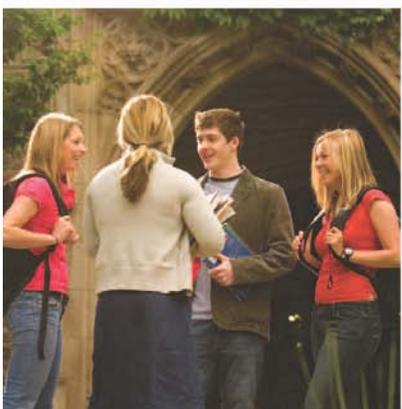




DIALOGUE
SUMMARY



11 MAY 2009

EVIDENCE >> INSIGHT >> ACTION

**Dialogue Summary:
Strengthening Primary Healthcare in Canada (Dialogue 1)**

11 May 2009

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at the regional/provincial level and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

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Dialogue

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Table of Contents

SUMMARY OF THE DIALOGUE 4

SUMMARIES OF THE FOUR DELIBERATIONS..... 5

 DELIBERATION ABOUT THE PROBLEM 5

 DELIBERATION ABOUT POLICY AND PROGRAMMATIC OPTIONS..... 6

 Option 1 - Building on the strong base of physician-led primary healthcare by supporting the expansion of chronic disease management in physician-led care through a combination of electronic health records, target payments, continuing professional development, and auditing of their primary healthcare practices 6

 Option 2 - Building on promising pilot team-based models of primary healthcare by supporting the targeted expansion of inter-professional collaborative practice..... 6

 Option 3 - Undertaking a major series of reforms to support the use of the Chronic Care Model in primary healthcare settings, which means a combination of strategies focused on self-management support, decision support, delivery system design, clinical information systems, the health system, and the community 7

 Considering the full array of options..... 7

 DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS 8

 DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES..... 8

SUMMARY OF THE DIALOGUE

A number of dialogue participants concluded that the underlying policy issue needed to be reframed. Having originally begun the dialogue with a focus on improving access to primary healthcare, they concluded that the real issue lay in ensuring the sustainability of Canada's publicly funded health systems through a reorientation of community-based primary healthcare systems. The envisioned reorientation involves moving away from primary healthcare systems built around providers and moving towards systems built around the healthcare needs of patients and their families.

Drawing on the input from the evidence brief, their own knowledge and experiences, and the insights from the deliberations, a number of dialogue participants concluded that:

- there is great variation in primary healthcare systems across Canada and a lack of a common vision for a primary healthcare system;
- primary healthcare systems in Canada are underperforming relative to the systems in most of the countries to which we commonly compare ourselves;
- primary healthcare systems in Canada are not financially sustainable as they are currently designed, and perhaps these systems should not be sustained in their current forms given how they have failed to deliver the quality of care and outcomes that Canadians expect of them, and as anticipated in the two health accords of 2003 and 2004;
- Canada needs a national patient-centred primary healthcare strategy that is supported by high-level political leaders – ideally First Ministers – with a pan-Canadian vision; this strategy should articulate the structural features of primary healthcare systems that, under a pan-Canadian vision, would be commonly adopted across all federal, provincial, and territorial publicly funded health systems;
- synthesized research evidence is available, and should inform decisions about the necessary common structural features, as well as later decisions within each publicly funded health system about those structural features that meet unique local needs and are well-suited to unique local contexts;
- a broad-based national coalition of stakeholders, including those provider groups that are ready for change, should lead the push for a national primary healthcare strategy; and
- there are lessons to be learned about how best to (and how not to) build the case for such a strategy, from existing smaller-scale reform efforts in Canada which are often focused on single diseases, from other domains within Canada which have had initial success with at least one level of government, and from other countries which have demonstrated success at jurisdictional levels.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

Participants generally agreed with the three take-home messages about the problem as they were summarized in the evidence brief:

- chronic diseases now represent a significant share of the common conditions that the primary healthcare system must prevent or treat;
- Canadians’ access to cost-effective programs, services, and drugs is not what it could be, either when they themselves identify the need for care or (more proactively on the part of healthcare providers) when they have an indication or need for prevention or treatment, particularly chronic disease prevention and treatment; and
- health system arrangements have not always supported the provision of cost-effective programs, services, and drugs.

They also agreed with the point made in the evidence brief that one key dimension of the broader context for the problem is that Canada’s publicly funded health systems are distinguished by a private delivery / public payment “bargain” with physicians, but no similar bargain with other healthcare providers, with teams, or with organizations other than hospitals. Some dialogue participants argued that this bargain has left us with a static system that is built primarily around a single group of providers (a “silo”), not a dynamic system that is built around the needs of patients (and populations) and that fosters the dynamic substitution of providers when required by their patients’ (or population’s) needs.

Dialogue participants noted a number of other key features of the context:

- primary healthcare systems, particularly fee-for-service remuneration models, are largely designed to remunerate physicians for reacting to acute illnesses, and not to proactively prevent and manage chronic diseases or long-term ill health more generally;
- primary healthcare systems, particularly decision support and clinical information systems, are largely designed to function using a stable body of knowledge, and not to incorporate the continual, dramatic expansions of knowledge in real time;
- primary healthcare systems have experienced many isolated pilot programs, some of which have influenced larger-scale reform at a local or regional level, but systems have not always learned from these

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

- 1) it addressed an issue currently being faced in Canada;
- 2) it focused on different features of the problem, including (where possible) how it affects particular groups;
- 3) it focused on three options (among many) for addressing the policy issue;
- 4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, three options for addressing the problem, and key implementation considerations;
- 5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible options for addressing it;
- 6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
- 7) it ensured fair representation among policymakers, stakeholders, and researchers (although this particular dialogue did not have as full representation as would typically be the case);
- 8) it engaged a facilitator to assist with the deliberations;
- 9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: “Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed”; and
- 10) it did not aim for consensus.

Participants’ views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue and by those who review the dialogue summary and the video interviews with dialogue participants.

experiments using a common approach to evaluation or built upon them in coordinated and integrative ways;

- the interface between primary healthcare systems and specialized care systems has grown more complex as continued specialization has led to a profusion of disease-specific clinics; and
- education and training programs have largely prepared health professionals for the current primary healthcare system (working in silos), and not for the types of practice environments that involve collaborative teams; some education in collaborative practice is taking place, but many students are disappointed to find that opportunities for true collaborative practice in the real world remain quite limited.

DELIBERATION ABOUT POLICY AND PROGRAMMATIC OPTIONS

Dialogue participants discussed three options that had been “worked up” as concrete examples of what could be done differently.

Option 1 - Building on the strong base of physician-led primary healthcare by supporting the expansion of chronic disease management in physician-led care through a combination of electronic health records, target payments, continuing professional development, and auditing of their primary healthcare practices

One participant pointed out that this option is effectively the approach that was adopted by a few provinces in their negotiations with provincial medical associations several years ago, and that an intensive effort should be put into examining the impacts of these changes. Others noted that this approach has been supported by some physician groups, in part out of a recognition that physicians “can’t do it all on their own.” They also observed that it requires a definition of a team, adding that a diabetes educator “does not a team make.” A number of participants rejected this option out of hand on several grounds: 1) it focuses on the management of disease in individuals but less so on the implementation of disease prevention and health promotion strategies, and much less still on improving the health of populations overall; and 2) it focuses on some process improvements but leaves a major potential process improvement – the dynamic substitution of providers when required by patients’ (or population’s) needs – off the table.

Option 2 - Building on promising pilot team-based models of primary healthcare by supporting the targeted expansion of inter-professional collaborative practice

Several participants noted the lack of a strong evidence base about the effectiveness of collaborative practice teams for a broad range of chronic diseases given the relatively recent introduction of these teams, the diversity of teams that have been studied (many were likely physician-led teams, not collaborative practice teams), and the weak designs used in the studies that examined the teams. One participant noted, however, that some jurisdictions, such as Québec, have a long history of collaborative practice teams (CLSCs), yet they seem to be moving away from them. The rationale for this change and the lessons learned should be examined carefully. Another participant pointed out that other jurisdictions, such as Saskatchewan, have well established community health centres in select cities. The reasons why this model was not widely adopted in such jurisdictions should also be examined carefully.

Several participants also noted the lack of strong evidence about the optimal composition of collaborative practice teams in primary healthcare in general. They also noted that it may be possible to develop minimum common structural features that are required across all publicly funded health systems and that modifications may be needed in relation to unique local needs and contexts. One participant noted the strong concordance

between a collaborative approach and how First Nations, Inuit, and Métis populations strive to organize their programs and services. Another participant noted that the key part of the descriptor is collaborative practice, not inter-professional teams, because the teams may include individuals who have not historically been deemed “health professionals.”

A number of features of collaborative practice were identified as warranting further clarification: 1) how does accountability work in a collaborative practice team comprised of individual health professionals, each of whom has their own professional accountabilities and roles, and yet with an emphasis on shared decision-making across team members; 2) how does accountability work in large urban populations where links to local communities and attention to population health needs are more virtual than real; and 3) how does one ensure that collaborative practice is used as a substitute for current care and not merely as an add-on service, and whether a requirement for rostering all patients is a pre-condition for ensuring the dynamic substitution of collaborative practice teams where appropriate.

Option 3 - Undertaking a major series of reforms to support the use of the Chronic Care Model in primary healthcare settings, which means a combination of strategies focused on self-management support, decision support, delivery system design, clinical information systems, the health system, and the community

Many participants highlighted aspects of the Chronic Care model that they saw as central to the future of primary healthcare, including features such as supporting self-management and clinical information systems, and that had also been discussed as part of Option 1. They also noted the lack of a high-quality systematic review documenting that the whole (i.e., the entire Chronic Care Model) is greater than the sum of its parts (i.e., its six features). However, some participants noted that the different features of the model should be explicitly assessed in terms of whether they should constitute some of the structural features of primary healthcare systems that are common across all federal, provincial, and territorial publicly funded health systems. One participant noted that a limitation of the model is that it is about redesigning healthcare to manage chronic disease in individuals once the disease has developed, and much less about preventing illness in populations.

Considering the full array of options

Before discussing the full array of options together, a few participants noted that there will always be a role for alliances with other sectors, both for disease prevention and health promotion (e.g., smoking or obesity campaigns) and for broader efforts to promote health and well-being (e.g., community services but also many other domains that have an impact on the determinants of health). Participants debated whether healthcare systems should still play a lead role when the response to identified problems can more appropriately come from elsewhere.

A large number of participants supported a combination of Options 2 and 3, recognizing that population-based, needs-driven collaborative practice models are themselves the type of “delivery system design” envisioned as one key feature of the Chronic Care model. This support also derives from the recognition that collaborative practices need to embrace many features of the Chronic Care Model whether or not the practices are addressing chronic disease per se, such as supporting self-management and clinical information systems (i.e., electronic health records, although it was pointed out that ideally these records would incorporate not just healthcare data but data about the determinants of health). In saying this, however, many participants noted that physician-led practices and physician-led team practices are likely to remain part of our system for a long time to come, so new primary healthcare approaches will need to collaborate with these existing practices while striving to ensure that it is not only complex care that is handled through collaborative practice models. One participant also noted that it will be important to keep in mind some of the criticisms of

collaborative practice models, most notably that some patients perceive that they can no longer see their physician. Other participants noted that collaborative practice models can be virtual. Co-location is not necessarily a requirement.

Many participants also noted the importance of establishing accountability for all primary healthcare practice models, that rostering was a pre-condition for the measurement of performance, and that performance indicators needed to address both processes of care and outcomes. Such accountability is needed in order to ensure that primary healthcare systems deliver the quality of care and outcomes that Canadians expect of them, and at a cost that is financially sustainable. Two participants noted that investments in this hybrid approach may need to be targeted in order to ensure that it achieves value for money.

The rationale for choosing among options was not always clearly articulated by dialogue participants. Some invoked values, others research evidence, and still others their own knowledge and experience in other sectors (e.g., nursing in the acute care sector). No participants explicitly highlighted likely stakeholder support or opposition as a key factor in their decision.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

While few participants were overly troubled by the barriers identified in the evidence brief, several pointed out repeatedly that physician-led care will be with us for a long time and, while physicians have the potential to influence how patients perceive reforms that physicians do not like, some physician-led care, particularly among more recent graduates, is moving more towards collaborative practice even if that practice remains notionally physician-led. Most participants felt that primary healthcare systems needed to be built around patients or populations, not around providers or even around teams of providers. One participant noted that a big problem with our current systems is that healthcare providers can exclude people from care, which should be more difficult with a redesigned model.

One participant pointed out the paradox that additional resources might be needed to entice physicians into new models, yet it is when financial crises happen that real change can sometimes be engineered. Another participant noted that a province-by-province assessment of local success stories and attitudes among different groups could inform a targeted approach to raising awareness among key constituencies.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

Many participants agreed that moving forward on collaborative practice models requires high-level political commitment. “It needs to be driven by leaders” who can clearly articulate the public interest. Several participants argued that this commitment has to come at the highest level, with First Ministers being the ones to champion reform. Getting First Ministers on board will require demonstrating that change will help to sustain the system and will not create a political backlash among providers and the public.

Demonstrating that change will help to sustain the system requires “stories, eloquently told.” To paraphrase one participant: “no Health Minister would want to be unprepared for a pandemic, so how can we help to create a sustainable healthcare system that is well prepared for the mounting burden of chronic diseases.” Several participants noted that there are lessons to be learned about how best to build the case, including negative examples such as the repeated failures to reform primary healthcare in the past, as well as mixed positive/negative examples like the national cancer strategy and the Kelowna Accord both of which initially garnered support but have not been widely taken up at the provincial and territorial levels or fully

implemented. Another participant suggested that Health Ministers might benefit from being exposed to a simulation of “what would have happened if we’d acted on the vision of the Lalonde report (1974).”

Guarding against a political backlash requires finding allies among physician leaders but also among many other professional groups, charities focused on chronic diseases, and political leaders among First Nations, Inuit, and Métis populations, among others. It also requires attention to the reality that many Canadians have a general practitioner / family physician and are generally happy with the care they receive. Contrasting this care to the care they would receive in other healthcare systems may be one way to show them that they could raise their expectations and support needed changes in Canada’s healthcare systems.