
Community Health Centres

**An Integrated Approach to Strengthening Communities,
and Improving the Health and Wellbeing of
Vulnerable Canadians and Their Families**

**Canadian Alliance of
Community Health Centre
Associations**



**Regroupement canadien
des associations de centres
communautaires de santé**

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EXECUTIVE SUMMARY:

Why it's time to develop comprehensive community care and support its integration with primary care

Canada's current recession poses the most threat to vulnerable individuals, families and communities struggling with poverty and/or social and environmental issues harmful to health and wellbeing. Laid-off workers need support managing the stress and navigating through social assistance programs, low-income families need access to healthy food and those who have lost their homes need care appropriate to their lack of shelter.

Now, more than ever, is the time to focus on the social determinants of health. A growing body of evidence shows that the health of individuals and populations often suffers when the social, financial or environmental circumstances in which they live are inadequate. Programs and services in sectors outside health care are often better predictors of health outcomes than biomedical and lifestyle factors.¹ These programs must be further developed.

To act on this imperative, this paper proposes that Canada's federal government finally implement the reform measures recommended by many previous investigations of Canada's health and social policy delivery systems. It specifically recommends:

- Increased delivery of comprehensive community services addressing the social determinants of health and reducing health disparities;
- Promotion of integrated models of care, delivering primary care for individuals and families in combination with comprehensive community care services.

Because an individual's health depends on social, economic and environmental factors, we need to correct the separation of primary clinical care from other social services and community development activities. Creating more innovative integrated agencies that offer one stop-community based hubs for integrated delivery of primary care, social services and community development activities should yield major gains: a better start for children, poverty reduction, a decrease in youth violence, fewer avoidable hospital visits, better prevention and management of mental illness and improved chances for seniors to age at home. The worsening health disparities resulting from the current recession could be reduced and the overall health of Canada's population improved.

¹ Raphael, Dennis. *Option Politiques*, March 2003

The direction for change we are recommending is also prescribed by the World Health Organization (WHO) in a wide variety of international declarations signed by Canada. Although recommendations for increased integration of primary care with community care have come from many experts and task forces studying Primary Health Care in Canada, the integration of primary care, social services and community development activities has not systematically occurred. Health care efforts remain narrowly focused on treating individuals when they become ill, rather than mobilizing local communities to keep the overall population well.

Currently, the integration of primary care with other social services and community development activities occurs through only one venue: Canada's relatively small number of Community Health Centres (CHCs). This paper recommends the federal government actively promote such models of care, ensuring this method of integration.

What is happening at Canada's CHCs and what makes them worthy of major new investments? Under one roof, CHC nurses, doctors and other interdisciplinary team members make the best and most cost-effective use of available resources in offering high quality primary care health services for individuals. Under the same roof, social workers and community development workers deliver programs and services that address the social determinants of health, creating a positive impact on the health and well being of individuals, families and the entire community being served. The different domains of work – primary care, social service provision and community development activities - are closely integrated and the synergies between the different domains greatly benefit the Canadian communities now able to access CHC services and programs.

If individuals and families need non-medical supports to protect their health, they are not left to navigate, on their own, through silos of services, each of which do not sufficiently maintain health and wellbeing. Through the CHC, they can access intersectoral programs adapted to serve in coordination, such as those responding to situations of domestic abuse. CHC health promoters conduct outreach work in local neighbourhoods, liaise with medical and other personnel to identify the local problems of those served by the health clinic. Together, primary care and community development teams then develop and deliver programs to reduce these problems.

The support provided by CHCs is nimble and mobile, delivered on the streets, in shelters, in schools, in community centres - wherever CHC interdisciplinary teams can make the easiest connection with those who need the most support. Programs and services are developed in direct response to whatever urgent needs the local community members prioritize. Local residents are active as volunteers, playing a vital role in the implementation of CHC programs, building greater self-reliance and resilience in the communities. A growing body of research reveals this recipe of mixing interdisciplinary primary care services for individuals with comprehensive community care services is a very effective model of care for communities most vulnerable during such economic crisis as we are currently facing.

Because of these benefits, US President Barack Obama has just initiated a dramatic expansion of CHCs in the United States. CACHCA recommends the federal government, working in partnership with provincial governments, take similar action. Detailed recommendations can be found at the end of this paper. In brief, they call for the federal government to:

- 1) **Lead by example: develop and deliver integrated models of primary care and comprehensive community care and establish intersectoral partnerships across federal agencies and departments for those population groups directly served by the federal government (i.e. present and past military personnel, people living in correctional institutions and eligible First Nations populations);**
- 2) **Adopt the Canadian government document *Achieving Health for All (1986): A Framework for Health Promotion and the World Health Organization declarations on Primary Health Care* to guide reform.**
- 3) **Support the transition to integrated models, comprising primary care and comprehensive community care, in communities across Canada.**
- 4) **Support Community ‘Capacity-Building’**
- 5) **Invest in infrastructure for existing CHCs and create new CHCs**
- 6) **Invest in Community Infrastructure to support co-location of local NGOs**

- 7) **Fund local programs through integrated models in the domain of comprehensive community care, to tackle social determinants of health and strengthen local communities**
- 8) **Create a Community Partnership Fund for Intersectoral Programs**
- 9) **Promote best practices**
- 10) **Develop indicators to measure what matters**
- 11) **Fund research on integrated models and intersectoral approaches**
- 12) **Establish a Ministry of Community Care and Development to oversee the implementation of the recommendations**

In the urgency of this current recession, let us move rapidly to implement the long awaited transformation of Primary Care and increase focus on the social determinants of health. Acting on these recommendations will break down silos and barriers to support reaching the 'at-risk' populations who need it most in every community across Canada.

Vulnerable individuals and families will finally be able to access the care they urgently need to protect their health. Local Canadian communities will become stronger, building a solid foundation of better health and wellbeing for future generations to come.

PREFACE

This paper has been prepared by the *Canadian Alliance of Community Health Centres* (CACHCA) whose mission is to protect and improve Canadians' health and wellbeing and to build stronger communities. There are over 300 Community Health Centres across Canada. CACHCA focuses on the importance of integrating interdisciplinary primary care with the delivery of comprehensive community services and programs that address the social determinants of health.

Within Canada, CACHCA transfers knowledge regarding the best practices of this optimal approach developed in various Canadian Community Health Centres (CHCs).

Internationally, CACHCA advocates for Primary Health Care to be delivered within the framework established by the World Health Organization (WHO). CACHCA partners with other associations and organizations which share its commitment to create a more complete, comprehensive and effective primary health care network.

For more information please visit www.cachca.ca

Definitions

There is no common definition accepted for **primary care** across the various jurisdictions in Canada. However, all jurisdictions include general medical and nursing, preventive and curative services as the major part of their primary care services to their residents in local communities in their province or territory. To facilitate the understanding of the reader, it is these services that we are calling primary care services.

Comprehensive community care includes support to families and specific population groups, as well as other types of care, outside of primary care, for individuals. 'Capacity building' in the community as a whole and for vulnerable population groups is a major focus. Integrated models providing primary care and comprehensive community care serve all of the target groups mentioned in comprehensive community care.

Community: serves an identifiable population where individuals and their families have a sense of local identity and/collective empowerment and where they can participate in local decision-making (not larger than the population of an MP's federal riding).

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INVESTING IN CHCs

What makes the CHC approach a good investment to improve health and strengthen communities?

In upcoming recession response plans, as well as longer-term plans to improve the quality of life in Canada, the federal government must invest its money strategically. U.S. President Obama and the U.S. Congress have concluded the CHC approach, integrating primary care with comprehensive community services, is a very strategic investment. Their \$1.8 billion investment represents a doubling of the CHC program in the U.S.A. and builds on a previous doubling of the network initiated by the Bush administration which opened or expanded 1,297 new centres nation-wide. In response to the stimulus measure, Tom Van Coverden, President and CEO of the National Association of Community Health Centres in the U.S.A., said, “The new investment will make our economy and our people healthier”.

Making a similar robust investment in Canada’s existing 300 Community Health Centres and encouraging the growth of the new CHCs across the country will yield the same results in our country. Speaking at the Association of Ontario Health Centre’s recent conference, *Completing the Vision: the Second Stage of Medicare*, Roy Romanow, the former head of Canada’s Royal Commission on Health Care, told delegates:

“Day in and day out, community health centres are already at the forefront of the next stage of Medicare. By shattering silos and modeling interdisciplinary practice, by showing leadership on genuine community collaboration and responsiveness, by ensuring that it is people, from the ground up who must be involved in shaping the future of health care, and putting a population health approach at the forefront of your thinking, you are leading the charge for positive transformation of Medicare.”

The following attributes contribute to the promise and potential Romanow has highlighted:

CHCs respond to the social determinants of health.

The “Ottawa Charter for Health Promotion” identifies the prerequisites for health as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Health Canada included

the following determinants of health, many of which are societal: social support networks, physical and social environments, coping skills, income and social status, biology and genetic endowment, education, employment and working conditions. A large body of research indicates the social determinants listed above are more important to the health of Canadians than biomedical and lifestyle factors.²

At Canada's community health centres, the programs and services delivered take these social determinants into account. In addition to nurses, doctors and other staff from the health sector, health centres also employ social workers, community development workers, child care workers and other professionals from the social and community sector. These professionals develop and provide customized programs and services for clients whose health is threatened by poor food security and lack of education, as well as medical and lifestyle factors.

To be more effective and efficient, CHC services are often offered in group settings. Mutual support is encouraged and activities can include client training in facilitation so self-help activities can be strengthened and expanded. Care is offered through continuous healing relationships with members of a health care team, not just through in-person visits with doctors.

CHCs mount community wide initiatives that reduce the root causes of social, health and economic problems. CHCs develop programs that not only mitigate, but actually reduce, the root causes harming people's health. CHCs programs encourage teens to finish high school, improve food security in local neighbourhoods, increase literacy and address local environmental issues – whatever is identified as the most urgent determinants of health in the local community being served. In many cases, these programs evolve into independent community based non-governmental organizations, strengthening mutual support and community resiliency.

CHCs are especially effective in supporting vulnerable populations.

Because of their focus on the social determinants of health, CHCs are especially effective at improving health in communities facing barriers to accessing needed care. In consultation with local residents and community leaders, CHC interdisciplinary teams identify the groups of people in their community in most urgent need of care. CHCs have expertise in ensuring access for people encountering a diverse range of

² Raphael, Dennis. *Option Politiques*, March 2003

social, cultural, economic, legal or geographic barriers that contribute to the risk of developing health problems. The staff and volunteers in CHC's integrated care model carry out 'patient-centred' programs and support services using case managers to coordinate care where needed. CHCs are proactive in ensuring these services are delivered in locations the "at-risk" populations find most convenient and accessible.

CHCs work in partnership with other sectors, including organizations in the social service, education, housing, and justice systems. No other primary care models in Canada work with such a high level of intersectoral activity. CHCs partner with many networks such as schools, local police, local businesses, municipal services and a wide range of other specialized social service agencies. This integrated and coordinated approach means that intersectoral programs can be initiated for high needs individuals and families who require a wide range of diverse supports to ensure their health and wellbeing.

CHCs strengthen civil society by encouraging citizen empowerment

Research shows the more communities are engaged in decisions about their health and the services necessary to bring about local improvements, the better their health outcomes.³ Rather than relying on government to provide all the answers, CHCs harness the ideas and energy of community residents. This community development approach builds on the leadership, knowledge and life experiences of community members, partnering with them in contributing to the health of their community. Programs and services are developed in direct response to what community members identify as the most urgent local health issues.

Community capacity building is part of the mandate of CHCs and local residents and clientele are recruited to participate as volunteers in the delivery of these programs and services. In a number of provinces, CHCs are governed by locally elected community Boards that ensure their Centres' programs and services continue to be responsive to the needs and aspirations of local residents.

CHCs attract multiple sources of funding

In addition to provincial government funding, many Community Health Centres are able to attract multiple sources of funding from

³ Patzer, Karen. *A Review of the Trends and Benefits of Community Engagement and Local Community Governance in Health Care*. Association of Ontario Health Centres, June 2006.

donor agencies interested in attaining better population health outcomes through a more comprehensive approach to the delivery of health, social and community development services.

CHCs provide a collegial interdisciplinary work environment

Experience in CHCs demonstrates that interdisciplinary efforts work best when there is a collegial, as opposed to hierarchical, working environment in place. A common philosophy and shared values are the foundation for team-based delivery of care. All team members are located at the centre and collaboration takes place, both informally in the corridor, etc. and formally at case discussions. At Canada's CHCs, all health professionals carry out the full scope of practice they are trained to provide. And all staff are paid in a similar fashion, ensuring synchronicity between financial and clinical goals.

CHCs live up to the spirit and intent of World Health Organization declarations

The government of Canada has signed a wide array of World Health Organization agreements that map out the cornerstones of a high performing Primary Health Care system.⁴ These cornerstones include: community participation, intersectoral coordination and a focus on the social determinants of health. At this time, Canada's Community Health Centres are the only agencies in Canada that live up to the full spirit and intent of these agreements.

⁴ For example, the 1978 Alma Ata Agreement, the 2005 PAHO declaration on *New Directions on Primary Health Care* (see Appendix One) and the recently signed 2007 PAHO declaration *Renewing Primary Health Care in the Americas*.

EXAMPLES OF CHC MODEL

Five examples of Community Health Centres in action

Across Canada there are hundreds of examples demonstrating the positive impact of CHCs addressing the social determinants of health. To provide a snapshot, here are five.

Pathways to education: tackling education as a key determinant of health

Pathways to Education™ is an award winning initiative that began at Toronto's **Regent Park Community Health Centre** and has now spread to other parts of Canada. Mobilizing volunteers and employing wide-ranging approaches, the program supports youth to complete high school and move on to post-secondary education. Pathways reduced the dropout rate in Regent Park from 56% to 10%. Pathways also deliver tremendous economic returns. According to a recent report by the Boston Consulting Group, the return on \$1 invested in Pathways is \$25 and the cumulative lifetime benefit to society of a student in Pathways (compared to the pre-Pathways students) is \$400,000.

Responding to unforeseen crises in local communities

Whether it be a disaster in Canadian history (i.e., the ice storm in Quebec and eastern Ontario), the closing of a factory in a small town, or a fire or robbery in a local neighbourhood, the local CHC provides support and connects victims with local informal resources, such as a store for inexpensive clothing or a local food bank, as well as formal resources, in partnership with municipal services and local NGOs. Often the CHC takes a lead role in building a coordinated response to these unanticipated events. Bringing the community together to problem solve and find rapid solutions to unplanned events has had the added benefit of strengthening local civil society.

A recent situation occurred with the city-wide public transit strike in Ottawa this past winter. The municipality asked the CHCs to respond to the significant challenge, created by the 60 day long shut-down, for the local citizenry in accessing health services. **Somerset West CHC** set up a transit hotline for clients without transportation and joined with other local CHCs in providing taxi chits for those unable to otherwise access health services.

Reducing unemployment

Many CHC clients have needs that go beyond job training. For example, at **LAMP Community Health Centre** in Toronto, a community based adult literacy program, has helped hundreds of persons learn the basic skills of reading and writing. In some cases participants have moved directly into employment or into job training courses. In all cases, their enhanced literacy has fostered greater feelings of citizenship and participation in the community

Facilitating Access and Preventing and Managing Chronic Disease

A few years ago, the **Saskatoon Community Clinic** faced long waits for care, like many other primary care clinics. The clinical and administrative staff worked closely with the clinic's patient/members to implement Advanced Access, a new booking and management system which eliminated most waits for care while enhancing the delivery of services for patients with chronic diseases such as diabetes and coronary heart disease.

These results were achieved as part of the Clinics' participation in the Saskatchewan Health Quality Council Collaborative. A long history of interdisciplinary practice enabled this team to easily pull together around a chronic disease focus. Clinical team members mounted many complementary activities, such as foot care programs, hypertension clinics, seniors groups and individual patient education. Outreach workers also responded to challenges faced by community members in accessing care. They arranged transportation and childcare to encourage attendance. They also trained participants to take on the leadership of community kitchens and physical activity initiatives that complemented clinical care. This comprehensive approach is typical of many other CHCs in their chronic disease prevention and management strategies.

The Clinic became a model practice for the Saskatchewan Health Quality Council Collaborative and the Clinic's then lead physician, Dr. Carla Eisenhauer, became the Access Clinical Lead in the Saskatchewan Chronic Disease Management Collaborative.

Promoting empowerment and community resilience

One of the CHCs in the west end of Montreal , **CLSC NDG/ Montreal/Ouest**, began an in-house program to create more integrated and effective care for women experiencing conjugal violence

that has now led to the creation of a community-based NGO, staffed by some of the same women who first came to the program for support. The program began with physicians and other health personnel receiving training to identify the signs of abuse and, when appropriate, make referrals to social workers who would then offer counseling. As research evidence shows that it normally takes dozens of violent incidents before a woman leaves her spouse, the Centre staff responded positively to the women's request for on-going support. The CHC therefore arranged ongoing group therapy sessions with trained counselors. This later evolved into peer support groups enabling participants to help and learn from each other. Over the next three years, again with the assistance of a community organizer at the CLSC, the women participating in these sessions gained sufficient self-esteem to seek and locate funding from a variety of sources, funding used to set up a new fully independent agency called AWARE. This NGO offers a hotline service for women experiencing abuse and provides training to the police on how to respond to conjugal violence.

THE OPPORTUNITIES

Problems that can be solved if the CHC approach to integrating primary care with comprehensive community care services becomes more widespread

Explaining his reasons for expanding CHCs in the United States, President Obama recently said: “Community Health Centers have proven their ability and capacity to expand access to health care, lower costs and improve quality of care.” These same arguments - as well as additional ones - also apply in Canada. Some of our country’s most urgent problems will be addressed if the federal government works with the provinces to promote the growth of CHCs and to replicate their practices more widely across the country.

CHCs reduce health disparities

Research shows that the kind of intersectoral interventions provided by Community Health Centres have a positive impact on reducing health disparities.⁵ These disparities are a very serious problem facing our country. Consider the following: the poorest fifth of Canada’s population faces a staggering 358% higher rate of disability compared to the richest fifth; 95% more ulcers; 63% more chronic conditions; 128% more mental and behavioral disorders; and 33% more circulatory conditions.⁶ With its focus on vulnerable populations and developing programs that respond to the root causes of social, health and economic problems, the integrated model of CHCs can be expanded to play a large role in reducing these disparities.

CHCs can address provider shortages in underserved communities

Many communities cannot access the care they need because of health care provider shortages. When health providers know they are going to be part of a CHC team, whose members provide critical mutual support in managing the high demand for their services, they are more likely to commit to practicing in an underserved community. For example, in its 2005 expansion of CHCs, Ontario’s provincial government placed CHCs in a wide array of rural and northern communities that traditionally have had difficulties maintaining the services of physicians working in private practice.

⁵ Rachlis, Dr. M. *Prescription for Excellence: How innovation is saving Canada’s health-care system*

⁶ Lightman, E et al. *Poverty is Making us Sick: A Comprehensive Survey of Income and Health in Canada*. Wellesley Institute, December 2008.

CHCs can improve health care quality, especially the treatment of chronic diseases

The CHC model of care delivers a high quality of health care. In the United States, a recent study by the United Health Foundation found that CHCs compare favorably with national measures of clinical quality and patient satisfaction, and that they showed a strong ability to raise performance levels consistently over time. The study concluded that, although CHCs serve low-income and medically underserved populations, they are in fact a promising model for all primary care delivery.⁷

Research in Canada is showing similar results, particularly in the prevention and treatment of chronic disease. For instance, Ontario's Health Quality Council's 2008 report concluded that "Overall, care for diabetes and coronary artery disease was better at CHCs" than at other models of Primary Health Care investigated in its study, even though CHCs serve the most difficult population groups.⁸ As in the case of the Saskatoon Community Clinic mentioned above, CHCs achieve this success because their chronic disease prevention and management programs are specifically tailored to the local needs and circumstances of the communities they serve.

Speaking at the Association of Ontario Health Centres 2008 conference, Dr. Mary Bell, one of Canada's leading rheumatologists who has partnered with Canadian CHCs on a number of research projects, gave high praise to CHC representatives in attendance:

"You have been leading inter-professional education and practice in primary health care for more than 30 years. You have been leading in quality of care for that same amount of time because of your model of care, and I think if anyone is going to take on chronic disease management it should be you."

CHCs address unemployment and stimulate economies in vulnerable communities

In addition to the effective role they play delivering primary care and comprehensive community care, Canada's CHCs also make important contributions to stimulating local economies and providing job

⁷ Shin P, Markus A, and Rosenbaum S. *Measuring Health Centers Against Standard Indicators of High Quality Performance: Early Results from a Multi-Site Demonstration Project*. Interim Report. Prepared for the United Health Foundation, August 2006.

⁸ Ontario Health Quality Council, *Q monitor: 2008 Report on Ontario's Health System*, pg 96

training for residents. Community health centres employ people in their communities, including critical entry-level jobs, and provide training and career building opportunities that are community-based. CHCs also purchase goods and services from local businesses and engage in capital development projects. In many cases they also provide job training for community residents and have often played a significant role in revitalizing business districts by providing affordable services and local employment in the communities they serve.

CHCs' as a public health response in local communities

A network of centres would provide an ideal infrastructure to provide surveillance for communicable, environmental and other threats. The system would also provide a platform across the country for a public health response to the present swine flu outbreak or terrorist threats such as smallpox or anthrax.⁹

⁹ Rachlis, Dr. M., *The Federal Government Can and Should Lead the Renewal of Canada's Health Policy*, 2003

THE OBSTACLES

Why have more CHCs not been created across Canada?

The preceding success stories beg the question: given the promise and potential of the CHC model of care, why has it not spread more widely in Canada? The answer: history has presented many obstacles. As Roy Romanow pointed out in his 2002 Royal Commission report on the future of the health care, proposed innovations in Primary Health Care have run up against “entrenched practices in the prevailing culture of our health care system” as well as “powerful interests and long-standing privileges.”¹⁰

It is important to remember Canada’s Community Health Centres were part of the original long-term vision for medicare, what its founder Tommy Douglas called the “second stage of medicare”. The first stage of medicare removed the financial barriers through the creation of a publicly funded insurance system to cover costs for doctors and hospital. The second stage of medicare, envisioned by Douglas and other medicare founders, was all about breaking down the other barriers to good health. Douglas described the Second Stage of Medicare as “keeping people well,” rather than “just patching them up when they get sick.”

Keeping people well has been the CHC mission right from their start. The focus has always been on improving overall population health - not just health care. CHCs were established during the doctors’ strike in Saskatchewan in 1962. Some years later, in other parts of Canada volunteer doctors, nurses and youth workers opened street clinics that eventually became Ottawa’s Centretown Community Health Centre, Winnipeg’s Klinik, and Vancouver’s REACH Clinic.

Meanwhile a growing number of policy experts began pointing to CHCs as the most positive model for transforming Primary Health Care in Canada. In 1972, Dr. John Hastings, Dr. Horace Kriever, Dr. Jean Rochon and others wrote a report for the Federal and Provincial governments called *The Community Health Centre in Canada* which recommended the creation of a large number of CHCs working within a fully integrated health system. And in 1980 when Justice Emmett Hall reviewed Medicare for the federal government he noted:

¹⁰ *Royal Commission on the Future of Health Care*, 2002, pg 119

“When utilized, the community health centre concept can point the way to a reorientation of our sickness system to a health care system.”¹¹

Later in 1986, the Ottawa Charter on Health Promotion introduced the concept of “healthy public policies” reinforcing the importance of an intersectoral approach to keeping people well and creating new innovative models that integrated primary care with comprehensive community care services. Another 1986 Canadian government document: *Achieving Health for all: A Framework for Health Promotion* also stressed the importance of addressing the social determinants of health by fostering public participation in health promotion, strengthening and coordinating community care health services and finding the right kind of service delivery models to help governments coordinate healthy public policy.

However, through the 1980’s and 1990’s, most of the federal/provincial and territorial jurisdictions across Canada responsible for health care continued with their entrenched, and much narrower, approach. In large part, hesitancy to move forward with more integrated and comprehensive models of care was caused by continuing opposition from the medical profession. As Roy Romanow pointed out in his Royal Commission report, “for general practitioners and family physicians, fee-for-service payment plans can be a major obstacle to primary health care”.

Romanow’s report had followed the 1995 *Victoria Report on Physician Remuneration* commissioned by the Federal, Provincial and Territorial Advisory Committee on Health. This earlier report advocated a rapid, phasing out of the fee-for-service model for paying primary care physicians and replacing it with rostering of patients to multidisciplinary primary care organizations. The Canadian Medical Association and the College of Family Physicians in Canada strongly opposed the recommendations and the report was shelved.

There have been few champions in the Ministries’ of Health and so Canada’s Community Health Centres - that use salaried and other similar-types of compensation for physicians, as opposed to fee for service and include a large array of other disciplines - have been left by the wayside.

¹¹ Hall EM. *Canada’s National-Provincial Health Program for the 1980s: A Commitment for Renewal*. Department of National Health and Welfare. Ottawa. 1980.

In more recent years, calls for innovative integrated models have continued. For instance, in 2005 the Health Council of Canada noted “there are numerous innovations with positive evaluations, for example, organizations such as the Women’s Health Centre in Winnipeg and in the community health centres in Quebec .These and other models go a long way to realizing the ambitions and goals of the 2003 Health Accord, but they are the exception rather than the rule. These ... should be pursued aggressively....”¹²

However new strategic directions in Primary Health Care that respond to the all important social determinants of health have still not materialized. Provincial Ministries of Health have largely limited their action to encouraging family physicians to move from solo to group medical practice - a tactic that does little to respond to the social determinants of health. Meanwhile the development of CHCs, where staff makes the social determinants of health part of their core business, remains in low gear.

Currently, only Quebec has achieved a complete network of 149 CHCs, (known as CLSCs) developed during the 1970’s and 1980’s as part of an ambitious health and social service reform initiative guided by an integrated Ministry of Health and Social Services. The catchment areas of these centres cover the entire area of the province of Quebec.

With 73 CHCs, Ontario is the province with the second largest number of centres. Meanwhile, in all the other provinces the number of CHCs remains very small. Yet, accolades continue to grow even in these provinces. Last month the Health Council of Canada, in its report entitled “*Getting It Right: Case Studies of Effective Management of Chronic Disease Using Primary Health Care Teams*”, described the North End Community Health Centre in Halifax, N.S. as “an urban program that is transforming the delivery of primary health care in Atlantic Canada”.

In summary, CHCs are responsible for many significant innovations in health care, public health, and community services. But they have been incompletely implemented across the country leaving many individuals, families and communities without the support they need to avoid illness and injury.

¹² Health Council of Canada, *Primary Health Care: A Background Paper to Health Care Renewal in Canada, Accelerating Change*, p 18

RECOMMENDATIONS

CACHCA looks forward to future discussions with federal leaders on how forthcoming economic stimulus packages, as well as longer term planning, can encourage the growth of innovative care models, offering more comprehensive care for individuals, families and communities.

The following are a number of initial ideas for discussion. They focus on strengthening and expanding CHCs, and similar integrated models of care, in order to better address the social determinants of health. They also touch on complementary strategies to improve overall population health and reduce health disparities. Each of those recommendations involving particular fiscal arrangements with the provinces are written solely as examples of partnership. There are many ways to create the necessary specific F/P/T partnership with each province to carry out the recommendation.

The Federal Role - Leading by Example

1) Within the Federal Government, establish a standing intersectoral (cross Departmental) Advisory Committee to review federal initiatives in regard to the extent they support or inhibit the promotion and development of integrated models of primary care and comprehensive community care, and make recommendations to Cabinet through the responsible Minister (see Recommendation 12).

The federal government could lead by example, ensuring that silos are broken down and that an integrated model of comprehensive community care with primary care is applied across the departments and agencies it funds (i.e. those agencies delivering support to present and past military personnel, people living in correctional institutions and to eligible First Nations populations).

This recommendation builds on two recent federal government reports stating the need for a more integrated approach to caring for Canadians:

- the Romanow commission noted that Aboriginal people have a much lower health status and less access to health services than other Canadians. The report noted the need for a more comprehensive approach and so recommended that all present funds for Aboriginal peoples' health be pooled into one fund to facilitate the redesign of services.
- the recently released Senate report on aging, entitled "*Canada's Aging Population :Seizing the Opportunity*", recommended that 'the Government of Canada lead in national efforts to improve the situation for Canadian seniors by moving towards integrated models of care for the elderly.'

Integrated Models, Comprising Primary Care and Comprehensive Community Care, such as Community Health Centres

2) Adopt the Canadian government document *Achieving Health for All (1986): A Framework for Health Promotion and the World Health Organization declarations on Primary Health Care to guide reform.*

This document identifies the prime goal of reducing inequities between income groups by influencing the social determinants of health. Its framework is closely aligned with an array of World Health Organization declarations that Canada has signed, outlining the optimal direction for the development of Primary Health Care. The most recent examples are the WHO-Pan American Health Organization vision and declaration on Primary Health Care of 2005 and 2007. These agreements identified equitable distribution, community participation, intersectoral coordination and a focus on the social determinants of health as key cornerstones for Primary Health Care development.¹³

3) Support the transition to integrated models, comprising primary care and comprehensive community care, in communities across Canada.

These agencies would be open to all in the local community, but would ensure access to vulnerable persons such as new Canadians, off-reserve Aboriginals, those with chronic mental illness and the homeless, as well as official language minorities who have difficulty accessing the traditional primary care system.

In the primary care component, these integrated agencies would likely employ a minority of family doctors - as in Quebec, where the CLSC network employs fewer than 20 percent - but would have a key role to liaise and partner with private practitioners in the overall network of care.

These agencies would provide an ideal infrastructure allowing surveillance for communicable, environmental and other health threats. The system would also provide a country-wide platform for a public health response to the present swine flu outbreak or terrorist threats such as smallpox or anthrax.¹⁴

¹³ *Renewing Primary Health Care in America's*, PAHO, 2007 <http://www.paho.org/English/AD/THS/primaryHealthCare.pdf>

¹⁴ Rachlis, Dr. M., *The Federal Government Can and Should Lead the Renewal of Canada's Health Policy*, 2003

The federal government should support the transition to integrated care models comprising primary care and comprehensive community care in communities across Canada, by providing matching funds for these transitional costs with the provinces.

Community Building

4) Support Community ‘Capacity-Building’

Federal government funding of these integrated agencies, directly or in partnership with the provinces, could strengthen local communities. These agencies support the capacity of communities to convene key players, combine their ideas and resources and devise local solutions to reduce poverty and improve the health and wellbeing of vulnerable groups in the local community. This funding would “provide coaching assistance to help communities identify their assets, develop strategic plans and assess progress against their identified objectives”.¹⁵

CHC Infrastructure Expansion

5) Invest in infrastructure for existing CHCs and create new CHCs

Because Canada’s CHCs are currently the only agencies in Canada which fully live up to the spirit and intent of the WHO declarations on directions for Primary Health Care, the federal government should follow the example of U.S. President Obama by contributing further to the work of CHCs by investing major funds to renovate and equip existing centres, and to building new centres.

Canada has a strong demand for the expansion of CHCs. In some provinces, many communities have applied to their respective provincial governments to build CHCs in their communities. These requests have not been answered. Meanwhile, across Canada, existing CHCs are struggling with waiting lists for their community-based programs and services, often because of limited building capacity.

The Wellesley Institute, one of Canada’s leading think tanks on health equity, has recently submitted to the federal government recommendations that \$360 million be put to infrastructure and start-up funds to implement a pan-Canadian Community Health Centre program.¹⁶ The money would be ear-marked for one-time

¹⁵ Torjman et al. *Who Does What in Comprehensive Community Care*. 2004

¹⁶ *The 7% solution. Federal budget recommendations - 2009*. The Wellesley Institute, January 2009.

transfers to the provinces, on a per capita basis, for CHC infrastructure projects and operational start-up and, according to the Institute, would kick start the creation of 140 new Community Health Centres. This expansion would mean over a million Canadians would have access to CHC programs and services.

Using its fiscal powers, the federal government could partner with provincial/territorial governments to fund the construction of buildings to house new CHCs or other agencies that integrate primary care with comprehensive community services. Funds could also be made available to renovate and add space to the physical structures of existing centres.

The provincial responsibility for ongoing operations in local communities would be enhanced through better coordination of existing primary care resources with other local social and community resources, which are often fragmented and disconnected.

Supportive and Enabling Activities

There are many key community functions which can be supported by the integrated model of CHCs. In addition to supporting the basic or core model, it is recommended that funding be provided for the following activities:

6) Invest in Community Infrastructure to support co-location of local NGOs.

During this recession it is especially important for the federal government to ensure that support reaches vulnerable populations effectively and efficiently. This will require tearing down silos between the provision of health, social and community development services and between other sectors, such as education and justice. Co-location of CHCs and other community-based agencies increases intersectoral action, ensures better integration and coordination and facilitates access for people needing a comprehensive range of services and activities. CHCs and other community-based agencies often have to raise money on their own to locate under the same roof.

To expand this collaborative approach in Ontario, a coalition of community health agency associations is asking for a \$150 million **Community Hub Infrastructure Fund**. This fund would finance local communities developing multi-service hubs, focusing on 'at-risk'

youth, families living in poverty, isolated seniors, disabled persons and newcomers.¹⁷ The coalition, which consists of the Association of Ontario Health Centres (AOHC), the Ontario Community Support Association (OCSA) and the Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP), says fifty multi-service hubs could be created, many of them in existing buildings.

CACHCA proposes the federal government earmark matching funds for such community hub initiatives. These infrastructure dollars should be given to projects that are environmentally sustainable according to LEED standards or otherwise. The financial contribution would encourage provinces to take increased action in breaking down silos and encouraging more effective, integrated and user-friendly access to health, social and community services across the country.

7) Fund local programs through integrated models in the domain of comprehensive community care, to tackle social determinants of health and strengthen local communities

In the domain of comprehensive community care, emphasis must be given to developing support for vulnerable populations. Community development strategies can be used to ensure that persons from these vulnerable populations participate in devising the programs. To respond to unmet needs such as social integration and community alternatives to institutionalization, activities for vulnerable populations require increased emphasis. There is need for social support networks or support groups for caregivers of people with chronic disease and for families dealing with mental illness, as well as other activities mentioned in the *National Caregiving Strategy for the Elderly* (Senate report on Aging, 2009).

These activities should be developed in close consultations with community members equipped with on-the-ground knowledge about the local area's most pressing unmet needs.

8) Create a Community Partnership Fund for Intersectoral Programs

The federal government should consider funding, possibly through matching funds with the provinces, a Community Partnerships Fund to encourage a more integrated and effective approach to health.

¹⁷ *Community and Social Services Infrastructure Fund proposal - Bring Services Closer to People, Creating Jobs*. Prepared by the OCSA, AOHC and the OFCMHAP

Integrated agencies comprising primary care with comprehensive community care could apply to this fund with organizations from other sectors providing services in the local community for support of innovative preventive intersectoral programs and services targeted at vulnerable populations. To ensure that these programs are adapted to the specific needs of the community, the clientele to be served must be involved in planning the programs.

Improvements in physical and social environments could be developed, ensuring that all persons, including those with a handicap, disability, or other vulnerabilities can participate. These measures would include improvements to playgrounds, public recreation facilities and equipment in order to have better and safer spaces to be active. Programming in these public recreation facilities could be adapted to persons with a chronic illness or disability, or persons from other marginalized groups.

Other improvements include literacy programs for teenagers and adults, who do not have a grasp of either official language, in locations which they frequent and in which they are comfortable.

The fund would encourage local community initiatives like Pathways to Education™ mentioned earlier in this report.

9) Promote best practices

To learn more about ‘best-practice’ in models integrating primary care with comprehensive community care, the federal government should:

- create a network of Centres of Excellence across Canada to provide leadership in discussion of issues such as interdisciplinary teams, case management, group interventions, intersectoral partnerships, and community empowerment;
- develop ‘best practice’ manuals and toolkits for transition to and implementation of integrated care models; and
- assist communities to make links with each other, encouraging knowledge transfer and exchange of ‘best-practice’ methods.

This knowledge transfer will enable more communities across the country to benefit from the health promotion and Primary Health Care principles applied in Community Health Centres and recommended by previous government policy papers and the World Health Organization.

Research and Evaluation

10) Develop indicators to measure what matters

A significant obstacle in transitioning to more integrated models of primary care in combination with comprehensive community care services participating in intersectoral programs is how to measure success. While there are many indicators for measuring the success of clinically focused primary care, there are almost no agreed indicators for a more comprehensive approach. The development of these indicators should be focused on the care of ‘at-risk’ population groups in the social service, health, justice, employment, and education sectors identified in government reports for whom governments have not had great success. The wellness indicators being developed by organizations, such as the Atkinson Foundation, could also be used.

If the federal government would fund the development of such indicators, the success of preventive and intersectoral measures to improve the health, wellbeing and possibly employability of these population groups could become apparent to decision-makers across the various Ministries. Governments could then monitor overall performance and not only silo interventions as we advance integrated systems optimally designed to reduce disparities and improve the health and wellbeing of all Canadians.

11) Fund research on integrated models and intersectoral approaches:

Using its fiscal powers, the federal government can create positive directions for change by funding research on integrated models and intersectoral approaches that reduce social and health inequalities and improve the wellbeing of vulnerable Canadians. This research could include:

- documenting successful international strategies;
- evaluating current intersectoral strategies being implemented across the country; and
- mandating research agencies to prioritize research in empowering vulnerable families and communities through:
 - comprehensive community care;
 - integrated care models with intersectoral partnerships;
 - involvement of vulnerable population groups in devising and evaluating services; and
 - community capacity building that facilitates neighbourhood renewal (e.g. financing arrangements and evaluation practices).

Move From Talk to Action

12) Establish a Ministry of Community Care and Development to oversee the implementation of the recommendations

Despite many past reports cited in this paper recommending similar directions for change, the federal government has not yet been successful in delivering the changes required. Following Health Canada's most recent effort, the creation of the Primary Health Care Transition Fund, primary care reform across Canada has focused largely on improving medical services for individuals in primary care, rather than intersectoral strategies that address the social determinants of health with community wide impact.

Only Quebec has developed a complete network of community health centres, enabled in large part by the creation of an integrated Ministry of Social Affairs in the 1970s (now Ministry of Health and Social Services). Its responsibilities include intersectoral coordination with other Ministries regarding the social determinants of health. This Ministerial mandate, along with a corresponding responsibility for implementation by the regional health and social service agencies for over 20 years, led to the completion of the community health centre network now facilitating local intersectoral coordination.

The same integrated approach is needed at the federal level in order to initiate the recommendations in this report. Without increased coordination in the implementation of health policy with other social policies, it will be very difficult to develop comprehensive community care and overcome the entrenched practices that currently prevent a more integrated and comprehensive approach.

Over the past 20 years, the level of intersectoral coordination required, between federal Ministries and with other levels of government, to successfully address the social determinants of health has not been attained.

CACHCA therefore recommends that the federal government create a new Ministry of Community Care and Development to oversee the planning, implementation, and monitoring of the recommendations in this report. More specifically, this Ministry would be responsible for the implementation of integrated models of care for those population groups served directly by the government of Canada. It would be responsible for the coordination of all federal government departments

responsible for these services. It would also be responsible for ensuring partnerships with other departments and agencies that have an important impact on the health and wellbeing of these population groups.

In order to ensure effectiveness, this Ministry would:

- create collaborative working relationships for policy dialogue between the federal government and its departments and the community groups and social policy institutes working with impoverished communities. In collaboration, these groups could look to reduce inequalities and identify policy barriers that impede effective community interventions;
- appoint an external advisory group to the Minister of persons with expertise and experience, to share information and provide advice on the implementation of the recommendations in this paper; and
- require that managers have experience and expertise with vulnerable population groups in the fields of comprehensive community care, integrated care and intersectoral partnerships.

CONCLUSION

Leading the charge for the improvement of social policy in Canada

The current recession is putting very serious pressure on the health and wellbeing of many Canadian individuals, families and communities, especially those at the bottom of the socio-economic ladder. As we weather the economic storm around us, it is vitally important to guard against worsening social, health and economic disparities and to protect the health and wellbeing of Canadians.

To achieve this end we must find models of care that increase emphasis on comprehensive community care integrated with primary care. Community Health Centres already offer this potent mix - a fact U.S. President Obama has recognized in his major new investment in American CHCs. Governments across Canada would be wise to follow his example.

CACHCA looks forward to working with the federal government to enable the long-awaited transition. Working together we can continue breaking down the barriers that stand in the way of optimal health and wellbeing for all Canadians.

