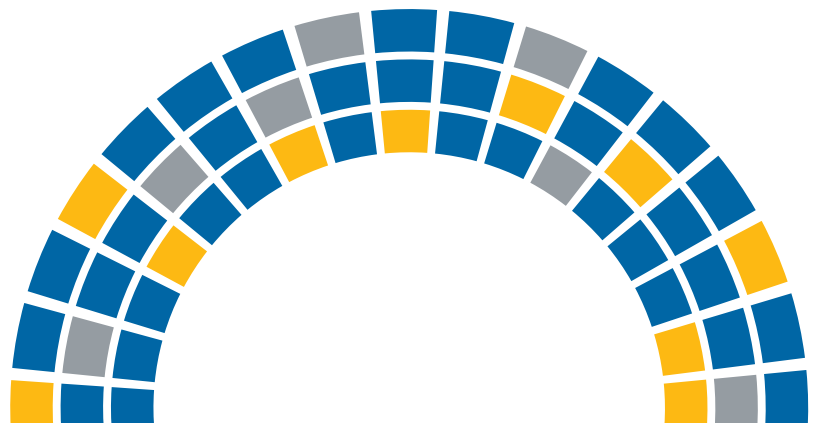
The health care needs of Canadians are evolving. Indeed, in 2019 the Ontario government announced that the province's health care system would be transformed into one that is more efficient and appropriate for all residents. As with any policy reform, however, not all regions of the province are alike, and Northern Ontario has needs and priorities that differ from those elsewhere.

In that context, this paper examines the management of chronic disease in Northern Ontario and discusses reforms to the health care system that address the unique needs of Northern Ontarians in access to and delivery of effective chronic disease care. One promising approach to chronic obstructive pulmonary disease (COPD) is INSPIRED – **I**mplementing a **N**ovel and **S**upportive **P**rogram of **I**ndividualized care for patients and families living with **R**espiratory **D**isease, which has been shown to reduce the number of unnecessary visits to health care providers by those with COPD. Although this approach has been implemented in other areas of Ontario and elsewhere in Canada, it has not yet been tried in Northern Ontario.

The paper concludes that the medicare model requires much-needed changes — as the health needs of Northern Ontarians change, so too should the system. Implementing policy that is targeted and continues to prioritize effective chronic disease management is essential for quality health care in Northern Ontario.

Introduction

As chronic disease is a predominant health issue, the management of chronic disease must continue to be a health policy priority for Northern Ontario. The region cannot continue to be the poor cousin to its southern counterpart. This paper is intended to draw the attention of provincial policymakers to the unique characteristics of Northern Ontario and to the inequities and health disparities its citizens face. The authors critically examine the medicare model and the need for an evolution of its delivery and funding to ensure it meets the needs of Canadians, especially those living with chronic disease in northern communities. Despite efforts to mitigate its effects, those living with chronic disease continue to be high users of health services. Unless fundamental changes are made to how our health care system is funded and delivered, we could be stuck spinning our wheels when it comes to chronic disease management in Northern Ontario.



Background

Medicare in Canada is a pillar of our national identity and a sense of pride for many Canadians (Armstrong and Armstrong 2010; Coletta 2018; Martin 2017; Picard 2017). The medicare system has been effective in covering hospital and physicians' costs; however, this narrow scope has produced gaps in coverage and challenges in terms of ensuring equitable access (Marchildon 2013, xxi). These issues are exacerbated within the northern and rural context for many reasons, including sparse and widely distributed populations, lack of health care providers and specialists, distance and the need to travel for services, lack of services, and variations in the social determinants of health. In recent years, concerns have arisen regarding the comprehensiveness and fiscal sustainability of the Canadian health care system (Advisory Panel on Healthcare Innovation 2015; Marchildon 2013, xv). Canada's federal system of government has shaped the development of medicare (Martin 2017, 23): the delivery of health care services lies with each province and territory, while the federal government is responsible for providing monetary support of health care in these jurisdictions (Marchildon 2013, 21; Martin 2017, 24). Knowing this, both the federal and the Ontario provincial governments have implemented strategies to address complex issues. Specifically, the Ontario government has proposed the priorities of improving access, connecting health services, informing Ontarians, and protecting the universal public health care system (Hoskins 2016a, 2016b; Ontario 2015b, 9).

Where one lives affects access to health care, and the experience of individuals living in Northern and rural Ontario is very different from that of their southern counterparts. In particular, residents of Northern Ontario face issues regarding (1) access to timely, quality, and comprehensive health services (Kulig and Williams 2012, 6); (2) specific population health needs, such as higher disease incidence, prevalence, morbidity, and/or mortality (Health Quality Ontario 2018, 25; Kulig and Williams 2012, 2; NELHIN 2016, 8–9); and (3) health service utilization (Kulig and Williams 2012, 60; NELHIN 2016, 8–9). Knowing this, it is vitally important that provincial goals be considered within the context of Northern Ontario.

The North West Local Health Integration Network (NWLHIN) and the North East Local Health Integration Network (NELHIN) are the first- and second-largest LHINs, respectively, in Ontario (Ontario LHIN 2014a, para. 1). Although Northern Ontario is huge, accounting for 91 per cent of the province's landmass, it hosts only 6 per cent of its population (NWLHIN 2018, 18; Ontario LHIN 2014b, 6). This equates to a population density of 2 people per square kilometre in the Northeast and 0.5 people per square kilometre in the Northwest, compared with the provincial average of 14.8 people per square kilometre (Statistics Canada 2017a, 2017b). In addition, 30 per cent of the population covered by the NELHIN and 34.2 per cent by the NWLHIN live in rural areas, compared with Ontario's average of 14 per cent (NELHIN 2016, 9; NWLHIN 2017, 7). The Northern Ontario Health Equity Strategy, as outlined by Health Quality Ontario, brings health inequities experienced by Northerners to the forefront. This strategy outlines recommendations for action, including the creation of a Northern Network for Health Equity, "developed in the North, by the North, for the North" (Health Quality Ontario 2018, 1).

Provincial health disparities and inequities, when it comes to chronic disease management, are exacerbated by the distribution of health care resources in the North. For example, although Ontario boasted 26,502 physicians in 2017, only 4.6 per cent of those were outside of Census Metropolitan Areas (CMAs) or Census Agglomeration regions (Statistics Canada 2015).¹ This was the lowest distribution percentage in Canada, and well below the national average of 8.2 per cent (Canadian Medical Association 2018). In 2017, in the two CMAs in Northern Ontario, there were 382 physicians (general physicians and specialists) in Sudbury and 334 physicians in Thunder Bay (Canadian Medical Association 2017).

This issue is compounded by a paucity of medical specialists such as respirologists, gerontologists, neonatologists, cardiologists, and infectious disease specialists (CBC News 2014) — in 2013, for example, 200 specialist vacancies were reported in Northern Ontario (Ontario LHIN 2014b, 8). Although the Ontario government has attempted to address the shortage of physicians in the North by offering incentives to recruit and retain health professionals in the region (Ontario 2013, para. 1), the issue of access to care in the region remains challenging. It is important to note, however, that, since 2011, 94 per cent of graduates from the Northern Ontario School of Medicine have set up practices in the North (CBC News 2017).

Issues related to both the lack of and the poor distribution of health human resources in Northern Ontario are well documented (Ontario LHIN 2014b). This suggests an imbalance between where services are offered and where the target

¹ CMAs are defined as areas surrounding an urban core with a population of at least 100,000, of which at least 50,000 live in the urban core. Census Agglomeration regions are defined as regions surrounding an urban core with a population of at least 10,000 (Statistics Canada 2015).

population resides, leading to challenges regarding access to comprehensive and coordinated health services for chronic disease management. This is, in part, due to the distribution of health care professionals in Northern Ontario. Professional isolation, increased client caseloads, and decreased access to continuing education opportunities are just some of the challenges Northern health professionals face (Ontario LHIN 2014b, 10). As a result, health care professionals tend to choose to work in larger centres, such as Sudbury or Thunder Bay.

Although interprofessional models of health care (such as Family Health Teams) can reduce some of the detrimental effects of this imbalance (Donato 2015), these models are often adapted to local situations in a non-standardized approach. This can affect coordination of care between health centres, a vital aspect of Northern health care. The patchwork nature of service distribution in the region, in combination with sheer distance across the North, mean that individuals often need to travel to receive the care they need (Statistics Canada 2015). Travel in the North can be unsafe and onerous, however, due to weather and road conditions, especially for individuals in ill health. This adds another barrier to care, and often results in individuals' deciding to forgo seeking needed health services (Statistics Canada 2015).

Provincial initiatives such as the Ontario Telemedicine Network attempt to mitigate the need to travel for health care, but these require financial resources for the community (Ontario Telemedicine Network 2015). However, equipment costs and challenges associated with the use of technology can be barriers to receiving optimal comprehensive care. Northern Ontarians are not always able to see their health care provider when needed, and instead might use hospital emergency departments. In the North, as much as 60 per cent of visits to emergency departments by individuals with a primary care provider could have been avoided if the provider had been available (Health Quality Ontario 2017b, 40). This demonstrates lack of improvement in follow-up visits after hospitalization and the need for further improvement in the transition between acute and community care. Since chronic conditions "have complex care needs, involving primary care, home care, hospitals, and specialists...[e]stablishing smooth transitions between these areas of care is critical to managing [them]" (Health Quality Ontario 2013, 5). Overall, the barriers Northern Ontarians experience in both location and time contribute to the fragmented nature of care and, ultimately, to a disparity in health care relative to Southern Ontario.

The obstacles Northern Ontarians face have been acknowledged, and initiatives have begun to mitigate them. One such promising example is the introduction of Family Health Teams (Ontario 2016, para. 1). Despite the lack of coordination among centres, as noted earlier, Family Health Teams reduce barriers by providing interdisciplinary and after-hours services in a coordinated effort to meet the needs of their community (Ontario 2016b). Family Health Teams reduce barriers of both location and time, as access to a variety of local health care professionals might reduce the need to travel. In addition, access to services after-hours might prevent unnecessary visits to emergency departments. Due to Northern Ontario's size and the region's small, scattered population, it is difficult for such initiatives to be as effective as possible. As such, this distribution needs to be accounted for. This is especially important for complex conditions where individuals need prolonged interdisciplinary care, such as in the case of chronic diseases.



Chronic Disease Management

Canadians are generally living longer and healthier lives; however, many are also living with multiple chronic diseases (Health Council of Canada 2007; Morgan, Zamora, and Hindmarsh 2007; Ploeg et al. 2019). This is in part due to medical advances that “convert acute life-threatening diseases into chronic illnesses” (Morgan, Zamora, and Hindmarsh 2007, 7). Because of this shift from acute to chronic disease, patients with one or more illnesses that are chronic require a substantial amount of costly health services. If the ever-increasing number of people living with chronic illnesses is not well managed in the community, these patients often “bounce in and out of hospital and [emergency departments] for every exacerbation of their illness” (Health Council of Canada 2007, 9; Martin 2017, 36). This is neither sustainable for the health care system nor does it positively affect the quality of life of those living with chronic illnesses. The factors contributing to this revolving door include lack of access to an appropriate health care provider and services, not having their underlying issues fully addressed, or simply not having anywhere else to go. The main reason for this situation is the manner in which the Canadian health care system is delivered and funded. Established in the 1950s and deliberately designed to treat patients with acute, episodic needs (Picard 2017; Verma et al. 2014), this reactive approach to health care does not align with proactive approaches to health care, such as public health and other suggestions to evolve the health system that will be discussed below.

Cancer, diabetes, cardiovascular disease, and respiratory disease are four chronic diseases that account for 79 per cent of all deaths in Ontario (Lung Association – Ontario 2018). The Ontario Ministry of Health and Long-Term Care is interested in high-cost users of services and resources because this small fraction of Ontarians accounts for a substantial amount of health care spending. It is estimated that 39,000 Ontarians consume 30 per cent of all hospital and home care costs (CIHI 2014). In fiscal year 2018/19, health care spending in Ontario was \$61.3 billion, up from \$59.3 billion in the previous year (Financial Accountability Office of Ontario 2019). These data suggest that approximately \$20.4 billion in health care spending goes to just 0.3 per cent of the population, and the amount is expected to rise as the number of Ontarians living with chronic disease increases. Another study suggests that, in 2013, 5 per cent of health care users consumed 61 per cent of hospital and home care funding (Rais et al. 2013). In 2011, direct health care costs for lung disease alone in Ontario was approximately \$5.1 billion (Smetanin et al. 2011). In 2010, the direct health care costs for diabetes was \$4.9 billion, while the direct and indirect costs for cardiovascular disease in 2009 and cancer in 2011 were \$22 billion and \$7 billion, respectively (OCDPA 2014), and these costs are likely increasing. In short, chronic disease costs the health system an exorbitant amount of money. From a national perspective, the population of seniors in Canada is expected to increase from less than 15 per cent of the total at the start of this century to more than 25 per cent by the middle of the century (Clemens and Velhuis 2018), and seniors are the largest consumers of health care spending.

Individuals with chronic diseases are classified as high-cost users, as they frequently access health services and require a significant amount of resources. In the NELHIN area, the incidence, prevalence, rates of hospitalization, and emergency department visits are among the highest in the province for certain chronic diseases, including chronic obstructive pulmonary disease (COPD) (Gershon, Mecredy, and Ratnasingham 2017), diabetes (Booth et al. 2012), and stroke (Hall et al. 2018). Health Quality Ontario reports that, in the NWLHIN region, 24.5 per cent of people reported having two or more chronic diseases, while in the NELHIN area, it was 25.3 per cent; the overall provincial rate sat at 19.7 per cent (Health Quality Ontario 2017a, 24).

First Nations and Métis individuals are also more likely to have chronic conditions, which can be caused by socio-economic conditions, as well as limited options for physical activity (Health Quality Ontario 2017a, 24; 2018, 25). It is reported that around 21 per cent of First Nations individuals live with diabetes, while the average provincial and Northern Ontario rates sat between 10 and 13 per cent (Health Quality Ontario 2018, 25).

Finally, the NWLHIN area has the highest rates of readmission within one year for COPD, diabetes, and chronic heart failure (NWLHIN 2018, 20). Given the higher incidence and prevalence of chronic disease and rates of health service utilization by those living in Northern Ontario, this further highlights the health disparities and inequities experienced by those in the North. It also further substantiates that changes are still needed in chronic disease management for northern residents. As such, a comprehensive focus on chronic disease management would bring more balance to health expenditures in Ontario.

Discourse about improving continuity and coordination of care aims to smooth patient transitions, decrease fragmentation, and improve consistency of services, regardless of location in the province (Health Quality Ontario 2018, 7; Hoskins 2016b; NELHIN 2016, 18). Wagner's (1998) Chronic Care Model is frequently referred to in the literature as an example of a combination of multipronged strategies to improve chronic disease care. Barr et al. (2003) have enhanced the model to include elements of population health promotion and prevention efforts, as well as recognition of the social determinants of health and enhanced community participation. Chronic disease management should also include an upstream approach that addresses the root causes of or contributing factors to illness in an attempt to avert illness while accounting for the effects of social determinants of health such as income, housing, education, food security, race, and gender (Barr et al. 2003; Marchildon 2013; Martin 2017). This way of thinking about chronic disease management demonstrates clear associations between the health care system and the community. It also focuses on many aspects of chronic care, including delivery system design, self-management, and building healthy public policy. This approach also encourages us to think about "reorienting health services beyond the provision of clinical and curative services to an expanded mandate that supports individuals and communities in a more holistic way" (Barr et al. 2003, 78).

A focus on chronic disease prevention and management (CDPM) transformation would transform the health care system and help to ensure its sustainability (Morgan, Zamora, and Hindmarsh 2007, 7). Currently, the health care system does not enable physicians and other allied health providers to provide coordinated and comprehensive CDPM for reasons that include the manner in which the system is designed, the delivery of highly fragmented care, and the lack of clinical information systems where information for effective clinical decision making can be appropriately shared (8). Furthermore, in order to address the CDPM deficit, there should be a focus on population-based and patient-centric models of care² that encompass health promotion and disease prevention strategies (9). This should be done in conjunction with addressing the needs of individuals who are currently living with chronic illness in terms of disease management and to ensure they are receiving timely, coordinated, continuous, and appropriate care across all sectors of the health care system.

A focus on CDPM and community-based outreach would reduce costs by ensuring greater continuity of care. Challenges of access to services in Northern Ontario result in fragmented care among health sectors; this directly affects those living with chronic conditions, as evidenced by their increased health service utilization. Efforts on the part of LHINs across the province via the Community Health Links initiative (NELHIN 2016, 17) aim to provide coordinated, consistent, and effective care for people with complex conditions. A specific example of how this is enacted is through community paramedicine programs designed to help seniors and high-needs patients at home to avoid emergency department visits and hospital admissions (Ontario 2014). So far, these programs are underway in both Sudbury and Thunder Bay and areas they service (City of Greater Sudbury n.d.; City of Thunder Bay n.d.; NWLHIN n.d.; TbnnewsWatch.com Staff 2016). In 2017, the Ontario government invested \$771,200 in community paramedicine programs in the NELHIN area including: Cochrane, Manitoulin-Sudbury, Algoma, Nipissing, and Parry Sound (Ontario 2017). In the NWLHIN area, as of January 2017, community paramedicine and telehomecare projects were underway in Thunder Bay and had expanded into the District of Thunder Bay subregion (NWLHIN n.d.). There is potential to build upon this initiative with the fiscal goal of decreasing unnecessary health service use and costs. These programs also provide chronic disease self-management training for patients. It remains to be seen, at this point, exactly what will happen to initiatives such as these as a result of the changes to health services that the Ontario government has recently announced. The authors discuss these changes and their implications relative to chronic disease management later in this paper.

The Canadian Foundation for Healthcare Improvement (Verma et al. 2014) supports efforts that focus on CDPM. A comprehensive community-based outreach approach that supports those living with chronic illnesses would decrease unnecessary use of emergency and acute care services and readmissions. This approach would provide access to a health care team that would address individuals' health needs in their home or community and intervene appropriately, preventing unnecessary use of health services, thus decreasing health care costs.

The evidence regarding health service utilization, hospitalization, and emergency department visits in Northern Ontario reveals the need to address the issue of continuity of care between acute and community care settings. One approach that has been sporadically adopted both provincially and nationally, with documented benefits and evidence of reducing the revolving-door effect that those living with COPD often experience, is called INSPIRED, an acronym for Implementing a **N**ovel and **S**upportive **P**rogram of **I**ndividualized care for patients and families living with **R**espiratory **D**isease (CFHI 2017, n.d.b; Marciniuk et al. 2010; O'Donnell et al. 2008; Picard 2018).

Since 2014, the INSPIRED approach for COPD — a quality improvement collaborative partnership between the Canadian Foundation for Healthcare Improvement (CFHI) and Boehringer Ingelheim (Canada) Ltd. — has provided funding, training, coaching, and resources for a network of 19 interprofessional health care teams across Canada. Each team has received

² A population-based model focuses on a particular group of individuals, while, in a patient-centric model, not only is care provided based on an individual's health needs, but the patient plays an active role (Iowa 2016; OneView 2015).

\$50,000 in seed funding to adapt and implement the program. This approach has reduced emergency department visits, hospital admissions, and days in hospital by 60 per cent at the Queen Elizabeth II Health Sciences Centre in Halifax, for example (CFHI n.d.a). Although seven health care teams and associated facilities have implemented the INSPIRED approach for COPD in Ontario, none are in Northern Ontario or in any other rural or remote area in the North (CFHI n.d.b). This might be due in part to the unique and diverse challenges that smaller and more rural areas in Northern Ontario face relative to geography, infrastructure, and health human resources. That is not to say that larger centres such as Sudbury and/or Thunder Bay, or hubs such as Sioux Lookout, could not implement this approach.

This program is a facility-to-home clinical initiative that, through improved care transitions, self-management, and engagement in advanced-care planning, has demonstrated a significant reduction in health care utilization and costs (Gillis, Demmons, and Rucker 2017). In an interview with the CBC News program *The Current*, health reporter and *Globe and Mail* columnist André Picard stated that, in Canada, “we deliver excellent health care but not because of the system but in spite of the system” (quoted in Hoath 2017, para. 11). He went on to suggest that Canada’s biggest single problem was not scaling up its successes. There are many examples of great initiatives that are being implemented in pockets across the country, even within Ontario, relative to chronic disease management that have not been expanded or “scaled up,” largely due to the federal and provincial jurisdictional aspects of health care delivery. Picard has further suggested that “innovation is stifled by the structure and administration of the health system, and by a dearth of leadership” (Picard 2017, 39). On the leadership point, Everett (2019, 12) notes that, for Northern Ontario, there is the challenge of senior administration and board leadership capacity in relation to talent and training gaps, succession planning, and the like, which can affect the ability to carry out innovation. Given these challenges, the INSPIRED approach is an example that Northern Ontario should look to as a model that could address chronic disease management.

The INSPIRED approach has already significantly decreased readmission rates and emergency department visits in various Ontario communities. According to the CFHI (n.d.b), if the INSPIRED COPD Outreach Program were implemented across Canada, it would have its biggest effect in Ontario, as preventable health care costs in the province represent 39 per cent of all projected health care savings in Canada. INSPIRED programs cost around \$1,000 annually per COPD patient to implement, but within five years such a program would net \$263 million in health care savings in Ontario, and \$1 spent on this approach would prevent \$21 in health care costs (CFHI n.d.b). These types of approaches to chronic disease management ensure that individuals receive appropriate care when they need it while reducing unnecessary health care costs. In order to scale up innovative approaches to chronic disease management such as this, a system needs to be created that focuses on chronic disease management through funding and delivery models.

Chronic disease management requires emphasizing that care needs to be provided in the right place at the right time (Health Quality Ontario 2017b, 62; Ontario 2015b, 12). It also aligns with Bill 41, the Patients First Act, 2016 (see Hoskins 2016b), as it aims to smooth the transition of patients between sectors and improve consistency of services regardless of location in the province. Due to the substantial health care costs required by high-cost users, interventions for this population not only improve patient outcomes and health-related quality of life, but also reduce overall health care spending (Chechulin et al. 2014; Health Council of Canada 2007). As such, chronic disease management, which includes coordinated and continuous transitions from acute to community care, ought to remain a substantial health policy priority, particularly in the unique context of Northern Ontario.



Discussion

Fragmented access to coordinated care is the common theme that runs through this paper. This patchwork nature of services distribution exacerbates the disparities experienced by Northern Ontarians, especially those with chronic conditions. Canadians are increasingly in need of community-based outpatient and ambulatory care services; however, medicare's historical focus on hospital-based and physician services neglects the use of such approaches. This focus makes it difficult for the Ontario health care system to keep up with contemporary needs. In *Better Now: Six Big Ideas to Improve Health Care for All Canadians*, Dr. Danielle Martin suggests that "the disconnect between the primary care universe and the hospital universe is an ongoing source of difficulty for patients and irritation for providers" (Martin 2017, 72). Lack of continuity of care and ineffective communication between primary care providers and the rest of the system leads to wasted time and money and inappropriate use of health services and resources. Recognizing the limitations imposed by medicare and the complex nature of chronic disease management, it is vital to consider the ethical, moral, legal, social, and political implications of initiatives put forth to address them. Potential sources of tension include reallocation of health care dollars within the system, redistribution of health human resources, and reconfiguration of how and where health services are delivered. Although addressing these priorities might not deliver either immediate or explicit benefits, both short- and long-term benefits could arise from such actions. These recommendations thus should be viewed as an investment in the future and as a way to ensure the health not only of Northern Ontarians, but of all Ontarians.

In consideration of the Northern Ontario Health Equity Strategy (Health Quality Ontario 2018), one of the top priorities for Northern Ontario health policy is to address the patchwork nature of health human resources and services by facilitating coordination and communication between centres in order to ensure access to coordinated care and smooth transitions via innovative approaches to chronic disease management. Recently, the Ontario government announced a strategy to transform health care by the merging and consolidation of 20 health agencies, including Cancer Care Ontario, eHealth Ontario, the Trillium Gift of Life Network, Health Shared Services, Health Quality Ontario, and Health Force Ontario Marketing and Recruitment Agency into one super agency that will establish local health teams for coordinating care (Crowe 2019, para. 2; Jeffords and Jones 2019, para. 1). With this announcement, the government intends to address system fragmentation by providing seamless access to all health services. As well, the province estimates that there will be "an annual savings of \$200 million by 2021-22" by amalgamating the Ontario health units (Langlois 2019). On the other hand, according to Agnes Grudniewicz, a health systems researcher from the University of Ottawa Telfer School of Management, there is no evidence that centralizing the health care delivery system will actually improve care and reduce costs (cited in Payne 2019, para. 12). Similarly, Dr. Bob Bell, former Ontario deputy minister of health worries that the current government's plan to transform health care will fix things that are not broken or break things that are still working — for example, Cancer Care Ontario, the province's highly regarded cancer service agency, is to be absorbed by the new superagency (Crowe 2019, para. 20). Overall, since the announcement, there has been scepticism over whether these changes will be beneficial, and predicting the exact savings or improved appropriateness and efficiencies of care will be hard to pin down.



Furthermore, the Ontario government has set the funding of public hospitals to less than the rate of inflation and population growth, depriving people of needed health care (Ontario Health Coalition 2019, para. 1). As people with chronic illness are among the most frequent users of hospital services, they will be the most affected. The government has also announced changes to the manner in which public health services will be organized throughout the province, and its intention to cut the public health budget by almost one-third. This will lead to a reduction in the number of health units in the province from 35 down to 10, and to a cut and restructuring of ambulance services that will lead to 10 giant regions as opposed to the previous 59 (Ontario Health Coalition 2019, para. 1). These government-level cuts and changes have the potential to affect proactive health approaches and chronic disease management in the province — particularly access to timely, quality, and comprehensive health services in Northern Ontario (para. 14). This approach does not coincide with a focus on community and public health services that include efforts to promote health and prevent disease. Moreover, this particular announcement is counterintuitive to a CDPM model.

Since the announcement of the strategy, many interested and/or involved groups have added their perspective to the public narrative about its implications. Despite this, it remains to be seen how the transformation of the health care system and the associated legislation, put forth by the current Ontario government, will unfold or what effects it will have on chronic disease management in Northern Ontario. What is clear is that chronic disease management should remain a health policy priority, particularly in the diverse context of Northern Ontario. Where health disparities exist and lack of attention persists, they should be challenged. It is also unclear how the proposed changes will address the unique needs of Northern Ontario and how they will mitigate the health disparities and inequities experienced by its residents. Given that the responsibility for health care delivery and organization lies within provincial jurisdiction, decisions and policies that are enacted or repealed are substantially influenced by the manner in which health care is funded through the Canadian medicare model.



Need for Medicare Evolution

There is no doubt that Canadians value their iconic health care system, which allows them to obtain health care services based on need, not on ability to pay. The system, however, is not without its challenges and does have imperfections. There are aspects of the system that work and those that do not. The need for medicare evolution has been discussed for the better part of two decades (Clemens and Veldhuis 2018; Marchildon 2013; Martin 2017; Picard 2017; Romanow 2002). Arguably, the impetus for this discussion was spearheaded by the foundational work of Roy Romanow who, in 2001, was appointed to head the Commission on the Future of Health Care in Canada and tasked by the federal government with inquiring and undertaking dialogue with Canadians on the future of Canada's public health system. He was also requested to recommend policies and measures, respectful of jurisdictional power, that would be required to ensure the long-term sustainability of a publicly funded health system that is universally accessible and offers quality services. In his detailed report, Romanow (2002) proposed a multitude of recommendations relative to how to improve access and ensure quality, investing in health care providers, primary health care and prevention, home care, and prescription drugs. He also specifically addressed the need to address disparities in health and access to care for rural and remote communities. The work of the Commission is seminal to discussions about Canada's health system, and has direct implications for chronic disease management.

What, however, has been done since the Romanow report? Have any changes been made based on his extensive recommendations? In 2012, ten years after the report's release, the Canadian Association for Health Services and Policy Research hosted a one-day retrospective/prospective on the Commission (Adams 2012). The main message was the repeated call for federal leadership in order to move the Commission's recommendations forward. In the years since Romanow, the documented ebb and flow of federal health care dollars has provided insight into the health priorities of various governments of the day (Adams 2012; Fuller 2017; Lewis 2013; Marchildon 2013). In his review of the Canadian health system, Marchildon (2013) suggested that there had been no major effort focused on rural or remote health care and no major initiative on the part of the federal, provincial, and territorial governments or Indigenous organizations to work together to address Indigenous health care, and that medicare remained unchanged. As Lewis (2013) suggests, however, it is easy to call for change with respect to Canadian health policy but much harder to implement.

More recently, discussion about the need to reform and redesign medicare has continued (see, for example, Clemens and Veldhuis 2018; Fuller 2017; Martin 2017; Picard 2017). Fuller (2017) suggests that an expansion of Canada's publicly funded health care system is exactly what is needed now. She goes on to state that there is a need to bring community-delivered services under medicare and to establish a national pharmacare program. Martin underscores the "need to address the challenges in health care that build on what's good about what we already have in place" (2017, 5), noting that Canadians are deeply committed to medicare and that this is, or should be, the foundation for change (15). In recent years, there has been a paucity of pan-Canadian health reform initiatives, yet, as Marchildon (2013, xx) points out, individual provinces and territories have reorganized their respective health systems, attempting to improve patients' experiences and the quality and timeliness of primary, acute and chronic care.

In his book, *Matters of Life and Death: Public Health Issues in Canada*, André Picard discusses the need to drag medicare into the twenty-first century. This notion is particularly relevant to chronic disease management. Picard suggests that Canada's "medicare model is a relic" (2017, 17). In fact, in its setup, organization, delivery, and funding, medicare has not significantly evolved over the past 70 years. Picard goes on to state that, although Canadians celebrate Tommy Douglas's role in shaping medicare, in fact "medicare was designed to meet the needs of 1950s Canada" (17) through hospital-based physician services. The health care needs of Canadians in the 1950s were mainly for acute care, however, and people did not live as long as they do now. Since people are living longer as a result of many factors, including technological advances, the care needs of Canadians have shifted to management and treatment of chronic disease. Despite this knowledge, the model for the delivery and funding of health care has not yet adapted to current reality.

A revolutionary shift in the model of medicare would support the manner in which chronic disease is managed and how it is experienced by patients, families, and health care providers alike. It also has the potential to reduce expenditures. In order even to begin addressing this issue, critical and difficult discussions need to take place regarding the fundamental methods of delivery and funding. In terms of delivery, the focus of medicare should be primary care — including a medical home base that enables centralized care coordination and electronic medical records — and the extension of universal health coverage to include prescription drugs, home care, and aspects related to the social determinants of health (Fuller

2017; Lewis 2013; Martin 2017; Picard 2017). With respect to funding, a major pitfall of the medicare model is that it fails “to define clearly what is covered by public insurance and what is not” (Picard 2017, 19). In addition, we should recognize that, in this case, universal does not mean unlimited; rather, while expanding areas that medicare covers, coverage should be restricted, across the board, to essentials (Picard 2017).

Picard suggests that the public-private debate over the health care system is a “false dichotomy” — that every health system has a mix of private and public delivery and funding, and that “the question is not whether or not we have private and public care; it's getting the mix right” (2017, 20). Canada has a two-tiered health system, but the split is not private-public but rather urban-rural (27), as clearly demonstrated in the statistics relative to the health status of Northern versus Southern Ontarians. Continued dialogue and discussions should take place that are appropriate, relevant, meaningful, and “have teeth” that address this gap and system reform, and subsequent policies and strategies should be developed and implemented with this split in mind.

Clearly, this is easier said than done. Although changing the manner in which the historical model of medicare is based might seem unfathomable, it is not impossible. There is no such thing as a perfect health care system in any country, but there are numerous international examples from which Canadian reformers might take lessons and inspiration. As Picard notes (2017, 41–2), in Mark Britnell book *In Search of the Perfect Health System*, the strengths and weaknesses of the health systems of 25 countries and the various traits are important to consider in creating a good health system. In terms of health equity, Raphael (2012) discusses the health systems of seven wealthy developed countries — Canada, the United States, Australia, Britain, Northern Ireland, Finland, Norway, and Sweden — and analyzes their differing approaches to responding to health inequalities. He suggests that Canada is not addressing health inequalities successfully, and could learn from other nations that are doing so, such as Finland (Raphael 2012, chap. 6) and Norway (chap. 7).

Clemens and Veldhuis (2018) suggest that rising health care costs amid constrained public finances, changing demographics (including the increasing number of seniors), increasing support for reform by average Canadians, middling performance, and/or a court case (Vancouver physician Brian Day's case making its way to the Supreme Court of Canada) could all be catalysts for genuine health care reform. Picard states that changing the historical model of medicare in Canada will require courageous leadership, political will to learn from others, and the will of the people: everyone has a role to play, and “we need a debate about structure and funding and priorities” (2017, 21). This notion, however, might not align with the historical and current understanding and implementation of medicare in Canada. Canadians are increasingly in need of community-based outpatient and ambulatory care, but the Canada Health Act and its focus on hospital and physician care makes it “legislatively challenging” to adapt to contemporary needs (Verma et al. 2014, 5). “Rising costs are real, but what matters more than what we spend is what we get for it,” and there is a need to improve the health care system's performance with respect to chronic, long-term problems (Martin 2017, 38). Martin argues that medicare is part of what it means to be Canadian, and that we should be committed to delivering high-quality, accessible services in an equitable way — that means thinking about how to deliver services better and making medicare a social program worthy of its iconic status (14). As Picard (2017, 21) declares, “It's time to stop talking and start acting.”



Conclusion

The recommendations and considerations in this paper would indeed be challenging to undertake from a governmental and administrative perspective. They might require the reallocation of health care dollars within the system, a redistribution of health human resources, and a reconfiguration of how and where health services are delivered. Between 2003 and 2018, the previous Ontario government commissioned many reports and initiatives that currently inform health care directions and priorities. The current Ontario government has outlined its platform of health priorities, some of which align with and others potentially deviate from those of the previous government. Tension also might exist between the current federal government and the Ontario government in terms of health care priorities and future directions. There might also be ethical, moral, legal, social, and political implications to consider relative to each of the priorities identified. Careful consideration of chronic disease management models of care has the potential to ensure greater continuity between acute care and community care services with an integrated care approach. This would reduce readmission rates and use of acute and emergency care services. As the authors have noted, the INSPIRED approach is one consideration for Northern Ontario.

Finally, the recommendations might not deliver immediate explicit benefit — both short- and long-term benefits could arise out of actions taken to address the identified priorities. Accordingly, these recommendations should be viewed as an investment in the future to ensure the health of all Ontarians, regardless of where they reside.

Chronic disease management in Northern Ontario and the manner in which health services are organized and delivered must continue to be a priority for policymakers. We need to ensure that provincial goals relative to health care are adapted to the Northern Ontario context. The barriers Northern Ontarians face in both location and time contribute to the fragmented nature of care and, ultimately, to health disparity in the region. Chronic disease management care provided in the right place at the right time will not only improve patient outcomes and health-related quality of life, but also reduce overall health care spending. Comprehensive, coordinated care between health sectors is vital. Meaningful policy discussions and development should not occur in silos, but engage a variety of ministries across the provincial government that play a role in health and social policies specifically in relation to the social determinants of health. Ultimately, the nature of appropriate chronic illness management and the pace at which it evolves will be determined by Canadian voters and their influence with elected government officials of all levels (Health Council of Canada 2007, 3). Finally, discussions about health policy and its development should take place in a manner that considers and addresses the diverse context and health disparities of Northern Ontario. Now is the time for the federal government to engage in discussions with the provinces about how to evolve the Canadian medicare system in a way that aligns with contemporary needs and places chronic disease management at the forefront of health policy discussions. Only then will we stop spinning our wheels.



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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.

Related Research

A Case Study in Northern Governance: Local Decision Making in the Northern Ontario Health Care System
Eric Everett

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Julie Duff Cloutier, Nichola Hoffman, Kristin Morin, and John Dabousi

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