

Access within a Fragmented Healthcare System: A Nurse's Perspective on Romanow

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Abstract

Access to healthcare remains both topical and problematic in Canada, although the reasons for this have changed over time. This issue is usually framed in terms of ensuring equal access to services. Changing the perspective on access to one framed in terms of ensuring comprehensive, effective and efficient healthcare highlights the problems associated with fragmentation of care delivery. Attempts to reform or restructure healthcare delivery with the goal of improving integration and coordination are constrained by the legislative context in which we understand the Canadian healthcare system. In this paper, I provide an overview of the legislation underpinning Canadian healthcare, particularly the foundational principles of Medicare as defined in the Canada Health Act, 1984 and the values underlying this legislation. Then I examine the issue of our fragmented healthcare system and articulate why I regard access as problematic. Finally, I argue for integration and coordination of services with reference to the Romanow (2002) report. I consider the reforms suggested by Romanow in the context of the existing legislation and the implications for nursing leadership.

Peter came for haemodialysis on Tuesday, Thursday and Saturday afternoons. One day I discovered during a routine foot check that he had an ulcer on his left foot that would require daily dressings. Peter's vision and manual dexterity were limited, so I called home care nursing to arrange to have a home care nurse change the dressing on his nondialysis days. The home care nurse asked: "Where are you calling from again?" I repeated that I was calling from the haemodialysis unit of Hospital A. There was a pause, then: "Well, that explains why Peter is never home on Tuesday and Thursday

afternoons for us to check his blood sugar. I didn't know he was on dialysis! You know, we've been seeing him for six months at the request of the diabetes clinic – do they know?"

This vignette illustrates the problem of access in the context of fragmented health-care delivery even within a regionalized (and, theoretically, more coordinated) provincial healthcare system. Had services been better integrated, the diabetes clinic, home care and haemodialysis unit could have worked together to monitor Peter's diabetes. At least two home care visits per week could have been eliminated, as we checked Peter's blood sugar at each dialysis treatment. Peter's access to care would have been improved by virtue of each care provider's comprehensive understanding of his health challenges. Duplicate testing and unnecessary appointments due to fragmented service provision cost both Peter and the healthcare system time and money. Such financial and human resource costs to the healthcare system contribute to longer waits for services, increased healthcare spending and reduced access. As this vignette illustrates, comprehensive and integrated care is also likely to be more effective and efficient.

I argue that the issue of access in healthcare remains both topical and problematic across Canada, although the reasons for this have changed over time and the manifestation of the problem may vary among provinces and territories for reasons that will be discussed later. The problem is usually framed in terms of ensuring equal access to healthcare (Armstrong 2002; Deber 2003), and it can be argued that equality of access has largely been achieved (Mhatre and Deber 1998). If, however, the issue of access is reframed in terms of ensuring comprehensive, integrated health-care, then I argue, as does Romanow in his 2002 report for the Commission on the Future of Health Care in Canada, that access to care continues to be problematic because of fragmentation in care delivery. I argue for the integration and coordination of services, and refer to the Romanow report to show how this can be done.

I also argue that attempts to reform or restructure healthcare services with the goal of improving integration and coordination are constrained by the legislative context through which we view healthcare services in Canada. Deber et al. (1998: 423) identify three dimensions of healthcare services: "financing – how services are paid for; delivery – how services are provided to recipients of care; [and] allocation – how resources flow from those who finance care to those who deliver it." The legislative context of Canada's health services both underpins the current financing, delivery and allocation of health services and provides the foundation for change.

In this paper I will first provide an overview of the legislation underpinning Canadian healthcare. I will give particular consideration to how the foundational principles of Medicare are defined in the *Canada Health Act* (CHA), and how these definitions continue to influence healthcare services in Canada. Then I will exam-

ine the issue of our fragmented healthcare system and articulate why I regard it as problematic for access. Finally, I will consider the reforms for Canadian healthcare suggested by Romanow in 2002 in the context of the existing legislation and the values underlying it, and how nurses might contribute to future policy development intended to improve access to healthcare.

Overview of Legislation

The current Canadian healthcare system remains heavily influenced by its foundational legislative history and the Canadian structure of government, that is, a confederation of provinces and territories with responsibility for governance divided between the federal and provincial or territorial governments. The Constitution Act, 1867 clearly established healthcare and other social programs, such as education, as a provincial rather than a federal responsibility; this distinction continues to influence the Canadian healthcare system over 130 years later.

The Act frames discrete provincial or territorial systems of healthcare delivery rather than one unified national system. While each province/territory must conform to federal legislation (the CHA) to ensure federal financing of healthcare services, there is considerable provincial/territorial freedom in the delivery and allocation of these services. What follows is a brief review of the history and content of the CHA and a discussion of its implications for healthcare services provision in Canada.

In 1957, the federal government laid the foundation for Canada's health insurance system by passing the *Hospital Insurance and Diagnostic Services Act* (HIDSA). This was an attempt to persuade provincial governments, by means of financial incentives, to administer and partially fund a universal hospital insurance plan. In 1968, medical insurance was added through the passing of the *Medical Care Act*, requiring provinces or territories to have healthcare insurance schemes that complied with five criteria to qualify for the transfer of funding from the federal government. By 1971, all 10 provinces had some form of medical and hospital insurance program (Iglehart 2000).

Passed in 1984 in an attempt to reinforce federal control of healthcare, the CHA replaced the HIDSA and *Medical Care Act* and confirmed the commitment of Canada's people to a healthcare system that adhered to the five funding criteria of the *Medical Care Act* (Iglehart 2000). These criteria have come to be regarded as the foundational principles of what is now known as Medicare. The CHA ensures some consistency in service provision across jurisdictions but leaves the method of delivery (including coordination and integration of services) to the discretion of the individual province/territory. This arm's-length approach is reinforced by the federal government's reduced influence since the mid-20th century, as reductions in transfer payments and remodelling of the federal financial contribution to health-

care allowed provincial and territorial governments more flexibility in the allocation of funds. Since 1984, the provincial and territorial governments have primarily led changes to the allocation and delivery of healthcare in Canada, resulting in differences in access across provinces/territories.

The importance of the guiding principles of the CHA to Canadians was recently reaffirmed in the *Report of the Commission on the Future of Health Care in Canada* (Romanow 2002). Although healthcare delivery and allocation of resources are largely determined at the provincial and territorial level, I maintain that access remains problematic primarily because the CHA's delineation of the foundational principles of Medicare restricts our thinking about the three dimensions of health services, namely, delivery, allocation and funding at the federal and provincial/territorial levels.

Foundational Principles of Medicare

The five foundational principles of Medicare are defined in the CHA as:

1. *Public administration:* The administration of the healthcare insurance plan of a province or territory must be carried out on a nonprofit basis by a public authority;
2. *Comprehensiveness:* All medically necessary services provided by hospitals and doctors must be insured;
3. *Universality:* All insured persons in the province or territory must be entitled to public health insurance coverage on uniform terms and conditions;
4. *Portability:* Coverage for insured services must be maintained when an insured person moves or travels within Canada or travels outside the country; and
5. *Accessibility:* Reasonable access by insured persons to medically necessary hospital and physician services must be unimpeded by financial or other barriers.

These definitions restrict healthcare delivery in the 21st century in a number of ways. In particular, the principles of comprehensiveness, universality and accessibility, with their explicit inclusion only of physician and hospital care, assume that care delivery by other healthcare professionals and in other jurisdictions (e.g., home care) is implicit in hospital care and/or dependent on the interpretation of medical necessity.

Hutchison et al. (2001: 118) note that this legislation effectively reinforces physician and hospital-centred healthcare and limits "the potential for innovations in healthcare delivery based on alternative settings and providers." I argue that this commitment to physician- and hospital-centred healthcare reinforces fragmentation of healthcare delivery and that these definitions are incongruent with current healthcare discourse about interdisciplinary healthcare delivery, primary healthcare and comprehensive and integrated care across the continuum. As will be discussed later, Romanow (2002) has proposed updating the CHA to remove some of the legislative

obstacles to reform and the restructuring of Canadian healthcare services.

Our understanding of the Canadian healthcare system is further complicated by the omission in the CHA of a definition for a medically necessary service. The common-sense definition is “one that a patient needs in order to avoid a negative health consequence” (Charles et al. 1997: 365). Perhaps this was the definition the policy makers had in mind when they drafted the legislation. However, over time a variety of politically motivated interpretations have come to be used, each having different implications for how access is interpreted in the context of the CHA. Charles et al. identify four predominant meanings of medical necessity used in healthcare policy discourse since 1957: (a) any service that is provided by a physician or hospital, (b) the maximum we can afford, (c) what is scientifically justified and (d) what is publicly funded across all provinces.

In spite of the above concerns, I caution, as do Charles et al. (1997), that we not focus all our attention on defining what medically necessary means in the context of the CHA for a number of reasons. First, trying to reconcile these multiple interpretations will divert attention from resolving the issue of fragmented care delivery. Second, continuing debate about what is medically necessary obscures the fact that healthcare occurs in a context that is broader than physicians and hospitals. Perpetuating the privileging of care delivered by certain care providers over that delivered by others detracts from interdisciplinary team care delivery. Third, and perhaps most important, focusing on what constitutes medically necessary care directs us to think of healthcare in terms of individual elements of care rather than in terms of comprehensive, integrated care. Instead, I argue that focusing on ensuring comprehensive, effective and efficient healthcare will redirect our attention towards identifying potential linkages between, and integration of, elements of care over time. Hollander and Prince (2002) provide evidence of how this can be achieved with specific population groups that require ongoing care, such as children with special needs, people with mental illness or the elderly. This shift in focus is more in keeping with the underlying values of the CHA.

Underlying Values

The principles of the CHA, in particular that of universality, are clearly rooted in a liberal egalitarian perspective, congruent with the dominant political discourse of the mid-20th century in Canada (Armstrong 2002: 14). Romanow notes, “Canadians have been clear that they still strongly support the core values on which our healthcare system is premised – equity, fairness and solidarity” (2002: xvi). He suggests that this philosophical and moral perspective underlies the consistent resistance of Canadians to moving away from a publicly funded healthcare insurance system based on equal and timely access to services based on need, to one that privileges wealth or social status. Romanow calls for a renewal of Canadians’

commitment to a publicly funded healthcare system and to these values through a “new Canadian Health Covenant, endorsed by governments and based on the values Canadians share” (2002: 47) to guide reform and modernization of our healthcare system and reduce fragmentation of care delivery. Romanow’s call is congruent with current healthcare discourse about the delivery of healthcare services.

Access in the Context of Fragmented Healthcare Delivery

There is a relatively recent move away from discourse about restructuring healthcare that focuses almost exclusively on enhancing efficiency and reducing costs, albeit acknowledging a need to maintain effectiveness (Burke and Stevenson 1998). More recent discourse includes integrated care delivery systems that enhance or enable coordinated care, that is, delivery of health services, although this too may be framed in terms of fiscal accountability (Armstrong and Armstrong 2003; Naylor 1999; Romanow 2002). As this shift in discourse lies beyond the scope of this paper, I will confine myself to examining the current understanding of the issue of fragmentation of care. I will illustrate the problems in access to care, identify some of the policy being considered to remedy those problems and propose a role for nursing.

That is the current understanding of “fragmentation of care”? Romanow (2002) maintains that healthcare services are disjointed and disconnected because they are delivered by multiple providers, usually working independently, in multiple and discrete settings. This approach remains a problem even in areas of the country that have moved to regional health authorities. I argue that the problem remains because while regionalization may alter the flow of financing for services, changes to the delivery and allocation of services are often still influenced and restricted by our understanding of the core principles of the CHA.

Romanow (2002) identifies two particular areas in which the system is fragmented; the first is the horizontal structure, that is, between specialists or specialties; the second is the vertical structure, that is, between levels of care delivery such as those that exist for residential care of the elderly (to this I add care settings such as hospitals, home care and ambulatory clinics). The problem for individuals seeking care is that they must “find their way through a maze of services and providers to get the best information and the full range of services they might need” (Romanow 2002: 122). Romanow argues that fragmented healthcare delivery not only reduces access but also is financially costly because of unnecessarily repeated investigations and consultations and costs generated by poor or inadequate care. I will illustrate the issue of fragmented care delivery, and the problems that this creates for access, from my clinical experience.

In care delivery for patients with chronic kidney disease, comprehensive renal services are usually set up to provide a continuum of care encompassing chronic

kidney disease followup and treatment, peritoneal dialysis, haemodialysis (community and hospital based) and transplantation (although this latter may be part of another hospital-based program, like solid organ transplantation). Care is typically provided by a multidisciplinary team of healthcare professionals and delivered in settings that range from home or community to hospital. However, any individual client may also be a client of home care services, other specialty programs such as diabetes or cardiac programs and healthcare providers who are not part of the renal program; these services are certainly fragmented in the sense that Romanow (2002) outlines. So, despite having access to multiple care providers, the individual may not have access to comprehensive and effective care, as the following example illustrates.

Mary was admitted for surgery to Hospital B on Monday after her usual treatment at a community haemodialysis unit. During her hospitalization she received dialysis at the in-centre haemodialysis unit. On Friday afternoon, after her treatment, the surgeon discharged her home. On Monday morning when Mary was late for haemodialysis, we called the inpatient unit. The unit clerk said: "She was discharged on Friday; didn't you know?" "No, we didn't; we're an outpatient department and don't automatically receive a discharge notification." We called the community haemodialysis unit to find out whether Mary had come in for treatment: "No, we thought she was in hospital." When there was no reply from Mary's home we called emergency services, who found her unconscious at home and brought her to the Emergency Room. Shortly after readmission, she had a cardiac arrest and required resuscitation. Mary later told us: "I went home by taxi, managed to crawl up the stairs to my apartment – there's no elevator, you know, and dialysis always makes me feel tired, so I went straight to bed. When I woke up I was too weak to get to the phone in the living room to call for help." Mary needed three more weeks in hospital and intradialytic parenteral nutrition (IDPN) for three months.

Although Mary had multiple care providers, the fragmentation of her care meant that no one adequately planned for her discharge from hospital. Again, despite regionalization of healthcare services, nobody had complete information about Mary's home circumstances or health because each service had a separate care record and the community liaison nurse had direct access only to the inpatient record. The problem was compounded by the fact that the hospital discharge planning occurred without consultation of either outpatient haemodialysis service. Had the care record and the care delivery services been integrated, Mary's discharge may have included discharge on a nondialysis day, home support services until she was able to care for herself independently and a home care nursing visit on the day of discharge to assess her ongoing home care needs. Such coordination would have saved money while giving Mary access to more comprehensive and effective care. However, even within a regional healthcare structure, the allocation of funding to separate programs does not support assessment of total costs across both healthcare services and those outside healthcare (such as emergency services), nor integration and coordination of delivery.

Reform within the Current Legislative Context

Romanow (2002) makes a number of recommendations for healthcare reform to address the issue of fragmented services delivery and improve access. I will consider these recommendations in the context of the existing legislation outlined earlier, and propose how nurses might contribute to this and future policy development intended to improve access to integrated, coordinated healthcare.

Changing the context

Romanow (2002) predicates his recommendations for improving integration of care by proposing modernization of the CHA. I will outline only those aspects of his proposal that relate to improving integration of care delivery services.

First, Romanow recommends reaffirming the principles of the *Canada Health Act* plus updating the principle of comprehensiveness and adding a principle of accountability.

Second, he proposes to update the principle of comprehensiveness by expanding the scope of publicly insured services beyond physicians and hospitals to include diagnostic and priority home care services (i.e., home mental health case management and intervention services, home care services for postacute patients, including medication management and rehabilitation services and palliative home care services to support people in their last six months of life) and, at a future date, prescription drugs.

Third, he recommends federal transfer funding for primary care renewal.

Romanow makes these recommendations under the aegis of reforming primary healthcare, which he defines from the perspective of individual Canadians as

access to a team or network of health care providers working together on their behalf to co-ordinate their care across different aspects of the health care system from counselling them on how to stay healthy or quit smoking to treating illnesses, providing hospital care, following up with home care services, or monitoring people's use of prescription drugs. (Romanow 2002: 117)

This definition clearly supports integration of fragmented healthcare delivery in the interests of increasing access to comprehensive, effective care.

Reform

In the above context, Romanow offers the following further, specific recommendations:

- The proposed Primary Health Care Transfer should be used to “fast-track” primary health care implementation ... reflecting four essential building

blocks – continuity of care, early detection and action, better information on needs and outcomes, and new and stronger incentives.

- The Health Council of Canada should sponsor a National Summit on Primary Health Care within two years to mobilize concerted action across the country, assess early results, and identify actions that must be taken to remove obstacles to primary health care implementation.
- The Health Council of Canada should play a leadership role in following up on the outcomes of the Summit, measuring and tracking progress, sharing information and comparing Canada's results to leading countries around the world, and reporting to Canadians on the progress of implementing primary health care in Canada. (Romanow 2002: 250)

Further specific suggestions towards providing continuity of care include the use of case managers to guide individuals through the healthcare system and coordinate all aspects of their care ("the case manager does not necessarily have to be a doctor or a nurse" [Romanow 2002: 122]). Such care might include diagnosis, treatment and rehabilitation in primary healthcare organizations; prevention and health promotion; and care networks or health management programs, probably focused on ongoing care (including medications, prevention or education activities and medical treatments) for individuals with chronic health conditions. Hollander and Prince (2002) suggest some creative strategies for financing, delivery and allocation of health services that should be considered for other individuals with ongoing care needs and their families, such as those with chronic illness.

Implications for Nursing

As a nurse, I applaud Romanow's inclusive and pragmatic approach to healthcare reform, as outlined above. His recommendations and suggestions are congruent with existing legislation and the underlying values of the CHA, and support the recommendations made by others writing about healthcare reform (Armstrong and Armstrong 2003; Coyte and McKeever 2001; Manga 1998). Romanow's proposal to include home care represents the first move towards explicitly naming nursing services in the CHA alongside physician services. Significantly, these proposed changes to the CHA do not challenge the existing legislation or the position of physicians. Nor do they challenge the current remuneration and funding schemes that have in the past been matters of dissent between the medical and political communities, diverting focus from potential healthcare reforms (Hutchison et al. 2001; Manga 1998; Naylor 1999). Instead, these recommendations and suggestions represent an alternative to what Hutchison et al. call "big bang change" and are the first steps in "cumulative, incremental change" (Hutchison et al. 2001: 122) guided by policy development at joint federal-provincial tables. I suggest that this focus on stepwise, incremental healthcare reform will serve not only the interests of the public but also nurses' ability to deliver safe, competent care.

The case histories presented in this paper illustrate the significant cost implications of continued fragmentation of care delivery; I will approximate these. For Peter, the monthly cost of duplicate routine laboratory testing (\$50.00) and unnecessary home care nursing visits (\$251.08) was \$301.08. For Mary, fragmented healthcare delivery cost an emergency services rescue (\$800.00), 21 hospital days (\$20,664.00), IDPN (\$612.00) and home care services for two months (\$1,168.00), for a total cost of \$23,244.00. By comparison, if Mary's care delivery had been integrated, two home care nursing visits (\$125.54), home care services for a month (\$584.00) and one more night in hospital (\$984.00) would have cost approximately \$1,693.54. The potential cost savings: \$21,550.46. Stories such as these present a compelling argument for working to transform fragmented care delivery into an integrated health-care system.

So, what role can and should nurses play in future policy development to reduce the fragmentation of care delivery and improve access? Judith Shamian, the first Executive Director of Nursing Policy for Canada, has noted that there are over 300,000 nurses (registered and licensed practical nurses) in Canada and that "every nurse can educate his or her immediately surrounding people" (2000: 20). I argue that Romanow (2002) has given Canadians a policy map for healthcare reform that can begin the transformation of fragmented healthcare delivery into a coordinated, integrated system and improve access to comprehensive, effective and efficient care. Nurses need to take the initiative and leadership to ensure that this vision becomes reality. The typical stages of the policy cycle (agenda setting and problem definition, policy formulation, implementation and evaluation) correspond closely with the nursing process. Nurses can and should become involved with the policy cycle at all levels.

I will use the example of information transfer to illustrate what nursing action might look like in terms of micro, meso and macro policy.

At the micro level, staff nurses in one hospital identified communication difficulties between the haemodialysis unit and inpatient units. They then collaboratively developed and trialed the implementation of a transfer sheet to improve communication and ensure that patients receive the appropriate care when being transferred to and from dialysis. This tool quickly became a permanent part of haemodialysis unit policy for patient transfer.

Taking this example to the meso level, nurses can argue for a hospital policy requiring similar documentation for all patients being transferred between hospital departments and between care settings, such as hospital and residential, community or home care. Although such policy has been implemented in some settings, it needs to become more widespread.

At the macro level, nurses can advocate convincingly for a single, integrated electronic care record for every individual cared for in our new healthcare system (perhaps using provincial and national associations as a vehicle). Nursing is the key profession across all sectors of healthcare. Strong nursing leadership in the development of a single, integrated electronic care record has the potential to eliminate the need for duplicate charting across multiple, discrete care records and provide all care providers with immediate, comprehensive and current information.

Conclusion

Nurses must take individual and collective leadership to counter the erosion of healthcare and nursing practice and to formulate policy (Varcoe and Rodney 2002). Situations such as those experienced by Mary and Peter will be less likely to occur if we focus our combined expert, nursing clinical resources on providing strong nursing leadership to coordinate care and support integration of services. Such leadership requires us to advocate for and support policy changes to the funding, delivery and allocation of healthcare services such as those proposed by Romanow (2002) and Hollander and Prince (2002). Our practice-based knowledge of healthcare delivery successes, challenges and opportunities, supported by research and theory, is a powerful platform from which to propose, develop and implement policy to realize an integrated healthcare system.

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