ATTACHMENT TWO TO: VIHA'S DRAFT FIVE-YEAR STRATEGIC PLAN
STAFF REPORT TO THE PLANNING & PROTECTIVE SERVICES COMMITTEE
MEETING OF WEDNESDAY, FEBRUARY 22, 2006

MAJOR THEMES & OBSERVATIONS

1. Imbalance in the System

"Hospitalization of the elderly is a default for …other parts of the system … that doesn't always work well for older people" and "***elderly people need the support that helps them remain independent and healthy." Hospital wards being "saturated with patients who should go to long-term care facilities and large numbers of hospital and nursing home patients who could be treated at home, except for a lack of available home care.*** "

The Plan states **"*acute care utilization in VIHA is higher than that of BC overall but this may need to be revisited in the light of a special and aging population."*** Assuming that acute care rates are age/sex standardized the influences of population variation between jurisdictions has been removed. No elaboration on the ***special and aging population*** and its impact on hospital use.

2. Social Determinants of Health

"Public heath policies recognize that macroenvironmental factors (national socioeconomic factors and the physical and social environment) are the principle determinants of inequalities in health. These factors influence the living and working conditions of the individual and the health behaviours which individuals adopt (smoking, poor diet, lack of physical activity, excessive alcohol consumption etc.). Interventions which tackle only adverse behaviours will have little success; they offer microenvironmental solutions to a macroenvironmental problem. Interventions to reduce inequalities in health ... must tackle macroenvironmental problems (income and education) and the physical and social environment as well as adverse behaviours and access to health care."[1]

"Neighbourhood social economic environment has an independent influence on child overweight and obesity levels."[2] "Living in lower socio-economic environments increases the odds of being overweight (similar to findings of international studies involving adult populations)."[3] Less affluent neighborhoods have social and physical environments unconducive to maintaining healthy body including a lack of local facilities, safety concerns, lack of personal resources (money, time and transportation to be involved in organized activities) and or a lack of awareness (or interest) in organized activity. The authors suggest that "the neighborhood may be a site for implementation of policies to target overweight and obesity, including ensuring that neighborhoods are safe and have infrastructure for physical activity."[4]

3. Service Integration

Opinion on the potential for more service integration ***versus*** more home and community care for the elderly and mentally ill (as a means of improving access and patient flow) would be helpful.

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[1] *Closing the Health Inequalities Gap: An International Perspective, WHO Europe, University of Dundee and NHS Health Scotland, 2005*
[2] *Neighbourhood Socio-Economic Status and Prevalence of Overweight Children and Youth; L. Oliver and M. Hayes; Canadian Journal of Public Health, November-December 2005.*
[3] *Ibid #3.*
[4] *Ibid #4.*

4. Detail, Substance, Evidence

The lack of evidence on the availability of ***infrastructure*** to support the initiatives in the Plan is also a concern. How will home support services grow 14% in the next four years with a current shortage of home support workers (estimated at 30% of the required workforce) and questions about the potential for an expanding workforce with the current labour market and job conditions?

What does the **"*targeting of additional home support hours to intermediate level clients to prevent them from deteriorating as quickly and reduce emergency admissions of elderly residents"*** mean? Which of the three distinct intermediate care levels are to be targeted and is this change of policy introduced in 2001/2002 which saw a 35% decline in Intermediate Care Level 1 clients (39% decline in hours)?

Where is the evidence that ***"further shifting from heavy forms of care (residential care) to lighter forms of care (assisted living and home supports)"*** for chronic disabled people is feasible?