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Research Highlights

Frontline Health Care in Canada: Innovations in Delivering Services to Vulnerable Populations*

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In this Issue

Dr. Trevor Corneil (centre) is the Director for Urban Primary Care for Vancouver Coastal Health and an associate professor at UBC. He also spends time counseling patients in several clinics in Vancouver's Downtown East Side.

Frontline health care is the under-recognized, under-researched and untold side of the health care story in Canada. Research by the Canadian Policy Research Networks (CPRN) makes it clear that there are people throughout this country who are vulnerable, at-risk and marginalized, whose health care needs can and do go unmet. In spite of the generally high standard of living and the promise of universal access to quality health care in Canada, this report reveals critical and pressing disparities. It also identifies specific, vulnerable populations who suffer a burden of illness and distress greater than other residents of Canada. These people are more likely to become ill, yet they are less likely to receive appropriate care. They are:

- people living in rural areas, on farms or in small communities;
- residents of the far north;
- homeless street youth and people;
- Aboriginal peoples living on and off reserve;
- recent immigrants and refugees;
- the mentally ill;
- senior citizens living in isolation;
- the poor;
- disadvantaged children and youth;
- people with disabilities;
- people with limited literacy;
- women in precarious circumstances.

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Access to primary health care services is a critical issue facing people who are living on Canada's frontlines. Whether access is restricted because of social position, economic hardship, geographic isolation, disability, ethnic group identity, language, gender or any of the other issues that can create barriers to access to health care services in Canada, frontline health services attempt to address these issues head-on.

The purpose of this report is to tell the story of frontline health in Canada, and to define the issues and challenges. In simplest terms, there are two sides to the frontline health story – the people and the providers.

Many frontline service providers have an explicit open-door policy – nobody can be turned away. Health care services are provided to people based on need and need alone. From our discussions with frontline providers, it is clear that they are under-resourced, have too few staff who are spread too thin, and who are often inadequately trained in the specific skills needed to care for these marginalized populations.

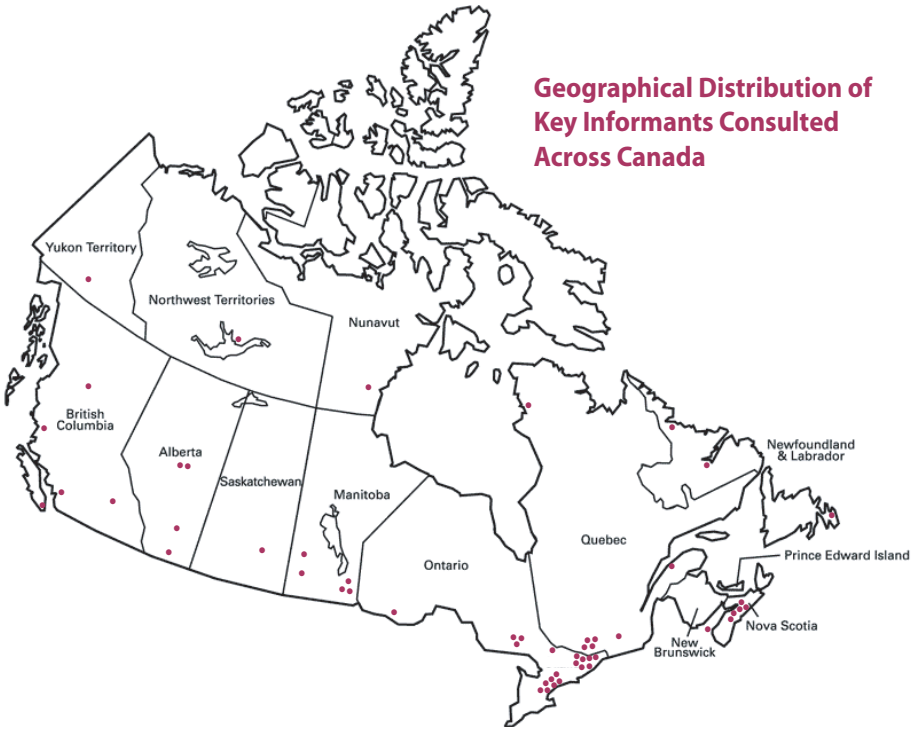
To develop a comprehensive profile of these frontline workers, data has to be collected almost on a case-by-case basis – there is no single organization or source that holds this information.

In addition, experts working with vulnerable populations point out the absence of health data analyzed by ethnicity and racial visibility.

Innovation is evident in the daily activity of frontline health providers. Across Canada, community health centres, community organizations, innovative initiatives, hospitals and mobile services are creatively attempting to address the health needs of marginalized, rural and remote populations. The goal of this report is to connect these issues and innovations to current public policy.

In producing this agenda-setting report, CPRN traveled across the country to get a better understanding of what frontline health care providers and clients need. Qualitative research methods were used including an environmental scan, a literature review, key informant interviews with frontline practitioners and site visits. It is a unique approach that draws on the perspective of the frontline practitioners, providing us with rare insight into the communities they serve and the challenges they face. It sheds light on this remarkable, yet small, group of frontline health care workers who manage to provide crucial care and services to vulnerable populations, largely under the most arduous

Geographical Distribution of Key Informants Consulted Across Canada



conditions. Our research also highlights findings that have implications for public policies that can further develop, support and sustain existing services and health care providers.

This study opens the door to further research in what is a seriously under-researched dimension of Canadian health care. While this report contributes to our understanding of the frontline health care story, it should be regarded as the first step leading to more in-depth research.

Rural/remote and northern populations

Compared to urban residents, people living in rural, remote and northern communities have shorter life expectancies, higher death rates and higher infant mortality rates. Seventy percent of all traumatic deaths in Canada occur in rural areas, even though only 30 percent of Canadians live there. Yet, only 18 percent of physicians and nurses work in these communities. The Romanow Report spoke of the "inverse care law", a phenomenon in

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Issues and Challenges for Vulnerable Populations

Vulnerable populations may live in the urban core, the suburbs, small towns, villages or remote locations. They represent a broad cross-section of Canadians. What they have in common are generally lower levels of health and greater barriers to health care than the mainstream population. Those barriers include:

- critical shortages of doctors, nurses, health care providers and specialists;
- lack of culturally or linguistically appropriate services;
- lack of gender or transgendered appropriate services;
- transportation and travel;
- literacy barriers;
- discrimination/stigmatization based on race, gender and/or sexuality.

Canada whereby "[p]eople in rural communities have poorer health status and greater needs for primary health care, yet they are not as well served and have more difficulty accessing health care services than people in urban centres". Farmers, for example, have a higher rate of accidents and injuries than urban-dwelling Canadians due to the nature of their work, the type of equipment and tools they use and the conditions they work in. Rural

More than 30 percent of the population lives in rural and remote communities, but only 18 percent of physicians practice there.

Canadians generally suffer from poorer health, they have more lifestyle-related illnesses, are more likely to smoke and more likely to be overweight.

Infant mortality rates are a gauge of the general health of a community. The farther north you go, the higher that rate rises. For example, the rate in Nunavut is more than three times the national average.

Chronic gaps in access to services for rural Canadians include mental health services, palliative care, major surgery, cancer care beyond chemotherapy, major trauma, dialysis, dental health services, nutrition and addictions services, and services for children with special needs. In most cases these services are not available – if they are, they are usually not culturally or linguistically appropriate, and only available sporadically.

Northern and isolated communities face additional and unique health needs posed by geography and long distances. The need to travel imposes an increased financial burden in the form of transportation costs and hotels; it also means people are separated from their families and community supports. Travelling long distances for health services may also adversely affect health outcomes because of delays and the hazards of transport or inclement weather. This is particularly the case for pregnant women.

Due to the dwindling number of family physicians in rural and remote communities, many pregnant women have to travel significant distances, away from family and other children, to give birth in regional hospitals, far from their support system. Studies have shown that in communities lacking maternity services there is an increased incidence of perinatal deaths and premature births. The health of rural seniors is also linked to the availability of transportation to the local doctor's office or to major centres for specialized health services.

In some remote communities the weather plays a critical role in determining access when transportation is involved. In northern communities, roads may be accessible only during the summer or winter months. In island communities, ferries are affected by storms and other weather conditions.

Most rural health researchers agree that the distance to health care providers and facilities is increasing for rural residents as physicians and hospitals become more concentrated in urban and urban fringe areas. According to a recent study, more than two-thirds of residents of remote northern communities live more than 100 kilometres from the nearest physician. The shortage of nurses, including nurse practitioners, is most prevalent in northern and far northern communities.

Health Canada's First Nations and Inuit Health Branch – responsible for health services staffing in approximately half of Canada's First Nations communities – at any time can be short by up to 50 percent of nursing staff for remote nursing stations and outposts. Many nurses will work in remote communities for only very short periods

More than two-thirds of residents of remote northern communities live more than 100 kilometres from the nearest physician.

of time, occasionally as little as 6 weeks, leading to instability in health service delivery in some cases. For many Canadians, living in rural or remote areas there is a significant problem with continuity of care, not only with respect to nurses but also general practitioners and specialists. In general, physicians, nurses and other health care providers are concentrated in urban centres, where the healthiest people in Canada live. The lack of health care in many rural and remote areas due to the decreasing presence of health care providers and facilities is alarming.

and have high rates of chronic long-term disease, mental illness, and infections.

Street youth are a sub-set of the homeless population that differ in terms of their health needs and the appropriate approaches to meeting those needs. Mortality rates of street youth are about 40 times that of other youth of the same age. The rates of sexually transmitted diseases are also particularly high, estimated at more than ten times the rate in the general youth population according to the

It is estimated that well over 100,000 Canadians are living in absolute homelessness.

The Frontline Health report also addresses the stigmas involved in seeking care in rural, remote or northern communities. For example, when only one addiction counsellor or HIV clinic services a small population, the very act of walking into their offices or parking in front of their building may discourage residents from seeking care for fear of being stigmatized in the community. In the smallest communities, and commonly in the territories, the service providers are likely to be related in some way, to the patient seeking care. This poses some challenges around privacy and confidentiality.

Inner City and Marginalized Populations

It is very difficult to determine the specific health status of inner city populations as their health care needs are not necessarily assessed and measured as inner city populations. This includes the homeless and under-housed, recent immigrants and refugees, Aboriginal peoples, street youth, and others. Marginalized inner city populations often have severe and complex health issues.

Marginalized inner city populations can be characterized by one or more of the following: low employment or unemployment; less education; older age; social dysfunction; homelessness or inadequate; overcrowded housing; mental health issues; long term diseases; language and cultural barriers; transportation barriers; no health card and substance abuse. Inner city populations generally lack proper nutrition, have poor oral and dental health,

Public Health Agency of Canada. Other prevalent issues amongst these youth are mental health issues, social issues and drug and alcohol abuse. Many of these young people have a better chance of overcoming their challenges if given adequate and appropriate services in a timely fashion. Frontline service providers are struggling to meet the needs of this growing population of street youth.

The homeless population in particular is in a state of precarious health. As one expert noted, "the homeless experience absolute health deterioration in every realm." It is estimated that well over 100,000 Canadians are living in absolute homelessness. Inner city and marginalized populations often face discrimination and stigmatization as they struggle on the margins of society in poorer health than the general population. Until their basic needs are met with regards to housing, income and food, their health status will continue to suffer. They require services for prevention and care of mental health issues and also for parallel services such as shelter, health care follow up and post-hospital services. Specific services targeted at street youth or the transgendered, for example, are also lacking.

Generally, female immigrants and refugees have higher rates of hypertension, HIV/AIDS, diabetes, sickle cell anemia and lupus than the general population. Poverty, violence, inadequate housing and gender biases also contribute to overall poorer health among immigrants and refugees. Some provinces, such as British Columbia and

Aboriginal peoples have a life expectancy 6-14 years shorter than the average Canadian; the infant mortality rate for Aboriginal peoples is double that of the Canadian population.

Ontario, don't provide medical services for immigrants until three months after arriving in Canada. Their options, then, are to see a private physician, go to the emergency ward of a hospital or find a drop-in clinic. Many new Canadians don't have the money, transportation, language or the social skills needed to navigate their way through a still-foreign health care system. Their remaining choice – according to CPRN's research, it's a common one – is not to seek any health care at all.

Aboriginal peoples have a life expectancy 6-14 years shorter than the average Canadian; the infant mortality rate for Aboriginal peoples is double that of the Canadian population; they have a higher prevalence of all major chronic diseases and high rates of suicide, fatal injuries, smoking and alcohol consumption. Experts working in the area of Aboriginal health research highlight the following barriers to accessing health care: financial, social, cultural and language barriers, transportation barriers and barriers in the education of health care professionals.

Frontline Health Services

Our research highlights a number of innovative, creative and effective health care models that are struggling to deliver frontline care and services to marginalized populations, in spite of extremely challenging conditions and demands.

The frontlines of Canada's health care system are present everywhere, not just in remote or isolated communities. Frontline health care services attempt to meet community needs and fill service gaps. Frontline services are effective and responsive and often incorporate health delivery systems different from mainstream health care systems

The Immigrant Women's Health Centre takes health care right to where many of their clients work with their Mobile Health Clinic. Dr. Susan Keen is a member of the Mobile staff.

such as hospitals and doctor's offices. In some cases they join existing programs (like community health centres). But often they have to invent their own.

Frontline health care providers have chosen to respond to the needs of the underserved as best they can: doctors, nurses, social and healthcare professionals who serve on the margins in street clinics, inner city emergency departments, mobile outreach units, solo rural practices and remote outposts. From what we have learned in our cross-country research, some of these health care professionals are specialized in their area and/or in the population they serve (such as those working with street youth with HIV).

There are several points at which marginalized populations in urban areas typically access health care services. These include: hospital emergency departments, community health centres and innovative health initiatives. The most common access points for rural residents are family physicians, small rural hospitals, community health centres or clinics, nursing stations and mobile health units.

There is often a great deal of overlap between these access points, as, for example, most rural hospitals are staffed by local family physicians. Generally speaking, the further away a rural community is from an urban centre the fewer the options for health care services and the less specialized the service providers are.

Hospital Emergency Departments

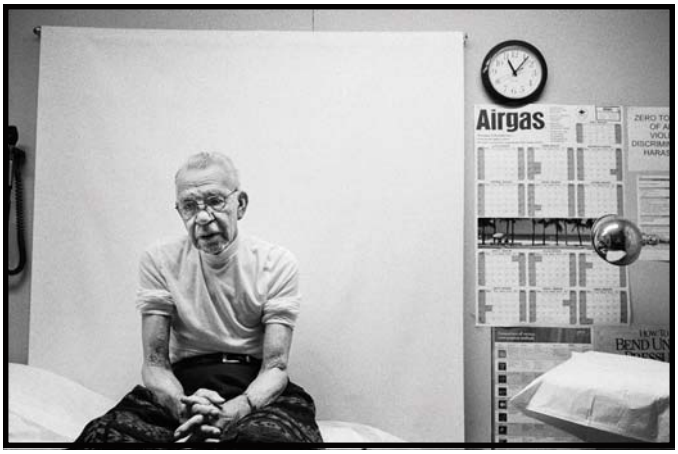
The emergency departments in urban and rural hospitals are another access point for people who experience challenges in seeing health care providers. This could be due to unavailability of other health care providers, a lack of health insurance, unfamiliarity with the health care system, discrimination, and lack of available and appropriate care.

Paramedics also offer emergency health care services to rural residents and additional primary care to "hard-to-reach" clients, although they are not typically considered mobile health care providers. In the emerging field of Community Paramedicine, paramedics are given additional training and responsibility to provide health services in addition to the standard first response to emergency calls. In Long Island, Nova Scotia, for example, community paramedics are trained to give intravenous and antibiotic injections, wound care, assess falls, give flu vaccinations, B12 injections and tetanus shots. Paramedics offer critically important health care services to rural residents and work in close collaboration with small rural hospitals in ensuring access to health care. In Toronto, paramedics have been offering enhanced services to the downtown homeless population.

Some rural hospital emergency departments are "one retirement away from closure".

Many small rural hospitals have an emergency department, staffed by local family physicians, some with additional specialized training in emergency care, surgery or anesthesia. A number of these emergency departments are being closed down or are offering restricted hours due to shortages of physicians or nurses. According to informants, some rural hospital emergency departments are "one retirement away from closure." A study undertaken in Ontario on rural health care over a decade ago concluded that "hospital-based services for [rural] populations, such as inpatient care and obstetrics, are being threatened both by a lower number of physicians and by an attrition of services."

The mortality rate from an injury in rural Canada is twice as high as in urban Canada, given a similar injury. Therefore rural emergency departments have to be prepared to handle these accidents. There are other unique patterns of injury encountered in the rural workplace be it the farm, the forest, the mine or in fishing outports. Road accidents, bad weather, poor roads, lack of vehicle maintenance and inadequate use of restraint systems all contribute to these increased injury and mortality rates.



Senior citizens often have multiple health issues, sometimes complicated by social and economic isolation. A doctor or nurse who takes extra time to listen can make a world of difference.

Community Health Centres (CHCs)

Urban and rural Community Health Centres (CHCs) are non-profit organizations that offer a range of coordinated primary care and related services with an emphasis on one or more priority group(s). Services are provided in an inter-disciplinary manner and are specifically designed to meet the health needs of a particular group(s).

Community Health Centres are sponsored and managed by incorporated non-profit community boards made up of members of the community and others who provide health and social services

CHCs, to the best of their resource abilities, attempt to provide crucial social programs and services. These

Young people can feel frightened or shy about asking for help with healthcare. Providing an atmosphere where they are not judged and feel safe can make a difference in their lives.

Community health centres (CHCs), to the best of their resource abilities, attempt to provide crucial social programs and services.

programs offer support in the areas of employment, education, living and working environment, isolation, social exclusion, income, violence, housing and poverty. The Alex Community Health Centre in Calgary, for example, offers fresh food programs, a food bank, a laundromat, and a book club. Other CHCs offer home support and home management services, particularly for seniors. These programs potentially reduce future health care needs. In fact, many CHCs began as community support networks, then expanded into health care. CHCs often serve a pivotal role in referring clients to other services, and most provide care and service to anyone who comes to their door.

Urban Community Health Centres

There are over 300 community health centres across Canada that play a key role in delivering health services in urban areas. Typically, these centres will service a specific catchment area, although some CHC's have made it their mandate to serve specific populations. For example, the Sherbourne Health Centre in Toronto focuses on services for the homeless, newcomers, lesbian, gay, bisexual, transsexual and transgendered. Women's Health in Women's Hands, also in Toronto, provides health services to black women and women of colour. The Immigrant Women's Health Centre in Toronto specifically provides reproductive and sexual health care to immigrant and refugee women in a female environment, while La clinique des jeunes de la rue in Montreal targets street youth because they are not cared for within the mainstream health care system. For many of these centres, clients are not required to have a health card.

Aboriginal Community Health Centres

Some provinces, such as Ontario and Manitoba, have community health centres for Aboriginal communities. These are located on- and off-reserve, in urban settings and remote areas. These centres often provide pre and postnatal care, HIV/AIDS support, diabetes care, immunization, sexual and reproductive health care as well as basic lab and pharmacy services. The services are provided in a culturally appropriate way, with traditional

healing either substituting for or combining with Western medical methods.

Informants for the study identified the Aboriginal Health and Wellness Centre in Winnipeg as an exemplary primary health care model. It is a community-driven centre, in that consultation with the community resulted in a holistic family medical facility which does clinical work, founded on Aboriginal and life course philosophy. Dr. Judith Bartlett, a physician and former board member, says the centre "delivers on a holistic approach and model" to health care. The centre currently has the capacity to serve only 700 clients, so, in a community of 60-70,000 Aboriginal people, health care needs are still going unmet. Informants interviewed for this study suggest creating more clinics targeted at Aboriginal peoples.

In a community that has 60-70,000 Aboriginal people, the centre currently has the capacity to serve only 700.

Go home, stay warm and drink plenty of fluids. How often do doctors give this simple, effective medical advice? Imagine hearing this advice when your home is the street.

Rural Community Health Centres

Rural CHC's operate similarly to their urban counterparts. They also tend to involve an inter-disciplinary team of health care providers offering a range of health promotion, prevention and primary care services to rural residents. According to the Canadian Alliance of Community Health Centre Associations, in rural areas a CHC serves a community or cluster of communities with a population ideally below 25,000. Another important distinguishing point of CHCs is that the physicians are on a salary, rather than working on a fee-for-service basis. Many of the experts we interviewed emphasized that having doctors on salary and working with an interdisciplinary model of care strengthened the work they do. As well, nurses working at community health centres sometimes work in expanded roles. Some community health centres believe nurses are underutilized and are actively looking at ways to expand the role of nurses.

In some provinces, the need for rural CHCs was precipitated by the closure of small rural hospitals. In other instances, they were set up explicitly to reduce reliance on the emergency departments of rural hospitals, which are often over-crowded and under-staffed. There are examples of provincial governments – British Columbia for example – establishing rural CHCs, and still other instances of regions, communities and local citizens joining together to establish community-owned CHCs, as in Manitoba.

Innovative Health Initiatives

While innovative health initiatives exist across Canada, health care needs still go unmet. These initiatives recognize that there are specific groups such as street youth, people with HIV/AIDS, immigrants, refugees,

Health professionals like Kim Daly, Nurse, Manager and co-founder of the Victoria Youth Clinic know they can make a real difference in their patients' lives. Kim sees working on the frontlines as a mission.

resources, while recognizing that these mainstream services often are not suitable for some individuals in the first place. Some clients may be banned from accessing mainstream services due to their behaviour or as the result of "abusing" services.

Innovative health initiatives have developed different delivery practices and systems to accommodate their target populations. Some are open in the evening or 24 hours a day while others are using mobile health units. Health care professionals, most often nurses, travel on foot or by bus to get to clients. The Immigrant Women's Health Centre in Toronto uses a bus to reach working immigrant women who would otherwise be unable to access care. Mobile units also reduce the need to take time off work or to be away from family members. The Canadian National Institute for the Blind has an *Eye Van* that is another unique and highly successful example of

Ottawa Inner City Health is unique in its ability to pull together a range of health care professionals ... who offer integrated and managed care to a transient population with complex health needs.

women, the homeless and substance users with health care needs that are not addressed by mainstream health services. Ottawa Inner City Health (OICH), for example, is a non-profit corporation that delivers primary health care, chronic and convalescent care, palliative care and addictions management to the chronically homeless. It is unique in its ability to pull together a range of health care professionals – physicians, nurse practitioners, nurses, mental health specialists and personal support workers – who offer integrated and managed care to a transient population with complex health needs, including mental health issues, addictions and chronic/long term disease.

Innovative health initiatives like OICH are also effective in preventing the inappropriate use of mainstream health

Relatively straightforward health problems can become life threatening when you live hundred of miles and many hours from an emergency room or even a family doctor.

Innovative health initiatives have developed different delivery practices and systems to accommodate their target populations.

enhanced access using mobile services. The *Eye Van*, is a state of the art eye clinic designed to fit in a 48-foot long trailer. Each year, since its inaugural journey in 1972, the *Eye Van* has delivered vision care to more than 30 small towns and communities across northern Ontario.

Rural and remote communities across Canada also benefit from variations on the mobile health care model. Mobile services share the common goal of delivering education and health care to "hard to reach" clients, whether they are geographically or culturally isolated, or because of financial hardship.

Innovative health initiatives serve other important roles. They can be used as a community or family "home" where clients are encouraged to rest, hang out, clean up and eat nutritious food. They often employ harm reduction strategies to deal with addictions and ultimately help to restore clients to mainstream society (e.g., Victoria Youth Clinic).

While innovative health initiatives like the ones described here exist across the country, they are at the mercy of insecure funding and face increasing demand for their services. Informants for this study stressed the lack of research, recognition, coordination, funding and support for this demanding yet critically important work on the frontlines of health care.

Issues and Challenges for Frontline Health Care

Inadequate Training

Health care professionals are not always adequately trained in the health care issues specific to inner city or rural populations. The social and economic context of the homeless population, substance users, recent immigrants and refugees, and Aboriginal peoples may be unknown to health care professionals, in particular recent graduates. Young physicians may not understand population health, community development, and the cross-cultural issues of the inner city population. Medical education is deficient in preparing doctors to deal with addiction, disease, infection, and mental illness, often all in the same client. There is also a lack of training in caring approaches to illnesses such as HIV/AIDS.

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Overall Shortage of Health Care Professionals

There is a recognized shortage of health care professionals and providers right across Canada. In rural, inner city and isolated areas, the understaffing of emergency medical services is particularly acute. One estimate is that Canada lacks about 1,500 rural family doctors. Over the last several years, the number of family physicians in rural areas has been declining for many reasons. On average, rural family physicians are older and

One estimate is that Canada lacks about 1,500 rural family doctors.

often when they retire, there are no younger physicians to replace them. Some rural family physicians also choose to relocate to larger urban areas due to the stress of the heavy workload and decreasing supports as rural hospitals close. There is also a critical shortage of nurses especially in the north and far northern communities. There are significant and often life-threatening shortages of

There are significant and often life-threatening shortages of paramedic staff.

paramedic staff according to a recent report by Ontario health care workers. Paramedics working rurally or in remote communities will have less frequent exposure to emergency cases, which may mean their skills are not as highly tuned, yet they often face much more serious conditions which require a higher level of skill and experience. Older, more mature and experienced paramedics are in high demand in these communities, but given the very high stress, older professionals may find the work unappealing and salaries are not generally high enough to compensate for the stress and workload.

Conflicting Funding Models

Community Health Centres operate as non-profit organizations with the majority of their funding coming from the provincial government or municipal/regional health authorities with some specific program funding and research funding from private foundations and donors, or other government departments. Dr. Judith Bartlett, a Winnipeg physician, notes that while the mix of funding for community health centres is working, there is a big problem with the methodology. Funding comes attached to specific reporting and evaluation criteria that are not standardized. For example, federal and provincial funding come with different reporting frameworks. Therefore critical staff time is spent complying with funding requirements. Global funding would allow for more efficient and effective management.

Lack of Community Health Centres

The number of rural CHC's is small but the potential to offer more comprehensive health services to rural residents is high. Provinces such as Ontario and BC have been investing heavily in this model, including expansion of rural networks. In Quebec the local community service centre model (CLSC) has been serving the health needs of rural residents for many years; however they are under threat due to recent plans to amalgamate services.

Inadequate Services in the Suburbs

There is a need for more health care services, particularly for marginalized populations, in the urban periphery and not just in the downtown core. This is especially crucial as the suburban areas of Canada's cities continue to grow and attract people. Suburban areas are not only attracting the middle and upper class but also lower income families and individuals. There is a need for services beyond the traditional downtown core of the inner city that has to be recognized.

Lack of Integrated Care

There is an increasing recognition that integrated care is more successful in improving the health status of marginalized populations. This is especially important for vulnerable clients who may see several different health care providers to address their health care needs. The need for follow up and integrated care is becoming even more crucial as marginalized populations are being discharged from hospitals earlier and earlier due to stress on the mainstream health system. Currently, treatment regimes and services are often organized for people with homes and family supports.

Decades of research in Canada and internationally, clearly show the importance of these factors (the "determinants of health") in shaping the overall health of a population. In fact, social issues appear to explain more about variations in health and well-being than any combination of individual factors.

Focusing on social issues reinforces how individual and physical environment factors have social aspects. Obesity, for example, is dependent on the quantity and quality of food available as well as the opportunities for physical activity.

Differences in people's access to these factors can create differences in people's health. The Health Council of Canada refers to these differences as "health disparities", and in a 2005 report, the Council stated that "health disparities are the number one health problem in the country and health care alone is powerless to overcome them".

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Health Determinants

Many of the experts consulted for this report warn that the health problems of Canada's vulnerable populations are not solely the result of a lack of health care providers, services, facilities, or inappropriate delivery systems. There are a number of other factors that need to be addressed. Many of these factors occur well before a person becomes ill and seeks out health care. Research has shown that the range of factors that determine health includes:

- lack of nutritious, affordable food;
- availability of adequate housing;
- poverty;
- education;
- child development;
- gender;
- genetics;
- work conditions;
- physical and social environment;
- health practices;
- social networks;
- culture.

Understanding the interdependence of these health determinants is critical. No one determinant on its own – including health care services – can guarantee good health for any given population. Health services are certainly essential, but this report underscores that a number of other considerations – work, housing, environmental conditions, income, nutritious food, social networks, gender and culture – also contribute to good health.

Our research on frontline health services has found that providers understand well the range of factors that affect health. And some frontline health programs do go beyond just treating their individual patients; they attempt to address the social, economic and community factors that influence the health of the populations they serve.

Conclusion

The Frontline Health Report clearly addresses the question, "What can be done to ensure support for frontline health services in Canada?" Support begins with recognition, and while there are no simple answers, the report provides a broader understanding of frontline health in Canada.

Our research has shown that while the needs and issues of frontline populations are diverse, they commonly face restricted access to health care due to geographic, social or physical barriers. Similarly, frontline health providers must also deal with common barriers such as geographic and social isolation, insufficient training and services, inadequate networks and support, and inappropriate funding models.

And yet, these dedicated and resourceful professionals strive to find a way to meet the needs of their respective communities. Innovation is always evident in the daily activity of frontline health providers. Across Canada, community health centres, community organizations, innovative initiatives, hospitals and mobile services are attempting to creatively address the health needs of marginalized and rural and remote populations.

There are a number of innovations in how frontline health care is being delivered:

- Building partnerships among frontline health providers; public agencies; faith-based and other community organizations; and other allied health professionals;
- Developing new education, training and support models that help to attract, prepare and retain frontline medical professionals;
- Specific models of care for particular populations, e.g. women, ethno-cultural groups;
- Taking care and services out to the community – e.g., community health centres, street-based outreach programs and mobile services;
- Using technology such as virtual communities and tele-health (psychiatry, homecare, psychology, diagnostic services, etc.);
- Utilizing interdisciplinary teams and integrated service models that combine health services with other social services, i.e., "one-stop shops";
- Undertaking community economic development initiatives that provide services, skill development and income for individuals and agencies;
- Adopting new funding models, e.g., moving from fee-for-service arrangements to salary; organizations on global budgets.

This overview of frontline health shows that good communication, mutual trust and collaborative decision-making – within organizations, and between partners and sectors – contributes to success. Roles and responsibilities are understood, and if they are not, or if they need to change, governance arrangements support information flows that ensure shared understandings and effective decision-making.

In talking with the people living and working on the frontlines, our research has found that frontline health services need more than recognition. They also need adequate staffing, financial resources, management, infrastructure, networks, partnerships and technology to sustain them.

There also needs to be a broader acknowledgement that frontline health services will be needed more and more, if action is not taken to address the underlying social causes of many of the health problems faced by the people living on Canada's frontlines. The more attention given to these health issues and determinants and the more we can draw upon those successful, innovative models for delivering health care services to marginalized populations, the less pressure there will be on these health care services.

Partners in Research on Frontline Health Care in Canada

This report gives us a new insight and perspective on the people and health care professionals who live and work on the frontlines, the challenges they face on a daily basis, the gaps in the health care system and how they attempt to fill these gaps.

AstraZeneca Canada, one of the world's leading pharmaceutical companies, supports communities as part of its commitment to improving the health and quality of life of Canadians. Frontline Health is AstraZeneca's new corporate citizenship program. AstraZeneca has partnered with CPRN, through commissioning this report, to better understand the frontlines of Canada's health care system.

CPRN is one of Canada's leaders in quality, relevant social policy research. It is a non-profit charitable organization based in Ottawa. CPRN's neutral position, coupled with evidence-based research, sets it apart from other policy research think tanks. Its mission is to create knowledge, lead public dialogue and encourage debate on social and economic issues to help make this a more just, prosperous and caring society for all Canadians.

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The **Family Network** supports CPRN's mission to help make Canada a more just, prosperous and caring society. To this end, we seek to identify the "best policy mix" for Canadians at every stage of their lives, from infancy to old age. Family life does not exist in a vacuum. Families in all their diversity "nest" in a series of overlapping social, economic and physical environments. A wide array of policy issues therefore affects Canadian families. Some of these, like child care and parental supports, are the traditional concerns of family policy. Others, like those that determine who is a citizen, or seek to reshape the social fabric of cities, or change the tenor of intergovernmental relations, are less often recognized as "family" domains. Our research touches on all of these issues.

Research Themes

With expertise in Canadian, European and developing society contexts, the Family Network brings local and global knowledge to bear on Canadian policy questions. We undertake research and policy analysis in several intersecting areas of social policy:

- Child and family policy
- Canada's social architecture and ageing population
- Governance and social policy
- Citizenship and diversity
- Social cohesion
- The importance of "place" as a policy issue and policy "lens"

We organize our work under four horizontal policy research streams:

- The Best Policy Mix for Canadians
- Governance and Social Policy
- Citizenship and Diversity
- Cities and Communities

CPRN is a national not-for-profit research institute whose mission is to create knowledge and lead public dialogue and debate on social and economic issues important to the well-being of Canadians, in order to help build a more just, prosperous and caring society.

You can access or download full reports and presentations from our Web site at www.cprn.org