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health planner

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Murray MacKenzie, President and CEO of North York General Hospital, shown here with TDHC Board Chair Carole Kerbel, received a plaque of appreciation from the DHC at its April 16 Board meeting. Mr. MacKenzie, who is retiring in June, was honoured for his leadership in meeting the health care needs of the French-speaking community. His hospital was one of the first in Toronto to make a commitment to achieving French Language Services designation.

What's Inside

TDHC Stresses Urban Health Issues To Romanow Commission

The Toronto District Health Council (TDHC) has brought its views on urban health to the attention of the federal Commission on the Future of Health Care in Canada, headed by former Saskatchewan Premier Roy Romanow.

At the invitation of the Commission, TDHC Board Chair Carole Kerbel took part April 3 in a day-long expert stakeholder workshop. She went armed with information about Toronto's distinctive health concerns drawn from recent TDHC reports and other sources including the federal census emphasizing the increasing complexities of urban health.

Ms. Kerbel stressed the need for a more systemic approach to urban health issues, in light of the fact that more than one-third of Canada's total population lives in the Toronto, Montreal and Vancouver regions, with Toronto accounting for the greatest concentration of residents in the country.

Results of the 2001 federal census show that Toronto's population has reached 2.5 million, while the Greater Toronto Area (GTA) population is more than 4.6 million. "That's close to one-sixth of the population of Canada," with the City of Toronto – and its health care infrastructure – at the core serving residents as well as the extended referral population, Ms. Kerbel told the Commission.

"The future of health care in Canada will depend on how well the system reflects the changing ethno-cultural face of the country, as well as the trend of increasing urbanization and complexity."

Toronto is Canada's largest city, and one of the most ethno-culturally diverse cities in the world. It is home to the country's largest medical school, and contains the nation's greatest concentration of hospitals. Despite all this, there is tremendous variation in health status among certain sub-populations.

Ms. Kerbel stressed the evidence from various TDHC reports that have identified distinctive challenges associated with the urban population who have difficulty accessing care. This includes disproportionate numbers of refugees, immigrants, people living in poverty, and the homeless.

The incidence of certain infectious diseases, including tuberculosis and AIDS, is higher in Toronto than elsewhere in the province. Toronto

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Monitoring: a form of learning

Ontario's 16 District Health Councils (DHCs) are in the process of releasing their respective Local Health System Monitoring reports, based on a common set of indicators developed specifically to provide a standardized framework for planning, monitoring and evaluating changes to the health system. The project was based on the *Health System Reform Monitoring Template* and *Toronto's Health System Report Card* developed in the late 1990s by the Toronto District Health Council (TDHC).

To avoid duplication of effort, each DHC on behalf of the entire group developed certain elements of province-wide data such as demographics, utilization measures, sentinel events and health system resource descriptors, working with the province's five Health Intelligence Units. The collaboration, supported by the Ministry of Health and Long-Term Care, resulted in a province-wide data set released in CD-ROM form in October 2001 as a comprehensive tool for planning. The CD, containing data on utilization measures, sentinel events, population demographics and health system resources, was highlighted at the Action Centre conference. It has been used by DHCs both to identify local trends in access and service delivery, and to respond to external queries.

"Theories about innovation and learning organizations now include monitoring as a distinct way of learning. This concept complements the traditional concepts of learning by doing, using and interacting," says Toronto District Health Council (TDHC) Board Chair Carole Kerbel. "In a rapidly-changing environment as complex and dynamic as health, it is crucial to plan for the future and to monitor whether we are actually getting there."

In the 1990s, Ontario's health care system underwent rapid change aimed at improving efficiency in response to various pressures, including demographics, restructuring and reform, and new drugs and technologies. The TDHC recognized the value of monitoring and evaluating those changes over time as a way of learning about the impacts of restructuring and innovation on population health status. The current initiative was designed based on knowledge from the TDHC Health System Report Card project.

The TDHC saw system monitoring as a way of informing its advice to the Minister of Health and Long-Term Care about the health needs of Toronto. Recognizing the value of having comparable data, all DHCs passed resolutions agreeing to participate in the current project, with the goal of producing 16 local but comparable reports.

A survey and informal feedback indicate that DHCs see value in that outcome. "Another result of the DHCs working together to leverage their resources is an effective model for future collaboration," says Project Manager Kathleen Clements.

Chair's Message

As Chair of the Toronto District Health Council, at arm's length from both government and service provision, I have a unique perspective on the complexities of health care delivery and population health, particularly in an urban setting such as Toronto. This has given me new insights into the development of the advice that the DHC provides to the Minister of Health and Long-term Care and how that is translated into policy.

I also have a renewed appreciation for the common ground that unites those who work in government, DHC staff and other planners, people who deliver health care, and the volunteers who give freely of their time, expertise and wisdom...people who want the best possible outcomes from a system that is undergoing a process of transformation.

In the face of a rapidly-evolving system, the TDHC – like its counterparts across provinces – has had to meet new challenges and step into new roles. I'm pleased with the leadership role that TDHC has been able to play.

As Board Chair, I'm grateful for the opportunities that I have had so far to make a difference in the work of the TDHC, and the quality of advice that it offers to the Minister of Health and Long-term Care. This work is possible only through the contributions of the many volunteers – consumers and providers alike, at the Council level and in committees – who put so much time and effort into helping TDHC ensure that the Minister and his staff have the best information and evidence possible on which to base policy decisions.

Co-ordinated Communication Needed for Emergencies

Clearly defined lines of communication are part of the key to improved coordination of inter-organizational response to large-scale emergencies, according to a report released in March by the Toronto District Health Council.

The report, *Recommendations for Improved Emergency Response Coordination in Toronto's Health Sector*, is the work of a committee made up of representatives from municipal, health, social service and emergency response agencies. The group was formed to bridge gaps between municipal emergency services and the health sector – including hospitals – identified in Year 2000 contingency planning.

"The benefit of having this done is that for the both short- and long-term, we're going to have a better coordinated response in a situation where more than one institution or more than one sector is involved," says Dennis Fair, Canadian Red Cross Regional Director for the Toronto Region, who co-chaired the committee along with North York General Hospital Vice-President Edward Darby.

The report contains recommendations structured around three complementary models for coordinating response to large-scale emergencies in Toronto. Those consist of the incident management model that originated with fire service authorities in California, as well as a communications model and a CBRN (Chemical/Biological/Radiological/Nuclear) response model.

The terrorist actions of September 11, 2001 in the United States underscored the committee's recognition of gaps in the ability of first responders – police, fire and ambulance – to communicate with other elements of the health and social services sectors, including hospitals, public health and the Red Cross in the event of a large-scale emergency.

While first responders would be on the scene of a disaster with flashing lights and sirens, it's equally important for other organizations to be plugged into the developing situation, says Toronto EMS Emergency Management Supervisor Bruce England.

Toronto's acute care hospitals with emergency departments are a top priority, but all hospital sites as well as Long-term Care facilities, Community Care Access Centres and other organizations should be in the loop, depending on the magnitude of the situation.

The Central Ambulance Communications Centre of Toronto Emergency Medical Services (EMS) will be the conduit of information between first responders at a large-scale emergency and the health sector, including hospitals.

Lines of responsibility and command also vary, depending on the nature of the emergency. The incident management model is based on the concept of shared command, so that the appropriate lead agency can be identified quickly and efficiently.

For example, in the month after Sept. 11, there were more than 100 reports a day of anthrax. Such calls should go to public health, which deals with biological hazards.

The report recommends that Toronto EMS (Emergency Medical Services), through its Central Ambulance Communications Centre, or dispatch centre, serve as the conduit for two-way radio communications between incident management authorities and the health sector in a large-scale emergency.

A disaster simulation, based on the hypothetical scenario of the release of Sarin nerve gas, was conducted in February of this year.

"The only thing more difficult than preparing for an emergency is explaining why you were unprepared," says Associate Medical Officer of Health Dr. Bonnie Henry, head of the Toronto Public Health Department's new Emergency Services Unit.

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accounts for more than 60 per cent of Ontario's TB cases, and more than 80 per cent of the multi-drug-resistant cases of TB.

Toronto also has the highest rate of low birth weight in the province. TDHC research indicates that this is more common in low-income areas and areas with high levels of recent immigration. Toronto also has a high rate of teen pregnancy.

International immigration was a major factor in Toronto's four per cent population growth between 1996 and 2001. More than 445,000 immigrants settled in the Toronto area during that period, while Ontario's entire population increased by only 656,000. This contributes to the following picture:

- 37.7 per cent of Toronto residents identify themselves as members of a visible minority, compared to 9.7 per cent in the rest of Ontario;
- 49.6 per cent of Toronto residents are immigrants, compared to 19.3 per cent in the rest of Ontario;
- 28 per cent of immigrants living in Toronto arrived in Canada recently, compared to 16 per cent in the rest of Toronto;
- 6 per cent of Toronto residents cannot carry on a conversation in either English or French, compared to one per cent in the rest of Ontario.

Twenty-eight per cent of Toronto's population lives below the low-income cut-off point developed by Statistics Canada, compared to 18 per cent elsewhere in Ontario. In 1997, 36 per cent of the women 75 or older in Toronto were below the low-income cut-off.

Between 1988 and 1996 the average annual number of hostel users in Toronto has been around 25,000, more than a third of whom are said to be suffering from severe mental illness.

The scale, diversity and systemic complexities of Toronto and the GTA encompass a broad range of institutions, organizations and agencies as well as populations and communities. Some issues span federal, provincial and municipal jurisdiction; others are supported in a fragmented way by different ministries or departments of different levels of government.

Ms. Kerbel stressed the fact that to date medicare has been mainly a mechanism to pay for hospital and medical services. However, "we know more about determinants of health today than we did when medicare was created, and the conceptual framework for improving population health status has evolved considerably," she said.

"The ideal health care system is one built on incentives for sound health promotion and disease prevention practices that prevent hospitalization and physician visits unless necessary, as opposed to one that rewards them at the expense of less costly alternatives," she says. "It should be possible to modify – and improve – the Canada Health act, while remaining true to the principles of medicare."

Planning for the future of health care in Canada must reflect what we can discern about the future, as opposed to what we know about the past, Ms. Kerbel says.

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