A HEALTH OUTCOMES REPORT

Why Health Care Renewal Matters: Learning from Canadians with Chronic Health Conditions

DECEMBER 2007

Health Council of Canada | Conseil canadien de la santé

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MORE THAN NINE MILLION CANADIANS, or one-third of youth and adults in Canada, have one or more chronic health conditions – long-term problems such as arthritis, diabetes, cancer, and heart disease. These conditions affect well-being and quality of life and represent a significant, and growing, health care and economic burden for Canada.

PREVENTING AND MANAGING chronic health conditions is everybody's business. To a great extent, chronic health conditions are rooted in the way we live. A handful of avoidable risk factors – things that we can change, such as overweight, physical inactivity, poor eating habits, and smoking – feed our current epidemic. Sustained programs and supportive policies that enable people to reduce these and other risk factors are smart investments in Canada's future. For those who already have chronic illness, access to high quality health care can help

patients prevent complications, reduce the future need for expensive health services, and secure a better quality of life.

ULTIMATELY, THE NATURE AND PACE of efforts to provide better health promotion, disease prevention, and chronic illness care will be determined by the Canadian public and their influence with elected officials at all levels of government. For meaningful progress to occur, interested Canadians need to be engaged in identifying priorities, problems, and potential solutions. In turn, governments want to learn from the

> "Chronic non-communicable diseases ... must urgently receive more resources, research and attention ... Inaction is costing millions of premature deaths throughout the world."
>
> Grand challenges in chronic non-communicable diseases, *Nature*, 22 November 2007

experiences and expectations of Canadians and to demonstrate that health care renewal is moving in the right direction.

THEREFORE, IN THIS REPORT we turn to Canadians living with chronic health conditions to learn from them about their experiences with care, and we turn to governments to learn about activities now underway to prevent chronic illness and improve care.

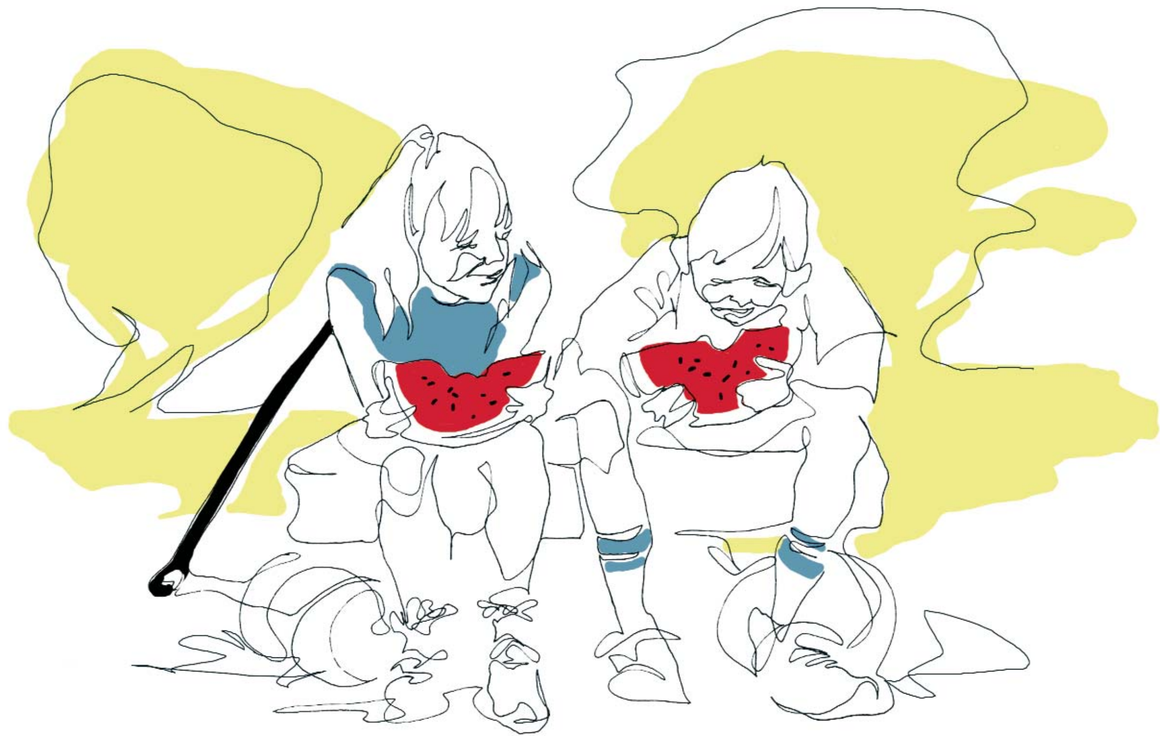
> We use information from a Statistics Canada survey of 133,000 adults in 2005 to learn about the health and lifestyles of

Canadians and how these relate to their use of health care.

- We report on the findings of a public consultation we hosted earlier this year to hear from a diverse group of close to 2,000 Canadians with chronic health conditions, mainly diabetes.
- We commissioned a telephone survey of nearly 2,200 Canadians in 2007 to learn more about their experiences with primary health care and chronic illness care, particularly as they relate to priorities in health care renewal in this country.
- The problems Canada faces are shared by countries worldwide,

> “Reducing risk to health is the responsibility of governments – but not only governments. It rightly remains a vital preoccupation of all people, in all populations, and of all those who serve them.”
>
> Dr. Gro Harlem Brundtland, Director-General, World Health Organization, in *The World Health Report 2002: Reducing Risks, Promoting Health*

and so we worked with several other organizations to ask 3,000 Canadians and 9,000 adults in six other countries about their experiences with primary health care and chronic illness care. > We juxtapose these first-hand accounts with governments' promises to improve the situation and snapshots of current efforts in health care renewal. We feature ActNow BC, a province-wide strategy that is using an all-of-government approach and extensive partnerships to reduce risk factors for chronic disease.



IT'S IMPORTANT TO NOTE that these survey results describe Canadians' experiences in the last one to two years, but do not necessarily reflect the impact of changes currently underway in the health care system. It will take time before we see the effect of current reforms on the health of Canadians and their subsequent use of health care. Meanwhile, our survey results can inform ongoing efforts to improve care and provide a baseline to monitor how our health care system performs in the future.

KEY FINDINGS AND COUNCIL ADVICE

A case for action

From Canadians with chronic health conditions, we learned that:

- They experience a poorer quality of life: half of adults with two or more chronic conditions report moderate or severe disability in daily living.
- They use a large share of health care resources: the one-third of Canadians with one or more of seven high-impact, high-prevalence chronic conditions use 67% of all visits to community nurses, 51% of all visits to family doctors, 55% of all visits to specialists, and 72% of nights spent in hospitals.
- There are serious gaps in the accessibility and quality of their ongoing care.
- Canadians support public investments to improve health and prevent disease.

The World Health Organization reviewed international research and concluded that the negative impact of many of the common risk factors for chronic disease can be reversed quickly, that most benefits will accrue within a decade, and that even modest changes in risk factor levels can bring about large improvements in the health of populations. In our first report on health outcomes, *Why Health Care Renewal Matters: Lessons from Diabetes*, we reviewed research evidence and determined that even small improvements in the quality of chronic illness care make a big difference in improving health and reducing the need for future care.

Relatively simple actions, if adopted by many people, could dramatically reduce risks to health and save health care dollars. A recent Canadian study concluded that if everyone lowered their consumption of salt by less than one teaspoon a day, we could see a 30% decrease in cases of high blood pressure (one of the most prevalent chronic conditions), or one million fewer Canadians with this condition. Direct cost savings – from reduced need for physician visits, laboratory tests, and medication to treat high blood pressure – are estimated at $430 million per year.

Other Canadian research illustrates the important link between social and physical environments and the risk for chronic disease; for example, obesity tends to be more common in smaller communities, and diabetes rates in Toronto are higher in neighbourhoods where people have to travel farther to buy fresh fruits and vegetables. These circumstances require more complex solutions involving many sectors of society.

(See also “A case for action” p.12.)

Promoting health and preventing chronic conditions

Using an internationally accepted standard for enabling people to increase control over and improve their health – the Ottawa Charter for Health Promotion – we assess how well Canada is doing to:

- build healthy public policy;
- strengthen community actions to promote health;
- create supportive and healthy environments; and
- reorient health care services to support health and prevent disease.

Canada’s governments are clearly investing in health promotion and disease prevention. In many cases, this work engages multiple partners (within and outside of government) to magnify the impact of societal investments that support health. Some of this work addresses social determinants of health, which creates conditions that can help Canadians make needed changes in the way we live to reduce our risk for chronic disease. Governments could do much more to monitor and report on progress towards achieving the country’s health goals by setting and reporting on local targets.

> “Money spent on fixing sick people may be necessary right now because we never focused on prevention … Please keep in mind that health care does not exist in isolation from everything else … it’s time to look at the big picture.”

Health Council of Canada’s public consultation on health care renewal and chronic illness, spring 2007

Are we making progress? Without more routine monitoring and reporting about the results of these activities, it's difficult to say.

Are our investments sufficient? Probably not, particularly in comparison to what we spend on services for sick patients. We fund failure (caring for people after they get sick) rather than success (preventing avoidable illness). Consider that the total expenditure on health care was $141 billion in 2005 including $40 billion on hospitals and $8.5 billion on public health. The lion's share of health care spending goes to care for people with chronic health conditions. What if we funded prevention more aggressively by spending $40 billion on public health? Might we then, when more Canadians enjoy better health and well-being, be able to spend many fewer billions on illness care?

OUR ADVICE TO GOVERNMENTS

Invest in success by ramping up initiatives proven to prevent chronic health conditions and their complications.

Adopt an all-of-government approach (in other words, all ministries) to engage the full range of public policy that can create the social and environmental conditions people need to shift to healthier lifestyles. Create productive partnerships with non-government organizations, local authorities, and industry to harness collective efforts supportive of health. Routinely measure and monitor the impact of these investments.

OUR ADVICE TO CANADIANS

Continue supporting public investments in healthy living.

Take responsibility for your own health and your family's, but also recognize that we need a massive cultural shift to slow the rise of chronic disease in Canada. Many factors affect whether or not people can make changes in the way they live, and public policy can make or break people's chances of success.

Improving the accessibility and quality of chronic illness care

Using key principles in patient-centred care, we assess how Canada is doing to ensure that:

- Canadians have access to needed care;
- patients are engaged in their care;
- care is coordinated;
- health care teams deliver integrated and comprehensive care; and
- information about health care is publicly available.

The vast majority of Canadians with chronic health conditions have a regular medical doctor or place where they receive care (98%). More than 80% have been going to the same doctor or clinic for at least three years, including 59% who have used the same provider for more than seven years, an indication of good continuity of care.

But team care, which can make a difference in the health of people with chronic conditions, is far from the norm for Canadians. Only 33% of adults with chronic health conditions report that a nurse is regularly involved in their care. Even fewer (18%) report that another health care professional such as a dietitian works in the place where they get ongoing care, though people with chronic health conditions may get these services elsewhere. These numbers are very similar for Canadians without any of the seven select chronic conditions covered in our surveys.

Getting timely appointments with their regular doctor or clinic is too often difficult for patients with chronic conditions, resulting in unnecessary trips to emergency. Canada ranks among the worst (along with the US) of seven countries on some important dimensions of access to care. Canadians who have chronic health conditions experience:

- long waits for primary care (just 36% in Canada could get same-day or next-day appointments vs. 60% or more in five of the six other countries);
- high use of hospital emergency departments for any reason in the past two years (45% in Canada vs. 24–36% in five of the six other countries); and
- high use of emergency departments for conditions that could have been treated by their regular doctor (41% in Canada vs. 20–32% in four of six other countries).

This is despite expanded hours of access to family physicians in many Canadian communities and our place as an international leader in the use of 24/7 telephone access to health information and advice. Other factors, such as the inefficiency of scheduling systems, likely underlie the long waits for appointments with primary care providers. There is much that Canada can learn from other countries about the use of proven practices to improve timely access to a regular source of care.

In terms of financial barriers to care, Canada ranks midway among seven countries. However, 10% of Canadians with chronic conditions report they did not fill a prescription or skipped a medication dose due to costs in the past year.

Though Canadians with chronic conditions see health care providers frequently (doctors at least four times and nurses eight times a year, on average), troubling questions remain about the quality of that care – a greater concern than the number of times patients get through the door or which door they use.

We've reported previously that too few Canadians with diabetes, as a case example, do not receive the care that experts recommend. Now, we've learned from Canadians that chronic illness care in Canada is far from being truly patient-centred. Patients with chronic conditions generally feel their primary health care providers communicate well (60 – 90%), but too few report that their care providers regularly consider their values and traditions (55%) and goals (34%); involve them in decisions regarding treatment (50%); or offer them a written plan for managing their own care (33%).

Reminders from doctors' offices about the need for follow-up care (39%) and referrals to services that can help patients adopt healthier lifestyles (15%) remain disturbingly uncommon in Canada, though they should be standard practice for patients with chronic health conditions. Though their need for assistance may be greater, these patients are not much more likely than Canadians without chronic conditions to get advice or help from their regular health care provider to change personal habits to improve their health.

Yet most Canadians with chronic health conditions (74%) give a high rating to the overall quality of their regular medical care. How should we make sense of this apparent contradiction? It tells us that, based on what most people know and expect from health care providers, patients are satisfied with and express confidence in the system. But it also tells us that many people don't yet appreciate how much better their care could be.

OUR ADVICE TO GOVERNMENTS, HEALTH CARE POLICY-MAKERS, MANAGERS, AND PROVIDERS

Invest in proven strategies that improve the quality of care and engage people in managing their own chronic health conditions.

This requires a shift from a "find it and fix it" culture to a "prevent it, find it, manage it" mentality. We continue to recommend a redesign of the traditional family doctor's practice to introduce teams, technology, and training for change that will help achieve better care for patients with chronic health conditions and, ultimately, better health outcomes. Across the country, efforts are underway to reorient care to help Canadians better manage and prevent chronic health conditions. These are encouraging developments, but despite years of talk, we're still in the early stages of badly needed reform.

OUR ADVICE TO CANADIANS

Expect more from your health care system and the people responsible for it.

Give permission to governments and the health care community to invest now and invest heavily in strategies proven to be cost-effective at improving health care. Canada can treat the causes of our less-than-ideal care for chronic health conditions, but it will require that you hold high expectations.

> "We have to be given the tools and confidence to do as much for ourselves as possible in partnership with our health care practitioners."

Health Council of Canada's public consultation on health care renewal and chronic illness, spring 2007

Monitoring progress

Without better data, those responsible for health care renewal – political leaders, health care policy-makers, managers and health care providers – are working in the dark. Without more transparency and public reporting, Canadians will not be well-informed about the results of these public investments, and governments will find it increasingly difficult to make informed decisions about investing in health.

Canada needs a surveillance, or information-tracking, strategy that can integrate information about our risks for poor health, the environments we live in, our ability to get the care we need, the quality of the care we receive, and the results of that care. A few provinces have made great strides in developing this kind of information system locally. The Public Health Agency of Canada has made a commitment to develop a coherent and integrated national surveillance system, but each province and territory will need its own information to manage its population's health and health care system.

OUR ADVICE TO ALL OF CANADA'S GOVERNMENTS

Develop and use appropriate information systems that support better tracking, research, and public reporting on chronic health conditions and the results of investments to promote health and improve Canadians' access to high-quality chronic illness care.

Conclusion

This is the second in a series of reports in which the Health Council of Canada examines health outcomes as a marker of the effectiveness of our health care system and the necessity of health care renewal. What we've learned from Canadians strengthens the case for immediate, comprehensive, and sustained action to promote healthy living, prevent long-term health problems, and improve care for people who have chronic health conditions. Health care renewal matters greatly to individuals whose health and well-being are at stake, and it matters to everyone since we collectively bear the health and economic burden of failure to do what is possible. Collectively we could share in success if we act together. We know what to do and how to do it. As good stewards of public health and public dollars, governments should lead and sustain efforts to help Canadians maintain the best possible quality of life and avoid unnecessary illness. Canadians understand that, without these investments, we jeopardize our future health; with them, we help secure it.

More available at www.healthcouncilcanada.ca

- Data supplements:
  - Population Patterns of Chronic Health Conditions in Canada
  - Canadians' Experiences with Chronic Illness Care in 2007
- Health Care Renewal and Chronic Illness: Report on a Public Consultation

Other reports on health and health outcomes from the Health Council of Canada

- Why Health Care Renewal Matters: Lessons from Diabetes (March 2007)
- Their Future Is Now: Healthy Choices for Canada's Children & Youth (June 2006)
- The Health Status of Canada's First Nations, Métis, and Inuit Peoples (July 2005)

A CASE FOR ACTION

There is much that public policy and health care can do to stop the rise in chronic health conditions in Canada and to lessen the devastating consequences of chronic diseases among people who have them. Here are our top 10 reasons to improve health promotion, disease prevention, and chronic disease management in Canada.

1 The burden of chronic health conditions on Canadians, the health care system, and our economy is enormous and growing. Canadians with chronic conditions account for over 70% of all nights spent in hospital.

2 One in three adults in Canada, or close to nine million people, report having at least one of seven high-impact, high-prevalence chronic conditions. More than one-third of these people have multiple long-term health problems.

3 Many people with chronic conditions suffer complications that add to their health problems and reduce their quality of life. Half of Canadians with multiple chronic conditions report moderate to severe disability in daily living.

4 More Canadians are developing chronic conditions because of rising risks such as obesity.

5 Chronic conditions are more common among older Canadians (77% of people 65 years or older have at least one chronic condition), among some ethnic groups, and among people with low income but cut across all ages and circumstances.

6 The World Health Organization (WHO) estimates that at least one-third of the total economic and social burden of disease in developed countries is caused by a handful of largely avoidable risks: tobacco, alcohol, high blood pressure, high cholesterol, and obesity.

7 The WHO has determined that most benefits from reducing these risks will accrue within a decade, and even modest changes in risk factor levels can bring about large improvements in the health of populations. Modest lifestyle changes, such as losing four kilograms over three to six years, have been shown to dramatically delay or prevent the onset of diseases such as diabetes in high-risk populations.

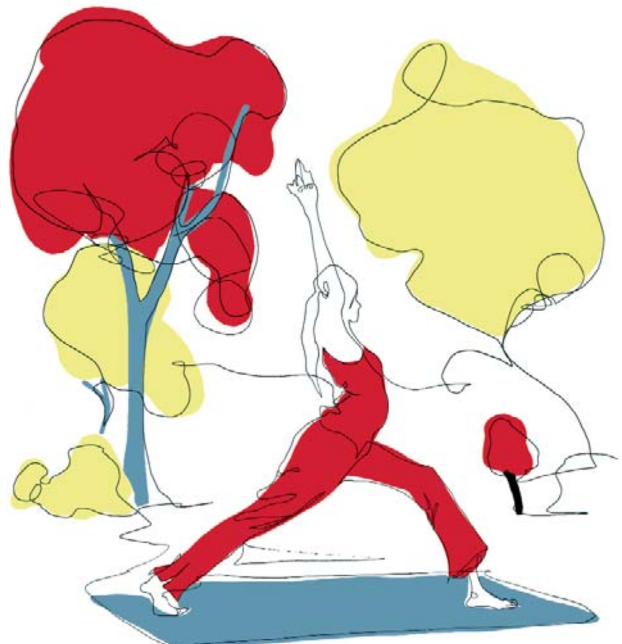
8 The quality of chronic illness care in Canada could be greatly improved: less than half of Canadians with diabetes, for example, get all the laboratory tests and procedures that experts recommend to prevent complications of the disease.

9 Underuse, overuse and inappropriate use of medications are ongoing concerns, and prescribing practices can vary widely across the country. Too few people with diabetes, for example, receive medications that are effective at preventing cardiovascular problems and more than half of people with diabetes have poor heart health.

10 Investing in prevention pays off – in lower health care costs and a healthier society.

1

WHY REPORT ON THE HEALTH STATUS OF CANADIANS AND HEALTH OUTCOMES?



In defining the role of the Health Council of Canada, Canada's First Ministers gave the Council the task of reporting on the health status of Canadians and the results, or outcomes, of the care we receive. Canadians are, by international standards, quite healthy. So why focus on health outcomes and why now? Because health outcomes are a marker of the effectiveness of our health care system and the necessity of health care renewal. Changing how the health care system works can change health outcomes; so too can changing public policies that influence other determinants of health.

Building on our March 2007 report, *Why Health Care Renewal Matters: Lessons from Diabetes*, we continue our focus on the urgent challenge of chronic health conditions – long-term health problems that affect more than one in three Canadians and have a huge impact on health care services and quality of life.

In this report:

- We present a case for action – immediate, comprehensive, and sustained – to promote healthy living and prevent avoidable health problems and unnecessarily costly care;
- We turn to Canadians living with chronic health conditions to learn from them about their experiences with care;
- We turn to governments to learn what policy-makers, health care providers, and others are doing across Canada in 2007 to improve care and prevent chronic illness;
- We summarize evidence from research about how to promote health and prevent disease and to help people living with chronic illness enjoy the best possible quality of life.

With all this research in hand, we share what it tells us about Canada's progress on health care renewal – particularly progress toward the First Ministers' commitments to improve health and health care. We offer the Health Council's perspective on what is helping and what is hindering progress towards better health outcomes for Canadians.

We hope this report speaks usefully to governments, non-government organizations, industry, and especially to Canadians. We want to help Canadians understand the benefits that will come from investments to close the gap between what we know and what we do to prevent chronic health conditions and to care for people who have them.

What are health outcomes?

Health outcomes are a measure of the effectiveness of our health care system and of the impact of public policies that influence health. Health outcomes are the result of services, programs, policies, and personal behaviours that influence our health and well-being.

What do we mean by quality of care?

Quality health care means doing the right thing at the right time in the right way for the right person. Quality of care can be measured in a number of ways, for example:

- How do people experience care?
- Does care match expert-recommended guidelines?
- Is care coordinated, safe, and efficient?
- Does care help to prevent avoidable health problems?

What are chronic health conditions?

Chronic health conditions usually develop slowly, last a long time, and in most cases, have no cure. A chronic health condition may severely limit a person's ability to work, go to school, or take care of daily needs.

In this report, we focus mainly on seven chronic health conditions that affect many people and / or have a large impact on health care use or quality of life. The seven select conditions are:

- arthritis
- cancer
- chronic obstructive pulmonary disease
- diabetes
- heart disease
- high blood pressure
- mood disorders

2

WHY CARE ABOUT CHRONIC HEALTH CONDITIONS? A CASE FOR ACTION

Canadians are quite healthy by international standards,[1] but chronic health conditions – problems such as diabetes and high blood pressure – are on the rise. Though these health problems are more common among vulnerable populations, chronic conditions cut across all ages, incomes and circumstances. Because most seniors have chronic health conditions, the social and economic burden of these conditions will deepen as our population ages.

We can change that future – if we act now. Though there is a hereditary link to some conditions, many chronic health conditions and complications from them are rooted in the way we live. Public policies and health care programs that are designed to promote healthy lifestyles and improve the environments in which we live, work and play can help to prevent disease and reduce the burden it brings to our families and communities.

The case for action is based on these facts:

- Chronic health conditions are on the rise and now affect at least one in three Canadians – more than nine million people. One-third of these people have multiple long-term health problems.
- Chronic health conditions threaten the length and quality of Canadians' lives.
- Chronic health conditions represent a significant, and growing, health care and economic burden for Canada.
- A handful of avoidable risks, also increasingly common, cause most of the burden of chronic disease. Preventive action now can secure a healthier future for Canadians and a more sustainable future for our health care system.

To make this case for action, we gathered evidence from research and analyzed data collected by Statistics Canada in interviews with nearly 133,000 Canadians in 2005.[2] For details on the survey and more on what we learned from Canadians with and without select chronic health conditions, please see our data supplement *Population Patterns of Chronic Health Conditions in Canada*, a companion to this report and available at *www.healthcouncilcanada.ca*.

> "You have to be well off to be a diabetic. Diabetes is an exclusive club and the membership price is high … the working poor need not apply."
>
> Health Council of Canada's public consultation on health care renewal and chronic illness, spring 2007

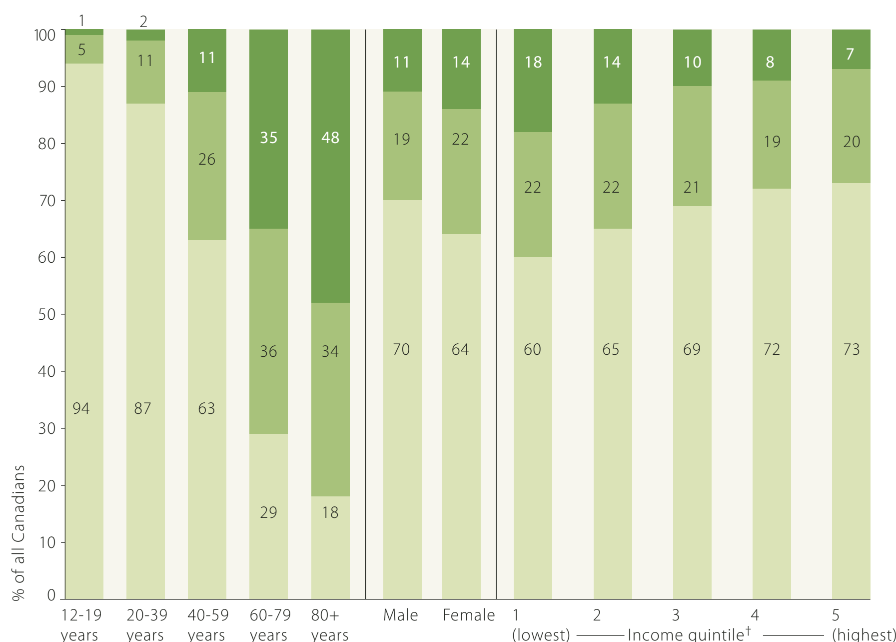


FIGURE 1

Chronic conditions* are more common among lower-income Canadians, women and seniors

- No select chronic conditions*
- 1 select chronic condition*
- 2 or more select chronic conditions*

Graph shows crude prevalence for people aged 12 and over. Income data are not adjusted for age or gender differences. Numbers may not sum to 100% due to rounding.

* Select chronic health conditions include arthritis, cancer, chronic obstructive pulmonary disease, diabetes, heart disease, high blood pressure and mood disorders.

† Income quintiles divide all Canadians into five equal-sized groups based on household income. People in quintile 1 have the lowest incomes; the highest in quintile 5.

Source: Statistics Canada. Canadian Community Health Survey (Cycle 3.1), 2005.

Chronic health conditions are on the rise and now affect at least one in three Canadians – more than nine million people. One-third of these people have multiple long-term health problems.

While the prevalence of some chronic health conditions remains stable or has declined, for other conditions rates are rising. For example, in 2005, almost 5% of the population aged 12 and older (1.3 million Canadians) had diabetes compared to about 3% (722,000 people) a decade ago. Similarly, almost 15% of us (4.1 million people) had high blood pressure in 2005, compared to almost 9% (2.1 million people) in the 1990s.[3]

Nine million Canadians – about one in three youth and adults ages 12 and up – report that they have been diagnosed by a health care professional as having at least one of seven high-prevalence, high-impact chronic health conditions: arthritis, diabetes, cancer, chronic obstructive pulmonary disease, heart disease, high blood pressure, and mood disorders. These select chronic health conditions are much more common among lower-income Canadians, women, and seniors (Figure 1). Some ethnic groups are also disproportionately affected by these conditions. For example, First Nations adults living on reserve have diabetes at rates four times higher, and rising faster, than other Canadians. First Nations people are also more likely to experience complications from diabetes such as amputations and kidney disease.[4]

More than one-third of people with chronic health conditions also report that they have multiple long-term health problems, and certain conditions tend to cluster. For example, more than half of people with arthritis or high blood pressure, and three-quarters of people with heart disease or diabetes, have other select conditions. Health care services must be tailored to address these patterns of multiple chronic health conditions when patients seek care (Figure 2).

Chronic health conditions threaten the length and quality of Canadians' lives.

Chronic health conditions can have profound effects on people's sense of well-being and their ability to continue their everyday activities at home, work and play. Not surprisingly, health status declines and disability increases as people develop more long-term health problems. We found that more than one-third of people with one chronic health condition report moderate or severe disability (36%) and half of those with two or more conditions report moderate or severe disability (51%). Those with none of the select conditions report the highest quality of life and are most likely to report no or mild disability (Figure 3).

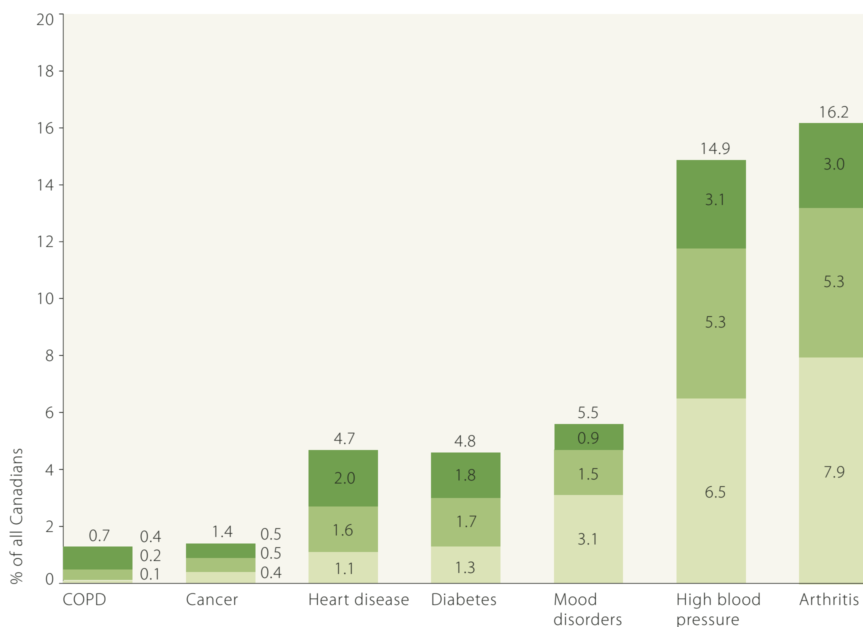


FIGURE 2

Arthritis and high blood pressure are common chronic health conditions*

- 1 select chronic health condition*
- 2 select chronic health conditions*
- 3 or more select chronic health conditions*

*Select chronic health conditions include arthritis, cancer, chronic obstructive pulmonary disease (COPD), diabetes, heart disease, high blood pressure, and mood disorders.

Source: Statistics Canada. Canadian Community Health Survey (Cycle 3.1), 2005.

Some chronic health conditions, such as heart disease and cancer, tend to cut lives short while others, such as mood disorders, are more likely to reduce a person's quality of life. If our goal is, as the authors of one Canadian study put it, to add "years to life and life to years," we should look broadly across our population and target efforts to improve both life expectancy and quality of life.[5]

Chronic health conditions represent a significant, and growing, health care and economic burden for Canada. People with chronic health conditions are higher users of health care services than those without long-term health problems and the more conditions people have, the more health care they use (Figures 4 and 5).

Compared to Canadians with none of the select chronic health conditions, those with three or more chronic conditions:

> use twice as many consultations with a family doctor, 1.5 times as many consultations with specialists and other doctors, and four times as many consultations with nurses (these are health care consultations outside of the nights that patients stayed in hospitals);
> are 11 times more likely to receive home care services;
> are four times more likely to stay overnight in hospitals;
> spend three times more nights in hospitals.

A handful of avoidable risks, also increasingly common, cause most of the burden of chronic disease. A number of chronic diseases share common risk factors, which explains why so many people have multiple long-term health problems. Tobacco, alcohol, high blood pressure, high cholesterol, and obesity are the major culprits, and the World Health Organization (WHO) estimates that at least one-third of the total "burden of disease" in developed countries is caused by these five risk factors.[6]

In recent decades, Canada has seen a surge in risk factors among young and old, fueling concerns that today's adults could be the first generation in history to develop health problems such as heart disease and stroke at younger ages than the generations before them.[7] Obesity among North American children is leading to early onset of chronic disease and greater likelihood that more years will be spent in ill health.[8] As we described in *Why Health Care Renewal Matters: Lessons from Diabetes*, rates of chronic disease and their risk factors are high and vary somewhat across Canada's regions. For example:

> Nearly 60% of adults and more than one in four children in Canada are either overweight or obese, and obesity has risen in every province over the past 20 years.
> Close to half of Canadians (40% to 55% across the provinces and territories) are not active enough to maintain good health.[4]

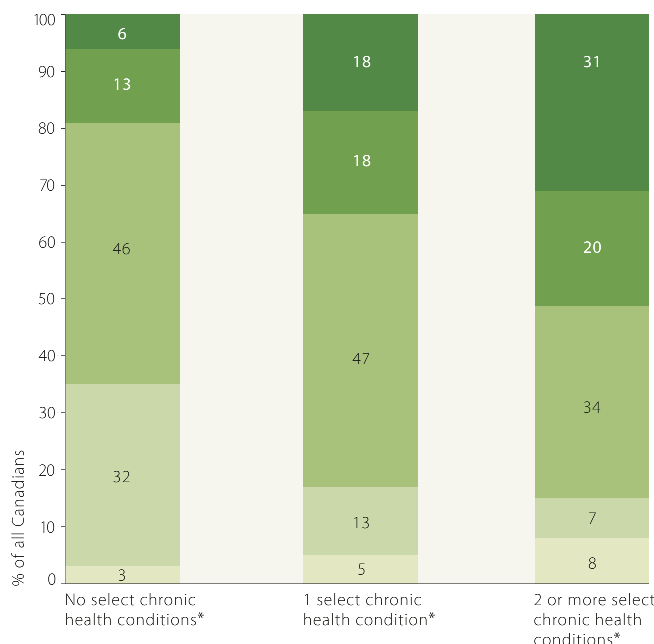


FIGURE 3
Canadians with chronic health conditions* have poorer health status and greater disability

Severe disability
Moderate disability
Mild disability
No disability
Missing

Disability classification is based on Health Utilities Index (HUI) categories developed by Feeny et al. 2004.[23] "No disability" refers to individuals with HUI scores of 1.00; those with an HUI between 0.89 and 0.99 are grouped as having "mild disability;" those with an HUI of 0.70 to 0.88 are considered to have "moderate disability"; and those with HUI scores of less than 0.70 are classified in the "severe disability" group. "Missing" includes "don't know" responses, refusals, and not stated.

* Select chronic health conditions include arthritis, cancer, chronic obstructive pulmonary disease, diabetes, heart disease, high blood pressure, and mood disorders.

Source: Statistics Canada. Canadian Community Health Survey (Cycle 3.1), 2005.

Communities that have higher rates of chronic disease should be able to achieve lower rates, as others have done. A study showing that people in Atlantic Canada have the most risk factors for heart disease, while western provinces have the least,[9] also found that almost half of the regional differences in deaths related to heart disease could be explained by regional differences in risk factors (e.g. smoking, obesity, diabetes, and high blood pressure), social determinants of health (e.g. education levels and unemployment rate), and community characteristics (e.g. population density and ethnic makeup).[10]

Physical and social environments are among the other factors that may help account for differences in health status in different parts of Canada. For example, there is an inverse relationship between obesity and the size of the community where people live. Adults living in Canadian cities have lower obesity rates (20%) than the national average (24%) and much lower than those living outside of urban areas (29%). This may in part be due to people's ability and willingness to walk more in densely-populated cities where they can rely less on motor vehicles.[11] Diabetes rates in Toronto are higher in "inner suburb" neighbourhoods where more people rely on cars and have to travel farther to grocery stores.[12]

Much of the burden of disease* in developed countries can be attributed to 7 risk factors

% of burden of disease* linked to risk factor

Risk factor	%
Tobacco smoking	12%
High blood pressure	11%
Alcohol use	9%
High cholesterol	8%
Overweight	7%
Low fruit and vegetable intake	4%
Physical inactivity	3%

* Burden of disease means the combined cost of health care, social costs due to early death, and reduced quality of life as a result of health problems. The WHO uses a measure called disability-adjusted life years (DALY) to represent this health and economic cost. One DALY is equal to the loss of one year of healthy life. For example, a person who lives to age 70, but suffers an incapacitating stroke at age 65, has lost five DALYs.

Source: World Health Organization. *The World Health Report 2002: Reducing Risks, Promoting Healthy Life*. Geneva: Switzerland. *www.who.int/whr/2002/en/*

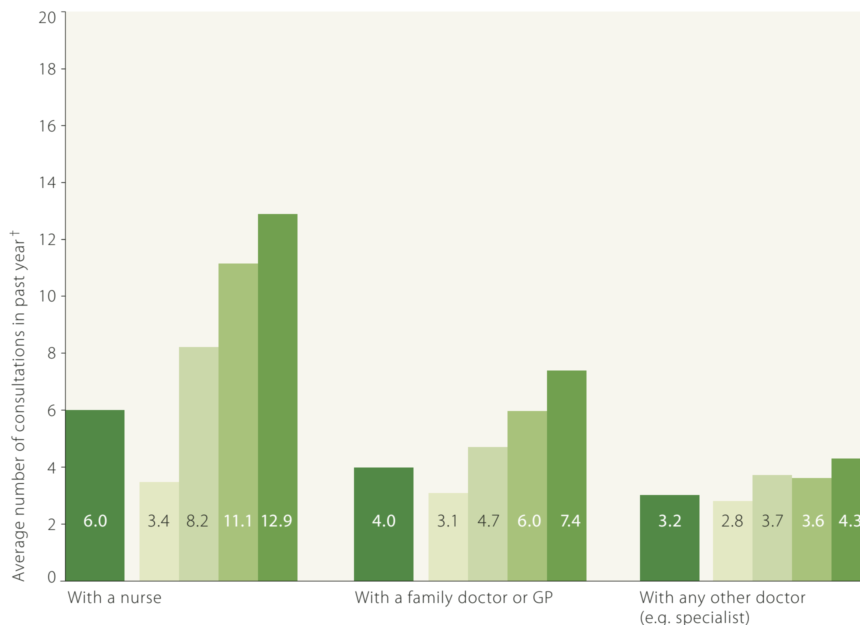


FIGURE 4

People with 3 or more chronic health conditions* consult with nurses and doctors most often

- All Canadians
- No select chronic health conditions*
- 1 select chronic health condition*
- 2 select chronic health conditions*
- 3 or more select chronic health conditions*

* Select chronic health conditions include arthritis, cancer, chronic obstructive pulmonary disease, diabetes, heart disease, high blood pressure, and mood disorders.

† Consultations for any reason or diagnosis. Excludes consultations during hospital overnights.

Source: Statistics Canada. Canadian Community Health Survey (Cycle 3.1), 2005.

Preventive action now can secure a healthier future for Canadians and a more sustainable future for our health care system.

There is tremendous opportunity to reduce the burden of chronic disease. According to the WHO, 90% of type 2 diabetes, 80% of coronary heart disease, and one-third of cancers globally could be avoided if we all ate a healthier diet (less salt, sugar, and fats; more fruits and vegetables), got more physically active, and stopped smoking.[13] After synthesizing evidence from international research, the WHO concluded that industrialized countries stand to gain another five years of healthy life expectancy if they can do better at preventing chronic illness. For many of the risk factors for chronic disease, negative impacts can be reversed quickly, most benefits will accrue within a decade, and even modest changes in risk factor levels can bring about large improvements in people's health.[6]

Studies in Canada have estimated how reducing risk factors can prevent chronic disease, lower the demand for health care, and save money. For example, if everyone lowered their daily consumption of salt by less than one teaspoon (1,840 mg of sodium/day), this could result in a 30% decrease in cases of high blood pressure in Canada, or one million fewer Canadians with this condition. Direct cost savings – from reduced need for physician visits, laboratory tests, and medication – are estimated at $430 million per year.[14]

Getting people to reduce their salt intake has been shown to be cost-effective in lowering blood pressure, through programs directed at high-risk individuals and large populations. At the same time, the WHO recommends tackling the whole suite of risk factors associated with chronic disease.[6]

In *Why Health Care Renewal Matters: Lessons from Diabetes*, we reported that complications from diabetes, which currently affect about 40% of people with the disease,[15] can be avoided with proper management of blood sugar, cholesterol, blood pressure, and weight.[16] Even modest reductions in blood sugar levels (a 1% reduction) have been linked to a 37% decline in risk of damage to blood vessels (which lead to conditions such as kidney disease and eye damage), a 14% lower rate of heart attack, and a 21% reduction in deaths related to diabetes.[17]

More survey results...

Population Patterns of Chronic Health Conditions in Canada: A Data Supplement

www.healthcouncilcanada.ca

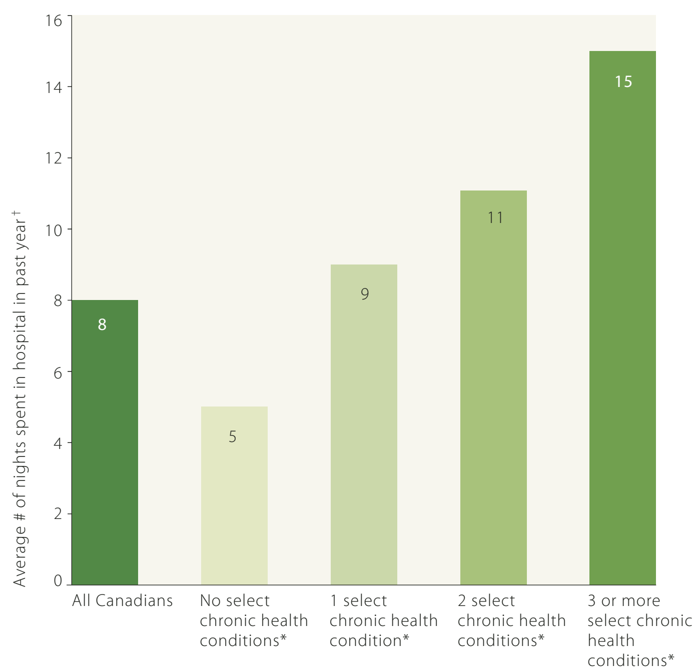


FIGURE 5

Canadians with 3 or more chronic conditions* spend many more nights in hospitals

Note: results not standardized for age or gender differences between populations.

* Select chronic health conditions include arthritis, cancer, chronic obstructive pulmonary disease, diabetes, heart disease, high blood pressure, and mood disorders.

† Hospital stays for any reason or diagnosis.

Source: Statistics Canada. Canadian Community Health Survey (Cycle 3.1), 2005.

There is much that public policy and health care can do to stop the continuing rise in chronic health conditions in Canada and to lessen the devastating consequences of chronic diseases among people who have them. Sustained, well-executed, and targeted social marketing campaigns can be a cost-effective way of improving consumers' knowledge about nutrition, their attitudes about food, and the things they eat.[6, 18] These interventions are particularly effective when targeted for people who are at high risk for developing chronic disease.[19]

ActNow BC, a province-wide initiative in British Columbia, is founded on the evidence that public policy can create a healthier future and reduce our use of health care. In 2004, the BC Provincial Health Officer projected the additional health care costs for people with diabetes, and estimated how much those costs could theoretically be reduced if the incidence of diabetes declined by 25% or 50% over 10 years.[20] Potential outcomes were modelled after a widely reported study on nutritional and physical activity change,[21] and potential savings to the health care system were estimated at $100 million to $200 million annually (Figure 6). This and other research demonstrating the cost-effectiveness of programs that help people make lifestyle changes to reduce their risk of diabetes influenced the BC government's decision to implement ActNow BC (*www.actnowbc.ca*). While a population-level program such as ActNow may not achieve the same results as a clinical trial, it is expected that the program will have a positive effect on the incidence of diabetes and other chronic diseases. By increasing healthier lifestyles among the population, a successful program could possibly achieve an even greater payoff in terms of quality of life, as well as health care cost savings. We feature ActNow BC in Chapter 3.

The way health care is organized and delivered can also help to delay or prevent the onset of chronic health conditions and reduce the risk of complications from them. In *Why Health Care Renewal Matters: Lessons from Diabetes*, we cite evidence that when Canadians with diabetes receive recommended lab tests and procedures, they are less likely to be admitted to a hospital and the total costs of their hospital and physician care are lower than for patients who do not receive recommended care.[22] As we'll explore further in this report, the evidence available from research and experience supports a call to action: preventing and managing chronic health conditions is everybody's business. Sustained and coordinated strategies to help Canadians stay healthy can and do work. These investments pay dividends in very human terms and in real cost savings to society.

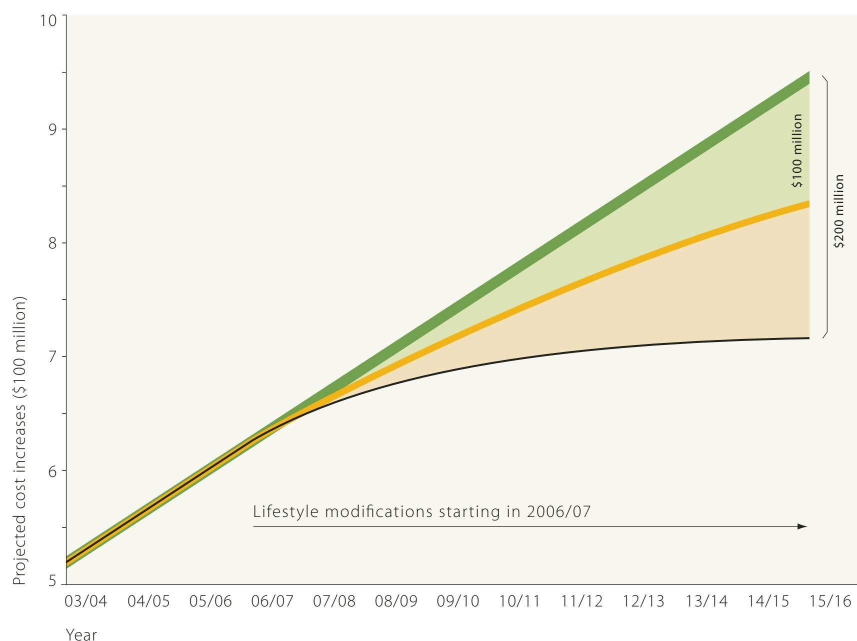


FIGURE 6

Can changing lifestyles reduce health care costs?

Projected annual growth in health services costs to BC Ministry of Health for people with diabetes, with implementation of lifestyle modification program, British Columbia 2003/04 to 2015/16

- Projected cost no reduction incidence
- Projected cost based on 25% incidence reduction by lifestyle modification program
- Projected cost based on 50% incidence reduction by lifestyle modification program

Source: Provincial Health Officer's Annual Report 2004, The Impact of Diabetes on the Health and Well-Being of People in British Columbia. Reproduced with permission of BC Ministry of Health.

For the purpose of this analysis, the resulting estimates were modelled from a widely reported study involving a nutritional and physical activity intervention for non-diabetics at risk of developing diabetes.[20] It must be acknowledged that the results of a specific clinical trial are not necessarily attainable at the population level, but can assist in the development of goals for a population prevention strategy.

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3

HEALTH PROMOTION AND DISEASE PREVENTION— HOW ARE WE DOING?

The decline in smoking among Canadians, from 35% in 1985[1] to 23% in 2005,[2] helps illustrate that it is possible to change social norms to reduce risks for chronic disease, although high rates of smoking continue to plague some areas of the country. This success is widely understood as the result of sustained and multi-faceted strategies to restrict smoking and encourage people to quit or not start – strategies including legislation, tax policy, public education campaigns, and support at workplaces and from health care professionals.

Canadians should expect governments to lead similarly sustained and multi-faceted action to promote other aspects of healthy living, such as eating habits and exercise. One of the lessons from our experience with reducing tobacco use is that changing behaviour to improve health cannot be achieved by simply telling people what's best for them. Also required are public policies that help create the conditions for change. Governments recognized this in the 2003 and 2004 health accords when they spoke about helping Canadians to prevent and manage chronic disease.

In this chapter we look at where we are today in relation to key strategies enshrined in the Ottawa Charter for Health Promotion, which emerged from the first International Conference on Health Promotion hosted by the World Health Organization, Health and Welfare Canada, and the Canadian Public Health Association in Ottawa in 1986.[3] Twenty years later, these actions are still recognized as important to help people increase control over their health and prevent chronic conditions:*

- Build healthy public policy;
- Strengthen community actions;
- Create supportive environments;
- Reorient health care services.

We use ActNow BC, a government-led strategy to reduce common risk factors for chronic diseases in British Columbia, to demonstrate how these elements can be integrated in a comprehensive approach to improve health across a large population. ActNow BC's goal is to be the most comprehensive health promotion program in North America.[4] (For more information on ActNow BC, including its specific goals and targets, see *www.actnowbc.ca* and our profile of the program in *Why Health Care Renewal Matters: Lessons from Diabetes.*)

* The Ottawa Charter also includes two other health promotion actions (i.e. development of personal skills and moving into the future) that are not described in this report.

What governments promised

In February 2003, the prime minister and premiers signed the *First Ministers' Accord on Health Care Renewal,* which made general commitments to a "healthy Canadians" agenda:

"Coordinated approaches are necessary to deal with the issue of obesity, promote physical fitness and improve public and environmental health. First Ministers direct Health Ministers to continue their work on healthy living strategies and other initiatives to reduce disparities in health status."

In September 2004, First Ministers signed the *10-Year Plan to Strengthen Health Care* in which they made further general commitments to advancing "prevention, promotion and public health."

"All governments recognize that public health efforts on health promotion, disease and injury prevention are critical to achieving better health outcomes for Canadians and contributing to the long-term sustainability of Medicare by reducing pressure on the health care system. In particular, managing chronic disease more effectively maintains health status for individuals and counters a growing trend of increasing disease burden."

"Governments commit to accelerate work on a pan-Canadian Public Health Strategy. For the first time, governments will set goals and targets for improving the health status of Canadians through a collaborative process with experts. The Strategy will include efforts to address common risk factors, such as physical inactivity, and integrated disease strategies. First Ministers commit to working across sectors through initiatives such as Healthy Schools."

In October 2005, all ministers of health endorsed a set of national healthy living targets, which call for a 20% increase by 2015 in the proportion of Canadians who are physically active, eat healthy food, and are at healthy body weights (*www.phac-aspc.gc.ca/hl-vs-strat*). They also adopted the Health Goals for Canada, developed collaboratively by governments, public health and other experts, stakeholders and citizens (*www.phac-aspc.gc.ca/hgc-osc*). Ministers agreed that these goals would inform each provincial and territorial government in development of their own initiatives.[5]

Then we shine a light on what policy-makers, health care providers, and community partners are doing across Canada in 2007 to promote health and prevent chronic health conditions.

Build healthy public policy

Governments are stewards of resources that have great potential to promote or harm the health of their populations. They should effectively engage every aspect of government to ensure that public policy-makers are aware of the health consequences of their decisions and accept a shared responsibility for improving health. Coordinated actions across government ministries – such as transportation, education, and finance – should capitalize on public investments and ensure that regulations and taxation policy have a positive impact on health.[3,6] Government strategies should be based on the best available evidence from scientific research, involve a wide range of partners and disciplines, and take a long-term perspective.[7] Measurable goals and targets must accompany government strategies to assess the impact of public investments: Are the money and effort well spent? Are they achieving their intended outcomes? Are there unintended results?

A unique feature of the ActNow BC strategy is its "all-of-government approach" that requires each department to use its influence to help reduce the prevalence of common risk factors for chronic diseases. Each ministry has been directed to contribute to reaching the provincial goals and to establish short-term and long-term outcomes to evaluate their programs. Ministries have responded with dozens of initiatives: for example, the Ministry of Employment and Income Assistance funds programs to help low-income residents quit smoking and improve their healthy cooking skills; the Ministry of Tourism, Sport and the Arts funds an outdoor leadership training program that helps Aboriginal youth get jobs in recreation. A Minister of State for ActNow BC and a committee of senior executives from each ministry

Health promotion

Health promotion aims to achieve equity in health by making conditions favourable for as many people as possible – by addressing barriers to good nutrition, educational success, or adequate income, to name only a few of the factors that influence people's health. This cannot be done through the health care sector alone; it demands coordinated action by governments, non-governmental organizations, industry, and local authorities such as city governments, health authorities, and schools, among others.

SELECTED ACTIVITIES FROM ACROSS CANADA

What's being done to coordinate actions across government ministries to increase health promotion efforts and improve health outcomes?

In **Prince Edward Island,** the Ministries of Health, Social Services and Seniors, Education, and Community and Cultural Affairs participate with community partners in the province's Healthy Living Strategy, which focuses on reducing tobacco use, improving eating habits, and increasing physical activity to slow the growth of chronic disease. These ministries also jointly support PEI's Tobacco Reduction, Healthy Eating, and Active Living Alliances, in which community organizations join forces with government departments to increase the province's capacity for action in health promotion.
www.gpei.ca/infopei/index.php3?number=1001897&lang=E

In **Newfoundland and Labrador,** a Provincial Wellness Advisory Council brings together a wide range of professional associations, non-government agencies and six government departments (Education; Environment and Conservation; Government Services; Tourism, Culture and Recreation; Health and Community Services; and Human Resources, Labour and Employment). The Council helped to develop the Provincial Wellness Plan, launched in March 2006 with a $3.7 million budget that year. Healthy eating, physical activity, tobacco control, and injury prevention are the focus of Phase I. Other wellness priority areas such as mental health, child and youth development, environmental health, and health protection will get attention in Phase II. Six Regional Wellness Coalitions, supported by regional health authorities, lead and coordinate local activities, and community groups can receive up to $50,000 in Provincial Wellness Grants to conduct projects that support the priority areas.
www.gohealthy.ca

In the **Northwest Territories,** the Healthy Choices Framework has resulted in interdepartmental action plans to address unhealthy behaviours, under the territory's 2006–2010 strategic plan. The framework aims to promote healthy living and disease prevention in six core areas: tobacco, sexually transmitted infections, injury prevention, healthy eating, active living, and mental health. A total of $400,000 was budgeted for the framework in 2006/2007, with another $180,000 in 2007/2008 on an ongoing basis.
www.hlthss.gov.nt.ca/pdf/reports/health_care_system/2006/english/hss_action_plan_2006_2010.pdf

ensures that their efforts work together towards the province's measurable targets. Changing societal norms takes time, but receiving buy-in from all of government fuels a jurisdiction's ability to attain this goal much more quickly.[4, 8]

Strengthen community actions

The impact of coordinated actions across government ministries to reduce the risk of chronic disease can be multiplied through collaborative partnerships with non-governmental organizations, industry, local authorities, and others. In effective health promotion, communities take ownership of issues and set priorities, plan strategies, and implement them.[3] For example, population-wide interventions to promote healthy eating and reduce tobacco use, or to lower blood pressure by reducing salt intake are very effective separately or in combination. Population-wide and targeted interventions to reduce the incidence of diabetes or HIV infections are highly cost-effective.[6, 9, 10, 11]

The bottom-up approach of "capacity building" is one important way to strengthen community actions. This means helping working partners develop the skills and resources they need to effectively hold together the programs and services they deliver, which increases their chances for long-term success.[12]

ActNow BC engages non-profit organizations such as the BC Healthy Living Alliance and 2010 Legacies Now as "true and equal partners" of change and infuses them with stable and sufficient funding to enable them to carry out health promotion programs over the long term.[8] For example, in August 2007, the BC Healthy Living Alliance – a partnership of influential not-for-profit organizations interested in promoting health – received a $22-million grant to implement its strategies on healthy eating, physical activity and tobacco reduction. Through the alliance's broad membership and volunteer base in nearly 200 BC communities, initiatives under these strategies are expected to have far-reaching impact throughout the province. The alliance will measure the impact of these programs by conducting an external evaluation of the outcomes.[13]

SELECTED ACTIVITIES FROM ACROSS CANADA

In the **Yukon,** the health promotion unit of Yukon Health and Social Services has established more formal collaboration with educators under the umbrella of school health. A Healthy Eating Program has been introduced, with the goal of encouraging all segments of the population to adopt healthier lifestyle choices through better nutrition and physical activity.
www.hss.gov.yk.ca/programs/health_promotion

Ontario's Action Plan for Healthy Eating and Active Living (HEAL), launched in June 2006, is engaging sectors and communities to address key risk factors for chronic disease – poor nutrition and physical inactivity. The $10-million strategy supports initiatives such as the Healthy School Recognition Program in partnership with the Ministry of Education to promote healthy behaviours and practices in school environments. To date, over 1,300 schools have participated in this program.
www.mhp.gov.on.ca/english/health/HEAL/actionplan-EN.pdf

Manitoba in Motion was launched in October 2005 as part of a provincial strategy to make Manitobans healthier by increasing physical activity across all age groups. The initiative involves four government departments (Health; Healthy Living; Aboriginal and Northern Affairs; and Culture, Heritage, Tourism and Sport) and many non-government partners including the Manitoba Fitness Council and Sport Manitoba. Based on the Saskatchewan in Motion model (profiled in the Health Council's 2006 report *Their Future Is Now: Healthy Choices for Canada's Children & Youth*), the strategy has four components: building partnerships, increasing public awareness, developing strategies for target areas, and measuring success.
www.manitobainmotion.ca

The Tåîchô Community Services Agency in the Northwest Territories is a unique example of an all-of-government approach that combines the delivery of education, health, and social services. The agency is managed by the Tåîchô people in collaboration with the Government of the **Northwest Territories**, and provides services sensitive to the culture, traditions, and needs of Tåîchô people. One example is the Tåîchô Healing Path Wellness Strategy, which empowers members to work towards health and wellness with practical support through services such as lifestyle-change counselling, family counselling, public health and clinical services, and access to educational programs and services.
www.tlicho.ca/services-agency

BC Healthy Living Alliance

- BC Lung Association
- BC Pediatric Society
- BC Recreation and Parks Association
- Canadian Cancer Society, BC and Yukon Division
- Canadian Diabetes Association
- Dietitians of Canada, BC Region
- Heart and Stroke Foundation of BC and Yukon
- Public Health Association of BC
- Union of BC Municipalities

www.bchealthyliving.ca

> "For over eight years I tried to introduce a diabetes awareness program within the local Band-owned stores I had managed in North Saskatchewan, to no success! I believe that industry has to work closely with assisting the public in providing more information at the level when food is being purchased."

Health Council of Canada's public consultation on health care renewal and chronic illness, spring 2007

Create supportive environments

Our health is inextricably linked with the natural and built environments we live in – from the design of our streets and the quality of the air we breathe, to the kind of work we do and the atmosphere in our workplace. Changing patterns of family, work, and leisure can also help or hinder health. Creating environments that support good health means ensuring that the contexts in which we live and work are safe, stimulating, satisfying, and enjoyable.[3]

In the prevention of chronic health conditions, this means creating the conditions that enable people to abandon harmful behaviours (e.g. smoking) and adopt healthier habits (e.g. walking more, driving less). All sectors of society can help to create supportive environments: governments (e.g. family support policies, transportation), non-government organizations and industry (e.g. workplace policies), local authorities (e.g. school policies, community design), communities and families (e.g. attitudes about active living for children and seniors).

SELECTED ACTIVITIES FROM ACROSS CANADA

Since November 2004, **Health Canada** has been working with the Heart and Stroke Foundation of Canada and a multi-stakeholder task force (including federal departments and agencies, industry associations, voluntary organizations, and scientific experts) to develop recommendations and strategies to reduce trans fats in Canadian foods to the lowest level possible. In June 2007, the federal minister of health announced that Canada will adopt the limits proposed by the task force in its final report, *TRANSforming the Food Supply,* making Canada the first country to require that the levels of trans fat in prepackaged food be included on the mandatory nutrition label.

www.hc-sc.gc.ca/fn-an/nutrition/gras-trans-fats/tf-ge/tf-gt_rep-rap_e.html

The **Public Health Agency of Canada** works with provinces and territories to address common risk factors for chronic disease through a number of collaborative initiatives, including: the Integrated Strategy on Healthy Living and Chronic Disease and the Pan-Canadian Public Health Network.

www.phac-aspc.gc.ca/media/nr-rp/2005/2005_37bk3_e.html and www.phac-aspc.gc.ca/publicat/healthpartners/index.html

What's being done in Canada to mobilize communities so they are true partners in advancing health promotion and disease prevention?

The Health Integration Initiative in **Nunavut** supports health committees in each of the territory's 25 communities to help them pursue wellness strategies that use a holistic, integrated, and community-centric approach to health care and social services delivery.

www.gov.nu.ca

In **Ontario,** Thunder Bay Fast Forward is a broad community development plan that has been working since 2001 to improve health, strengthen the local economy, and increase quality of life in that northern Ontario city. More than 70 organizations participate. Progress in health indicators from 2001 to 2003 included lower rates of smoking and obesity and higher rates of people getting regular physical activity.

www.thunderbay.ca/index.cfm?fuse=html&pg=641

Through its many partnerships, ActNow BC is active in schools, workplaces, and communities, and activities are led individually or jointly by leaders in the various sectors engaged in the program. Since the start of ActNow BC in 2005, more than 130 towns, cities and First Nations have registered as "Active Communities" with action plans to increase physical activity levels among their populations; 100% of school districts – encompassing over 1,300 elementary and middle schools with more than 350,000 students – have integrated physical activity throughout the school day, in addition to gym classes; and the Ministry of Health has piloted a Workplace Wellness initiative at ministry sites and meetings, with 12 other ministries following suit. As employers, the Ministries of Environment and Health run a Work Bike program that provides bikes and safety courses to encourage employees to cycle to downtown meetings.[4, 8]

Reorient health care services

In 1986, the Ottawa Charter called for reorienting health services so that they "contribute to the pursuit of health;" while the health care system must treat the sick, it should also embed health promotion and disease prevention in its everyday services. There is good evidence that health care providers can make a difference: for example, advice from physicians helps patients stop smoking.[14] In March 2007, the Health Council echoed this call when we recommended that we shift health care services from their current "find it and fix it" orientation to a "prevent it, find it, manage it" approach to stem the tide of chronic health conditions among Canadians and better match the complex, ongoing needs of people with chronic disease.[15]

SELECTED ACTIVITIES FROM ACROSS CANADA

In **Newfoundland and Labrador,** as part of the Provincial Wellness Plan, the Department of Health and Community Services funds the Alliance for the Control of Tobacco, an umbrella organization of not-for-profits involved in public education to reduce smoking. The Alliance's Tobacco Reduction Strategy (2005-2008) describes initiatives focused on prevention, protection and cessation.

www.actnl.com and www.smokingsucks.ca/pdf/ACTguts.pdf

The **Chronic Disease Prevention Alliance of Canada** is a networked community of organizations and individuals who share a common vision for an integrated system of chronic disease prevention in Canada. It brings together disease-specific stakeholders (diabetes, cancer, heart, stroke, respiratory) and a cross-section of chronic disease stakeholders, including provincial/territorial and risk-factor (e.g. physical activity, nutrition, tobacco) perspectives. The "Cube Project" is mapping prevention activities and priorities, to recommend ways to achieve an aligned and integrated system for primary prevention.

www.chronicdiseaseprevention.ca

In **Ontario,** the Communities In Action Fund – part of ACTIVE2010, Ontario's Sport and Physical Activity Strategy – was established in 2004 to invest in community projects that remove barriers to sport and physical activity participation. Since its inception, more than $25 million in non-capital grants have supported over 800 organizations at the provincial and local levels, benefiting approximately one million people including children and youth, low-income families, Aboriginal communities, older adults, women and girls, visible/ethnic minorities, and people with disabilities.

www.mhp.gov.on.ca/english/sportandrec/ciaf/fund.asp

In **British Columbia,** Interior Health region's new Community Action for Health program provides seed funding to local healthy living alliances and networks to enhance their ability to support health promotion and illness prevention in their community. The goal is to create local environmental and policy changes that support the provincial ActNow BC targets. The program will support projects that work upstream to support comprehensive and sustainable change.

www.interiorhealth.ca/NR/rdonlyres/0FC3FDA8-9520-43AA-9CD1-923AF15081BF/3665/WhatisCommunityActionforHealth.doc

British Columbia's Primary Health Care Charter, adopted in May 2007, endorses this kind of reorientation (*www.primaryhealthcarebc.ca*). It lays out a broad strategy to tap the "great potential of primary health care to improve the health of the population and contribute to the sustainability of the health care system." Chronic disease – prevention, management, and coordination of care – takes centre stage in this charter, which describes a range of system-wide changes in health care that will help the province achieve the risk-reduction goals of ActNow BC. For example, family doctors can now receive incentive payments when they assess middle-aged men and women for risk of heart disease and create action plans with their patients. Also supporting a stronger focus on prevention are established provincial programs like the Dial-A-Dietitian electronic database, which helps nutritionists respond to calls from the public with up-to-date, evidence-based information on healthy eating.

"What's really needed is a focus on the determinants of health for people with mental illness ... There have to be the resources and choices available for people to be able to engage in healthy behaviours and an environment ... that is conducive."

"Doctors need to be more assertive about weight and lifestyle issues of patients. Time spent on education at this point would save a lot of suffering later when the illness has been diagnosed."

Health Council of Canada's public consultation on health care renewal and chronic illness, spring 2007

SELECTED ACTIVITIES FROM ACROSS CANADA

In **Ontario,** the Culture Counts project of the Centre for Addiction and Mental Health (CAMH) has produced a guide for community education and knowledge exchange in mental health and addiction with culturally / linguistically diverse communities. Culture Counts is a partnership between CAMH, the Ontario Public Health Association, local public health agencies, and seven community-based organizations serving Polish, Portuguese, Russian, Tamil, Punjabi, Somali, and Serbian people in Toronto, Peel Region, Ottawa, and Windsor.
www.camh.net/About_CAMH/Health_Promotion/Community_Health_Promotion/Culture_Counts/index.html

In **Saskatchewan,** the Saskatoon Health Region has community developers who work with community groups in their efforts to achieve healthier communities. The health region has three core objectives: to encourage community participation in health, focus on the creation of healthier communities, and expand understanding of factors that sustain the health of communities.
www.saskatoonhealthregion.ca/your_health/ps_primary_health_community_development.htm

Through the Community Action Program for Children, the **Public Health Agency of Canada** provides long-term funding to community coalitions to deliver programs that address the health and development of children (0-6 years) who are living in conditions of risk. The program places a strong emphasis on partnerships and community capacity building. Each province / territory receives a base allocation of $500,000 per year to allow for at least one major project of significant intervention.
www.phac-aspc.gc.ca/dca-dea/programs-mes/capc_main_e.html

What's being done in Canada to create supportive environments?

Brighter Futures is a community-based health promotion program, funded by the First Nations and Inuit Health Branch of Health Canada through contribution agreements with territorial governments and First Nations communities within provinces. In **Nunavut** for example, Brighter Futures projects were delivered in every community for 2006/2007, and aimed to improve the physical, mental and social well-being of Inuit children, their families and their communities.
www.hc-sc.gc.ca/fnih-spni/promotion/mental/brighter_grandir_e.html

Under **Nova Scotia's** Pathways for People Framework for Action, the Department of Health Promotion and Protection is working with other government departments, municipalities, and community groups to advocate for active transportation, which includes both recreation and transportation for utilitarian purposes such as walking, biking, and rollerblading.

From the patient's perspective, how are we doing as a health-promoting country today? In 2007, the Health Council asked Canadians who have chronic health conditions about health promotion and disease prevention services they received from their primary care provider over the past 12 months.[16]

More than one-third feel that that these providers "always" or "usually" give them the help they want to reach or maintain a healthy body weight (39%). Almost half report that their primary care providers talk with them about specific things they could do to improve health or prevent illness, such as things to help them stop smoking, reduce alcohol use, or cope with stress (48%). More than half report that these providers "always" or "usually" give them the help they need to make these changes (57%). These rates do not differ much than those for Canadians with no chronic health conditions, which suggests that these services may not be particularly tailored to people who most need them (Figure 7).

When Canadians were asked about the care they received for their specific chronic conditions over the past six months, almost half (49%) said they were asked questions about their health habits. However, a similar proportion (42%) indicated they were "generally not / almost never" helped to set specific goals to improve eating or exercise.[16]

The advice of the Ottawa Charter is as relevant for Canada today as it was two decades ago. On reorienting health care, the Ottawa Charter says this will require stronger attention to health research; today we need continued research to identify how health care providers can be most effective in improving health outcomes. They also said it will require changes in the education of health care professionals, so providers can offer care that focuses on the needs and preferences of the patient, not solely on the problem that caused a patient to seek health care. That is the subject of the next chapter.

> "Managing an illness should be a multi-disciplinary function but be available in a centralized environment ... The faster the person is on the road to recovery the faster that individual will hopefully be able to become a positive contributing member to society once again."
>
> Health Council of Canada's public consultation on health care renewal and chronic illness, spring 2007

SELECTED ACTIVITIES FROM ACROSS CANADA

In **British Columbia** the LocalMotion program gives local governments extra resources to improve traffic, safety, reduce energy consumption, and encourage physical activity. The Ministry of Community Services has allocated $40 million over four years for bike paths, walkways, greenways and improvements for people with disabilities.
www.localmotion.gov.bc.ca

As part of ACTIVE2010, the **Ontario** Trails Strategy – launched in October 2005 with an annual budget of $3.5 million over five years – guides the development, management, and promotion of a diversified trail system to help address a chronic disease risk factor – physical inactivity. The Trails for Life grant program provides funding to increase physical activity and promote the health and economic benefits of trails.
www.mhp.gov.on.ca/english/sportandrec/A2010_TrailStrategy.pdf

In **Saskatchewan,** the *in motion* program supports several initiatives across the province around active transportation such as biking and walking.

A partnership of community trail groups, provincial and local government departments, and regional and provincial not-for-profit organizations in **Nova Scotia** is working to develop a comprehensive province-wide trail system resulting in 500 kilometers of new trail over the next four years.

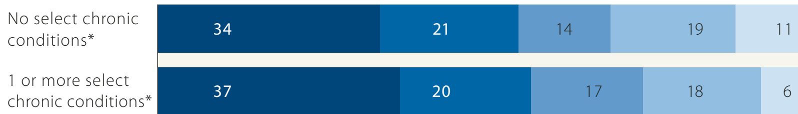
The **PEI** Healthy Eating Alliance is one of three risk-factor reduction alliances in the province. Formed in 2001, the alliance includes over 30 community organizations, educators, and government agencies, and individuals who work together to improve the eating habits of Island children and youth. For example, the Alliance created a School Healthy Eating Toolkit (funded by Public Health Agency of Canada, Canadian Diabetes Strategy) with a rationale for school nutrition policies and practical information on operating healthy school food programs. The Alliance recently launched a three-year PEI Healthy Eating Strategy.
www.healthyeatingpei.ca

In **Newfoundland and Labrador,** the Healthy Students, Healthy Schools initiative is underway to ensure that school environments support children's health. School Food Guidelines – developed in partnership by the Departments of Health and Education, school administrators, teachers, students, and parents – will be fully implemented across the province by September 2008. Regional health authorities will provide health coordinators for each school district. A new curriculum for grades K-12 makes physical education mandatory for graduation. More than $2.4 million has bought new physical education equipment for schools over the past two years, with programs moving away from a sports-only model and focusing on young

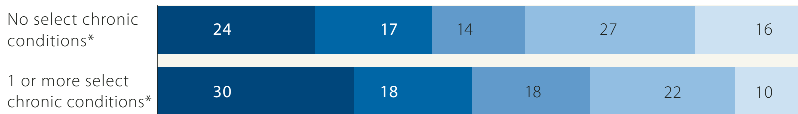
FIGURE 7
Do primary care providers promote disease prevention and healthy living?

Did your primary care provider …

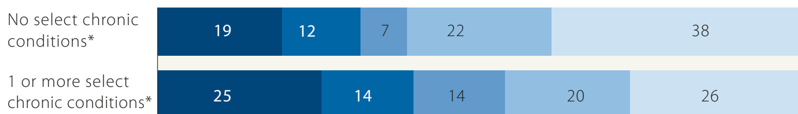
Help you change habits/lifestyles to improve health/prevent illness?



Talk about specific things to improve health/prevent illness?



Help you reach or maintain a healthy body weight?



% of Canadians who visited a family doctor or general practitioner in past 12 months

- Always
- Usually
- Sometimes
- Rarely/Never
- Not applicable

Note: Percentages may not add up to 100% due to missing, refusal, and "don't know" responses.

* Select chronic conditions include: arthritis, cancer, chronic obstructive pulmonary disease, diabetes, heart disease, high blood pressure, and mood disorders.

Source: Statistics Canada, Canadian Survey of Experiences with Primary Health Care, 2007.

SELECTED ACTIVITIES FROM ACROSS CANADA

people leading more active, healthy lives. A Living Healthy Schools website provides resources and information for schools and communities.
www.livinghealthyschools.com

With funding from the **Public Health Agency of Canada,** a partnership of national and provincial agencies is collaborating on evaluating and disseminating a Seniors' Mental Health Policy Lens, an instrument for developing or critiquing policy, legislation, programs and services that support the well-being of older adults.
www.seniorsmentalhealth.ca/best%20practices.htm

What is being done in Canada to reorient primary health care services to promote health and prevent chronic disease?

The McAdam Health Centre in **New Brunswick's** River Valley Health region focuses on health promotion and disease prevention services – such as diabetes and asthma education and screening, tobacco cessation, and education on how to use medications safely – in addition to palliative care and 24/7 emergency services.

Integrated Primary Health Care for Elsipogtog First Nation in **New Brunswick** combines community-based services, particularly mental health services, for the Mi'kmaq community of 2,700 people with services provided by physicians and nurse practitioners from the Beauséjour Regional Health Authority. The community identified a need for improved access to culturally appropriate community-based services as well as more access to physician services.
www.hc-sc.gc.ca/fnih-spni/services/acces/elsipogtog_e.html

In **Ontario,** the Dryden Area Family Health Team has designed a program called It's Your Health! which focuses on health promotion and disease prevention services such as nutrition programs to prevent weight-related complications. Patients and providers work together to assess patients' needs using the team's Your Health Toolkit and then set up appointments with appropriate providers.

In **Saskatchewan,** the Hudson Bay Primary Health Services Project of the Pasquia Health District uses health promotion principles in everyday interactions with clients and focuses on promoting good health practices, early diagnosis, treatment, and disease prevention. The multidisciplinary team includes physicians, primary care nurses, public health nurses, other nurses, social workers, nutritionists, physical therapists, and home care workers, among others. The nurse practitioner is able to spend the additional time putting social supports in place and teaching self-care management.

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4

QUALITY OF CHRONIC ILLNESS CARE – HOW ARE WE DOING?

Quality in health care includes many aspects of care: for example, do patients receive the tests and procedures that experts recommend for their conditions? Are patients actively involved in decisions about their care? Do providers listen well so that they can respond effectively to patients' concerns? Patients expect their health care providers to respect and respond to their needs and preferences, and to share information and decision-making about their care. This dimension of health care services has come to be known as *patient-centred care*. Patient-centred care is fundamental to a high-quality health care system[1, 2] because it can make a real difference in patients' health.[3]

Through their commitments on health care renewal in 2003 and 2004, Canada's governments recognized the importance of improving access to quality primary health care, the foundation of care for people with chronic health conditions. In our first report on health outcomes, *Why Health Care Renewal Matters: Lessons from Diabetes*, we assessed whether people with type 2 diabetes were receiving timely, recommended care. We learned that, despite the tremendous efforts and good intentions invested in delivering health care, the way that care is currently provided leaves too many people vulnerable to developing avoidable chronic conditions and related complications.

Here we turn to Canadians with chronic conditions to learn about their recent experiences with health care. Using key elements of patient-centred care,[5] we look at where we are today to ensure that:*

- Canadians have access to needed care;
- patients are engaged in their care;
- care is coordinated;
- health care teams deliver integrated and comprehensive care; and
- information about health care is publicly available.

To learn from Canadians, the Health Council undertook several initiatives in 2007. We hosted in-person dialogues in Halifax, Thunder Bay, and Vancouver and online activities to hear from a diverse group of close to 2,000 Canadians, including many with diabetes. (See p. 45, "The Health Council of Canada consults with Canadians".) We commissioned Statistics Canada to conduct a telephone survey of nearly 2,200 Canadians to learn more about their experiences with primary health care and chronic illness care. (For more on this survey, please see our data supplement *Canadians' Experiences with Chronic Illness Care in 2007*).

* The 2020 Vision of Patient Centered Care includes two other actions that are not reported here because they require surveys of physicians rather than patients. These two other actions are: use of clinical information systems that support high-quality care, practice-based learning, and quality improvement; and seeking routine patient feedback.

What governments promised

The 2003 *First Ministers' Accord on Health Care Renewal* committed governments to speed primary health care reforms so that Canadians routinely receive needed care from an appropriate health care provider. The First Ministers agreed to the goal that by 2011, "at least 50 per cent of residents have access to an appropriate health care provider, 24 hours a day, seven days a week." In the 2004 *10-Year Plan to Strengthen Health Care,* this target was described a little differently: "the objective of 50 per cent of Canadians having 24/7 access to multidisciplinary teams by 2011."

First Ministers agreed in 2003 to use comparable indicators on key health outcomes and to develop the necessary data infrastructure for reporting to Canadians. The 2004 plan committed governments to establish a best practices network and to continue to work with Canada Health Infoway, to realize the vision of an electronic health record.

We also worked internationally with other organizations to ask 3,000 Canadians, as well as 9,000 adults in six other countries, about their experiences with health care. (See p. 44 for more about this survey.)

We also asked federal, provincial, and territorial governments about their recent initiatives in the area of chronic disease management, so we could shine a light on what is being done to enhance patient-centred care for people with chronic health conditions. It's important to note that our survey results describe Canadians' experiences during the last one to two years and don't necessarily reflect the impact of changes currently underway in the health care system. It will take time before we see the effect of current reforms.

"Patients want care which (a) explores the patients' main reason for the visit, concerns, and need for information; (b) seeks an integrated understanding of the patients' world – that is, their whole person, emotional needs, and life issues; (c) finds common ground on what the problem is and mutually agrees on management; (d) enhances prevention and health promotion; and (e) enhances the continuing relationship between the patient and the doctor."

Dr. Moira Stewart, professor and director of the Centre for Studies in Family Medicine at the University of Western Ontario [4]

"The doctor called me in and told me that I was diabetic. He said that the diabetic nurse and the dietitian would contact me. It took over a month for the dietitian to call, longer for the diabetic nurse. In the interim, I felt frightened, and looked in books and on the Internet for information. Every time I have needed to talk to the diabetic nurse, it has taken a long time to make an appointment. If we are going to take care of ourselves, we need prompt access to diabetic practitioners (even if we live in northern BC)."

Health Council of Canada's public consultation on health care renewal and chronic illness, spring 2007

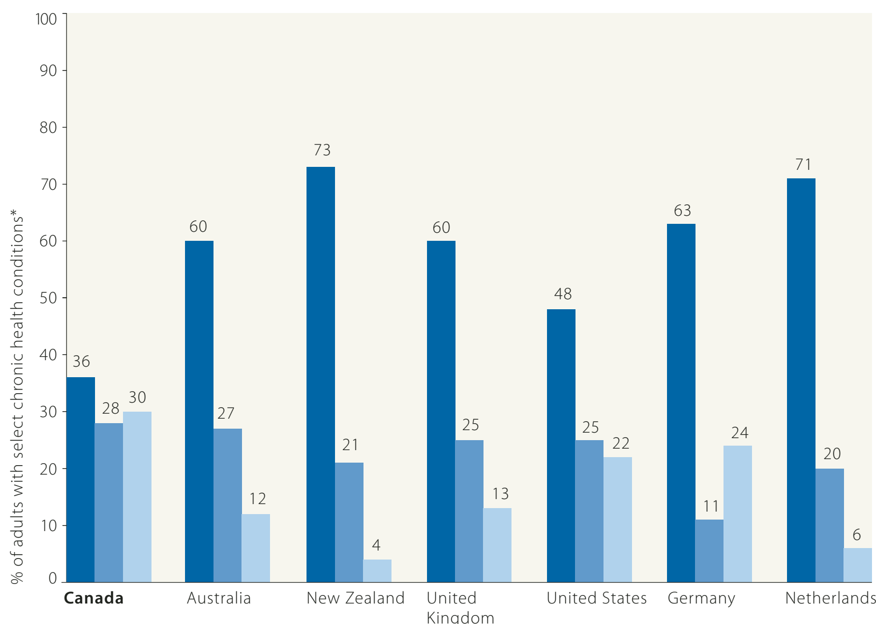

FIGURE 8

Canadians wait longer than patients in other countries

Wait time for appointment when last sick or needed medical attention in past 12 months

- Same or next day
- 2–5 days
- 6 or more days

* Select chronic health conditions include arthritis, asthma, depression, diabetes, cancer, chronic obstructive pulmonary disease, heart disease (including heart attack), and high blood pressure.

Source: The Commonwealth Fund 2007 International Health Policy Survey of the General Public's Views of their Health Care System's Performance in Seven Countries.

Do Canadians have access to needed care?

Through our surveys, we learned that the vast majority of adults with chronic health conditions have a regular medical doctor, have long-standing relationships with these providers, and often visit doctors and nurses. This is encouraging, as there is strong evidence that people who have a regular source of care are less likely to use emergency rooms or to be hospitalized.[6] On the surface, access to care looks sufficient, though we recognize that in many communities people cannot find local doctors to be their regular source of primary health care. As we peel away the layers of questions about access, however, we find that the news about whether Canadians get care when and where they want it is less positive.

> **Most adults with chronic health conditions have a regular source of care (98%) and have had one for a long time.** Over half have been seeing the same primary health care provider for more than seven years (59%), and many others have been going to their provider for three to seven years (25%).[7] A similar proportion of adults have a regular source of care in the six other countries surveyed: Australia, New Zealand, the United Kingdom, the United States, Germany, and the Netherlands.[8]

> **Use of health care increases as the number of chronic conditions goes up, a pattern that signals our health care system is serving the people most in need.** People with three or more chronic conditions consult with nurses 13 times a year on average, and with family physicians seven times a year – in addition to any health care services they receive during overnight stays in hospitals (Figure 4, p. 19). In our international comparison, Canadians with chronic health conditions visited their regular primary care provider slightly more often than in three countries (New Zealand, the United States and the Netherlands) and slightly less often than three others (Australia, the United Kingdom, Germany).[8]

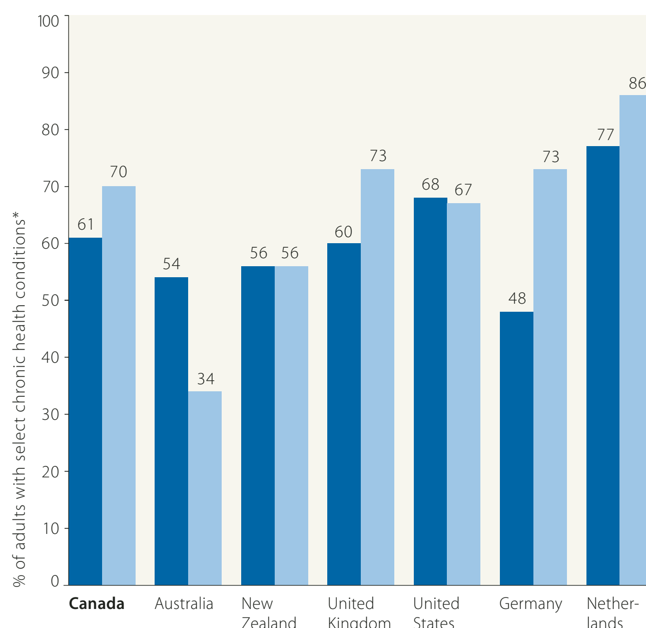

FIGURE 9
Access to after-hours care

Regular doctor or place of care offers:
evening hours / weekend hours

* Select chronic health conditions include arthritis, asthma, depression, diabetes, cancer, chronic obstructive pulmonary disease, heart disease (including heart attack), and high blood pressure.

Source: The Commonwealth Fund 2007 International Health Policy Survey of the General Public's Views of their Health Care System's Performance in Seven Countries.

› **Canadians with chronic health conditions report that they wait longer than in other countries.** Only 36% of Canadians with chronic health conditions can get a same-day or next-day appointment when they are sick or need medical attention, the bottom place in our seven-country comparison. In New Zealand and the Netherlands, more than 70% of adults get this level of timely access. Another 30% of Canadians wait six days or longer to get an appointment, compared to 6% or less in New Zealand and the Netherlands (Figure 8). For routine or ongoing care, one in five Canadians with chronic health conditions report difficulty getting care when they needed it in the past year (20%). Waiting too long for an appointment was the most common difficulty cited.[7]

› **Delays in accessing care occur despite the fact that after-hours care from Canadians' regular providers is available at levels similar to most of the other countries** (Figure 9). This suggests that other factors, such as the efficiency of scheduling systems, underlie international differences in wait times for appointments and there is much that Canada can learn from other countries to improve our situation.

› **Too many people with chronic conditions visit emergency departments, and often unnecessarily.** Almost twice as many adults with chronic conditions in Canada (45%) used a hospital emergency department in the past two years compared to, for example, 24% in Germany.[9] Among this group, many more Canadians report that their emergency visit was for a condition they thought could have been treated by their regular doctor if he or she had been available (41% in Canada, compared to 20% in Germany) (Figure 10).[8]

› **Costs prevent few patients from seeing doctors and getting tests, but more face financial barriers to drugs and dental services.** Some Canadians with chronic health conditions report that they did not see a doctor (4%) or skipped a test, treatment, or follow-up visit (6%) because of cost. Slightly more did not fill a prescription or skipped a dose because of cost (10%), and even more did not see a dentist though they needed to (23%). Financial barriers to chronic illness care are least common in the Netherlands and more common in Australia, New Zealand and the United States, compared to Canada (Figure 11).

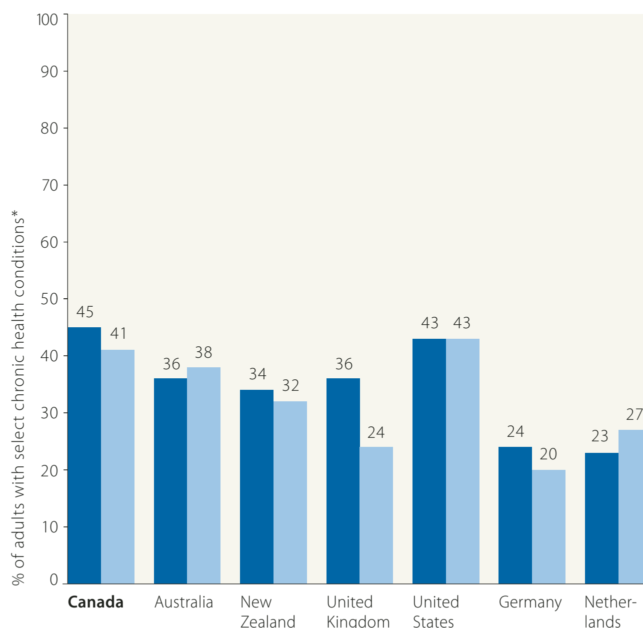

FIGURE 10
Avoidable visits to emergency departments

- Used emergency department in past 2 years
- Last visit to emergency was for condition that patient's regular doctor could have treated if available

* Select chronic health conditions include arthritis, asthma, depression, diabetes, cancer, chronic obstructive pulmonary disease, heart disease (including heart attack), and high blood pressure.

Source: The Commonwealth Fund 2007 International Health Policy Survey of the General Public's Views of their Health Care System's Performance in Seven Countries.

Are patients engaged in their care?

Most Canadians with chronic health conditions report that their primary health care providers communicate well and spend enough time with them. But too few patients are actively engaged in planning and managing their care or get connected to helpful educational resources and community supports. This is not good news: self-management programs, for diabetes or hypertension in particular, are effective at improving health outcomes.[13] People with chronic health conditions must be actively engaged and supported in adopting or maintaining a healthy lifestyle and in managing their own medical conditions.

> **Most Canadians with chronic health conditions report that their regular primary care provider communicates effectively.** Their providers explain things in an understandable manner (90%), know important information about their medical history (85%), offer information about treatment options so as to involve patients in decisions (81%), and spend enough time with them (80%). Adults in other countries report similar experiences.[8]

> **Not enough Canadians with chronic health conditions are actively engaged in planning and managing their care.** Too few report that their primary care provider regularly considers their values and traditions when recommending treatment (55%), asks about their goals in caring for their chronic condition (34%), or helps them create a treatment plan that they can carry out in their daily life (44%).[7] Only one-third report being given a written plan or instructions by any health care professional to help them manage their own care (33%), compared to half of adults with chronic health conditions in the US (51%).[8]

> **Too few Canadians with chronic health conditions get connected with educational resources and community supports that might help them manage their own conditions.** Only around 15% are regularly encouraged by their primary care providers to use a specific service such as an educational seminar to help cope with their chronic condition, attend programs such as support groups or exercise classes, or see a dietitian, health educator or counsellor.[7]

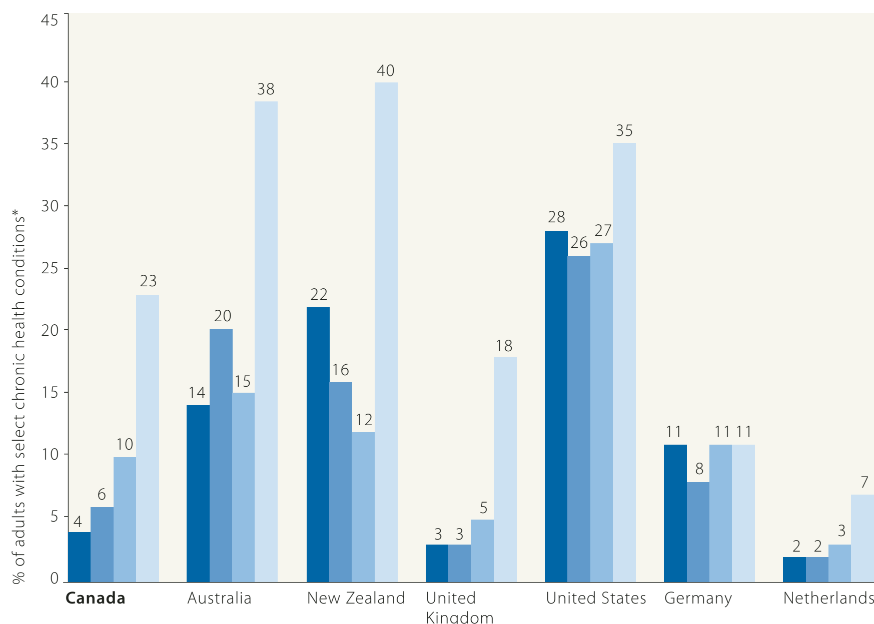

FIGURE 11

Financial barriers to care

In the past 12 months:

- Had medical problem but did not see doctor because of cost
- Skipped test, treatment, or follow-up because of cost
- Did not fill prescription or skipped dose because of cost
- Needed dental care but did not see a dentist because of cost

* Select chronic health conditions include arthritis, asthma, depression, diabetes, cancer, chronic obstructive pulmonary disease, heart disease (including heart attack), and high blood pressure.

Source: The Commonwealth Fund 2007 International Health Policy Survey of the General Public's Views of their Health Care System's Performance in Seven Countries.

Is care coordinated?

Most Canadians with chronic health conditions report that their primary health care and specialty care are coordinated. This is positive, though higher responses from patients in other countries suggest that we could do better. Too few Canadians receive recalls and reminders to coordinate follow-up care or to ensure they receive the lab tests and procedures recommended to prevent complications from chronic diseases.

> **When Canadians have to see more than one doctor for chronic illness care, most feel these providers do a good job coordinating their care.** Two-thirds report that their regular doctor "always" or "often" coordinates care from other doctors (63%). Among people who saw a new specialist in the past year, most report that their regular doctor helped them decide who to see (63%) and provided that specialist with information about their problem (78%).[8] Although Canada is ahead of other countries in this area, there is substantial room for improvement to ensure that more Canadians with chronic health conditions receive coordinated care.

"I think the support I'm receiving is great… but it costs me too much to get meds and other things, e.g. I have to go to a foot doctor and only $10 of the $175 appointment is covered."

"I had to make a decision, continuing my university or working to pay for my insulin pump… I made the switch back to shots… University was much easier on a pump, I had better control and the flexibility needed to live the student life. Better control meant better focus, meaning better grades and better scholarships."

"I dream of being one of those people who have a great benefit plan and can have an insulin pump and supplies paid for… I am a Correctional Officer in a provincial jail… Even though I make great money I often don't have enough for my diabetic supplies… Then, I come to work and watch as the nurse hands out hundreds, if not thousands of dollars worth of drugs to the inmates!… perhaps it is time for us little people to get a helping hand."

Health Council of Canada's public consultation on health care renewal and chronic illness, spring 2007

SELECTED ACTIVITIES FROM ACROSS CANADA

What is being done in Canada to improve access to primary health care and chronic illness care?

In **Saskatchewan,** HealthLine has expanded to offer crisis support for people with mental health and addictions. Specially trained social workers and registered psychiatric nurses are available to handle crisis calls and provide referrals. HealthLine provides 24/7 call centre access to health information and advice and is offered in English, with translation in many other languages including French, Cree, and Dene, and TTY access for those with hearing and speech difficulties.
www.health.gov.sk.ca/healthline/

In January 2007, **Nova Scotia** established an incentive payment for family physicians who work evening and weekend office hours.

In **British Columbia,** Practice Support Program teams help family physicians to adopt advanced or open-access scheduling[10] to improve their ability to provide same-day appointments.
www.practicesupport.bc.ca/

New Brunswick committed funding in 2007/2008 towards the development of a chronic disease management strategy for diabetes to improve access to necessary medication, supplies, and devices.

Effective October 2007 the **Newfoundland and Labrador** Prescription Drug Program was enhanced to cap annual out-of-pocket drug costs at 10% of net family income; lower-income individuals and families will pay no more than 5% to 7.5%.
www.health.gov.nl.ca/health

More children in **Newfoundland and Labrador** can access dental care following an expansion of the Children's Dental Health Program, effective September 2007. The program now covers regular preventive dental care for 13- to 17-year-olds in families with low incomes, while still covering all children age 12 and under.
www.health.gov.nl.ca/health/

KO Telemedecine is a First-Nations-run program that serves First Nations people living in remote communities in **Ontario**. The program uses telecommunications technology such as digital stethoscopes and patient exam cameras to enhance clinical encounters and support community-based health education and training sessions in remote settings.[11] Partnering with KO Telemedecine, the Kenora Area Health Access Centre runs a diabetes eye screening clinic at White Dog First Nation (Wabaseemoong Independent Nation) and uses teleophthalmology to offer clients with diabetes the chance to receive care from an eye specialist.
http://telehealth.knet.ca

> **When Canadians with chronic conditions need to use hospitals, most feel their care is coordinated with their primary health care provider.** About two-thirds report that their regular doctor seemed informed and up-to-date about the plan for follow-up care after stays in hospitals during the past two years (68%) and about the care they received from the emergency department (60%). Other countries do better: in Germany, 87% of patients report good coordination after hospital admission (Figure 12).

> **Too few chronic illness patients in Canada receive reminders about follow-ups or preventive care to help avoid complications (39%) compared to adults in other countries.** For example, most US patients report getting reminders (70%).[8] In addition, most Canadians were "generally not / almost never" contacted after a visit with their primary health care provider to see how things were going (62%).[7]

Is integrated and comprehensive care delivered by health care teams?

Though most Canadians with chronic health conditions report that their health care providers work well together, too few of these patients are served by integrated health care teams. Health care teams are a key component of patient-centred care. The integration of health care professionals such as pharmacists and nutritionists into teams of nurses and doctors – with each actively participating in a comprehensive approach to care – has been shown to contribute to significantly better health among people with chronic health conditions such as diabetes. Teams are particularly effective when they include a case manager who coordinates care, arranges referrals, and follows up with patients.[17]

SELECTED ACTIVITIES FROM ACROSS CANADA

Since April 2003, **Alberta's** Capital Health Regional Diabetes Program has coordinated and integrated services for people with diabetes. Physician referrals go through a central 24-hour phone line to connect patients with an assessment team (nurse, dietitian, and physician), education services, and referrals to specialty clinics. While new referrals to specialists have almost tripled, wait times have dropped from several months to several weeks or days. In 2006, the region began screening intensively for diabetes, with the goal of identifying 100% of people with the disease or at high risk. With its central disease registry that collects patient test results, the region has identified more than 90% of people with diabetes and 59% of patients have reached their treatment goals.[12]

What is being done in Canada to better engage patients in managing their chronic health condition?

Through an initiative called Diversity and Social Inclusion in Primary Health Care, **Nova Scotia** has developed Canada's first set of provincial cultural competency guidelines to address the delivery of culturally appropriate primary health care.
www.gov.ns.ca/health/primaryhealthcare/diversity.htm

In **Saskatchewan,** the Live Well with Chronic Conditions program is a six-week course led by trained volunteer peer leaders, many of whom live with a chronic disease. Participants learn about self-management, developing action plans and setting goals, communication skills, and dealing with the symptoms and emotions that often accompany chronic illness.
www.saskatoonhealthregion.ca/about_us/strategic/transforming_live_well.htm

British Columbia added the Complex Patient Care Fee to its Full Service Family Practice Incentive Program in April 2007, to recognize that care of patients living with more than two chronic illnesses is often complex and demanding. This fee is intended to better support thoughtful treatment planning based on patient goals and improved care coordination.
www.health.gov.bc.ca/phc/gpsc_incentive.html

The Vascular Intervention Program (VIP) at Group Health Centre in Sault Ste. Marie, **Ontario**, studied whether patients at high-risk for vascular disease could significantly reduce their risk through a personalized action plan aimed at increasing their involvement in making lifestyle changes and managing their own health. The research project, co-funded by the Ministry of Health and Long-Term Care, also focused on increasing collaboration among providers on the health care team.

- **At most, only one-third get regular care from any professionals other than doctors.** Though people with chronic health conditions may get these services elsewhere, among the chronic illness patients who have a regular doctor or place of care, only one-third report that a nurse at the same location is regularly involved in their care (33%). Fewer report that a health professional other than doctors and nurses work at their regular place of care (18%).[7] In contrast, about half of adults in the UK and Germany have another health professional such as a nurse regularly involved in the management of their condition.[8]

- **Canadians with chronic health conditions feel their various health care providers work well together** at their regular place of care (89%), with professionals who patients see at other places (89%), and with other parts of the health care system such as hospitals and specialists offices (89%).[7]

"I have finally gotten my sugar under control and I have lost 105 lbs! All of this could have been underway when I was 20 [and diagnosed with pre-diabetes], but I did not get the education from the beginning. I believe training, education, commitment and resources are the key to beating diabetes and maintaining a healthy lifestyle."

"From my experiences, I know that pharmacists have a lot to offer to patients with diabetes and other chronic diseases like asthma and COPD. They seem to be well educated on these topics and seem willing to help in any way they can. However, I feel that they are not well utilized by the health care system. ... Possibly, if they were a part of clinics or counselling-oriented services purely dedicated to educating patients on chronic diseases they could, and probably would, have a much greater impact on the health care outcomes of the many patients that see them."

Health Council of Canada's public consultation on health care renewal and chronic illness, spring 2007

SELECTED ACTIVITIES FROM ACROSS CANADA

What is being done in Canada to better coordinate care for people who have chronic health conditions?

As of April 2007, 32,690 patients in **Quebec** benefit from their physicians' use of an electronic health information system that is based on sound application of research to practice. The MOXXI (Medical Office of the Twenty-First Century) Research Program at McGill University found that computer-assisted intervention could reduce the number of potentially inappropriate prescriptions among primary care physicians.[14] Now MOXXI is testing the potential benefits of an electronic prescription, drug and disease management system for physicians, community-based pharmacists and their patients.
http://moxxi.mcgill.ca/moxxihome.html

The Collaborative Mental Health Care Network in **Ontario** connects family doctors to mental health specialists who provide advice in diagnosis, psychotherapy, and pharmacology. The aim is to support family doctors in treating patients suffering from mental illness, eliminating lengthy waits for psychiatric consultations. This network is one of many resources highlighted on a website created by the Family Health Team at McMaster University for researchers and health care providers interested in shared mental health care.
www.shared-care.ca and
www.ocfp.on.ca/English/OCFP/CME/CMHCN/

In the **Yukon,** the Diabetes Collaborative has improved coordination and collaboration among health professionals and provided them an opportunity to learn and work together on activities such as group patient visits for diabetes care. The collaborative adopted British Columbia's Chronic Disease Management Toolkit.[15]

The **Nova Scotia** Primary Healthcare Information Management program (PHIM) was Canada's first program to electronically link primary health care patient records with all provincial acute-care hospitals, providing electronic delivery of laboratory and diagnostic imaging results.
www.gov.ns.ca/health/waittimes/ehr.htm#Prim

Nunavut's telehealth network has expanded to additional communities as a result of "A Tool to Help People from Far Away – The IIU Telehealth Network Initiative." While the purpose of this initiative was not to save money but rather to improve the range of medical, social and educational health services available in the North, Nunavut did realize economic benefits (conservatively estimated at $1.6 million) largely as a result of reduced travel costs.[16]

Is information about health care publicly available?

Patients should have accurate, standardized information about physicians to help them choose a practice that will meet their needs. Only limited information about the quality of care delivered by individual physicians or primary health care teams is available in Canada. For example, some jurisdictions report wait times for surgeries and other specialist care by individual physicians.

› **Few Canadians with chronic health conditions try to find information about the quality of doctors (such as reports on patients' experiences) to help them make health care decisions (21%), though many who have looked found useful information (65%).** Many more adults in the United States and Germany report seeking and finding useful information (Figure 13).

Helping teams deliver quality care

What can be done to better assist interprofessional teams to improve the quality of chronic illness care? One approach is the establishment of collaboratives, which bring health care professionals together to adopt new ways of delivering care. They learn about how to better engage their patients in managing their chronic conditions, use tools and technology that help patients get recommended follow-up care, and monitor the impact of these changes. Evidence suggests that this approach to teams improves health outcomes.[18, 19, 20, 21] Chronic disease collaboratives are underway in British Columbia, Saskatchewan, and Newfoundland and Labrador, and their work is highlighted in our March 2007 report *Why Health Care Renewal Matters: Lessons from Diabetes.*

More survey results ...

Canadians' Experiences with Chronic Illness Care in 2007: A Data Supplement
www.healthcouncilcanada.ca

SELECTED ACTIVITIES FROM ACROSS CANADA

What is being done to increase the proportion of adults who receive care from interprofessional primary health care teams in Canada?

In **Ontario,** the Maple Family Health Team in Kingston illustrates how the province's 150 teams are increasing access to chronic disease prevention and management programs. Family Health Teams include doctors, nurses, nurse practitioners, pharmacists, dietitians, physician specialists, social workers, health educators, mental health workers, and/or other health care providers depending on local needs.
http://maplefamilyhealthteam.ca/

The **Northwest Territories'** vision for primary health care is the Integrated Services Delivery Model (ISDM). This model is a team-based, client-focused approach that will increase focus on health prevention and promotion. Integration of services and collaboration between different health and social services teams is at the core of the ISDM.
www.hlthss.gov.nt.ca

In **Saskatchewan,** the Mīwayawin Health Services (formerly known as Battleford Tribal Council Indian Health Services) runs a nurse-led program to help diabetes patients manage their blood pressure and has found that it significantly reduces the number of patients who require kidney dialysis.[22] This research was part of a comprehensive chronic disease management strategy for diabetes, which is now testing ways to help patients monitor and manage their blood sugar.

An **Ontario** demonstration project (funded through the Primary Health Care Transition Fund) called IMPACT (Integrating Family Medicine and Pharmacy to Advance Primary Care Therapeutics) assisted family practices in integrating pharmacists into their health care teams, with the goal of improving patient outcomes such as blood pressure, cholesterol, blood sugar, and pain control. This project is profiled in the Health Council of Canada's commissioned report, *Optimal Prescribing and Medication Use in Canada: Challenges and Opportunities* (May 2007).
www.impactteam.info and
www.healthcouncilcanada.ca

In **New Brunswick's** Community Health Centres (CHCs) teams of health professionals with complementary skills deliver primary health care in several communities. As well as providing illness care, CHCs focus on the wellness of individuals, families, and communities, providing access to preventive programs and services.
www.gnb.ca/0051/0053/chc-e.asp

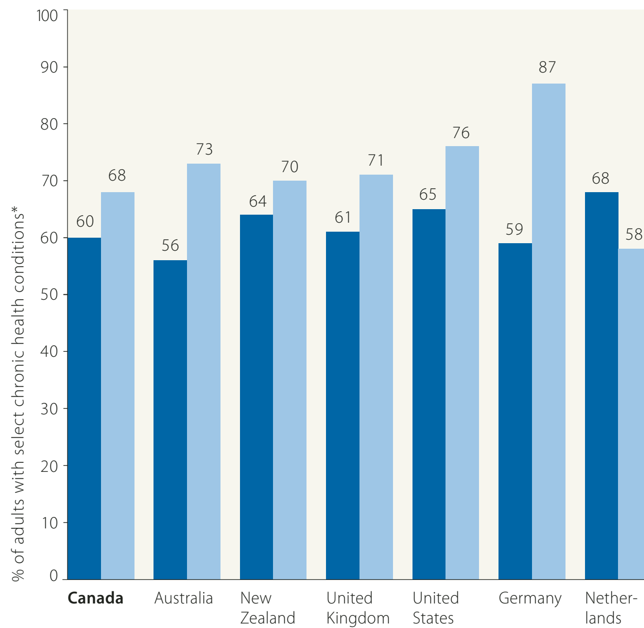

FIGURE 12

Coordinating care

- Regular doctor seemed informed and up-to-date about care received in emergency department
- Regular doctor seemed informed and up-to-date about plan for follow-up care after hospital stay

* Select chronic health conditions include arthritis, asthma, depression, diabetes, cancer, chronic obstructive pulmonary disease, heart disease (including heart attack), and high blood pressure.

Source: The Commonwealth Fund 2007 International Health Policy Survey of the General Public's Views of their Health Care System's Performance in Seven Countries.

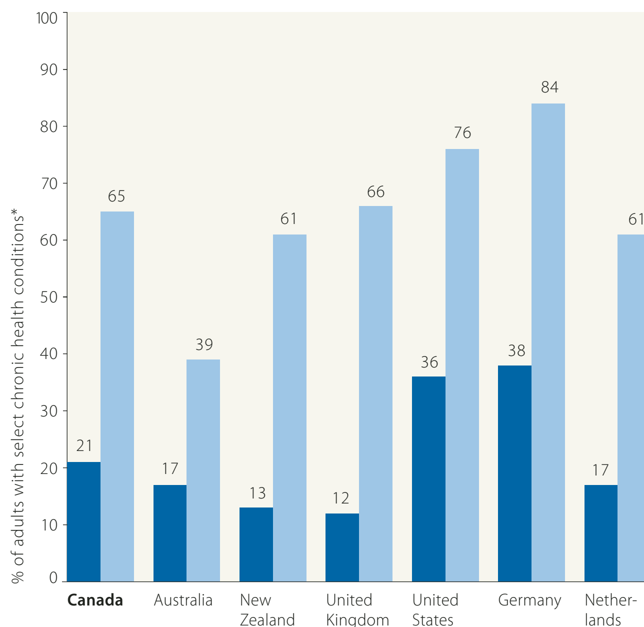

FIGURE 13

Looking for information on quality of care

- Have you ever tried to find information about the quality of doctors, including reports on patient satisfaction and experiences (past 2 years)?
- If you tried to find information about doctors, did you find anything useful?

* Select chronic health conditions include arthritis, asthma, depression, diabetes, cancer, chronic obstructive pulmonary disease, heart disease (including heart attack), and high blood pressure.

Source: The Commonwealth Fund 2007 International Health Policy Survey of the General Public's Views of their Health Care System's Performance in Seven Countries.

Patient-centred care is not just a feel-good exercise. By respecting chronic illness patients as partners in their care, and by ensuring that care is well coordinated among the different people they must see, patient-centred care makes a real difference to people's health and quality of life. In the last section of this report, we use what we've learned from Canadians and from research about high-quality health care to assess how well Canada is doing and how we can do better as a nation to improve the way we prevent and care for chronic health conditions.

"It is frustrating to have an appointment with the nurse, then go off to see the dietitian who often changes my food plan ... A team meeting would put everyone on the same page. We could set goals and targets allowing all involved to work collaboratively, rather then reading each other's notes and 'going from there'."

"The doctor cannot be expected to supply the magic bullet in chronic health conditions. We have to do our part. In order to do so, people need the simple tools we can all use, and the confidence and guidance to apply them."

Health Council of Canada's public consultation on health care renewal and chronic illness, spring 2007

About the International Health Policy Survey

In 2007, Health Council of Canada joined other organizations to commission a telephone survey of Canadians, as well as 9,000 adults in six other countries, to learn more about patients' experiences with primary health care, chronic illness, and other types of care. The survey was conducted in Canada in French or English between March 6 and May 7, 2007.

A stratified sample of 3,003 Canadians 18 years or older who live in private households in 10 provinces and two territories participated in the survey. To produce an international comparison useful for Canadians, the survey combines questions previously used in health care research. Results presented in this report are weighted to represent the age and gender distribution of the Canadian population.

Here we present responses from adults who reported that a doctor had ever diagnosed or treated them for any of the following chronic conditions: arthritis, asthma, cancer, depression, diabetes, chronic obstructive pulmonary disease, heart disease (including heart attack), or high blood pressure. Unweighted sample sizes (N) of adults with these select chronic health conditions: Australia (N=612), Canada (N=1,500), New Zealand (N=536), the United Kingdom (N=722), the United States (N=1,522), Germany (N=631), and the Netherlands (N=1,063).

The 2007 International Health Policy Survey of the General Public's Views of their Health Care System's Performance in Seven Countries was sponsored by The Commonwealth Fund with Harris Interactive as the surveyor. Co-funding of the Canadian sample was provided by the Health Council of Canada; the Dutch sample by The Dutch Ministry of Health, Welfare and Sport and The Centre for Quality of Care Research (WOK), Radboud University Nijmegen; and the German sample by the German Institute for Quality and Efficiency in Health Care.

THE HEALTH COUNCIL OF CANADA CONSULTS WITH CANADIANS

In 2007, the Health Council hosted in-person dialogues in Halifax, Thunder Bay, and Vancouver, and an online consultation with Canadians about chronic illness care. We heard from a diverse group of close to 2,000 Canadians who have chronic health conditions (diabetes, for the most part), have a family member who does, or know they are at risk for developing a chronic illness such as diabetes. Participants told us about what is working well in their experience and what needs improving, and they indicated their policy priorities for the care and prevention of chronic health conditions:

What's working well?

A proactive approach to chronic illness such as early diagnosis and prevention;

Diabetes clinics offering interdisciplinary care and one-stop access to treatment and information.

What's important in prevention and treatment?

A healthy lifestyle including diet and exercise;

Education to help people with chronic illnesses manage and live healthily with their conditions;

Effective sources of emotional and information support for people, e.g. from peer support groups, families, and workplaces;

Helpful and knowledgeable health care workers.

Concerns about care

Difficult access such as long waits, long drives to urban areas, and cost barriers for people with low incomes;

Unmanageable costs, sometimes affecting treatment options, for medical expenses not covered by provincial health plans;

Poor quality of care, such as lack of help learning to manage their diabetes and to make appropriate changes to their lifestyles and diets;

Too few government resources towards preventing diabetes, investments that would save money in the long run;

Poor cooperation among important players such as governments and industry, which share responsibility along with patients and health care providers.

Priorities for health care policy

Health care teams, which would have a big impact on improving care for people with chronic health conditions;

Better support systems such as education for self-care and help with affording healthy foods and exercise.

For more about this initiative ...

Health Care Renewal and Chronic Illness: Report on a Public Consultation

www.healthcouncilcanada.ca

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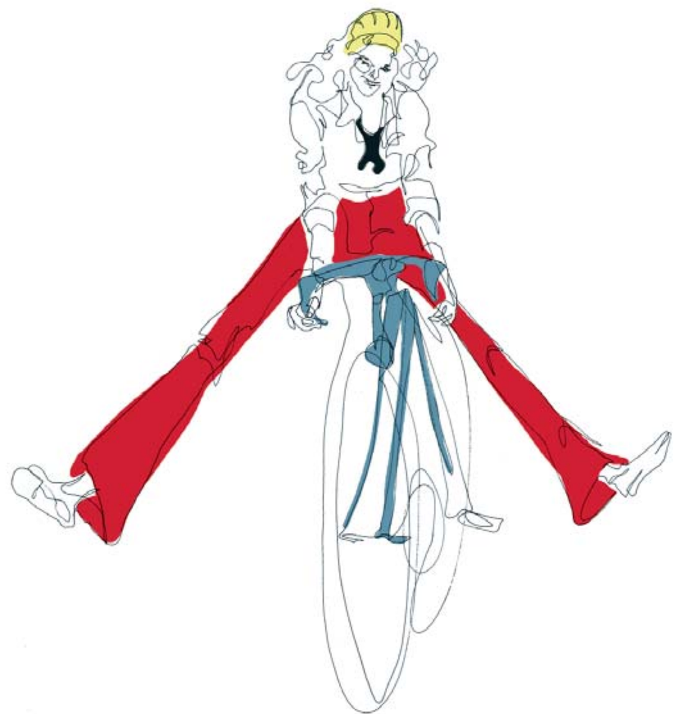
PREVENTING AND MANAGING CHRONIC HEALTH CONDITIONS — HOW CAN WE DO BETTER?



What have we learned from Canadians with chronic health conditions? They experience a poorer quality of life; they use a large share of health care resources; that there are serious gaps in the accessibility and quality of their ongoing care; and they support public investments to improve health and prevent disease.

What we've learned from Canadians illustrates why health care renewal matters. It matters greatly to individuals whose health and well-being are at stake. It matters to families, communities and society overall, since we collectively bear the burden of failure to prevent chronic health conditions or improve chronic illness care. Collectively we could share in success if we take action together. We know what to do and how to do it.

Promoting health and preventing chronic conditions

Canada's governments are clearly investing in health promotion and engaging in work to prevent chronic conditions. In many cases, this work engages multiple partners (within and outside of government) to magnify the impact of societal investments that support health. Some of this work addresses social determinants of health, which creates conditions that can help Canadians make needed changes in the way we live to reduce our risk for chronic disease.

Governments could do much more to monitor and report on progress towards achieving the country's health goals by setting and reporting on local targets. Are we making progress? Without more routine monitoring and reporting about the results of these activities, it's difficult to say. Are our investments sufficient? Probably not, particularly in comparison to what we spend on services for sick patients. We fund failure (caring for people after they get sick) rather than success (preventing avoidable illness). Consider that the total expenditure on health care was $141 billion in 2005 including $40 billion on hospitals and $8.5 billion on public health.[1] The lion's share of hospital spending goes to care for people with chronic health conditions: the one-third of Canadians with at least one of seven high-impact, high-prevalence chronic conditions use more than 70% of all overnight hospital stays (Figure 14). What if we funded success (prevention) more aggressively by spending $40 billion on public health? Might we then, when more Canadians enjoy better health and well-being, be able to spend many fewer billions on illness care?

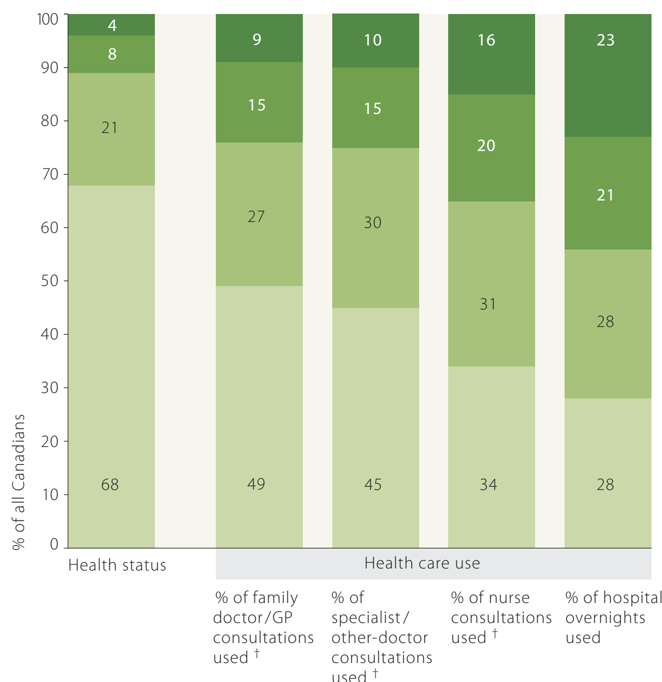


FIGURE 14

Relative use of health care services: people with multiple chronic health conditions* use a higher proportion of professional visits and hospital care

- No select chronic health conditions*
- 1 select chronic health condition*
- 2 select chronic health conditions*
- 3 or more select chronic health conditions*

* Select chronic health conditions include arthritis, cancer, chronic obstructive pulmonary disease, diabetes, heart disease, high blood pressure, and mood disorders.

† Consultations for any reason or diagnosis. Excludes consultations during hospital overnights.

Source: Statistics Canada. Canadian Community Health Survey (Cycle 3.1), 2005.

Canadians understand that, without these investments, we jeopardize our future health; with them, we help secure it. In 2004, when the First Ministers released their *10-Year Plan to Strengthen Health Care*, a national survey asked Canadians about their policy priorities for health care spending. Three-quarters of respondents (75%) said that focusing investments on "healthy living" would have an impact. Half (50%) felt this type of investment would make a "significant difference in improving the quality of health care."[2] Surveys before and since have found similar levels of public support.[3, 4] Canadians endorse action by political leaders and public servants to promote a healthy society and prevent disease.

OUR ADVICE TO GOVERNMENTS

Invest in success by ramping up initiatives proven to prevent chronic health conditions and their complications. Adopt an all-of-government approach (in other words, all ministries) to engage the full range of public policy that can create the social and environmental conditions people need to shift to healthier lifestyles. Create productive partnerships with non-government organizations, local authorities, and industry to harness collective efforts supportive of health. Routinely measure and monitor the impact of these investments.

OUR ADVICE TO CANADIANS

Continue supporting public investments in healthy living. Take responsibility for your own health and your family's, but also recognize that we need a massive cultural shift to slow the rise of chronic disease in Canada. Many factors affect whether or not people can make changes in the way they live, and public policy can make or break people's chances of success. It took decades – and many kinds of action – to reduce smoking and smoking-related illness. We can do the same for risk factors such as diet and exercise, but we must do it faster.

> "Since our daughter was diagnosed with [type 1 diabetes] at the age of two, we have observed the differences in the level of quality in treatment programs in different regions across the country. We have sadly witnessed that equal access to best practices is only a dream in 2006."

Health Council of Canada's public consultation on health care renewal and chronic illness, spring 2007

> "In the future, countries with the best health will be those that do the best job of preventing diabetes."

Dr. Doug Manuel, Senior Scientist, Institute for Clinical Evaluative Sciences[5]

> "Help those like me that can't afford the meds and maybe we won't end up to be such a drain on the hospital medical system down the road ... but like my landlord, preventive maintenance is not a top priority."

Health Council of Canada's public consultation on health care renewal and chronic illness, spring 2007

Improving the accessibility and quality of chronic illness care

The vast majority of Canadians with chronic health conditions use health care frequently and have a regular health care provider. More than 80% have been going to the same doctor or clinic for at least three years, including 59% who have used the same provider for more than seven years, an indication of good continuity of care.

But getting timely appointments is too often difficult for patients, resulting in unnecessary trips to emergency; except for the US, Canada ranks worst among seven countries in use of hospital emergency departments by chronic illness patients for conditions that could have been treated by their regular doctor. Once people with chronic conditions access routine and ongoing care, troubling questions remain about the quality of that care.

Chronic illness care in Canada is far from being the care that experts recommend[6] and it is far from being truly patient-centred. For example, patients generally feel their providers communicate well, but too few patients are encouraged to take an active role in managing their conditions. Reminders from doctors' offices about the need for follow-up care and referrals to services that can help patients adopt healthier lifestyles should be the norm for patients with chronic health conditions, but they remain disturbingly uncommon in Canada. Patients with chronic conditions are no more likely than Canadians without these problems to get advice or help from their regular health care provider to change personal habits to improve their health.

Yet most Canadians with chronic health conditions give a high rating to the overall quality of their regular medical care (Figure 15). How should we make sense of this apparent contradiction? It tells us that, based on what most people know and expect from health care providers, patients are satisfied with and express confidence in the system. But it also tells us that many people don't yet appreciate how much better their care could be.

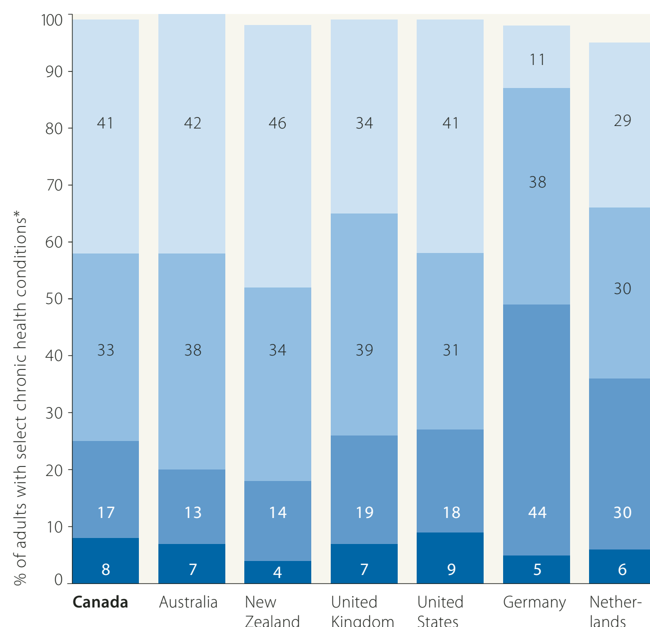


FIGURE 15

Patients give high ratings to primary health care

Quality of care from regular doctor or place of care in past 2 years:

Excellent · Very good · Good · Fair / poor

* Select chronic health conditions include arthritis, asthma, depression, diabetes, cancer, chronic obstructive pulmonary disease, heart disease (including heart attack), and high blood pressure.

Source: The Commonwealth Fund 2007 International Health Policy Survey of the General Public's Views of their Health Care System's Performance in Seven Countries.

What we've learned from Canadians suggests that we would all benefit if Canadians were more informed and involved in the process of health care renewal, so that political leaders, health care policy-makers and managers have endorsement to invest in improving the quality of care. In this report, we have highlighted programs that are reorienting care to help Canadians better manage and prevent chronic health conditions. These are encouraging developments, but despite years of talk, we're still in the early stages of badly needed reform.

Political leaders are likely to receive praise when they invest in increasing the number of health care providers, when in many cases the public might be better served by strategies that would help our existing providers work more effectively and efficiently. In an earlier report, we demonstrated that improving the quality of care for chronic conditions like diabetes does not mean that people should simply see their doctor more often.[6] We may need more health care providers – or more of the right kind of providers – for a variety of reasons, but that alone will not improve quality of care. It's what takes place during those health care visits that matters more.

"Many chronic care services being performed by specialists and family physicians could, and should, be provided by other health care providers with changes to their scopes of practice, if required. Looking at the four basic indicators [recommended care] for annual diabetes care – all of which are crucial for patients – it is highly questionable whether someone has to attend medical school to ensure that a patient's blood sugar is checked twice a year and cholesterol levels, feet and eyes are examined annually…

To what extent does the system have to provide additional financial incentives and invest in expensive monitoring information technology before all providers use simple evidence-based guidelines to provide standard appropriate care for their patients?"

Dr. Joann Trypuc and Dr. Alan Hudson, 2007[7]

- > Teams – Too few Canadians with chronic conditions have timely access to health care teams and case managers, despite strong evidence that their involvement results in better health outcomes.
- > Technology – Too few Canadians receive care from providers who use electronic information systems that help them learn about the quality of care they currently provide and what they need to do to ensure that care is aligned with expert guidelines.
- > Training – Too few Canadians receive care from providers who have the training and support to work in teams, work more effectively, and work to improve the quality of care.

Changing the way we deliver care – to keep patients' needs at the centre and ensure care is in line with expert guidelines – will require a great deal of time, attention, and money, but these investments will pay off in better health for Canadians and a more sustainable health care system.

OUR ADVICE TO GOVERNMENTS, HEALTH CARE POLICY-MAKERS, MANAGERS AND PROVIDERS

Invest in proven strategies that improve the quality of care and engage people in managing their own chronic health conditions. This requires a shift from a "find it and fix it" culture to a "prevent it, find it, manage it" mentality. Focus particularly on patients with multiple chronic conditions and on helping patients prevent these complex health problems from developing; these people have the worst quality of life and require more intensive health care services. We continue to recommend a redesign of the traditional family doctor's practice to introduce teams, technology, and training for change that will help achieve better care for patients with chronic health conditions and, ultimately, better health outcomes.

OUR ADVICE TO CANADIANS

Expect more from your health care system and the people responsible for it. Give permission to governments and the health care community to invest now and invest heavily in strategies proven to be cost-effective at improving health care. Canada can treat the causes of our less-than-ideal care for chronic health conditions, but it will require that you hold high expectations.

Monitoring progress

Given the extent of the current and needed investments in health promotion, disease prevention, and chronic illness care, Canada needs a surveillance, or information-tracking strategy that can track our progress in reducing the burden of chronic health conditions and signal the challenges ahead. Surveillance systems provide information about the health of Canadians so that health care policy-makers, managers, and providers can do their work – to improve health and health care – as effectively as possible.

In Canada, we have national, provincial, and territorial surveillance systems that provide data about how many people have specific diseases, such as diabetes or cancer, and some information about their health care. There are also information systems that track Canadians' risk factors for health problems and our use of hospitals. What we need are systems that can integrate information about our risks for poor health, the environments we live in, our ability to get the care we need, the quality of the care we receive, and the results of that care. To understand the impact of programs and policies that hope to reduce risks for disease or improve the outcomes of health care, we need these integrated information systems.

To this end, the Health Council of Canada supports a commitment in the Public Health Agency of Canada's Strategic Plan (2007 to 2012) to "streamline its surveillance into a coherent and integrated national surveillance system, positioning surveillance as a strategic resource for the Agency – one that all key stakeholders can maximize to its full potential."[8]

OUR ADVICE TO ALL OF CANADA'S GOVERNMENTS

Develop and use appropriate information systems that support better tracking, research, and public reporting about: the prevalence and distribution of chronic health conditions, risk factors that predict whether more people will develop chronic conditions, the results of investments in health promotion and disease prevention, Canadians' access to chronic illness care, and the quality and impact of that care. A few provinces have made great strides in developing this kind of information system locally. Though the Public Health Agency has made a commitment to develop a coherent and integrated national surveillance system, each province and territory will need its own information to manage its population's health and health care system.

Without better data, those responsible for health care renewal – political leaders, health care policy-makers, managers and health care providers – are working in the dark. Without more transparency and public reporting, Canadians will not be well-informed about the results of these public investments, and governments will find it increasingly difficult to make informed decisions about investing in health.

Conclusion

What we've learned from Canadians strengthens the case for immediate, comprehensive, and sustained action to promote healthy living, prevent long-term health problems, and improve care for people who have chronic health conditions. As good stewards of public health and public dollars, governments should lead and sustain efforts to help Canadians maintain the best possible quality of life and avoid unnecessary illness. Canadians understand that, without these investments, we jeopardize our future health; with them, we help secure it.

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ABOUT THE HEALTH COUNCIL OF CANADA

Canada's First Ministers established the Health Council of Canada in the 2003 *Accord on Health Care Renewal* and enhanced our role in the 2004 *10-Year Plan to Strengthen Health Care*. We report on the progress of health care renewal, on the health status of Canadians, and on the health outcomes of our system. Our goal is to provide a system-wide perspective on health care reform for the Canadian public, with particular attention to accountability and transparency.

The participating jurisdictions have named Councillors representing each of their governments and also Councillors with expertise and broad experience in areas such as community care, Aboriginal health, nursing, health education and administration, finance, medicine and pharmacy. Participating jurisdictions include British Columbia, Saskatchewan, Manitoba, Ontario, Prince Edward Island, Nova Scotia, New Brunswick, Newfoundland and Labrador, Yukon, the Northwest Territories, Nunavut and the federal government. Funded by Health Canada, the Health Council operates as an independent non-profit agency, with members of the corporation being the ministers of health of the participating jurisdictions.

The Council's vision
An informed and healthy Canadian public, confident in the effectiveness, sustainability and capacity of the Canadian health care system to promote their health and meet their health care needs.

The Council's mission
The Health Council of Canada fosters accountability and transparency by assessing progress in improving the quality, effectiveness and sustainability of the health care system. Through insightful monitoring, public reporting and facilitating informed discussion, the Council shines a light on what helps or hinders health care renewal and the well-being of Canadians.

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