Implementing Primary Care Reform in Canada: Barriers and Facilitators

By

Cathy Fooks
Director, Health Network
Canadian Policy Research Networks Inc.

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1.0 Introduction

Governments and health care stakeholders have been talking about reorganizing the way Canadians receive primary care services for a very long time (1). Yet it is hard to discern real change at the local level – publicly-funded medical and hospital services are organized largely the way they were at the inception of Canadian medicare. Despite solid evidence services could be organized more effectively and achieve better health outcomes for citizens, reform is slow in coming (2). Why?

This paper briefly describing the current policy directions taken by provinces in reforming their primary care services and analyzes implementation barriers and facilitators to realizing those policy directions.

2.0 Definitions

Terms abound: primary care, primary health care, primary care services etc. A recent review of international models makes a useful distinction between primary care and primary health care (3). The authors describe primary care as the diagnosis, treatment and management of health problems with services delivered largely by physicians. Primary health care is described as including primary care but also including the broader determinants of health such as sickness prevention and health promotion activities that are provided by physicians and others in a team-based environment.

It is clear when looking at current provincial reforms that a variety of terms are used somewhat interchangeably:

Alberta Primary Health Care is based on a holistic definition of health that recognizes the influence of social, economic and environmental factors on a person's well-being, is delivered by a variety of providers and emphasizes the coordination of health services, health promotion, illness and injury prevention to cover episodic illness and chronic conditions (4).

BC Primary Health Care is defined as the point at which a person enters the health care system and receives the health care services that meet most of their everyday needs (5).

Manitoba Primary Health Care is defined as first level contact with the health system where services are mobilized to promote health, prevent illnesses, care for common illnesses and manage ongoing health problems. It includes all human services that play a part in addressing the interrelated factors that affect health (6).

Nova Scotia Primary Health Care Renewal focuses on improvements in population health and allows citizens to select a primary health care provider and access a range of primary health care services (7).

Ontario Primary Care Reform has created family health networks to deliver primary care. Groups of physicians, supplemented with a nurse-staffed telephone service 24 hours a day, emphasize comprehensive care while promoting a stronger doctor-patient relationship (8).

Prince Edward Island focuses on primary health services described as those services that people access first and most often, such as family physicians, public health nursing, screening programs, addiction services and community mental health services (9).

Despite the different terminology and varying degrees of scope in provincial plans, there are a number of common elements consistently referenced in the policy documents. They are:

- *Team approach to service delivery:* this is loosely defined given that some provinces begin with the family physician and build other providers around him or her whereas other provinces start with a nurse or nurse practitioner and use medical resources at the next stage of contact.
- *Roster of patients:* there is a general desire to get patients registered with a specific group practice or team of providers. There appears to be varying degrees of formality about this aspect of reform with some provinces talking about "sign-up" periods and others not limiting patient movement amongst difference providers in any way.
- *Twenty-four hour access seven days a week*: this commitment appears to be largely after-hours access to a nurse by telephone.
- *Mixed funding formulas for services and programs*: there is fairly mild experimentation being proposed for new funding models such as capitation, salary and combinations of such in conjunction with fee-for-service payments. A number of provinces are proposing to move to a population-based funding model linked to specific demographic and health characteristics of enrolled populations.
- *Increased emphasis on health promotion and prevention*: all the provinces' policy materials emphasize a focus on health promotion and prevention.

If we take these common elements as a loose Canadian "model", we can examine the barriers and facilitators to implementation.

3.0 Analytic Framework

Three variables are proposed for the barriers and facilitators analysis:

- The legacy of Canadian health policy culture;
- The structure and design of Canadian health care;
- The supports required for policy implementation.

4.0 Canadian Health Policy Culture

The Canadian health policy culture is not an environment in which rapid change is easily achieved. Various policy legacies exist which effect the ability of leaders to lead change in positive and negative ways.

4.1 Barriers

Ten years ago health reform efforts highlighted the need for better integration, coordination and multidisciplinary care for primary care services. The solutions offered by experts was to reform physician payment mechanisms with a shift towards capitation and other alternative payment schemes (10)(11)(12)(13). The focus on physician payment was not surprising as medical services are publicly funded and are therefore the logical entry point for governments to lever change.

The language has not changed dramatically over the decade – integration, coordination and multidisciplinary care are still the policy descriptors for reform. And not surprisingly, the legacy of a focus on physician payment remains. Current efforts of primary care reform are organized around services provided by physicians, albeit in conjunction with others, and funding flows to the physician or group of physicians, not to patients or other health professionals.

Embedded within the history of physician payment in Canada is another legacy – that of paying physicians on a fee-for-service basis. Physicians entered Canadian medicare on the basis of existing fee schedules – a price for each service delivered. Although some experimentation has occurred over time, and physicians are indicating an increasing willingness to consider alternative forms of payment (14), fee-for-service is still the primary way in which primary care services are funded. Alternate payments only account for 11% of total clinical earnings in Canada (15). Fee-for service payment is predicated on single services delivered by one professional at a time. It does not facilitate care delivered holistically or delivered by teams of professionals and it does not compensate for time spent for administrative, managerial, educational or communication tasks.

Most expert reviews and some of the evaluations from the Health Transition Fund have identified the need to move away from fee-for-service payment in varying degrees (4)(16). Yet movement away from fee-for-service payment is not endorsed by provincial medical associations – the bargaining agents for Canadian physicians. Provincial governments have not, to date, been prepared to implement new funding models over the objections of the medical profession. And, because negotiations are bipartite between governments and medical associations, there is no opportunity for the influence and views of other health professions to be considered as part of allocation decisions.

A third legacy of the culture of Canadian health policy is the use of pilot projects. Rather than move to full implementation, provincial governments often attempt policy reforms of new initiatives through pilot projects. This often gives an impression that a final decision on

a policy direction hasn't been made, permits time for opposition to build, and leaves open the possibility of policy reversal when new Ministers or governments take office. Primary care reform in Canada is being introduced largely through pilot or demonstration projects.

4.2 Facilitators

While Canadian health policy culture has created some legacy problems for primary care reform, it also contains several positive legacies that could contribute to successful implementation.

Canadians are open to new models of care and service delivery and have been for some time. They are aware that a range of providers would benefit their health and are willing to consider their first point of contact with a primary health care system to be with someone other than a physician (17)(18). And while Canadians clearly want to maintain a close connection to a personal family physician, they also use a wide variety of other professionals and pay for their services directly (19).

Canadians have also expressed a strong interest in health promotion and prevention activities (20) which supports the thrust of current provincial efforts.

5.0 Structure and Design

The structure and design of Canadian health care provides some difficulties for implementing new models as well as opportunities.

5.1 Barriers

Although primary care design is being touted as an integrated reform, a closer look at actual implementation plans indicates that this is not the case; indeed, it could not be the case under current legislative arangements. Neither funding models or provincial health professions regulatory frameworks are structurally supportive of primary care reform.

Federal funding covers only portions of the comprehensive services being envisionsed for primary care. Some services are funded under the Canada Health Act (eg, physician services), some are funded through specific federal-provincial programmatic arrangements (eg, pharmacare) and some are covered only by individual provinces (eg, alternative health professionals). As well, funding at the provincial level is not always in one pot. For example, Ontario Family Health Networks must work through a different part of the Ministry of Health with a different funding stream to access nurse practitioner funding. Because funding is tied to providers rather than patients, it is not integrated. Attempting to implement new delivery models on the existing hodge-podge of funding arrangements cannot support integration and team-based care.

On the regulatory side, health professions legislation is based on distinct professions with their own educational requirements, practice standards and regulatory colleges. There is no common approach even in areas of overlapping scopes of practice. Professional liability

schemes are focused on individuals rather than teams and are legally based on professional autonomy rather than shared accountability. As well, increased specialization and calls for continually higher levels of educational certification as entry qualifications to practice would appear to be decreasing rather than increasing integration and team-based care.

5.2 Facilitators

One of the most positive facilitators for implementing primary care is the role played by the Primary Health Care Transition Fund. Initial evaluation reports are now available and make clear that much was learned about implementation at the local level from the providers' and patients' perspectives. Although many felt more time was required to undertake actual implementation, they were positive about new models of delivery (4)(16). This evidence provides a good basis for enlarging the scope of activity and the number of participants across the country.

Secondly, provincial governments have wisely chosen to offer a number of delivery models allowing providers to choose the model they feel best suits their individual circumstances and patients to change care providers if they wish. Although this likely lengthens the time required for implementation, providers will feel more in control of their practice arrangements and that the decision to change was theirs and patients will be more likely to enrol.

6.0 Required Supports for Policy Implementation

Change management literature tells us that that certain supports are required to implement change. Things such as personnel and skills, appropriate resources and information technology are needed to support the desired policy change.

6.1 Barriers

Health human resources planning has become an urgent policy issue for the Canadian health care system in the last five years. In particular, national strategies for physician and nursing personnel have been recommended. This is difficult to do in the absence of a clear vision for primary care and some consistency across provincial jurisdictions. Without a stronger link between national health human resource planning and local primary care delivery, implementation of primary care may be less than optimal. For example, a greater use of nurse practitioners is clearly envisioned but to date increased training slots and new funding models are have not materialized.

Information technology has been recognized as a necessary support to clinical integration and improved health outcomes and governments are investing in varying degrees. However, initial projects indicate the costs of real time information technology are more than anticipated (4)(16). This may deter some governments from province-wide implementation or slow down the time frame.

Another potential barrier is expressed concerns about the privacy of the health information that will be shared across practitioners or networks in the new delivery models. Although there is no evidence that the information will be any less secure than in current primary care

settings, citizens do occasionally raise the issue and privacy legislation specific to health information is being introduced or implemented in a number of provinces. Primary care reform efforts will need to ensure compliance with new legislative requirements and take into account citizens' sensitivities.

6.2 Facilitators

There are a number of supports in place for primary care reform that will likely facilitate implementation. New funding is being made available at the federal and provincial levels. Health information systems are being put in place to support changed delivery. Initial reports from early adopters of the new models are positive both from the provider and the patient perspective. And, some provinces have new health professions legislation that provides a more flexible regulatory scheme to take advantage of the full scope of practice of non-physician personnel.

7.0 Why Has Implementation Been Slow?

Although we often use the term health care system, Canadians don't really have a system. Each province and territory has its own particular set of programs, models, funding rules etc. Primary care is no different. Whatever the design for primary care in any particular jurisdiction, it is still viewed as a program on its own. It is still not connected to other parts of the health care system such as mental health services, long term care facilities, or home care programs.

Until a systems approach is taken that integrates the constitute elements of health care, primary care reform will likely be slow. Change is being attempted on a number of levels with somewhat competing demands for attention, resources and public support. It is difficult to see where the priority lies at present. This is combined with four year electoral cycles that negate political will to change the closer the election call becomes. Therefore, there are actually very short windows of opportunity to undertake reform, particularly when those affected are not entirely supportive of all aspects of the change.

Given these conditions, it is not surprising that primary care implementation has been slow and arduous.

8.0 Conclusions – Is it Impossible?

Despite the difficult policy environment, a number of factors have aligned which make the likelihood of success stronger as we begin 2004 than it has been historically. These factors include:

- there is an evidence-base for some of the elements of the reform packages;
- citizens are interested in comprehensive and accessible primary care services;
- a growing number of health professionals are expressing interest in new models of care and are participating in projects;
- the required supports are coming on-line, albeit slowly.

Perhaps the question now is not why has implementation been slow but rather how patient are we prepared to be?

9.0 References

1. Hutchsion B, Abelson J, Lavis J. Primary care in Canada: so much innovation, so little change. Health Aff 2001; 20(3):116-31.

2. Lamarche PA, Beaulieu MD, Pineault R, Contandriopoulos AP, Denis JL, Haggerty J et al. Choices for change: The path for restructuring primary healthcare services in Canada. Final Report. Ottawa: Canadian Health Services Research Foundation. November 2003.

3. Marriott J, Mable AL. Opportunities and potential. A review of international literature on primary health care reform and models. Ottawa: Health Canada. August 2000.

4. Alberta Health and Wellness. Primary health care as a model: lessons learned. August 2001.

5. BC Health Planning. Primary health care renewal in BC. www.healthplanning.gov.bc.ca

6. Manitoba Health. Primary health care reform in Manitoba. www.gov.mb.ca/health/primaryhealth.html

7. Department of Health. Primary health care renewal. www.gov.ns.ca/health/phcrenewal/vision/htm

8. Ontario Ministry of Health and Long Term Care. Primary care reform in Ontario. www.health.gov.on.ca/english/public/updates.archives/hu_03/docnurse/pricare

9. Prince Edward Island Department of Health and Social Services. Strategic Plan 2001-2005. www.gov.pe.ca

10. Ontario Health Review Panel. Toward a shared direction for health in Ontario. Toronto. 1987.

11. British Columbia Royal Commission on Health Care and Costs. Closer to home. Victoria: Government of British Columbia. 1991.

12. Premier's Commission on Future Health Care for Albertans. The rainbow report: our vision for health. Edmonton. 1989.

13. Minister's Implementation Committee. Health strategy for the nineties: managing better health. Halifax. 1990.

14. Canadian Medical Association. Physician Resource Questionnaire 2003. www.cma.ca

15. Canadian Institute for Health Information. Health care in Canada 2003. Ottawa: CIHI. 2003.

16. Knock M. Primary care demonstration project. Final report to the Health Transition Fund. Ottawa: BC Primary Care Reform Project. March 31, 2001.

17. Maxwell J et al. A citizens' dialogue on the future of health care in Canada. Saskatoon: the Commission on the Future of Health Care in Canada. November 2002.

18. Pollara. Health care in Canada survey 2002. Toronto: Pollara.

19. Pollara. Public input on the future of health care in Canada. Saskatoon: the Commission on the Future of Health Care in Canada. November 2002.

20. Fooks C and Maslove L. Understanding public views on concepts of population health and health determinants. Submitted to CPHI. September 2003.