Looking backward to move forward
Insights from Canadian primary healthcare reform evaluations

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Canberra, ACT, Australia

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Looking backward

Primary healthcare (PHC) in Canada
• 13 provincial and territorial health systems
• A publicly-funded and privately-provided medical care
  • Mostly fee-for-service reimbursement
• Mostly privately-funded allied health and social services
  • 35-40% of health expenditure is private – below 2% for medical
• A fairly homogeneous model of practice – the solo or small medical group
• Absence of rostering or registration of patients
Looking backward

Primary healthcare (PHC) in Canada
- 20-30% of patients not affiliated to a practice or doctor
- Increasing rates of orphan patients due to closing of clinics
- Problems of access to primary care, mostly for younger males and children
- High rates of emergency department consultations
- Reduction of uptake of general practice as a medical specialty
- Increasing number of patients followed by specialist for primary care
Among respondents that had a hospital emergency room visit in the past 2 years:

Emergency room visit was for a condition that could have been treated by the regular doctor, countries and provinces, 2010

Among respondents who were advised to see or decided to see a specialist in the past two years:

Waiting time (number of days) to see a specialist, countries and provinces, 2010

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aphcri.anu.edu.au
Have been admitted to the hospital overnight in the past 2 years, countries and provinces, 2010

<table>
<thead>
<tr>
<th>Country</th>
<th>Yes %</th>
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<tbody>
<tr>
<td>Canada</td>
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“Primary care traditionally seen as a distant observer of reforms of hospital and community health centres”
to move forward

Primary healthcare (PHC) reform is currently under way in various Canadian provinces
  • Recognition of the central role of primary healthcare into healthcare systems’ performance

Emerging models and policies are at various levels of implementation across jurisdictions
  • A natural experiment of change in PHC

Patients roster, groups, multidisciplinary, blended funding, clinical governance, quality improvement, local coordination information systems

• There has been some evaluations of these reforms, few cross provincial analyses
  – Lack of interprovincial studies;
  – Variations in designs and measurement instruments;
  – Few documentation of the impact of contexts on the implementation and impact of PHC reforms

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Our objectives

Using qualitative deliberative synthesis techniques to better understand primary care reform and its impact on people, providers, organisations and systems. Outlining the impact of context on policy prescriptions.

A policy analyses of PHC reforms in ten provinces and three territories

- Examines primary health care reform efforts in Canada during the last decade drawing on:
  - descriptive information from published and grey literature
  - and from a series of semi-structured interviews with informed observers of PHC in Canada

(Hutchison, Levesque, Strumpf, Coyle 2011)

Innovative and Diverse Strategies Toward Primary Health Care Reform: Lessons Learned from the Canadian Experience

Brian Hutchison, Jean-Frédéric Levesque, Erin Strumpf, and Natalie Coyle

McMaster University, University of Montreal, McGill University
A deliberative synthesis of PHC reforms evaluations in five provinces

- Examines the impact of models and factors facilitating reform through:
  - Case studies of provincial reforms
  - Deliberative synthesis involving reform evaluations researchers as well as decision-makers

(Levesque, Burge, Haggerty, Hogg, Katz, Pineault, Wong 2012)

Various quantitative and qualitative evaluations

- Primary care reform evaluation in Nova Scotia (Burge and Lawson)
- Studies of Family Medicine Groups implementation in Quebec (Haggerty, Pineault, Lamarche, Beaulieu, Levesque)
- Comparison of primary care models in Ontario (Hogg, Russell, Dharouge, Green)
- Assessment of chronic care in four intervention practices in Manitoba (Katz)
- Evaluation of primary care experiences in British Columbia (Wong and Watson)
### Four measurement perspectives

1. Capturing contextual influences
2. Measuring the nature of reform efforts
3. Understanding the levers of reform
4. Evaluating impact of reforms

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#### 1. Capturing contextual influences

- **A felt urgency for change**
  - Performance reports highlighting Canada’s deficits
  - A tired and de-motivated workforce

- **A history of separate community health centres and primary care providers**
  - Multi-disciplinarity is outside of primary care and doctors have resisted working inside a community orientation

- **A supportive socio-political context**
  - Recognition that primary care must be supported
“**A strong desire for change** has been observed in many provinces. Physicians are seeing their workloads increase because of the shortage of human resources relative to the increased complexity of clinical cases. Many are now more **receptive to changes.**”
Leaving medical practice within the next 5 years, countries and provinces, 2009

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Other health care providers in the practice, countries and provinces, 2009

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“If the policy environment has historically been neutral towards primary care and professionals generally opposed to the redesign of their practice, it is clear that the current socio-political context has changed throughout the country.”

2. Measuring the nature of reform efforts

- **Model-based reforms**
  - Ontario and Québec implementing a variety of practice models (organisational types)
  - Some efforts at modifying reimbursement models

- **Principle-based reforms**
  - Nova Scotia and British Columbia investing in quality improvement initiatives (best practice)

- **System integration**
  - Alberta, British Columbia and Québec implementing coordination organisations (networks and divisions)
### TABLE 1
System-level Primary Health Care Initiatives

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**Hutchison, Levesque, Strumpf, Coyle 2011**
### TABLE I

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Note: A + indicates a system-level initiative; an empty cell indicates the absence of a system-level initiative. ND = no data available.

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(Hutchison, Levesque, Strumpf, Coyle, 2011)
3. Understanding the levers of reform

• Coercive policies and incentives
  – Provincial governments have been the main drivers
    • Legislation supported expanded roles for other professionals
    • Best practice characteristics parts of contractual agreements
  – Funding of reform is crucial
    • Too little thwarts efforts and demoralizes
    • Too much proves overwhelming and unsustainable

• Normative influences
  – There was a few case of active lobbying by professional
  – Support and engagement of professional leaders was essential

• Mimetic influence
  – Presence of champion and an incremental process
“Few changes have been imposed on providers and it is more a discourse of incentives or demonstrations that is currently seen in many provinces. In many cases, the need to treat physicians as partners in reforms was identified as the key to success.”

“...in every province, the presence of certain champions among primary care providers has been crucial and they have often acted as role models for other physicians in order to generate the necessary uptake for new models or initiatives to grow.”
4. Impacts of reforms

- Most benefits of the reforms so far seem to have occurred with regards to:
  - patients’ affiliation with a usual source of care,
  - some benefits on the experience of care of patients,
  - higher workforce satisfaction

- Emerging evidence of the impact of new models on prevention and management of chronic diseases:
  - recognition of the value of older models, such as CHCs, on complex patients care
  - limited evidence of impact on quality of life and health outcomes

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General practice assessment survey scores by subdimensions across organisational types at baseline

- Accessibility
- Reception
- Continuity
- Communication
- Nursing

Solo provider, Private group practice, Family medicine group/network clinic, Local community health centre/family medicine unit
Figure 1 : Évolution du nombre de GMF et de médecins participants (MD) au Québec de 2002-2003 à 2010-2011


(Commissaire à la santé et au bien-être 2011)

Figure 1. Évolution du nombre et du pourcentage de personnes inscrites auprès d’un médecin affilié à un GMF


(Commissaire à la santé et au bien-être 2011)
### Overall view of the health care system, Canada’s respondents (practice), 2009

<table>
<thead>
<tr>
<th>Practice setting</th>
<th>Solo practice</th>
<th>Group practice</th>
<th>Family medicine group</th>
<th>Local com. health centre</th>
<th>Hospital / Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25%</td>
<td>20%</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
</tr>
</tbody>
</table>

### Improvement of the quality of medical care, Canada’s respondents (practice), 2009

<table>
<thead>
<tr>
<th>Practice setting</th>
<th>Solo practice</th>
<th>Group practice</th>
<th>Family medicine group</th>
<th>Local com. health centre</th>
<th>Hospital / Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>21%</td>
<td>16%</td>
<td>15%</td>
<td>15%</td>
<td>10%</td>
</tr>
</tbody>
</table>

### Disease burden across types

- **Solo**
  - Average elderly population
  - Low elderly population
  - Lower multimorbidity
  - Low home-care reception

- **Private group practice**
  - Low elderly population
  - Better perceived health status
  - Lower multimorbidity
  - Low home-care reception

- **Family medicine group / Network clinic**
  - Average elderly population
  - Worse perceived health status
  - Average multimorbidity
  - Average home-care reception

- **Local community health centre / Family medicine unit**
  - High elderly population
  - Worse perceived health status
  - High multimorbidity
  - High home-care reception

- **Specialist**
  - Average elderly population
  - High elderly population
  - High multimorbidity
  - High home-care reception
TABLE 3. Patient-reported CPS coverage by type of regular source of PHC. Patients with a regular source of PHC: Montérégie, Quebec, Canada, 2005

<table>
<thead>
<tr>
<th>Regular source of PHC</th>
<th>Overall (PCP) core ≥ 75%</th>
<th>Healthy diet counselling (PCP)</th>
<th>Tobacco use screening (PCP)</th>
<th>Tobacco cessation counselling (PCP)</th>
<th>HBP screening (PCP)</th>
<th>HbA1c test (W 18-69)</th>
<th>PSA test (M 50-79)</th>
<th>Colonoscopy screening (55-79)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private/Group</td>
<td>62.3</td>
<td>40.3</td>
<td>55.1</td>
<td>66.8</td>
<td>89.4</td>
<td>84.7</td>
<td>84.1</td>
<td>29.1</td>
</tr>
<tr>
<td>Private/Solo</td>
<td>44.8</td>
<td>42.7</td>
<td>58.2</td>
<td>75.5</td>
<td>96.2</td>
<td>87.9</td>
<td>83.6</td>
<td>40.3</td>
</tr>
<tr>
<td>Mixed/FMG</td>
<td>45.3</td>
<td>41.9</td>
<td>59.4</td>
<td>68.6</td>
<td>90.5</td>
<td>87.1</td>
<td>82.0</td>
<td>36.6</td>
</tr>
<tr>
<td>Public/CLSC-PMU</td>
<td>55.1</td>
<td>44.5</td>
<td>64.1</td>
<td>70.7</td>
<td>88.3</td>
<td>91.6</td>
<td>87.0</td>
<td>58.3</td>
</tr>
</tbody>
</table>

* p < 0.05
PCP = primary care physician.
HBP = high blood pressure

(Provost et al. 2010)
v2  J'ai noté "agrandir le stackbar...vous vous souvenez de quoi il s'agissait?"

vlemieux, 28/04/2010
Average percentage gap with mean scores of PACIC subdimensions across organisational types (12 months)

(Levesque et al. 2012)

Percentage of severe patients followed by specialists for their chronic illness (typology)

(Levesque et al. 2012)
Looking forward

• Canadian provinces and territories are experiencing an acceleration of primary care reforms
• Understanding their diversity and the levers that facilitate their implementation will help us better guide the continuation of reforms
• Change is happening where synergies between policy and professional leadership align
• It is starting to translate into population level impacts

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