



AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

UNIVERSITY OF NEW SOUTH WALES

APHCRI LINKAGE & EXCHANGE TRAVELLING FELLOWSHIP REPORT

Stream Four Report: Systematic review of comprehensive primary health care models

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SIGNIFICANCE FOR AUSTRALIA & LEARNINGS

The diversity of funding models in Ontario has enabled greater choice and flexibility for family physicians than is currently available in the Australian context. The comparison of different models provides additional evidence that a range of primary health care (PHC) models is needed to achieve PHC goals of quality, efficiency, access, and equity and to address differing patient as well as provider needs. The evidence that capitation models perform better on access is perhaps more significant for Australia than the findings for community health centres, as few centres in Australia include General Practitioners in the staff mix. The Ontario experience suggests that Australia would benefit from implementing a broader range of funding mechanisms to meet population health goals. The choice inherent in having a number of options has clearly been of benefit for both patients and providers and an important factor in their take up by family physicians.

The model of Family Medicine Groups in Quebec may hold considerable interest for the development of more integrated primary health care services such as HealthOne Centres in NSW, which aim to integrate GPs and community health services and GP Plus Health care Centres in South Australia. Given that most documentation relating to this initiative, including research and evaluation reports is available only in French, the initial contacts made during the Fellowship are a useful starting point for exploring international collaboration opportunities. This will be pursued by the Centre for Primary Health Care and Equity as part of undertaking the five-year evaluation of HealthOne.

The focus and investment in inter-disciplinary collaboration and the associated research agenda in a number of Provinces has the potential to inform Australian developments, including the move to more multidisciplinary team development in practices and linkages with other allied health professionals in independent practice.

CANADIAN CONTEXT

While Canada shares some similarities with Australia in terms of geography and demographics, a universal health insurance scheme (also known as Medicare), and concerns about cost and quality of primary health care services, there are important differences that have influenced primary health care reforms. Through the Canada Health Transfer, the bulk of health funding goes to the Provinces, which have constitutional responsibility for planning, development and

delivery of health services, subject to the principles of the Canada Health Act. This has resulted in considerable diversity between Provinces in how primary health care has developed.

Between the late 1990's-early 2000's, there were a number of reviews of the Canadian health care system, including the Romanow Commission which identified significant challenges such as fragmented health care delivery, little evidence that a 'system' operated, differing physician payment methods, services and outcomes and problems with access to primary health care services, due to a mixture of workforce shortages and mal-distribution⁸.

In recognition of the need for health care system reform, the Health Transition Fund (1997-2001) allocated \$150 million for projects to test and evaluate innovative ways to deliver health services. This was followed by the six-year \$800 million Primary Health Care Transition fund which was the first (and seemingly last) national investment designed to strengthen the PHC sector, with most of the money going to the Provinces. Since it finished, some but not all Provinces retain a commitment to reforming the sector, while others are focussing more on system wide responses to specific aspects of health care (for example chronic disease management).

It was acknowledged in the 1990's that Canada lacked research capacity and that there was a need to train the next generation of researchers and to build linkage and exchange mechanisms between researchers, decision-makers and practitioners. In response:

- The Canadian Health Services Research Foundation (CHSRF) was established to fund health services research in priority theme areas⁹ and to develop linkage and exchange capacity
- The Canadian Institute of Health Research¹⁰ (CIHR) and CHSRF jointly funded 12 Chairs for 10 years (2000-2010) to build future capacity, with common objectives of education, linkage and exchange, mentoring, and research¹¹.
- Five health service research training centres were funded, which were expected to include policy placements and explicit policy/research exchanges

The national Government also created a new permanent \$300 million per year program to establish a number of research professorships (Research Chairs).

PRIMARY HEALTH CARE REFORMS

The major focus of PHC reforms in Ontario, Quebec (the two largest Provinces) and Alberta has been the introduction of new service delivery models that involve a mixture of three major approaches:

- Networked general practices
- Alternative payment mechanisms
- Enhancing inter-professional collaboration

While there are important differences in how these models have been introduced, there are similar challenges in change management and developing more team-based and collaborative inter-disciplinary approaches. None of these Provinces have introduced meso-level organisational structures such as Divisions of General Practice to support the implementation of the reforms. From a research perspective (but not necessarily a policy perspective) this has been identified as a major barrier to sharing learnings and supporting practices and clinicians to implement the new models and ways of working.

⁸ Romanow Commission (2002) Building on Values: The Future of Health Care in Canada - Final Report.

⁹ One of which included Primary Health Care

¹⁰ The equivalent to the NH&MRC

¹¹ While none of these are designated PHC chairs, five are nursing and seven are generic health services research Chairs

3.1 ONTARIO

Ontario has been experimenting with a range of models since the mid 1970s, with the two earliest models being capitation funded groups of family physicians called Health Service Organisations (HSOs); and salaried and multidisciplinary community health centres (which include family physicians). More recently family physician centred models have included Family Health Networks (mixed funding) and Family Health Groups (FFS).

The newer models introduced in the late 1990s-early 2000s have built on and learnt from previous initiatives and developed in an iterative way. The Ontario Medical Association (OMA) has played an important role in bringing the membership along and their relationship with the Ministry of Health has been described as 'close', with the Government ensuring there is agreement and consensus with the OMA before introducing major changes.

Alternative payment mechanisms have resulted in financial gain for GPs and the minimal reporting requirements have avoided much of the administrative burden that remains a challenge in Australia. Funding has also been made available for administrative resources and to access professional expertise in, for example, governance. Findings from a recent comparison of these four models found that each offers benefits and drawbacks that attract physicians and patients with specific profiles and that a number of models are required to account for socio-demographic variations, and patient and provider needs. Generally salaried CHCs performed better than other models in relation to chronic disease management, prevention, health promotion and comprehensiveness; whilst capitation models (like HSOs) performed better on access. These findings are not inconsistent with other Canadian research¹².

Family Health Teams (FHTs), the latest model, are rostered capitation funded practices, which bring together family physicians, nurse practitioners and nurses as the core team, and often additional professionals including pharmacists, dieticians and mental health workers. Additional money is provided for physician leads and to support the employment of allied health professionals. This latter funding enhancement is one of the factors that distinguishes FHTs from earlier models which had a largely unfunded aim to encourage more interdisciplinary collaboration.

Family Health Teams will be expected to provide extended hours of practice, link with community organisations and have an emphasis on chronic disease management and preventive care¹³. This focus will be supported by incentives. FHTs have gone ahead rapidly with 150 being approved, (with about 2.5 million registered patients across 112 communities) and most are operational. While most are GP-led, some are community-led and others are based on a mixed governance model. There are different models for collaborative care and inter-professional teamwork, but in most cases other professionals are integrated into the practices.

In response to the need to assist practices with change management and team development, Quality Management Collaboratives are being funded across the Province to support implementation. Their initial focus will be on team development, training, and community partner linkages. A prospective five year evaluation of FHTs (\$500 million program), compared with other models, is being put together at present.

3.2 QUEBEC

Quebec Province has taken a quite different route. The two major models prior to the most recent reforms were salaried community health centres (known as CLSCs) and FFS family

¹² Lamarche PA .et al (2003) Choices for Change: The path for Restructuring Primary Healthcare Services in Canada

¹³ Ontario ministry of Health and Long Term Care. Introduction to Family Health Teams.

physicians. The Clair Report¹⁴ critiqued this parallel system and recommended that the models be integrated.

Unlike Ontario, Quebec elected for wholesale, rather than incremental reform with the implementation from 2002 onwards of Family Medicine Groups (FMGs) which are a partnership between a number of family physician practices and CLSCs. FMGs are capitation funded, generally comprise eight to 10 family physicians and nurses, involve voluntary patient registration (with individual GPs), and are expected to provide extended hours access.

Nurses from the local CLSCs are co-located on a permanent basis with the FMG with functional authority to the FMG, but financial responsibility remaining with the CLSC. Nurses have an enhanced role in prevention and chronic disease management. Like FHTs they have been popular, and by 2007 there were 127 established involving 1,500 GPs and 230 nurses, and over one million registered patients. Most are private clinics, but some are former CLSCs, and hybrid models. The Government has also provided considerable new funding (from the PHCTF) to support their establishment. At the same time, CLSCs have also changed, with mergers, a loss of autonomy and Government requirements that they provide a core range of services. While previously they were semi-autonomous organisations and governed by lay boards, the changes have brought them under a single governance model as part of hospitals and long term care.

The FMG evaluation found early discontent among both family physicians and nurses with the new arrangements as they were introduced, but that these had largely settled down after two years. While some FMGs are well integrated, others remain less so, and similar to the implementation of FHTs in Ontario, there is a continuing need for support and help to develop more integrated ways of working across and within the groups.

3.3 ALBERTA

The PHC reform focus in Alberta has been on establishing Primary Care Networks (PCNs) across the Province under the auspice of the Primary Care Initiative. The Provincial Government (Alberta Health and Wellness), the Alberta Medical Association and the Regional Health Authorities are all parties to this initiative. In essence PCNs are networks of family physicians and other primary care providers. They have been rolled out with some overarching principles, but the considerable diversity makes comparisons difficult, not helped by a lack of consistent/standard outcome measures. Across the Province, there are 26 networks involving 1245 family physicians. The greatest take-up has been in Calgary, where 40-70% of family physicians are involved. However like the FHTs, there is no data readily reported on the involvement of other primary health care providers.

¹⁴ Quebec's Health Review. The Clair Commission (2001)