



Canadian Disability Policy Alliance

**Alliance Canadienne concernant
les politiques reliées au handicap**

**Submission to the Standing Senate Committee on Social Affairs,
Science and Technology
First Session – Forty-first Parliament, 2011**

**Study: Examination of the Progress in Implementing the 2004,
10-Year Plan to Strengthen Health Care**

Chair

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About Us

The **Canadian Disability Policy Alliance** is a national collaboration of disability researchers, community organizations, and federal and provincial policy-makers, aimed at creating and mobilizing knowledge to enhance disability policy in Canada, and to promote equity and opportunity for disabled Canadians. The Alliance is funded by the Social Science and Humanities Research Council for a period of 5 years (2009-14).

Our **vision** for Canada is a place where people with disabilities enjoy full participation and citizenship, supported by a coherent framework of **legislation, regulation and programs**. This vision is achieved through:

- **United voices** – of researchers, consumers, policy makers, providers, educators, employers; across jurisdictions, across boundaries, across barriers;
- **Learning collaboratively** – through focused, interactive research cycles;
- Effectively using **tools for change** – producing context-sensitive, policy-relevant evidence to promote effective disability policy.

The Alliance operates as four teams, each dedicated to a particular policy sector: **Citizenship, Education, Employment & Health Services**.

The teams use the **Learning Collaborative** approach to:

- **PLAN** – identify stakeholders, assemble evidence, conduct policy analysis, compare jurisdictions, identify best practices, review literature;
- **DO** – identify and mobilize plan/knowledge to enhance policy relating to disability;
- **STUDY** – monitor and record the outcomes of knowledge mobilization;
- **ACT** – refine and broaden the scope of knowledge mobilization.

Three **key assumptions** underpin our activities:

1. The policy environment is perfectly designed to create the problems that disabled Canadians experience. In other words, the problems experienced by people with disabilities can inevitably be tracked back to the policy environment, either failure, absence or misapplication of policy.
2. We already know most of what is needed to support effective disability policy in Canada – in most instances, the research is available to provide evidence for good, sound disability policy. What is needed is context-specific, policy-relevant synthesis of the research.
3. People with a variety of expertise and skills are needed to translate knowledge about disability issues into effective disability policy – disabled consumers, their advocates and support systems; disability researchers and trainees; policy experts and public servants. All three of these types of people work together in the Canadian Disability Policy Alliance.

Executive Summary

The 2003 First Minister's Accord on Health Care Renewal and corresponding Ten Year Plan to Strengthen Health Care (2004) identified primary care renewal as a priority, including improved access to family physicians, multidisciplinary teams, and better management of chronic conditions. This brief asserts the particular importance of consideration of people with disabilities in improvements to the health care system. To date little sustained attention has been given to the unique needs of people with disabilities within the health care system. We offer several recommendations, all of which adopt a disability lens on policy analysis regarding primary health care renewal.

Background Information

Access to primary care has been a political imperative in every jurisdiction in Canada for the past ten years. Physician shortages and geographic distribution are usually cited as the main sources of access problems.

For people with disabilities, however, there are a number of additional barriers that not only delay or inconvenience access, they actually prevent it (McColl, Aiken, McColl & Smith, 2010).

People with disabilities encounter barriers at six points in the primary health care system. Like non-disabled Canadians, they may have difficulty finding a doctor or getting an appointment; however unlike their non-disabled counterparts, they also face barriers attempting to enter the practice, use the equipment and facilities, receive the necessary accommodations, and obtain a reasonable standard of care. These barriers may be:

- physical (such as stairs, narrow doorways, high tables and counters),
- attitudinal (such as unwillingness to assist and accommodate),
- expertise-related (lack of knowledge about disability and its complications), or
- systemic (policies and practices that differentially inhibit access) (McColl et al., 2008).

People with disabilities depend on primary care for access not only to both urgent and routine health care, but also for access to specialist care and to a number of disability supports for which the family physician is the usual authorizer (McColl & Jongbloed, 2006). Primary care is especially important for people with disabilities for a number of reasons:

- they have a thinner margin of health;
- the course of health issues and complaints is usually prolonged or complicated by the disability;
- there are often functional consequences of illness and treatments (such as bedrest) that can be further severely debilitating;
- they have fewer opportunities for health promotion, and are frequently disadvantaged in terms of the social determinants of health (DeJong, 1993);
- 43% of people with mild or moderate disabilities and 72% of people with severe disabilities have three to five chronic conditions (Statistics Canada, 2006);
- people with disabilities tend to experience earlier onset of chronic diseases associated with aging (McColl, Shortt, Gignac & Lam, 2010; McColl et al., 2003).

The research shows that people with disabilities tend to receive a lower standard of care for both routine and specialized health complaints (McColl et al., 2010). They are less likely to be thoroughly examined, to receive appropriate preventive and screening measures, and to receive appropriate sexual and reproductive care (McColl, et al, 2008; McColl, Aiken, McColl, Sakakibara, & Smith (in press). Furthermore, they are often disadvantaged in obtaining the necessary administrative support from family physicians to receive specialist health care, benefits and entitlements associated with the disability.

From the perspective of the primary care setting, people with disabilities represent a small proportion of the typical family medicine caseload (5-6%), who consume a relatively high proportion of the practice's resources (McColl & Dickenson, 2009). They typically visit more frequently, require longer visits, may need to attend with a personal support worker, require multiple professionals, and need greater coordination of care (McColl, 2005; McColl & Shortt, 2006; Donnelly et al., 2007).

In spite of high utilization, disabled adults experience three times as many unmet health care needs as their non-disabled contemporaries. Disabled participants are significantly more likely than their non-disabled counterparts to report cost as a reason for unmet needs (including opportunity costs, medication and equipment costs, and logistical costs of transportation and personal assistance). Unfortunately, those with the most severe needs also experience the greatest number of unmet health needs (McColl, Jarzynowska & Shortt, 2010; Tranmer, VanDenKerkhof, McColl (submitted 2011).

Recommendations

- 1. That physicians' offices be subject to public sector standards of disability accessibility.** There is a systemic anomaly whereby physicians' offices, despite being largely resourced by public funds, are considered private businesses, and thereby are not subject to the same standards of accessibility as the rest of the public sector. We recommend that physician offices be considered public sector premises, subject to the highest standard of disability access.
- 2. That primary care practices be prevented from systematically excluding patients, such as those with disabilities, who represent a potentially greater demand on the practice's resources.** The research has shown that some physicians systematically exclude patients who could represent a financial burden on the practice, specifically patients who consistently require more than the standard 10-15 minute appointment (Barros, 2003). Thus "the very patients who are most likely to benefit [from primary care] ... are least likely to be welcomed into a practice" (Kasperski & Ontario College of Family Physicians, 2005). Such practices undermine public confidence in the medical profession, and exert an undue burden on other physicians. We recommend adopting a policy whereby practices that are declared "open" accept patients on a first-come-first-served basis, until they are "full / closed".
- 3. That appropriate incentives be put in place for physicians to provide extraordinary services to their patients with disabilities without charging an administrative fee to the patient.** In addition to their need for excellent primary medical and health services, people with disabilities require specialized care and administrative services that are not adequately compensated in the fee schedule. For example, authorization for benefits such as disabled parking permits, disability tax credit, pension and insurance forms, all must come from the family physician. Assistance with transfers, dressing / undressing, communications all represent costs to the practice of providing service to disabled patients. Additional continuing medical education is also needed to maintain an appropriate standard of evidence-based care of disability-related health issues and concerns. We recommend that an appropriate stipend be paid to primary care settings to offset these costs without passing them on to disabled patients, many of whom are already financially disadvantaged.
- 4. That provinces be encouraged to adopt a more robust model of multidisciplinary primary care to serve the needs of patients with disabilities.** To date, primary care reform has proceeded with little consideration for the issues of people with disabilities. The need to manage these conditions efficiently and

effectively depends on multiple health professionals with a variety of skills (Dorland & McColl, 2007). While some jurisdictions have made progress on implementing this more robust model of primary care, access to these interdisciplinary teams remains limited, particularly to rehabilitation and disability specialists (McColl et al., 2009; Aiken & McColl, 2009). We recommend that further primary care renewal take into account a broader spectrum of regulated health professionals and disability services in the community.

- 5. That accountability measures built into the Canada Health Transfer agreement ensure the needs of disabled persons are being adequately met.** Pursuant to the Article 25 of the UN Convention of the Rights of Disabled Persons (Health), States Parties are obliged to “take all appropriate measures to ensure access for persons with disabilities to health services”.

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