Primary care reform in Canada: Getting it right

Across the country there is general recognition that today’s framework for primary care is not working and that dramatic change is needed to provide better support to physicians and to improve access to quality care for Canadians. Indeed, the Commonwealth Fund’s international survey of primary care physicians indicates that Canada remains below average on 19 out of 28 featured indicators of care, categorized across access to care, coordination of care, information technology adoption and performance measurement.¹

Ontario is the latest Canadian province to propose changes to primary care and the way it is structured and governed. Local Health Integration Networks (LHINs), Ontario’s 14 regional health planning, funding and integration entities, will assume responsibility for the provision of all primary care and the oversight of all primary care practitioners. Quebec is shifting resources and care away from their CLSCs (Centre Local de Services Communautaires) to GMFs (Groupe de Medecine Familiale) in an attempt to deliver care more equitably and cost-effectively. British Columbia has developed a strategic policy framework for primary and community care (one of several policy papers on the subject) as part of its ongoing efforts to bring care into the community. And Alberta has a long history of primary care policy innovations, being the first province to incent the use of EMRs and also the most advanced in enacting scope of practice changes with pharmacists, for example.

Are structural reforms enough?

Will these reforms make a difference? At a high level they might, but there is a risk they will breed cynicism among primary care providers and not necessarily lead to better care for Canadians. On the plus side, they may reduce some care siloes and make it easier for primary care providers to work in inter-disciplinary teams to deliver care – both worthy objectives. However, structural reforms alone will not answer the fundamental question asked by primary care providers: how will these changes help me deliver better care to my patients? And from a patient perspective: how will these changes allow me to access care when, where and how I need it?
This article considers companion reforms to these structural ones that are essential to truly address key issues highlighted by providers and patients:

1. making it easy for primary care providers to seamlessly coordinate care with social and community services and with specialists
2. giving every Canadian timely access to primary care, particularly on evenings and weekends
3. equipping patients to manage their own health information
4. engaging pharmacists as members of the primary care team
5. incenting and accelerating healthcare innovation in Canada

Provider concerns

Coordinating care with community services and specialists

For primary care providers in Canada, there are a number of barriers to delivering effective, comprehensive care to their patient populations.

- **Formal outcomes accountability is absent** from day-to-day physician practice. While all physicians want to provide the best possible care to their patients, they are not held accountable for achieving specific health outcomes, nor are they equipped with the data or performance reporting to do so effectively as individual practitioners and relative to their peers.

- **Care coordination across providers** remains a major issue, as a recent report by Health Quality Ontario (HQO) highlights.1 Ideal care coordination requires effective team communications, timely information flows and smooth care transitions. The HQO report notes particular deficits in coordination between primary care and social service and community providers. Only 36% of Ontario family doctors responding to the survey said it was easy to coordinate care in this regard. In Saskatchewan, the comparable number was 55%.

- **Access to specialists** is another major issue for primary care. Long specialist wait times or even knowing which specialist is appropriate for a referral can both delay care. Specialist access should be ripe for reform. A recent pilot in Champlain LHIN in Eastern Ontario, described below, is providing timely and virtual specialist referrals for primary care practitioners and is being well received.

Patient concerns

**Access to care and personal health information**

With notable exceptions (Vancouver being one), most Canadians who want a family doctor have one. However, getting timely access to primary care continues to be an issue, particularly after-hours and on weekends. Sometimes reassurance on how to deal with a sick child is all that is needed, but 7x24 call schedules, e-mail and good telehealth options are not routinely available.

Healthcare in Canada has been very slow to adopt innovations that have transformed other sectors such as financial services and travel. Online access to financial records allows Canadians to do their banking at their convenience. Home health monitoring for blood pressure and other key health indicators can help people manage their own conditions, but to call for professional back-up when they need it.

Canadians are also interested in managing their own health information and Saskatchewan is leading the way.

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**Eastern Ontario’s eConsult Service**

The web-based medical consultation tool, known as Champlain BASE eConsult Service, is the result of collaboration between the Ottawa Hospital, Bruyère Research Institute, the Champlain Local Health Integration Network, and the Winchester District Memorial Hospital. The solution ranked second in Canada Health Infoway’s 2015 ImagineNation e-Connect Impact Challenge for e-Requests for Services and can reduce wait times for specialty medical advice from months to an average of two days.2

Currently more than half of primary care providers in Eastern Ontario are registered users of the service.
Saskatchewan’s Citizen Health Information Portal

Saskatchewan’s Citizen Health Information Portal (CHIP) pilot program, which builds on work initiated in Alberta, integrates personal patient records with the province’s existing eHealth system – a pharmaceutical, chronic disease management and general health data repository, giving patients a real-time view of their overall health.

The 2016 pilot currently provides more than 1,000 citizens with online access to their own personal health information, as well as their children’s. They can access their medical files through a personalized log-in and augment them with key data, such as health metrics, emergency contacts, allergy information and reminders to take medication. The information can be used by individuals when travelling, or when working with physicians who are unfamiliar with their health history.

Collingwood: pharmacists as members of the primary care team

Medication management is another challenge for both patients and practitioners. Pharmacists can help, but only if they are connected to current and comprehensive drug information. The experience of Collingwood, Ontario is instructive. A pilot project, initiated in 2009, electronically connected seventeen pharmacies in Collingwood, Wasaga Beach, The Blue Mountains, and Clearview, along with 24 family physicians and four nurse-practitioners from the Georgian Bay Family Health Team. This project has been so successful that physicians and pharmacists have continued it to this day. It allows electronic prescribing as well as medication reconciliation – both important tools for quality care and patient safety.

Generally speaking, pharmacists are underutilized members of the primary care team. They can often dispense quick “retail” advice and avoid a primary care or emergency department visit.

Unleashing Innovation

What the US and Israel can teach Canada

Canada’s primary care system, and the other parts of the system with which it interacts, is stuck in a time-warp, and highly resistant to change. Unfortunately, high-level structural changes such as those introduced recently in Quebec and Ontario, will not address the fundamental problem of adapting quickly and effectively to evolving provider and patient needs.

We need to create a healthcare innovation engine and look to other jurisdictions that have made this work. The United States and Israel offer interesting case studies.

In the US, in recent years, the Centers for Medicare and Medicaid Services (CMS) has given hospitals, physicians, and other providers incentives to form accountable care organizations (ACOs), with responsibility for outcomes and costs held by a single entity rather than diffused across independent providers. This has unleashed innovations in delivering value-based (vs transaction-based) care.

Spurred by “meaningful use” and associated programs, providers are reimbursed based on their use of technology; not on its implementation. Patient reimbursement is being remodelled so providers get paid based on achieving clinical outcomes, and not based on the number of procedures performed. All of this is driving innovation as providers look to technology to help them deliver better care with better results.

Sadly, this innovation is not happening enough in Canada. A cross-border comparison makes the point: Canadian healthcare innovators are routinely advised to take their ideas to the U.S. market and not to bother with Canada because it is too difficult to bring innovation to our hidebound medicare system. What a shame.

TELUS participated in Ontario’s recent trade mission to Israel, a country known to have one of the most progressive primary care services in the world. One highlight of the trip was a tour and time with Clalit executives. Clalit is one of four Health Maintenance Organizations (HMOs) that collectively provide comprehensive healthcare services for all Israelis. Their services are primary-care led, innovative and highly responsive to the needs of their members. Innovation is spawned by design – the three HMOs (the fourth serves the orthodox community) compete fiercely for patients and market share, because that is the basis on which they are paid.
Delivering an excellent patient and provider experience through innovative use of technology helps them keep and attract both patients and providers. Israel has invested intensively in online personal medical records that allow patients and specialists to engage in discussion, treatment and follow-up and have also developed innovative telemedicine programs. As noted by Dr. Mark Britnell in his recent book, if Clalit was based in the US, the entire world would have heard of its success and been studying its formula.\(^iv\)

Incenting Canadian healthcare innovation

How do we apply these lessons in Canada? We first need a climate with the right incentives and from there we need to let local innovation flourish. Smaller provinces, at least by population, such as Saskatchewan are showing us the way. In more populous provinces, regional health authorities and LHINs should be encouraged and incentivized to experiment with a focus on improving patient outcomes and provider and patient satisfaction. We need to take “pilots” like the Champlain LHIN specialist program or British Columbia’s home health monitoring initiatives and scale them to a system level.

Doctors and homecare workers alike will be rapid adopters of innovations based on mobile technology if they see these innovations adding value to how they deliver care. Often, just using the power of technology to feed information back to primary care providers on how they are performing in delivering good care to their patient population will lead to immediate improvements.

Canada is seen as a laggard internationally in effectiveness of primary care delivery. It is past time to return Canada to a leadership position. There is an important new role for government in this mix – to shift emphasis from procurement of large-scale health IT to, instead, enabling new markets and spurring innovation that will allow primary care to flourish for providers and patients alike. Ontario sets an example with the newly created 2015 appointment of a Chief Health Innovation Strategist. The role, in part, is to streamline the adoption of health care innovations across the health system, shift to procurement practices that focus on outcomes, such as fewer hospital readmissions, and invest in assessing emerging innovative health technologies to get products to market faster. Certainly a step in the right direction.
References

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