

Towards a Broader Framework for Understanding Accessibility in Canadian Health Care

**Prepared for the
Canadian Nurses Association**

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Executive Summary

Access entails the ability of Canadians to gain entry into the needed health services at the needed time – thus ensuring greater health outcomes for all Canadians. The reality, however, for many Canadians is that the relationship between access and health is governed by many inconsistencies.

Much of the public and political discourse around accessibility to health services in Canada has been, of late, focused on wait lists and waiting times for a narrow range of surgical services provided by a narrow range of health providers, and furthermore, the resources (human and otherwise) needed to ensure that these particular services are provided in a timely manner. This intense focus on a narrow range of services has caused us to lose sight not only of what a really “accessible” health system should look like, but, perhaps more importantly, has obscured real problems with access to a range of services needed along a patient’s care pathway. This study is an attempt to develop a preliminary framework for understanding the host of factors that may influence or determine Canadians’ ability to access appropriate services.

The discussion on accessibility within this paper is predicated on three iterative stages: an environmental scan of literature, a set of key informant telephone interviews, and a workshop. The methodology used is primarily qualitative and descriptive in nature. The data from the key informant interviews was used to develop a preliminary model of accessibility and to refine the definition of access, lists of mediators, indicators as well as outcome measurements. The third stage to the research involved a workshop held in February 2006 in which the preliminary model and set of indicators was presented. The feedback from participants was used to further refine the model and indicator lists.

The model developed in this study is an attempt to reorient our thinking about accessibility to health services away from the current focus on wait times for particular surgeries towards a more holistic understanding of access which makes explicit the linkages between the services needed along a patient’s continuum of care. It is focused on the patient’s interactions with the health system, beginning with those factors that determine a patient’s need for services (and their need to access the system) and the mediating factors that influence the patient’s ability to access services. These mediating factors, along with the particular mix and availability of health services in both the public and private realms, determine individual and systemic outcomes.

The model builds on existing work and takes into account the following:

- The social, political and economic context;
- Patient needs, resources and choices;
- Mediating factors such as availability, affordability, accommodation;
- Demographic trends and issues;
- Public sector trends and prioritizations such as delisting, wait list management, advances in technology;
- Private sector trends and prioritizations such as private clinics and institutions, and third party intermediaries;

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- Provider trends and issues such as recruitment and retention strategies, expanding scopes of practice;
- Unmet needs;
- Alternative care provision;
- Availability of care (time, geographic or affordable);
- System outcomes which are measured in terms of equity, quality, effectiveness and patient safety; and
- Provider outcomes which are measured by productivity, satisfaction and teams.

There is considerable work currently underway to establish indicators of accessibility. Much of this work is focused on the development of benchmarks for hospital and physician based services which represent a good start. But this does not provide a view of the overall health system. A more holistic and consistent set of measurements is required to determine what services are needed, their effectiveness and their impact on outcomes. Dialogues around these indicators need to be intersectoral and systemic and include the perspectives of a wide range of stakeholders such as educators, employers, evaluators, funders, health professionals, IT specialists, policymakers, planners, and patients.

The study recommends the development of more specific and targeted performance measurements for the many care settings and providers that comprise the current health system. It also recommends examination of the role of care guarantees in determining timely access to services as well as the linkages between human resource planning and accessibility. But more importantly the study highlights the importance of expanding the current discussion on access to include a greater range of health services and sectors.

1. INTRODUCTION

This study is motivated by a concern that much of the public and political discourse around accessibility to health services in Canada has been, of late, narrowed to a discussion of access to a narrow range of surgical services provided by a narrow range of health providers. Thus, the discussion of “access” has become, for a whole host of reasons, a discussion of waitlists and wait times for five particular services. This paper is intended to broaden the discussion.

This intense focus on a narrow range of services has, we would argue, caused Canadians to lose sight not only of what a really “accessible” health system should look like, but more importantly, it has obscured the fact that the health of Canadians is challenged by a number of conditions and diseases, each needing appropriate health services and expertise. The result is something of a vicious circle – as attention is focused on those services deemed to be a priority, the system is giving priority to developing benchmarks to measure progress on improving access to those services, moving resources to those parts of the health system where those services are provided. As a result, effort is not being put to investigating, monitoring and measuring access issues for other health services, other diseases and conditions. Furthermore, these narrow range of services which are the focus of the current debate, are themselves linked to a whole host of other services which must be in place to be successfully delivered and achieve good outcomes for patients and their families. For example, a patient in need of a joint replacement requires, at the front end, a range of diagnostic and therapeutic services that can prepare a patient for surgery. These same services may obviate the patient’s need for the surgery itself or ensure that the patient’s wait for surgery comes with as little restriction on the lifestyle as possible. The success of the surgery is thereby dependent not only on what happens in the operating theatre but also on the patient being able to access a range of post-operative home-care, physiotherapy or rehabilitation services.

Following a brief discussion of the methodology employed in the paper – a combination of a detailed literature review, a small number of key informant interviews and a workshop attended by a range of health policy and stakeholder representatives, we examine how the discourse on access became narrowed to a focus on a small number of surgical procedures. The paper builds on the literature, interviews with key informants and the workshop participants to reexamine the concept and definition of accessibility. What is evident from this discussion is that, while there are any number of ways to both define and operationalize access, there is a strong consensus that the hallmark of an accessible health system is one that can provide the right service at the right time in the right context. But it is also evident that getting to that goal is far more complex and difficult than that simple definition might suggest.

The model that is developed in the heart of the study is really an elucidation of the host of factors that must be taken into account in moving toward a more holistic understanding of accessibility. It is focused on the patient’s interactions with the health system, beginning with those factors that determine a patient’s need for services (and their need to access the system) and those factors that influence the patient’s ability to access

services. From there it moves to a discussion of mediating factors, or those which either facilitate or hinder accessibility to appropriate services. Those mediating factors, along with the particular mix and availability of health services in both the public and private realms then are the determinants of the kind of outcomes the system produces at both the individual and systemic levels. The paper then makes a series of recommendations, based in part on the limitations in data and other knowledge uncovered in the study, concerning how to begin a more holistic debate or discourse around accessibility in Canada.

The model is presented as a way to reorient our thinking about accessibility to health services away from the current focus on wait times for particular surgeries towards a more holistic understanding that makes explicit the linkages that one service has to another across a patient's continuum of care. Questions on what access means, how it is operationalized, what resources are needed, what barriers exist, and how it is measured must be addressed. There is still a great deal that is not known about access to health services in Canada – and this is especially true for those services that exist outside of the core hospital and physician services covered under the terms of the *Canada Health Act*. Nevertheless the overall goal is to provide a starting point for a more fulsome discussion of what it means for the Canadian health system to be “accessible”. But this study is only a starting point and the model it provides is far from definitive.

2. METHODOLOGY

The discussion on accessibility within this paper is predicated on three iterative stages: an environmental scan of literature, a set of key informant telephone interviews, and a workshop. The methodology used is primarily qualitative and descriptive in nature.

The first stage involved an environmental scan of international Canadian peer reviewed and grey literature on models, definitions and current issues around accessibility in Canada. The materials were searched using a key word search of the internet and library search engines including PubMed and the Social Science Citation Index¹.

The second stage involved key informant interviews. A preliminary set of indicators, definitions, mediators, and models was sent to 11 key informants. They were then asked during a structured telephone interviews to provide feedback on the preliminary work and to fill in any gaps in knowledge around prioritizations and data needs.

¹ The keywords included the following around providers: “physician(s)”, “doctor(s)”, “nurse(s)”, “psychologist(s)”, “therapist(s)”, laboratory, “physiotherapist(s)”, “pharmacist(s)”, “health”, “medical”, “technician(s)”, “provider(s)”, “professional(s)”, “occupational”, “practitioner(s)”, “rehabilitation”, “respiratory”, “licensed”, “practical”, “occupation”, “radiologist(s)”, “operating”, etc. The keyword search for context and care provision included the following: “Canada”, “Canadian”, “Medicare”, “services”, “medical”, “mental”, “home-care”, “emergency”, “long-term”, “care”, “primary”, “emergency”, etc. The keyword list for the definition and conceptualization of accessibility included: “access”; “accessibility”; “indicator(s)”; “model(s)”, “definition”, “framework”, “conceptual”, “mediator(s)”, “facilitator(s)”, “barrier(s)”, “outcome”, “process”, etc. The characteristics of the patients/clients were included in a keyword search of: “gender”, “women”, “Northern”, “poverty”, “income”, “immigrant”, “Aboriginal”, “geography”, “rural”, “urban”, etc.

The results of the key informant interviews was used to develop a preliminary model of accessibility and to refine the definition of access, lists of mediators, indicators and outcome measurements. The third stage to the research involved a workshop held in February 2006 in which the preliminary model and set of indicators was presented. The resulting feedback was used to further refine the model and indicator lists.

The key informants and workshop participants were selected to represent the following groups:

- Representatives of nursing regulatory bodies;
- Front-line providers;
- Representative(s) of unions;
- Members of f/t/p health departments;
- Representative(s) from CIHI; and
- Representative(s) from the Health Council of Canada.

The data from all three sources was analyzed using a qualitative thematic analysis.

The first section describes the current situation around access in Canada including the commitments made by the First Ministers and the experiences of Canadians. We then discuss the definitions and models of access to health services found within the literature and noted by the interview respondents and workshop participants. This discussion forms the basis for the development of a model which serves as a roadmap for understanding accessibility in Canada and which outlines the pertinent issues related to the current Canadian debates. Finally, noted gaps in the literature and next steps for further exploration into accessibility are presented.

3. ACCESSIBILITY IN CANADA

Access entails the ability of Canadians to gain entry into the needed health services at the needed time – thus ensuring greater health outcomes for all Canadians. The reality, however, is that the relationship between access and health is fraught with many inconsistencies. For instance, much depends on the political and social constructions of “equitable access”; “medically necessary” services, “timeliness”; “appropriate”; and “reasonable access” as well as the identification of what constitutes an important health need within the Canadian health system.

At its most basic level, access to health is a personal issue – as individuals we need specific services determined by our individual health status. Our health status as individuals is, at the same time, highly dependent on our social circumstances – our level of education, employment status, family circumstances, financial situation, and support networks. Moreover, while basic hospital and physician services are free at the point of service, other services, including home care, dental care, long-term care and many mental health services, may have financial and other barriers to access.

Access can also be understood as an indicator of system performance. Most of the current discussion, as noted above, is around the timeliness of care for orthopaedic surgeries (esp. hip and knee replacements), cataract surgeries and advanced diagnostics such as MRI scans in most jurisdictions. Other procedures, such as cancer and cardiac surgeries have had less severe, yet still serious waiting periods. If we take a more comprehensive approach to system performance, we have large gaps in our knowledge about the extent of waiting periods for a wide range of services¹. One example here is the lack of inclusion of either entirely or partly privately funded (e.g. dental, psychology and physiotherapy services) within our discussion of access. Virtually all of the key informant interviews stressed the need for the current debate about access to reflect a broad continuum of care which includes the services from a wide range of providers. It was acknowledged that, for those services whose costs are not covered by Medicare, the issues of access, wait times and health outcomes must include financial factors.

Yet the public debate has focused almost entirely on issues involving access to specific surgical interventions, with the focus on availability of surgeons. Although important, surgery is only one point along a care pathway for a patient. Not only does this limited focus obscure issues around access to other services offered by physicians, it ignores barriers to access to services provided by other health providers. In other words, the current debate on accessibility by zeroing in on specific surgical wait lists has lost sight of the continuum of care and the full range of services that make up the health system.

Often what Canadians get are “bytes” of information which do not provide the underlying complexity of the system. As one interview respondent noted:

We have some models about things that do work...we are demonstrating that we can use providers better and need to communicate the success. From my perspective it is not so much that information is missing but how we communicate what we know and what we want to the public in a way [so] that they can understand the issues in a broader more holistic manner.

Many interview respondents noted that planning and policy making reflects a segmented approach to understanding access and that decisions aimed at improving access to diagnostics, surgery, etc, often do not map out the intricate interplays between various factors, for instance equipment purchases, human resource needs and population health needs². We cannot, for instance, concentrate resources into one area (e.g. elective surgery) without understanding the impact it will have on other health needs. A theme that emerged along these lines from the interviews and workshop is that the current movement to improve the timeliness of access to elective surgical procedures needs to be balanced with the need to ensure access to other services as well. There is a growing concern that in privileging certain procedures for special attention one runs a risk of undermining the integrity and sustainability of other services.

The First Ministers have grappled with laying out both a process and goals for health reform. In the 2003 *Accord on Health Care Renewal* governments committed to ensure that “all Canadians have timely access to health services on the basis of need, not ability to pay, regardless of where they live or move in Canada”³. The phrase “timely access to health services” suggests a broad conception of a fulsome range of services. The *Accord* itself

enumerates specific areas including diagnostic procedures, treatments, home and community care services, pharmaceutical care and primary care⁴.

Although this broad range of health services is reiterated in the *2004 Ten Year Plan to Strengthen Health Care* there is also evidence that what preoccupied the First Ministers was the issue of wait times and wait list management in five specific areas. The *Accord* committed \$5.5B to a Wait List Reduction Fund specifically aimed at wait times for advanced diagnostics, cataract surgery, joint replacements, cancer and heart surgery. For each of the five, governments agreed to create a set of evidence-based benchmarks for medically acceptable waiting times by December 2005 and the meaningful reduction in waiting times by March of 2007.

There is considerable information regarding access to physician- and hospital-based care, including the difficulties that Canadians face in accessing specialist care, routine care, and diagnostics. Indeed, Statistics Canada puts out an annual report on access to these services. Moreover, the Canadian Institute for Health Information (CIHI) recently outlined a report on wait times for health services; yet this again focused on physician-based and hospital services though they do include at the end an analysis of “alternative levels of care” post surgery or hospitalization⁵. There is therefore a gap in data and information on the accessibility of community-based health services, of public health initiatives as well as those services offered by providers who are not physicians. Data is not consistently collected for instance, on Canadians’ experiences with accessing needed mental health or home care services across the country. Nor is there a good information base from which to build an understanding of the experiences of Canadians vis-à-vis services offered by providers who work either entirely or partly within the privately funded system. At issue here therefore, is full knowledge of the barriers and enablers to access to appropriate services including those delivered through collaborative teams and those supported by electronic and information technologies.

4. EVIDENCE FROM THE LITERATURE, INTERVIEWS AND WORKSHOP

The following section draws upon the literature, interviews with key informants and response from workshop participants, highlighting emerging themes and issues that must be incorporated into any conceptual model.

4.1. Definitions of Access

While there is an extensive literature on accessibility to health services there are no generally accepted definitions of “access”. Much of the definitions and typologies in many ways reflect a singular theme – that access depends on the availability of services and that access to these services is mediated in some way through social, political and economic forces. Gulliford *et al*, for instance, incorporate in their study on accessibility in health within the National Health System (UK) argued that access requires the following components⁶:

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- If services are available, in terms of an adequate supply of services, then a population may ‘have access’ to health;
- The extent to which a population ‘gains access’ to health also depends on financial, organizational and social or cultural barriers that limit utilization. Thus utilization is dependent on the affordability, physical accessibility and acceptability of services and not merely the adequacy of supply;
- The services available must be relevant and effective if the population is to ‘gain access to satisfactory health outcomes’. This requires a careful examination of availability and utilization of resources, including the appropriate human resources; and
- The availability of services, and barriers to utilization, has to be evaluated in the context of the differing perspectives, health needs and the material and cultural settings of diverse groups in society.

Other definitions incorporate individual action as an important element of access. For instance, Aday, Fleming and Andersen define accessibility as:

Those dimensions which describe the potential and actual entry of a given population group to the health care delivery system. The probability of an individual’s entry into the health care system is influenced by the structure of the delivery system itself (the availability and organization of health care resources) and the nature of the wants, resources and needs that potential consumers may bring to the care-seeking process⁷.

The element of individual action was reiterated by the interview respondents. Many confirmed that each patient brings to the patient-provider relationship a pre-existing set of expectations about the type of services they need and/or want from their providers. Some of the interview respondents contextualized this within the current discourse over patient empowerment and rights.

In many ways access is a very complex term and as illustrated above, many attempts have been made to define and conceptualized it within the literature. Within the current discourse over access within the Canadian health sector the concept of access has been reduced to its essential components. Thus, when asked to define access, the vast majority of the interview respondents stated that it means: “*The right services at the right time, in the right place or context*”. This definition includes the following dimensions:

- **Temporal Dimension:** the care needs to be accessed at the time that it is needed or wanted;
- **Context:** care is provided in different settings including community care or home care; and
- **Appropriateness and Quality:** health service is delivered by a provider or care team which has the skills and knowledge to do so. Canadians may have access to services but not to the appropriate provider.

According to the interview respondents, the principle of “reasonableness” is also part of an understanding of access. What is reasonable is underscored by the availability of

resources and capacity, the effectiveness of the treatment and the urgency or severity of the need.

Finally, the concept of “appropriateness” opens up the discussion beyond the current debates over waiting times. In some cases one service may be needed; in others, many services may be required within a care plan. The appropriate service(s) may include preventative care and public health (e.g. immunizations) or it may involve services which extend beyond what is covered under the *Canada Health Act* (CHA). For instance, home care, long-term care, much of the mental health system, prescription medications and a host of other services all fall outside of the scope of the CHA, but they all can be key elements of a patient’s care pathway. To illustrate this point, one can think about a patient who has just undergone a surgery. The care pathway for that patient may include physiotherapy. While the surgical procedure may have been accessible, the physiotherapy services may not due to costs (physiotherapy services may not be covered by the province). As a result the patient may risk further surgical intervention⁸. Finally, another important element around appropriateness is that services reflect the cultural and demographic makeup of the population.

The participants in the interviews and workshop consistently made the point that access needs to be framed holistically and that to date, much of the planning process around access to health services has been segmented.

4.2 Core Values

In 2001 the Canadian Policy Research Networks as part of its Dialogue with Canadians on the Future of Health Care in Canada (undertaken on behalf of the Romano Commission), Canadian citizens prioritized the following issues around their vision for the Canadian health system⁹:

- The preservation of the core Medicare values of universal coverage, access based on need, and fairness;
- A system of primary care coordinated by a team of health professionals (doctors, nurses, pharmacists, and others), whose practice would include a focus on wellness and prevention supported by a central information system;
- Responsibility for their own care (e.g. follow-up on treatments, monitor conditions, etc);
- An electronic health card, or "smart card";
- Additional funds for their preferred health system ruling out greater private investment through a parallel private system;
- A consideration of user fees for extra services (e.g. second opinion);
- Public funding for health through taxation that would include:
 - Better accountability from providers and governments as well as users;
 - Greater transparency about where the money goes and its impact; and
 - Additional taxes must be earmarked for health;
- Creation of an "auditor general for health"; and
- Greater efficiency and co-operation within and among governments.

Much of the discussion within the workshop and key informant interviews reflected these core values. They reiterated the need for multidisciplinary teams with the appropriate mix of

skills to best respond to the needs of the community. They also argued that providers need to be able to better communicate with each other and with patients.

The interview respondents and workshop participants also noted the need for more cost effective strategies. For instance, they pointed to production efficiency to ensure that the investments (e.g. equipment, technology and personnel) in responding to a disease or health condition or situation translate into better health outcomes than the next-best option. This might include balancing the costs and outcomes associated with different care models and that provided by different providers¹⁰. For instance, delivering services in the community is often less costly than delivering those same services in an acute care facility. While we always need to be wary of professional interests and turf protection within these discussions, the fact remains that *if* “service X” provides comparable or better quality care at a lower cost, then this needs to be incorporated into discussions around access.

4.3. Mediating Factors

Much of the literature on access incorporates a more systemic analysis of mediating factors or factors which by their presence either impede or facilitate access to health. These mediating factors include, as Andersen (1995), notes, the physical, political and economic environments and the structure of the health system (policy, resources, and organization)¹¹. One typology on access developed by Penchansky and Thomas (1981), for instance, is predicated on a “fit” between the client/patient and the provider which is mediated by several factors including¹²:

- *Availability*: Prices in relation to the client’s ability to pay and perception of worth;
- *Spatial Accessibility*: the geographic or spatial accessibility of providers;
- *Accommodation*: the extent to which the provider’s operation is organized to meet the needs and preferences of the patient/client; and
- *Affordability*: the ability and willingness of clients to pay for services.

Other authors outline other mediating factors. Mackillop (2004), for instance, adds the awareness of services and the indications for their use among providers and patients as another important mediating factor¹³. Sinay (2002) argues that barriers to care include factors related to the receipt of services like financial capacity (e.g. lack of insurance or too little insurance, high co-payments and deductibles); health provider and organization-related difficulties (e.g. lack of physicians, hospitals in the network, and referral problems); and personal problems (e.g. those related to culture, language, or knowledge)¹⁴. Mediating factors also include spatial considerations (e.g. distance) though for a number of the interview respondents, this was related more to access to transportation than distance to services.

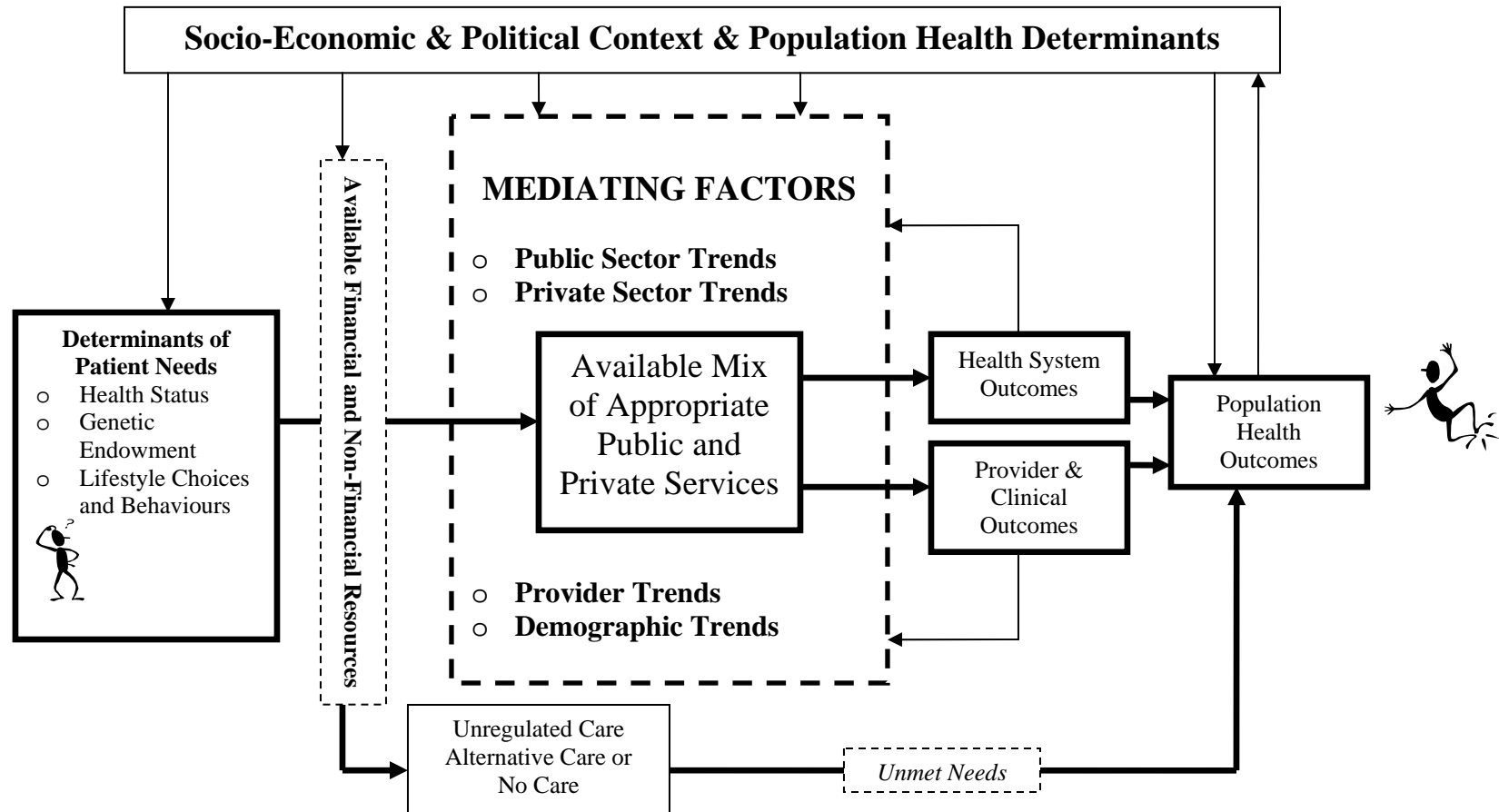
5. CONCEPTUAL MODEL

5.1 Overview

The following section builds on the themes developed in section 4 and provides a conceptual model for understanding access to health services in a broader context. The model developed below [Figure One] builds on previous definitions, typologies and models on access found within the literature and suggestions arising from key informant interviews and the workshop participants. One issue the workshop participants raised was that current models and definitions of access are rarely “forward looking”; that is, they often describe the system as it exists rather than envisioning what it is that we want our health system to be and how we can get there.

The conceptual model and indicator lists provide a roadmap for framing discussions around which services are available and for whom. Performance measurements or indicators are needed to measure and monitor the impacts of new policies or programs and ease of access. As defined earlier these measures would incorporate indicators of quality or care and patient safety. Indicator lists are provided in the Appendices and within the body of the paper, though it should be noted that the development of indicators and performance measurements is on-going in Canada and internationally.

FIGURE 1: A Conceptual Model for Accessibility to Health Services



The following are discussions of the various elements of the model.

5.2. Social, Political and Economic Context

Rather than attempt to elucidate all of these elements in the conceptual model presented, we have tried to indicate those points of intersection and to examine where specific elements of the social, political or economic context has a direct impact on the issue of how we think about accessibility to health services and where those services have an impact on or are conditioned by other social services or social needs of patients.

5.3. Patient Needs, Resources and Choices

According to the interview respondents and workshop participants services need to be patient-centred, with service delivery reflecting the continuum of care required by each patient. The patient is an active rather than passive participant in the development of care pathways which reflect genetic make-up, language, skills, cultural mores, affordability, transportation, etc. A patient may choose to seek alternative health therapies (e.g. traditional healers, Chinese acupuncturists¹⁵, homeopathy, etc). Or the patient may develop their own self-care plan based on available information (e.g. through the media, word of mouth or the internet), provider input, or through seeking “virtual care”, for instance internet support groups. He or she may also have access to care provided by family members, mainly women, who themselves often require support and respite.

These service choices may also be used to complement the services of regulated providers; the interplays between all sources of care, however, are often unknowns. So too, little is known about how these choices translate into unmet needs, or the “difference between health services deemed necessary to deal with a particular problem or the actual services received”¹⁶. It is as important to understand why Canadians may not choose to access care within both the publicly funded and privately funded sectors as it is in understanding how many Canadians do access care. For instance, negative experiences with service provided (e.g. experiences of adverse events or discriminatory practices) may factor into decisions to not enter the health sector. Finally, patients also have choices around the number of times they access services and under what circumstances though these choices may be ameliorated by their available resources, financial or otherwise. They may, for instance, over-utilize some health services or choose to use the health system responsibly. Much depends on which services are available.

5.4. Mediating Factors

There are various factors which govern the relationship between the decision to access services and service availability. Many of these factors are related to the resources available to the patient or client which are determined by the socioeconomic and political contexts (e.g. rates of poverty, unemployment, etc). The interview respondents and workshop participants were given a preliminary set of mediating factors. Their comments and prioritizations are woven into the following discussions. The mediating factors described below are illustrations.

5.4.1. Demographic Trends and Issues

There are numerous examples of how demographics and social trends mediate the availability of services. The literature review provided a wide range of population trends which mediate accessibility including: gender¹⁷, immigration status¹⁸, geographic residency¹⁹, ethnicity²⁰ (e.g. Aboriginal Canadians²¹), age²², and socioeconomic status²³. For instance, the influx of immigrants to urban areas plays an important role in determining the mix of needed services which includes cultural awareness and languages. Ensuring that all Canadians can access the most appropriate services means shifts in prioritizations, resource allocation and program development.

Examples of the mediating factors related to population health trends are outlined below.

- Aging Population

One of the most pressing population trends is that of an overall aging of the population. According to Health Canada by 2026, one Canadian in five will have reached age 65²⁴. Life expectancy at birth is expected to reach 81 years for men and 86 years for women in 2041²⁵. This has implications for the prioritizations of services needed that are needed now and within the future. For instance, the current benchmarking and the ensuring allocation of resources for cataract surgery and joint replacement surgery reveal to an extent, the political and social clout of the large age cohort especially since these interventions are relatively unheard of for Canadians 40 years of age and younger²⁶. A number of interview respondents and workshop participants stated that while there is a need for benchmarks in these areas; this took resources and time away from other subpopulations. One interview respondent took this one step further by arguing that pouring resources into enhancing access to some elective surgeries diverts resources away from other more pressing health concerns, including those of children.

- Aboriginal Health

Much work is underway to improve overall health outcomes for Aboriginal Canadians. To begin with, ensuring quality outcomes for Aboriginal Canadians has meant a fundamental reworking of the importance of the complexity of culture within health service delivery²⁷. Prioritizing Aboriginal health translates into a transformative reworking of Canadian health by highlighting the importance of culture in the patients' care plan which includes the availability of services of traditional healers and a holistic and balanced approach to health and wellness.

There have been commitments made in further prioritizing Aboriginal health and wellbeing. In November, 2005, the First Ministers confirmed their commitment to health improvements with the *Blueprint on Aboriginal Health*²⁸. This prioritization includes resource allocation and funding aimed at improving the health and well being of Aboriginal Canadians.

- Population Health Trends

Population health trends also emerge which directly impacts policy prioritization and service availability. Rates of obesity, smoking, sedentary lifestyles are rooted within both social and personal responsibility. For instance, investigations into rates of obesity have branched out from the individualist approach (e.g. lifestyle choices) to the connections between obesity and other determinants of health including job stress, access to high-quality foods, etc. Curbing this health trend therefore entails a multi-dimensional approach which includes access to other services such as the affordability of nutritious food and workplace fitness²⁹. Thus, attention needs to be paid on the various connections between obesity and access to several health services (e.g. access to nutritionists and dieticians for preventative services), the linkages between the social determinants of health and obesity (e.g. stress) and through the promotion of healthy lifestyle choices within the educational institutions and workplaces.

- Mental Health and Addictions

Another important prioritization in recent years is the greater attention being paid to the need for improved access to mental and addictions services in Canada due to the recognition of its impact not only on health outcomes (e.g. mortality rates) but on patients' quality of life, family cohesion and productivity. Partly this has meant breaking down barriers such as the stigma associated with mental illness but it has also meant understanding the most effective mix of services needed by patients which may include a wide range of private and public sector health services and community based services. The announcement of the position of a Mental Health Commissioner for Canada in November, 2005 and the recent release of *Out of the Shadows at Last* by the Standing Senate Committee on Social Affairs, Science and Technology³⁰ signal a movement towards addressing access to mental health services. We need, however, to be very clear about what services are the most effective for recovery keeping in mind the availability of practitioners.

5.4.2. Government Legislation, Policies and Priorities

There are several issues related to the organization of publicly funded services which serve as important enablers to accessing health services. The *Canada Health Act* (CHA) serves as an important enabler for accessing physician-based and hospital services. Provincial plans provide some services outside of the scope of the CHA such as home and long-term care, although these services often involve user fees or co-payments that can limit access. In addition, all provinces provide some services, such as prescription drug coverage, to specific populations such as low-income families or the elderly but this coverage varies considerably across Canada. Many Canadians rely on employer-provided insurance for access to non-CHA services but many Canadians must pay for these services out of pocket³¹. In many cases community-based services (e.g. some mental health services) are also provided through public funding, though again, access is often inconsistent across provinces and though little is known about their exact nature, waiting lists for these services may be extensive.

The *Canada Health Act* covers only those medically necessary services delivered by physicians or within hospital or clinical settings. Although there is a high level of consistency across provinces in terms of what services are covered under the CHA, there is some variation mostly in the scope and extent of coverage of “medically necessary” services

provided outside of hospitals or by health professionals other than doctors. Thus, many provincial health insurance plans may provide for bi-annual eye exams or some physiotherapy services or some form of home care and these services may have significant variations in terms of required user fees or co-payments.³²

The following provides a brief description of some of the public sector trends:

- Delisting

In an effort to contain costs within a system with scant resources, provinces have significant discretion to “de-list” non-CHA services and make access to those services conditional on an individual’s ability to pay (directly or through private insurance). In recent years there have been moves to remove the provision of physiotherapy and chiropractic services from provincial insurance plans or to move from annual to bi-annual eye exams. There is much less discretion to de-list physician and hospital services, though provinces can sometimes delay adding new procedures to the list of covered services and some minor procedures, like routine male circumcisions, have been removed from coverage in most jurisdictions. Many of these decisions are often made without developing a framework for understanding how the delisting of services impacts Canadians access to health services, their impact on health spending, and the impact on overall health outcomes.

- Gatekeeping and Referrals

The ease of accessibility to services is often mediated by the “gatekeeper” model of care. The current system tends to place physicians as the primary point of entry to other health services. Oft-times, the current shortage of family physicians structurally hinders patients from accessing appropriate care within a reasonable time frame. A point raised within the interviews is that physician-based referrals are not always appropriate. It has been suggested that changes need to be made in the way people can access primary care allowing for more patient control over the point of entry to specialist services. As noted by one interview respondent: “The system should be centered [on] the service rather than the health provider”. Another interview respondent noted that changes in referral practices are linked to changes in waiting times. If for instance, a physician refers a patient to a hip and knee replacement centre then the patient gets placed within the first available slot rather than spending time waiting for the visit to a specialist. In some jurisdictions patients are provided with information regarding waiting times for procedures thereby allowing for more informed decisions about the waiting period.

- Wait List Management

One of the key drivers of the current debate about accessibility has been the perceived failure of the public health system to effectively manage wait lists and wait times for certain surgical procedures. In 2005 the Supreme Court of Canada ruled in *Chaoulli v. A.G. Quebec* that the government of Quebec was violating the Quebec Charter of Rights by refusing to allow patients to purchase private insurance for those procedures for which they had waited an unduly long time to receive in the public system. As a direct result of these concerns both the federal Liberal and Conservative parties made the development of “care guarantees” for some surgical services key planks in their 2006 election campaigns.

Wait list reform in the publicly funded sector, while incremental and inconsistent across Canada is leading to positive changes in the timeliness of care. For instance, the efficient management and monitoring of waiting times through the Saskatchewan Surgical Care Network requires that regional health authorities assume responsibility for reducing waiting times through effective scheduling, and/or the management of the necessary human and financial resources³³. Other models involve streamlining the referral system. In the traditional referral practice, family physicians refer their patients to a specific specialist which creates a variable wait list. Within new models, patients are referred to a triage centre (e.g. a hip and knee clinic) which places them within one list. This ensures that the person with the greatest health and social need is given first available slot within a managed system. The Alberta Hip & Knee Replacement Project, which includes a standardized referral system, has already shown a marked reduction in waiting times for hip and knee replacement³⁴. Indeed, the development of a regulated list-length policy reduces uncertainty in reporting expected waits which in turn serves to improve resource planning³⁵.

- Advances in Technology

Finally, many of the innovations in pharmaceuticals, health technology and information technology (IT) will continue to shift the dynamics of accessibility in Canada. Improvements in surgical procedures can result in shorter hospital stays and greater reliance on post-operative home-care for which the patient may have to pay out-of-pocket expenses. New pharmaceuticals can mean the deinstitutionalization of psychiatric patients who may then need access to better and more coordinated community based services. Ever-improving diagnostic imaging requires either greater investments within the public system to meet both the demands and expectations of patients and providers or the shifting of those services to the private sector where access becomes a question of personal resources.

There have been vast improvements in our health information systems creating new avenues for service availability. In 2001, for instance, the Canada Health Infoway – established through the collaboration of the federal, provincial and territorial governments – was launched to develop and deliver several health information based solutions to ensuring more timely access to health information and records across Canada. This involves the creation of a more comprehensive information infrastructure for the development and delivery of electronic health records (EHR).

Electronic health records (EHR) ensures greater access to health records which would not only improve patient safety but also assist in the ease of intake for patients since they would not have to repeat their health or social history to different providers at each point of intake. The use of EHR systems may also facilitate the tracking of patients within the system, providing needed information on waiting times. Moreover, electronic health records not only facilitate the ease by which information about our health needs can be accessed, it improves the quality of our care by ensuring that providers can access information about our care at any point of our health plan. This improves the integration of services, reduces the occurrence of errors, and enhances the efficiency by reducing duplication and improving the flow of information³⁶.

As well, innovations in telehealth services have transformed accessibility concerns for many Canadians. For instance, telehealth services have been developed to mediate accessibility to health services for Canadians living in remote regions in Canada. Technology also enables self care. One example of this is the telehomecare services pilot in Toronto which uses technological advancements in enabling self-care among home care patients³⁷.

There are several technological advances noted in the literature and by the interview respondents as mediating accessibility in Canadian health. One of the most critical of these advances is the availability of telehealth services³⁸ and communications which mediates accessibility after hours and for Canadians living in remote and rural areas³⁹. There are many different capabilities of telehealth which ensure better accessibility including⁴⁰:

- The ability of two physicians to discuss a patient's problems by telephone;
- Health information being transferred, safely and confidentially, between computers via high-speed telephone lines;
- A patient getting a face-to-face examination by a remotely located doctor, through interactive video-conferencing; and
- Medical images previously photographed and stored on computers, being forwarded later to remotely located professionals.

5.4.3. Private Sector Trends and Prioritizations

An analysis of accessibility in Canada cannot downplay the importance of the marketplace and the divide between the private and the public. Seventy percent of health spending comes from public sources with the remaining thirty percent coming from a combination of private insurance purchases (by employers and individuals) and out of pocket payments by individuals. The delivery of health services is a complicated mix of private, quasi-public and direct public provision. Most physicians are private sector actors (although paid with public funds) while hospitals are operated by arms-length regional health authorities in most provinces or are not-for-profit private facilities paid with public funds in Ontario and Quebec. In addition, private sector actors, including but not limited to, multi-national pharmaceutical companies can play important roles in shaping the demand for the specific services and our expectations for what services we should have access to⁴¹.

At the one end of the spectrum are those that maintain that health services are the purview of the public sector and as such services should be publicly owned and financed. At the other end are those that argue that introducing market incentives into the health system will ensure speedier and more efficient access to health services and the development for-profit specialized clinics which would take some of the burden off the public sector.

Navigating this divide and its impact on access is difficult since it is manifested not only in terms of practice but in the manner in which providers are paid (e.g. fee for service, salary, mix funding models, etc). This also encompasses the role of both for-profit and not-for-profit third parties (e.g. private insurance, hospitals and services, R&D, etc) in determining appropriate care. A full analysis of these intersections is beyond the scope of this paper; the role of the marketplace in mediating access to quality care will need to be more fully mapped out. However as a simplistic description shows, there are many facets to the

private/public models and their role in accessibility. First, access to health services may involve a continuum of payment options which range from being entirely paid by public funds to those which are entirely out of pocket. We cannot, for instance, understand accessibility as solely resting within publicly paid for services but rather, need to extend our understanding to privately paid for services such as dentists, chiropractors, those who straddle the private/public payment divide (e.g. psychologists, physiotherapists, etc) and those who are paid through public funds through various models (e.g. fee for service, salary, etc). Some physicians, for instance, work under a salary though most work in private practice with their fees paid for through public funds. It is beyond the scope of this paper to make these intersections though they are of primary importance.

Secondly, private care itself is comprised of two separate models: for-profit which encompasses care which is owned by investors, and not-for-profit care which is owned by communities, religious organizations, or philanthropic groups (e.g. hospitals). As well, most physicians operate as small private businesses paid by public funds. It is difficult to compare for-profit and not-for-profit care provision since they generally do not provide the same services, have different priorities and serve different clientele⁴², there is a growing consensus that while for-profit hospitals and care provision in general may be appear to more innovative and more flexible, they may be more costly and provide less than optimal health outcomes⁴³. On the other hand, innovations in the public health system, such as those in reducing waiting times (e.g. Alberta Joint and Knee Replacement Project and provincial waiting times websites) show that flexibility and innovation can also be exhibited within the public sectors. There are, however, sides being drawn up between those who fear creeping privatization and thus adopt the “wait and hold” approach and those who argue that change has been too slow – that more privatization may stimulate the reduction in wait times.

- Private Institutions

Experiments in service provision, such as private clinics which provide standardized, highly replicable services (e.g. hernia operations) may increase access to services, though there is little evidence that it may apply to more complicated procedures such as cancer surgery⁴⁴. Nor, if they were forced to internalize all costs, such as the cost for shifting complicated cases back to the public sector, if they would remain profitable. As well, there is no reason that public sector services could not benefit from learning from private efficiency models.

- Third Party Intermediaries

A general discussion within the workshop centred on the inclusion of how third party intermediaries, especially private insurance, determine access to services. For instance, private insurance companies often serve as gatekeepers to what care is needed and available along the patients’ care pathways. One interview respondent noted that: “One of the things that insurance companies encourage is having gatekeeper role – they claim that it gets patients to right providers. But this limits access. If someone has a car accident getting the most appropriate treatment, for instance, from physiotherapists, is critical. Third party payers determine what and how many treatments are needed; although by the time intervention takes place, there has often been muscle tissue damage over time”. Their role in the timeliness of

access to appropriate services is critical. Third party payers may also have a policy of limiting or denying access to pre-existing conditions⁴⁵.

Another example offered by an interview respondent is the role of drug companies in mediating the availability of appropriate drugs for Canadians. Here, the decision to launch or not launch medicines within Canada are affected by changes in Canadian regulatory practices. Manufacturers may delay launching product in Canada or not launch it at all because of regulatory issues such as the Common Drug Review.

5.4.4. Provider Trends and Issues

There is an existing and growing shortage in health providers within the country and internationally. This shortage directly affects the availability of services. For instance, many Canadians lack a family physician⁴⁶ and there are critical shortages and misdistributions for other health professionals. The following highlights some of the human resource issues affecting accessibility.

- **Recruitment and Retention Strategies**

A human resource capacity within the system is intrinsically linked to accessibility. Ensuring the right skill mix and the availability of services is closely linked with the availability of providers. To ensure that we have a human resource capacity, several recruitment and retention strategies have been proposed or developed to maximize the availability of providers within the system. These include quality workplace and “magnet” hospital initiatives⁴⁷, retaining older workers⁴⁸, improving the assessment and integration of internationally trained physicians and nurses⁴⁹, and introducing measures to recruit First Nations, Inuit and Métis Canadians into not only health professions but also within leadership roles, research, policy, and teaching⁵⁰.

- **Maximization of Scope of Practice**

If providers are not working to their full capacity, then the availability of services is more difficult. . One interview respondent, for instance, noted that “Full scope of practice policies would also help use providers more efficiently and this especially true in emergency rooms where RNs could do so much more”. . Another strategy for ensuring the availability of appropriate care is the expansion of the scope of practice of providers, namely nurse practitioners⁵¹, midwives⁵² and pharmacists⁵³. The United Kingdom, for instance, has expanded the scope of practice for pharmacists since they are typically the first contact patients have with health system. The strategy of broadening scopes of practice, however, needs to be contextualized within impending human resource shortages in other providers. Work is needed, however, to ensure that the roles of providers are coordinated.

- **Interprofessional Collaboration**

An important component of primary care reform in Canada is the development of multidisciplinary teams which facilitates the ability of Canadians to access the most appropriate care provider ideally within a one-stop integrated care model (e.g. group health centres or primary healthcare advancement sites⁵⁴) which focus on the needs of the specific condition or patient⁵⁵.

The development of ideal mixes and availability of health providers and services has necessitated the incorporation of different educational models which train students to work together as teams rather than within their own professional silos. Currently, the model being investigated is the Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP) wherein students are trained to work to their full practice within teams⁵⁶.

The goals of IECPCP training include:

- Enhancing patient-, family-, and community-centred goals and values,
- Providing mechanisms for continuous communication among health providers,
- Optimizing staff participation in clinical decision making (within and across disciplines), and
- Fostering respect for the contributions of all providers⁵⁷.

Several initiatives are underway in Canada based on the IECPCP model. It is too soon to comment on their impact on job satisfaction and/or in optimizing health outcomes for Canada.

5.5. Availability of Appropriate Care

According to the interview respondents, access means the right services at the right time, in the right place or context. We therefore need to develop a more concise picture of what services and provider mixtures are appropriate for the patients' overall care plans (e.g. pre- and post operative care) which extend beyond services covered under the *Canada Health Act* and those (though inconsistent across the country) covered by provincial plans. Appropriate care within a patient's care pathway may require services provided within the privately funded system. Their availability (e.g. affordability) must be part of the overall discussion on access. A preliminary set of indicators can be found in Appendix Three.

Much of the discussion and policy around the appropriateness of available services and the ease by which they are accessed have typically been reductive in approach, reflecting acute and physician-based services though there is more of a willingness to expand this discussion to incorporate other providers. According to one interview respondent, the most appropriate service mix for a child experiencing behavioral problems at school may include the services of educational psychologists, general practitioners, psychiatrists, social workers and/or nurses. If these services are beyond the scope of the patient financially, are not available due to worker shortages, or the rationalization of services (e.g. delisting of services) then the term "appropriate" becomes more of a catchphrase with little operational value. The respondent noted that services may exist but be out of the reach of the low income people who need them the most.

According to the literature and the key informants, the availability of services has three components:

- 1) Time-based (services are available when they are needed);
- 2) Financially (services are affordable); and
- 3) Geographic location (services are available e.g. their existence within a health region).

Accessibility in Canadian Health Care

The first of these criteria – time-based availability, has been defined in Canada through waiting times for services and the number of patients or clients on waiting lists. Much of the activity around timeliness, as stated before, has reduced to diagnostics and four health procedures and interventions (e.g. cataract surgery, cancer care, coronary care and joint replacement surgery) and diagnostics. CIHI has recently released a document which outlines the difficulty in measuring waiting times for the five areas noting there are extenuating circumstances around differences in the types of patients, differences in defining waiting times, and differences in the ways to measure waiting times⁵⁸.

Time-based availability can also be defined through the need for after-hours care, or that which extends beyond the traditional 9-5 working days especially in light of the commitments made by the First Ministers to move towards accessibility to primary care 24/7. There is an operational disconnect issue here, however, between ensuring greater after-hours accessibility through the provision of walk-in clinics and telehealth services (which enhance the availability of care) and continuity of care⁵⁹.

Another element of availability to appropriate care is its affordability though this is also framed within discussions over the sustainability of health services in Canada rather than solely as an element of individual access. While the *Canada Health Act* and provincial plans ameliorate much of the issue around affordability, there is a lack of a robust discussion over the affordability of services available within the privately funded sector (e.g. dental health, optometry, and private practice psychologists).

The availability of appropriate services can also be understood geographically – or whether they are available within a health region or neighbourhood. Often this is framed within a discussion of what is reasonable given the dispersion of the population in Canada. What is reasonable varies for different population groups. For instance, a low-income mother without access to a car may not have reasonable access to services beyond her neighbourhood while geographic distances often impedes access to services for Northern residents.

There has been increased activity in developing consistent measures on various aspects of the health system, mainly due to greater demands for more accountable reporting structures. The Canadian Institute for Health Information (CIHI) has taken the lead in developing indicator lists around access, though to date, many pertain to hospital and physician based services. They are developing indicator lists on access to primary care which will yield invaluable information. In addition, there are indicator lists being developed for other sectors, for instance, the number of patients on waiting lists for home care services⁶⁰; and the average wait time to access a primary health team or organization for acute episodic care and non-urgent and routine care⁶¹. These types of indicators could feasibly be expanded to include other health professionals and care settings, for instance mental health services and community-based addictions services, and long-term care.

5.6. Outcomes

There are two levels of outcomes noted within the model. The first are the intermediate outcomes which related to specific system and provider outcomes. These outcomes may be viewed as the end-result of investigation; for instance, we may wish to know if the availability and mix of some services result in cost effectiveness for the overall health system or improve its quality. Ultimately, however, we want to know what factors are related to the optimization of health and quality of life outcomes for all Canadians. Thus, including outcome measures sets up the feedback loop to policy and program development and/or implementation.

There are some caveats. Not all outcome or performance indicators can be easily measured nor can they be accurately measured at any one time. For instance, measuring quality in health is often reduced to readmission rates, yet it is intrinsically linked to cost effectiveness models and efficiency. It is also difficult to ferret out the cause and effect of interventions with outcome measurements especially due to the complexities within the health system.

5.6.1 System Outcomes

It is important to be able to evaluate and measure access around several system variables. They include:

- Equity

Most Canadians value the Medicare system because it mediates the affordability of core services. This value has been enshrined within the Canada Health Act which defines accessibility as: “reasonable access by insured persons to medically necessary hospital and physician services must be unimpeded by financial or other barriers”. There is a moral obligation explicit within this definition – equitable access depends on an adherence to principles of fairness, equal merit, and the application of similar treatment for similar needs.

Monitoring the equity of the health system is typically done through monitoring differential health outcomes of various Canadian subpopulations (e.g. Aboriginal Canadians, women, and children). What is seldom researched and which has important implications for policy, is differential access to private services and other care settings (e.g. home care) which is mediated by their inclusion or exclusion within provincial insurance plans and the nature and extent of co-payment or user fees, and their health outcomes. One interview respondent, for instance, stated that little is known about the impact of delisting services on health outcomes.

- Quality Care

The key informants as well as the participants in the workshop stressed the importance of contextualizing accessibility within a discussion of quality care. Simply put Hospital A may perform more surgeries than Hospital B, but this does not mean that Hospital A has better outcomes or provides better quality care. Thus we cannot simply refer to a quantitative analysis of services per se in order to monitor accessibility; we need to also assess the quality of the services provided.

There is an inherent paradox that exists here between quality and provider productivity. We may have more people seen by physicians which increases accessibility in numerical terms; however we also need to reflect on whether this translates into optimal overall health outcomes. Thus, as OECD notes, quality of care indicators provide information around the “value” in the “value for money” equation in health which is a key issue in measuring the performance of health systems⁶². The OECD provides quality of care indicator lists for five program areas: Cardiac Care; Diabetes Care; Primary Care and Prevention; Mental Health and Patient Safety which are available on their website and currently developed a conceptual framework for developing indicators for quality care⁶³. Another example is the American Agency for Health Research and Quality’s *State Snapshots 2005* which presents a list of dashboard indicators used to compare state performance across various health areas from maternal and child health to mental health services⁶⁴.

- Effectiveness

The system must be effective, sometimes defined as whether the “health system interventions achieve defined goals for health outcomes, and for the outputs and quality of the process of care”⁶⁵. CIHI has developed several indicators around the effectiveness of services, though they mainly relate to ambulatory and acute care services⁶⁶.

- Patient Safety

Patient safety can be viewed as freedom from accidental injury or the avoidance of injuries or harm to patients⁶⁷. It is assured through the “establishment of operational systems and processes that minimize the likelihood of errors and maximizes the likelihood of intercepting them when they occur”⁶⁸. These could be measured through several indicators including incidents of foreign bodies left during procedure⁶⁹; wrong-site surgery⁷⁰; selected infections due to medical care; mortality for selected tracer conditions and procedures⁷¹; readmission for selected tracer conditions and procedures⁷²; admission after day surgery for selected tracer procedures⁷³; return to higher level of care (e.g. from acute to intensive care) for selected tracer conditions and procedures within 48 hours⁷⁴; rates of drug interactions; rates of misdiagnosis; in-hospital hip fracture⁷⁵; birth trauma⁷⁶, etc.

5.6.2. Provider Outcomes

Provider outcomes are linked to access and overall health outcomes. These could include workers who work in quality workplaces, are well trained, have a good work-life balance, and are mutually respectful and communicate well with each other. Linkages are being made between patient safety and outcomes to the working conditions of health care providers (e.g. shift work, extended work hours, etc). Other areas of exploration include the impact of the quality of relationships between providers⁷⁷ (e.g. communication, respect) and between providers and patients⁷⁸ (e.g. participation in consultation process, family counseling) on the optimization of outcomes.

- Multidisciplinary Teams

Some work on indicator lists around access to multidisciplinary care is already been underway, especially by the Canadian Institute for Health Information⁷⁹. The rate and success of multi-disciplinary teams can begin to be measured through the following indicators: percentage of GP/FPs who report working in the same practice setting as selected other

providers⁸⁰; number of multi-disciplinary primary health organizations or teams by region (rural/urban)⁸¹; percentage of population routinely receiving needed care from a multi-disciplinary primary health organization or team⁸². An indicator list also needs to reflect different units of analysis such as a health practice or institution. For instance, innovations in one-stop integrated care practices will need to be reflected in our overall analysis and measurements.

- Communications and Mutual Respect

The quality of the relationships between health providers within their workplaces and between patients and providers has important implications for the provision of quality care. This means assessing the quantity and quality of communications between health providers within various settings, and the more qualitative elements of mutual respect and relational dimensions. Much of the work in this area reflects the traditional physician-nurse relationship; in a cursory review of the literature, little of the research focuses on the relationship and quality and quantity of communication (or lack thereof) between other care providers working within the system.

- Productivity

Provider productivity, which is traditionally defined as “the ratio of outputs (goods and services produced) to inputs (resources used in production)”, emerged as an issue within the workshop. If a provider is more productive than another, than he or she sees more patients with the same resources or sees the same amount of patients with fewer resources. It provides an important measure of performance against available resources and may be developed according to accepted workplace standards or through qualitative self-assessment. There is also an important distinction between productivity and quality. A provider may be very productive in that he or she is able to see more patients than others in the same time span, but may not necessarily provide better quality of care. For instance, being rushed through a provider’s office may not give patients a chance to ensure that all of their needs are adequately addressed. Thus the availability of services is linked to the time spent in offices. One workshop participant argued that we cannot just count the times a provider sees a client, we also need to know what happened within that visit – for instance, the length of the visit and which issues were discussed.

Tomblin Murphy and O’Brien-Pallas (2004) suggest the following priority national indicators for measuring worker productivity: The proportion of health personnel working beyond some measure of maximum capacity; worked hours/activity statistics; and earned compensation/activity statistics⁸³. They however, note that we need to customize our indicators to capture the specific productivity of providers other than physicians and nurses: “The concepts of maximum capacity and/or activity statistics are not consistently defined for all types of health care providers. For example, research in these areas has been more prevalent for physicians, nurses and some of the allied health personnel.

Therefore, it must be recognized that this may be an area that requires further customization based on the type of health care professional”⁸⁴.

5.6.3. *Health Outcomes, Quality of Life and Patient Satisfaction*

The overall health outcomes, good or bad will all loop back to the policies and programs that we've prioritized. We have many measures by which to judge performance. We need to ensure that they are consistently collected so that we can make the best judgments about what we need in terms of service mix and appropriateness and how to tell if they worked or did not work to ensure the best outcomes. One approach, taken by the King's Fund Measuring Success in the NHS is predicated on the development of patient health outcomes through the use of patient questionnaires⁸⁵.

Many health indicators have been developed by various national and international agencies. The OECD, for instance, has created a series of health status indicator lists within their *Health at a Glance* series which is maintained by the Canadian Institute for Health Research⁸⁶. Other outcome measurements noted within the literature include patient satisfaction levels⁸⁷, psychological distress⁸⁸, and quality of life indicators⁸⁹. One caveat noted by one interview respondent is that the type of outcome measurement needs to be specifically related to the type of service provided.

6. CONCLUSIONS

6.1 Emerging Themes

A number of themes on accessibility to health services in Canada emerged from the environmental scan, key informant interviews and the workshop which informed the basis of the conceptual model. These themes include the following:

1. **Context:** The health system does not exist in a vacuum, but within a specific social, political and economic context which can directly and indirectly influence both how and when patients access services and how the system itself responds to issues surrounding accessibility. Levels of health spending by the state are subject to intense political debate and the need to balance that spending with other social spending or other political and economic objectives (e.g. lowering taxes or job creation). The changing demographic profile of the country shifts which services are needed. For instance, an aging population puts pressure on the systems ability to provide appropriate services for the elderly while a declining rural population often forces those remaining outside of Canada's cities to travel great distances for care. Technological advances within health can create pressures to continually invest in the "latest and best" while some technology, such as the internet has become a key vehicle for disseminating information (for both good and ill) about the health system by governments, stakeholders and private sector actors. The emergence of a public discourse centred on individual legal and constitutional rights in the past few decades is proving to be an emerging vehicle for citizen recourse when access to some services is curtailed or denied. All of these factors, and a host of others, coalesce to determine the expectations that Canadians have for the health system and provide both opportunities and constraints on how the system can or should respond.
2. **Development of a Roadmap:** According to the workshop participants, discussions on accessibility need to be more "forward looking" and incorporate planning and

prioritizations within the overall model. This involves an action plan which outlines what we want and how to achieve it while taking into consideration current trends in population health and policy prioritization. This involves a mapping out of how all the factors relate to one another. There are, for instance, relationships between the population health needs, the mix of providers needed to meet these needs and the factors which either impede or facilitate these needs (e.g. recruitment and retention strategies).

3. ***Determinants of Health:*** We know that access to services is only one component in producing good health outcomes. A myriad of social and economic factors (income level, income disparity, education level, access to a clean environment and adequate housing, access to social capital and level of social inclusion, etc.) can be more important in determining population health outcomes than the ability to access health services. At the same time, individuals' ability and need to access needed services can be significantly determined by those same factors that determine health outcomes.
4. ***Outcomes:*** The interview respondents and workshop participants stressed that an understanding of accessibility needs to incorporate system, provider and health outcomes and the interplays between them. One of the most common arguments that arose within the interviews and the workshop is we cannot separate access from the provision of quality care. Canadians deserve the best outcomes possible with the financial and non-financial (e.g. human) resources available. For instance, one interview respondent commented that: "We worry about joint replacement – we don't think about whether it was done well".
5. ***Mediating Factors:*** There are important mediating factors which intersect between need and the translation of need into the availability of services. These include demographics, social forces, population health trends, public and private system trends and issues, and trends related to providers (e.g. recruitment and retention strategies).
6. ***Patient Centeredness and Care Pathways:*** Accessibility needs to be framed within an expanded care pathway approach which includes health promotion and prevention strategies. For a number of interview respondents and workshop participants this was an important point. One interview respondent, for instance, noted that: "It not just about wait times for surgery it is about the continuum of care and care pathways". Another stated that: "There is a broad continuum of care – home care, psychology services, long-term, physiotherapy. It is not just about wait [times] for surgery, it is broader".
7. ***Private/Public Interface:*** We need to become much clearer on the private-public interface around payment options and delivery, especially in light of the need for better models of integrated care. For instance, most governments offer very few psychological services through public services therefore many Canadians needing their services need to pay out of pocket for these services or have access to private insurance. Moreover, the delisting of services such as physiotherapy has important implications for not only the health of Canadians but also in readmission rates. However, there is little discussion on these linkages. One workshop participant noted that: "What really upsets us about the

political debate... is that the private is viewed as bad and the public as good. There is a bunch of us in private sector, and this doesn't work. We need to broaden the debate”.

8. ***Expansion of Scope of Access to Include a Wide Variety of Services:*** The lens around accessibility to health services needs to be expanded to encompass the services provided by the multitude of providers along patients' care pathways. Most of the interview respondents and workshop participants agreed that this was an important factor and often they discussed the implications of how the narrowed scope of discussion misses the nuances of the services a wide range of health providers. For instance, according to one interview respondent, access to surgery can be constrained if there is a lack of providers other than surgeons such as operating room technicians. Another interview respondent further notes that: “Most people that really understand the issue know that it is about non-physicians”.
9. ***Connections to System Capacity:*** According to the interview respondents and workshop participants we need to explore the connections between resource management and system capacity (e.g. human resource planning) and the availability of health services. This involves:
 - Paying attention to the overall health system and the amount of resources available. For instance, focusing on elective surgeries may take resources away from long-term treatments or acute care cases; and
 - Exploring the linkages between health human resource planning and the availability of health services. One interview respondent noted here that often “[Health human resource] planning is not typically connected to health services planning and it should be. You need the people to provide the services”.
10. ***Unmet Needs:*** Often understandings of accessibility begin once the patient or client has entered into the system. The unmet needs of patients/clients and the rationales behind decisions to *not* access needed care are also important elements within an overall understanding of access. Yet as several interview respondent noted there is not much information on the unmet needs of Canadians therefore not much is known about it.
11. ***Information Transfer:*** A number of the interview respondents noted that information about waiting times and access in general is not communicated well to Canadians. Often Canadians receive only parts of information which does not allow them to make informed decisions about their care. One interview respondent, for instance, commented that: “For the average consumer access to sources about access are generally poor. Their first understanding of access comes from seeing family doctor”.
12. ***Data Limitations:*** Many of the interview respondents and workshop participants noted that they do not have access to comprehensive data about the nature of access to a wide range of services within the acute care setting and more so for other services and care settings. There is a dearth of information, for instance, around the affordability of privately funded services or the impact of policy decisions (e.g. delisting) on the quality of care received by Canadians. This has led to a lack of informed and comprehensive planning around service availability for a wide variety of areas. Where information is

available the interview respondents argued that it is often not well coordinated or integrated. As one workshop participant stated: “Just to have a comprehensive list of indicators would really help”. Other limitations to current resources noted by the interview respondents and workshop participants include the following:

- Most data sources do not provide information on how long patients have been waiting for services;
- Many data sources do not include the Territories, which skews the results;
- There are issues around scope of practice and reporting. For instance, a nurse in the city may specialize but nurses in rural areas are more generalized (e.g. public health, community health, etc); and
- The data sources and policy statements rarely speak directly to citizens; the educational value of these sources for enhancing citizen understanding of the issues involved in accessibility, therefore, needs to be considered.

6.2. Gaps in Knowledge

There were a wide variety of information needs noted by the interview respondents. On the main, there was a call for better evidence-based information on the accessibility issues arising from policy changes (e.g. delisting). Other gaps in knowledge reported by the interview respondents and workshop participants include the following:

1. General Gaps in Knowledge:

- Information on access issues regarding home care, public health interventions such as prenatal programming or immunization etc;
- Development of proxy measures of access (e.g. receipt of a health card as a proxy measure of access);
- Comprehensive data which captures the work of other providers in the system; and
- Appropriateness of access to care.

2. Gaps in Knowledge about the Private Sector:

- The impact of the delisting of services (e.g. the recent delisting of physiotherapy services in Ontario) on service availability and health outcomes;
- Statistics on the number of providers working within the private sector or within both the private and public sectors⁹⁰;
- The connections between affordability and access to some services such as pharmaceuticals, physiotherapy and psychology⁹¹; and
- The issue of data availability by third party intermediators was discussed within the workshop. There was a consensus that there needs to be more innovative ways of eliciting information about the private sector from third party intermediaries (e.g. private insurance brokers).

3. Gaps in Knowledge about Waiting Times

- The number of Canadians who are waiting for various health services including mental health services, home care, etc;
- The type of services (broadly defined) Canadians are waiting for; and
- The duration of the wait for various services.

4. Gaps in Knowledge about Process and Capacity

- Cost analysis of revolving door referrals at a national level;
- Capacity needs (e.g. data on volumes and dollars);
- The appropriateness or quality of referrals;
- The impact of regulatory changes (e.g. Canadian Common Drug Review) on access to services; and
- Data which breaks down the complexity within provider groups. For instance, little is known about family practice nurses – what they are doing and where they are practicing in the community.

7. RECOMMENDATIONS

There are several points that emerge. Although there is work being undertaken in Canada around the development of indicators for accessibility, much of this activity focuses on the development of benchmarks for hospital and physician-based services. It represents a good start but it is an incomplete picture. There are movements underway at the Canadian Institute for Health Information to develop indicators on access, for instance to primary care teams. Yet much of the discussion to date and the development of benchmarks has resulted in a concentration on access to five areas despite commitments made to more fully discuss access to other health areas (e.g. access to drug therapy, and home care). On balance, a good start has been made, now the momentum needs to steer the discussions around access to define what is “appropriate” and how this pertains to both privately and publicly funded services. Privately funded services are typically not included in discussions around access even though they comprise 30% of the overall health expenditures and are important components in the overall health system. One interview respondent in particular noted that what is needed is an “open, transparent and lively debate about the interface between the private and public sectors”.

Moreover, dialogues around accessibility need to be intersectoral and more systemic by including the perspectives of a wide variety of stakeholders including physicians, government, physiotherapists, nurses, psychologists, pharmacists, occupational therapists, speech therapists, patients, employers, government, etc. One interview respondent, for instance, noted that although employers play an important role in the accessibility of care, they are rarely asked for input.

Recommendations

1. Develop more specific and targeted performance measurements for the indicators for the many care settings and providers or link the existing databases within a comprehensive and integrated approach.
2. Another area for further investigation is that of the necessity and usage of patient recourse mechanisms such as care guarantees in expediting accessibility. While this is currently on the political and policy agendas, little is known about their composition and

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impact. We recommend an investigation into the role of care guarantees in determining timely access to services.

3. Citizens are provided with information which lacks comprehensiveness and does not promote the innovations taking place within the public sector. We recommend exploring effective knowledge transfer approaches to provide Canadians with more comprehensive information about the status of access in Canada including better information about what is working and what is not to manage waiting times.
4. Many of the interview respondents stressed the linkages between human resource capacity and accessibility. If, for instance, we seek to attain 24/7 access to appropriate care providers, then what does this mean for health human resource planning? We recommend exploring the linkages between human resource planning and accessibility.
5. Finally, this paper does not delve into any new areas, nor does it raise any points which have not been around for many years. In many respects this is a call to action to ensure that access to services is viewed holistically and thus that the current discussion on access be expanded to include other health sectors and services. For instance, we know that there are more cost effective and more efficient means of doing things, including queue management strategies within the public sector and we know that when we consider the mix of services needed that it needs to go beyond health services. What is needed is leadership from many sectors; including patient advocacy groups, provider groups, unions, government, researchers, and policy makers. We thus recommend identifying leaders who will move an agenda forward in exploring access as it pertains to services outside of physician base and acute care services.

APPENDIX 1: CURRENT POLICIES AROUND ACCESSIBILITY IN CANADA

To date, discussions and policy formation around accessibility are as follows:

- The College of Physiotherapists have developed policy statements using accessibility as an umbrella issue;
- The College of Family Physicians is working with CIHI on developing indicators for access.
- The College of Family Physicians of Canada did a paper in 2000 on primary care prescription for renewal and one on home care.
- The College of Family Physicians of Canada released two reports:
 - *Discussion Paper: Family Physicians Caring for Hospital Inpatients*, 2003; and
 - *Family Medicine in Canada: Vision for the Future*, 2004.
- The Canadian Medical Association has been working with the Wait Time Alliance on the development of evidence for benchmarking.
- The Office of Nursing Policy is doing work on First Ministers' Meeting (FMM) 10 year plan.
- The Canadian Nurses Association is promoting the continuum of care and care pathways.
- The work on the role of the Nurse Practitioner is part of the Canadian Nurses Association policy around access. "It is about getting different resources into the system but we need to coordinate their role with the role of other providers."
- The Canadian Nurses Association National Nursing Portal can help with access issues and can support things like telehealth which is helping on the access front.
- According to the Canadian Nurses Association, a full scope of practice policies would also help – use providers more efficiently. This is especially true in emergency rooms where RNs could do so much more.
- Cost effectiveness reports⁹² for psychological services have been around for many years as have had on-going discussions among Canadian Psychological Association members about accessibility.

To some extent, policy formation around accessibility is dependent upon the level of actors. For instance, it is easier to understand issues pertaining to accessibility and develop local solutions to ameliorating them at the regional health authority level since they have the best understanding of which services are best given the specific population health needs within their communities.

APPENDIX 2: INFORMATION RESOURCES

There are several sources available for understanding accessibility in Canadian health including:

- Members of Professional Associations and Regulatory Bodies⁹³;
- Reports from the provincial and federal Commissions on health care (e.g. the Romanow Commission report and Fyke Commission Report)
- The Health Council of Canada;
- Canadian Health Network;
- Manitoba Centre for Health Policy;
- The Canadian Medical Association;
- The Canadian Nurses Association;
- The Canadian Community Health Survey⁹⁴.
- Aggregate measures of physician supply and physician population ratios;
- OECD data on comparative supply⁹⁵;
- Canadian Council on Health Services Accreditation⁹⁶;
- The Canadian Institute for Health Information⁹⁷;
- National Physician Survey⁹⁸;
- Physician projections such as aging, provider behaviour, workload issues⁹⁹;
- Canadian Health Association policy documents;
- Statistics Canada Health Services Access Survey¹⁰⁰;
- The College of Family Physicians of Canada policy statements;
- The Western Canada Waiting List Project¹⁰¹;
- The Local Community Service Centres (CLSC) in Québec;
- The World Health Organization definition of Primary Health Care¹⁰²;
- Public opinion data¹⁰³ (IPSO-REID);
- Taming of the Queue Reports¹⁰⁴;
- Provincial Quality Councils¹⁰⁵;
- Ontario Cardiac Care Network;
- Conference Board of Canada;
- Canadian Home Care Association; and
- College of Psychiatric Nurses of Manitoba.

APPENDIX 3: INDICATOR LISTS

Preliminary sets of indicators on service availability are presented below. There are two very pressing limitations to these lists. First, what is needed in terms of a next stage approach is a more focused discussion around indicator lists – that is, which are the most valuable in terms of measuring system performance and which are not. Secondly, many of the indicator lists found within the literature focus on physicians and medical procedures thus they were used to develop indicators for other provider groups – they need to be rigorously evaluated. They are meant as illustrations.

The first general measure of availability to services is the proximity and distribution of services within a given area [Table One]. The interview respondents argued that distance to care needs to include the time it takes to reach a provider or service rather than simply the distance.

Table One: Indicators for Geographically Defined Availability

Dimension	Indicator List
Proximity	<ul style="list-style-type: none"> • Average distance to the nearest public health services; • Average distance to the nearest home care services; • Average distance to the nearest specialist services; • Average distance to the nearest long-term care facility; • Average distance to the nearest community based mental health centre; • Average distance to the nearest primary care centre; • Average distance to the nearest primary care team; • Average time to nearest emergency room services; • Average time to nearest hospital; • Average time to nearest primary care services; • Average time to nearest diagnostic services (e.g. MRI, CTs, etc); • Average time to nearest specialist services; • Average time to nearest addictions services; and • Average time to nearest mental health services.
Distribution of Services	<ul style="list-style-type: none"> • Primary care provider/patient ratios within a specified region¹⁰⁶; • Number of practicing primary care providers within a specified region; • Number of practicing specialists within a specified region; • Distribution of full time workload equivalent for providers¹⁰⁷; • Number of patients/clients reporting having a regular provider within a specified region; • Number of general practitioners accepting new patients into practice;

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	<ul style="list-style-type: none"> • Number of primary health teams accepting new patients into practice; • Number of home care services; • Number of long-term care facilities; • Number of physician practices/clinics; • Number of community care mental health services; • Number of hospital beds; • Number of primary care outreach services provided to persons with mental health issues or addictions; • The number of hospital beds available for continuing care; and • The number of beds for long-term care.
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Another measure of availability is that of time to care, measured through the proximity of services based on time elapsed to care, waiting times, and waiting lists.

Table Two: Indicator List for Time-Based Availability

Dimension	Indicator List
Wait Lists	<ul style="list-style-type: none"> • Number of patients on waiting lists for elective surgical intervention; • Number of patients on waiting lists for non-elective surgical intervention; • Number of patients on waiting lists for home care¹⁰⁸ services; • Number of patients on waiting lists for admission to long-term care facilities; • Number of patients on waiting lists for home-care services; • Number of patients on waiting lists for admission to mental health services; • Number of patients/clients on waiting lists for diagnostics (MRA, CT scans); • Number of patients/clients on waiting lists for physiotherapist services; • Number of patients/clients on waiting lists for occupational therapy services; and • Number of patients/clients on waiting lists for specialist services (e.g. internists, psychiatrists, oncologists, etc). <p>Notes: Home care services can be broken down by type of service required and provided (e.g. foot care, meals on wheels, palliative care, intravenous care, physiotherapy, wound care, etc.)</p>
After-hours care	<ul style="list-style-type: none"> • Number of primary health services with after-hours (evenings and

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	<p>weekends) service provision;</p> <ul style="list-style-type: none"> • Number of primary health services with 24 hour coverage; and • Proportion of communities with extended hours (evenings, weekends) for mental health coverage¹⁰⁹.
Waiting Times	<ul style="list-style-type: none"> • Average time between assessment and the provision of their first home care service; • Average waiting time between referral and assessment; • Average waiting time between assessment and intervention; • Average wait time to access a primary health team or organization for¹¹⁰: <ul style="list-style-type: none"> ○ Acute episodic care ○ Non-urgent and routine care • Average time between assessment and admission to long-term facility.

Financial-Based Indicators of Accessibility

The final set of indicators stems from the interview respondents. For a number of them, the financial availability of services requires further exploration.

Table Three: Indicators for Financially Based Measure of Access

Dimension	Indicator List
Affordability	<ul style="list-style-type: none"> • Percentage of population without access to provincial plans; • Prescription drug spending as a percentage of income;¹¹¹ and • Percentage of population without health insurance.

Appendix 4: Key Informants

Lynn Redfern
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Alberta Association of
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Canadian Physiotherapists Association

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Appendix 5: Participants, Roundtable on Accessibility Indicators

February 8, 2006, Ottawa, Ontario

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Research and Analysis
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Accessibility in Canadian Health Care

Paul Sajan
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Janet Davies
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ENDNOTES

¹ The few research studies located on waiting times; focus on acute care services and of these, on surgical waiting lists, which is hardly surprising given the current priorities placed on decreasing waiting lists for five key areas. The majority of the literature since 2002 within this area delves more specifically into the waiting times for acute care services, for instance, coronary bypass surgery, major joint arthroplasty and cancer care. See for instance, B. Sobolev, A. Levy, L. Kuramoto and R. Hayden (2005). Chances of Later Surgery in Relation to Wait Times. *BMC Health Services Research*. 5(63); K. Kelly, D. Voaklander, W. Johnston and M. Suarez-Almazor (2002). Equity in Waiting Times for Major Joint Arthroplasty. *Canadian Journal of Surgery*. 45(4):269-76; J. Klein-Geltink, L. Pogany, R. Barr, M. Greenberg and L. Mery (2005). Waiting Times for Cancer Care in Canadian Children: Impact of Distance, Clinical, and Demographic Factors. *Pediatric Blood and Cancer*. 44(4):318-27.

² One respondent for instance, noted that one jurisdiction bought new MRI equipment without training any personnel to run them – thus access to MRIs in the area stagnated until training took place.

³ 2003 First Ministers' Accord on Health Care Renewal. Available on-line at: http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/index_e.html.

⁴ *Ibid.*

⁵ Canadian Institute for Health Information (2006). *Waiting for Health Care in Canada: What We Know and What We Don't Know*.

⁶ Taken from: M. Gulliford, M. Myfanwy, D. Hughes, R. Beech, J. Figueroa-Munoz and B. Gibson (2001). *Access to Health Care. Report of a Scoping Exercise for the National Coordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO)*. Available on-line at:

http://www.sdo.lshtm.ac.uk/pdf/accessscopingexercise_executivesummary.pdf.

⁷ L. Aday, R. Andersen and G. Fleming (1980). *Health Care in the US: Equitable for Whom?* Beverly Hills, CA: Sage Publications. pp. 26.

⁸ An analysis of readmission rates, often an indicator used to measure quality care, therefore requires the incorporation of a wide variety of elements.

⁹ From the Commission on the Future of Health Care (2002). *Citizens' Dialogue on Health Care Yields Fascinating Results*. Media Release. Available on-line at:

<http://www.hc-sc.gc.ca/english/care/romanow/hcc0092.html>

¹⁰ See for instance, B.C. Psychological Association (2002). *Costs and Cost-Offsets of Psychological Interventions: Data in support of their Integration into an Universal-Access Health Care System*. Brief Presented to the Romanow Commission for Health Care Reform

¹¹ R. Andersen (1995). Revisiting the Behavioral Model and Access to Medical Care: Does it Matter? *Journal of Health and Social Behavior*. 36(1): 1-10

¹² R. Pechansky and J. Thomas (1981). The Concept of Access: Definition and Relationship to Consumer Satisfaction. *Medical Care* 19(2): 127-40.

¹³ W. MacKillop (2006). *Setting Standards for Access to Radiotherapy*. Paper presented at the Taming of the Queue Symposium, March 31st, 2006.

¹⁴ T. Sinay (2002). Access to Quality Health Services: Determinants of Access. *Journal of Health Care Finance*. 28(4):58-68. See also C. Schoen et al (2004). Primary Care and Health System Performance: Adults' Experiences in Five Countries. *Health Affairs*. Vol. 28: 487-492; A. Donabedian (1973). Aspects of Medical Care Administration. *Milbank Memorial Fund Quarterly*. Vol 50: 103-154.

¹⁵ Chinese acupuncture is currently being considered for regulation in Ontario. See for instance: MPP Consultation Group on Traditional Chinese Medicine and Acupuncture (2005).

Traditional Chinese Medicine and Acupuncture in Ontario: Report to the Minister of Health and Long-Term Care. Available on-line at:

http://www.health.gov.on.ca/english/public/pub/ministry_reports/tc_med/tc_med_eng.pdf.

¹⁶ C. Sanmartin, C. Houle, S. Tremblay and J. Berthelot (2002). Changes in Unmet Health Needs. *Health Reports*. 13(3) Statistics Canada 82-003.

¹⁷ Author unknown (2004). Canada Accused of Failing Women Patients. *British Medical Journal*. 329(192).; D. D'Amour, L. Goulet, J. Labadie, L. Bernier and R. Pineault (2003). Accessibility, Continuity and Appropriateness: Key Elements in Assessing Integration of Perinatal Services. *Health and Social Care in the Community*. 11(5):397-404.

¹⁸ Z. Wu, M. Penning and C. Schimmele (2005). Immigrant Status and Unmet Health Care Needs. *Canadian Journal of Public Health*. 96(5):369-73; S. Grewal, J. Bottorff and L. Balneaves (2004). A Pap Test Screening Clinic in a South Asian Community of Vancouver, British Columbia: Challenges to Maintaining Utilization. *Public Health Nursing*. 21(5):412-8.; N. Leduc, and M. Proulx (2004). Patterns of Health Services Utilization by Recent Immigrants. *Journal of Immigrant Health*. 6(1):15-27; F. Ahmad, A. Shik, R. Vanza, A. Cheung, U. George and D. Stewart (2004). Voices of South Asian Women: Immigration and Mental Health. *Women and Health*. 40(4):113-30.; G. Ogilvie, E. Shaw, S. Lusk, J. Zazulak and J. Kaczorowski, (2004). Access to Colposcopy Services for High-Risk Canadian Women: Can We Do Better? *Canadian Journal of Public Health*. 95(5):346-51.

¹⁹ Author unknown (2004).

²⁰ K. Yeates, D. Schaubel, A. Cass, T. Sequist and J. Ayanian (2004). Access to Renal Transplantation for Minority Patients with ESRD in Canada. *American Journal of Kidney Disease*. 44(6): 1083-1089.

²¹ D. Wardman, K. Clement and D. Quantz, (2005). Access and Utilization of Health Services by British Columbia's Rural Aboriginal Population. *International Journal of Healthcare Quality Assurance Incorporating Leadership in Health Services*. 18(2-3): xxvi-xxxi; S. Muttitt, R. Vigneault and L. Loewen (2004). Integrating Telehealth into Aboriginal Healthcare: The Canadian Experience. *International Journal of Circumpolar Health*. 63(4):401-14; B. Shah, N. Gunraj and J. Hux (2003). Markers of Access to and Quality of Primary Care for Aboriginal People in Ontario, Canada. *American Journal of Public Health*. 93(5): 798-801.

²² W. Ungar, C. Daniels, T. McNeill and M. Seyed (2003). Children in need of Pharmacare: Medication Funding Requests at the Toronto Hospital for Sick Children. *Canadian Journal of Public Health*. 94(2):121-6.

²³ D. Sin, L. Svenson, R. Cowie and S. Man (2003). Can Universal Access to Health Care Eliminate Health Inequalities Between Children of Poor and Nonpoor Families? *Chest*. 124(1): 51-5; D. Alter, D. Naylor, P. Austin, B. Chan and J. Tu (2003). Geography and Service Supply do not Explain Socioeconomic Gradients in Angiography use after Acute Myocardial Infarction. *Canadian Medical Association Journal*. 168(3):261-264.

²⁴ Health Canada. (2002). *Canada's Aging Population*. Available on-line at:

http://www.phac-aspc.gc.ca/seniors-aines/pubs/fed_paper/pdfs/fedpaper_e.pdf

²⁵ *Ibid.*

²⁶ C. Ballem (2005). *Achieving Timely Access: Improving Wait Times for Surgery in British Columbia*. Paper presented at the Taming of the Queue Symposium, March 31st, 2005.

²⁷ Here, there are three frameworks, First Nations, Métis and Inuit with both converging and diverging cultural values, history and priorities. There are a myriad of First nations people within Canada, though one overall set of values encompasses the importance of family and community and the restoration of harmony.

²⁸ First Ministers set 10-year targets to be met in collaboration with First Nations, Métis and Inuit Canadians:

- Improving access to the range of public health services that non-Aboriginal Canadians enjoy;
- The recruitment and training of culturally-appropriate health professionals in Aboriginal communities;
- The accreditation of a significant number of federally-funded health facilities on-reserve; and
- Improving primary care services in Aboriginal communities.

²⁹ Canadian Institute of Health Information (2006). *Improving the Health of Canadians: Promoting Healthy Weights*. Available on-line at:

http://www.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_470_E&cw_topic=470&cw_rel=AR_1217_E

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- ⁴⁵ Cream skimming, whereby the private insurers favour clients who are the least expensive and healthiest and leaving those with expensive health needs to the public sector is often noted as an issue around the private/public debates.
- ⁴⁶ According to the College of Family Physicians of Canada shortages in physician numbers reduced accessibility. They state that 16 per cent of Canadians (or about 5 million people) still don't have a family doctor and that 31 per cent of Canadians said that they themselves, a friend or family member had trouble finding a family doctor in the last year. Taken from the College of Family Physicians of Canada website: <http://www.cfpc.ca/English/cfpc/communications/news%20releases/2004%20Backgrounder%20vision/default.asp?s=1>.
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- ⁴⁹ For instance, in 2005, \$75 million was earmarked by the federal government over a five year period for improvements in the integration of internationally trained physicians, nurses and other providers into the Canadian health care system: <http://www.cic.gc.ca/english/press/05/0513-e.html>.
- ⁵⁰ Health Canada. *Health Human Resource Strategy*. Available on-line at: http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/recru/index_e.html
- ⁵¹ Canadian Nurse Practitioner Initiative (2005). *Nurse Practitioner Role to Strengthen Canada's Primary Health-Care System*. Available on-line at: http://www.cnpi.ca/documents/pdf/CNPI_news_conference_April_15_e.pdf
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- ⁵⁵ There was concern raised by a number of interview respondents that the concepts of interdisciplinary and multidisciplinary teams be more rigorously defined. Some providers defined multidisciplinary team formation as including teams of physicians while others define it solely as the relationship between physicians and nurses.
- ⁵⁶ See for instance, C. Fooks, (2005). Health Human Resources Planning in an Interdisciplinary Care Environment: To Dream the Impossible Dream? *Nursing Leadership*. 18(3): 26-29.
- ⁵⁷ From: Health Canada. *Interprofessional Education for Collaborative Patient-Centred Practice*. Available on-line at: http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/interprof/index_e.html.
- ⁵⁸ Canadian Institute for Health Information (2006a)
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- ⁶⁰ Manitoba Centre for Health Policy. *Recommended Health Indicators for Monitoring Regional Health Authority (RHA) Performance and Planning Service Delivery* Available on-line at: http://www.umanitoba.ca/centres/mchp/concept/dict/rec_indicators.html.
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- ⁷² *Ibid.*
- ⁷³ *Ibid.*
- ⁷⁴ *Ibid.*
- ⁷⁵ According to CIHI this indicator represents a potentially preventable complication resulting from an inpatient stay in an acute care facility. Variation in the rates may be attributed to numerous factors, including hospital processes, environmental safety, and availability of nursing care. High rates may prompt investigation of potential quality of care deficiencies. CIHI Health System Performance. Available on-line at: <http://dissemination.statcan.ca/english/freepub/82-221-XIE/2004002/defin3.htm#s>.
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- ⁷⁹ CIHI, for instance, is developing a series of indicator lists around multidisciplinary teams. See, for instance Canadian Institute for Health Information (2005) .
- ⁸⁰ Saskatchewan Health. http://www.health.gov.sk.ca/hlth_indicator_review/acga_e.pdf
- ⁸¹ First Ministers' Accord on Health Care Renewal (2003). http://www.uwo.ca/fhs/deansoffice/Health_Accord_Feb_2003.pdf
- ⁸² Canadian Institute of Health Information (2005). *Primary Health Care Indicator Development Project: 1st Consensus Conference Report on Conference Proceedings*. Available on-line at: http://www.cihi.ca/cihiweb/en/downloads/First_Consensus_Conference_Report_EN.pdf
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- ⁸⁴ *Ibid.* pp. 19.
- ⁸⁵ J. Appleby and N. Devlin, N. (2005). *Measuring NHS Success: Can Patients' Views on Health Outcomes Help to Manage Performance?* King's Fund. Available on-line at: http://www.kingsfund.org.uk/resources/publications/measuring_nhs.html.
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lost due to unintentional injury, incidence rate for invasive meningococcal disease, incidence rate for measles, incidence rate for Haemophilus influenza b (invasive) (Hib) disease, incidence rate for tuberculosis, incidence rate for Verotoxigenic E. coli, incidence rate for chlamydia, rate of newly reported HIV cases, prevalence of diabetes, exposure to second-hand tobacco smoke rate, self-reported health, teenage smoking rates, physical activity, body mass index, immunization for influenza for 65+ ("Flu Shot"), prevalence of depression. From Canadian Institute for Health Information (2004). *Comparable Health and Health System Performance Indicators for Canada, the Provinces and Territories*. Available on-line at: http://www.cihi.ca/cihiweb/dispPage.jsp?cw_page=prtwg_2004_e.

⁸⁷ These may include: The proportion of population reporting satisfaction with wait time or access to acute episodic care, non-urgent care, well care, mental health services (broken down by care setting and specialization), surgical intervention (broken down by type), home care services, telehealth services, and long-term care services.

⁸⁸ See for instance: Statistics Canada (2006). *Access to Health Care Services in Canada, January to June, 2005*. Available on-line at: <http://www.statcan.ca/english/freepub/82-575-XIE/82-575-XIE2006001.pdf>

Moreover, according to one interview respondent, we cannot underestimate psychological distress as an outcome since it served as the basis for the Supreme Court decision *Chaoulli vs. RH Quebec*.

⁸⁹ The key informants argued that the following were important outcome indicators for quality of life: resumption of employment wages lost, time off from work, and ability to function in daily activities.

⁹⁰ For instance, there is some data on dentists, pharmacists and physicians due to public sector billing, but other health care professionals working within the private sector or traversing both are more difficult to track.

⁹¹ For instance, there is a need for a set of indicators around accessibility to pharmaceuticals as determined by affordability and availability.

⁹² See for instance, B.C. Psychological Association (2002). *Costs and Cost-Offsets of Psychological Interventions: Data in support of their Integration into an Universal-Access Health Care System*. Brief Presented to the Romanow Commission for Health Care Reform.

⁹³ Cross-association information exchange is facilitated through such groups as HEAL (Health Action Lobby): <http://www.cchse.org/HEAL/heal.htm>. HEAL also held a conference on health human resource planning

⁹⁴ Statistics Canada. *Canadian Community Health Survey*. Available on-line at: <http://www.statcan.ca/english/concepts/health/>.

⁹⁵ Organisation for Economic Co-operation and Development website: http://www.oecd.org/document/30/0,2340,en_2649_37407_12968734_1_1_1_37407,00.html

⁹⁶ Canadian Council on Health Services Accreditation website: www.cchsa.ca

⁹⁷ The Canadian Institute for Health Information is reportedly expanding their minimum data sets to other professions.

⁹⁸ National Physician Survey Database, part of the NPS project co-led by the CFPC, the Canadian Medical Association (CMA), and the Royal College of Physicians and Surgeons of Canada (RCPSC), and supported by the Canadian Institute for Health Information (CIHI) and Health Canada. Available on-line at: <http://www.cfpc.ca/nps/English/home.asp>

⁹⁹ Note: This needs to also be expanded to include projections for other health care professionals.

¹⁰⁰ Statistics Canada: *Health Services Access Survey*. Available on-line at: <http://www.statcan.ca/cgi-bin/imdb/p2SV.pl?Function=getSurvey&SDDS=5002&lang=en&db=IMDB&dbg=f&adm=8&dis=2>

¹⁰¹ The Western Canada Waiting List Project. Available on-line at: <http://www.wcwl.org/>

¹⁰² Primary health care has been defined by the World Health Organization (WHO) as:

"... Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."

¹⁰³ This includes broad concerns about access to a wide range of services.

¹⁰⁴ The Taming of the Queue reports are available on the Canadian Policy Research Networks website: <http://www.cprn.com/en/theme-docs.cfm?theme=43>

¹⁰⁵ Saskatchewan Health Quality Council:

<http://www.hqc.sk.ca/portal.jsp;jsessionid=qwmp1p0ca1?NcV6iloX+MAZT+zXuyvn0TBIzBf0QfLQkUwK4QBZaJs5RT805SdC1c6owgPOP/HrKx8VmhwEmSQ=>; Health Quality Council of Alberta: <http://www.hqca.ca/>;

¹⁰⁶ Canadian Institute for Health Information (2005). *Primary Health Care Indicator Development Project: 1st Consensus Conference Report on Conference Proceedings*. Available on-line at: http://www.cihi.ca/cihiweb/en/downloads/First_Consensus_Conference_Report_EN.pdf

¹⁰⁷ *Ibid.*

¹⁰⁸ Manitoba Centre for Health Policy. *Recommended Health Indicators for Monitoring Regional Health Authority (RHA) Performance and Planning Service Delivery*. Available on-line at: http://www.umanitoba.ca/centres/mchp/concept/dict/rec_indicators.html.

¹⁰⁹ K. McEwan and E. Goldner (2001). *Accountability and Performance Indicators for Mental Health Services and Supports A Resource Kit*. Prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health.

¹¹⁰ From: Canadian Institute of Health Information (2005). *Primary Health Care Indicator Development Project: 1st Consensus Conference Report on Conference Proceedings*. Available on-line at: http://www.cihi.ca/cihiweb/en/downloads/First_Consensus_Conference_Report_EN.pdf

¹¹¹ Canadian Institute for Health Information (2004). *Plan for Reporting Comparable Health Indicators*. Available on-line at: http://www.cihi.ca/cihiweb/en/downloads/ACGA_CBN_TO_CDM_ENG.pdf



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