Respiratory Block

Individual & Population Health, 2002 March 19, 13:30-15:30

PRIMARY HEALTH CARE IN THE HEALTH CARE SYSTEM

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OBJECTIVES

The Medical Council of Canada "Objectives of the Considerations of the Legal, Ethical and Organizational Aspects of the Practice of Medicine" include the following objectives under General Organization:

6.3 Support Services in the Community
Competent candidates will demonstrate knowledge of and how to access services with respect to:
– The nature and role of provincial programmes and services (Public Health Departments and Social Service Agencies).
– Mechanisms and organizations which provide social services related to health.
– The co-ordination of services (ambulatory; in-patient; chronic care; rehabilitation services).
– Individuals able to assist with access to community services (home care co-ordinator, etc.)

6.4 Organization of Medical Practice
Competent candidates will demonstrate the knowledge, skills, and attitude with respect to:
– The advantage/disadvantages of different practice situations.
– The different remuneration models available in fee-for-service, salaried practice, and capitation (including managed care).

We have added the following additional objectives for this University of Ottawa session:

1. Know the definition of primary health care, its scope within Canada and internationally, and its relationship to secondary and tertiary care.
2. Be familiar with the major reforms currently proposed for primary health care in Canada.

PBL CASE: Sharon Smith (arrived at emergency department with pneumonia and multiple problems) [See summary at end of this Web page]

FORMAT OF SESSION:

1. Introduction by R. Spasoff, to introduce the issues and place them in context.
2. Panel discussion focussing first on how physicians working in various primary care settings would manage Ms Smith's problems, then on broader issues of primary care and primary care reform.
3. Questions and discussion

READINGS: Please read the notes before the session. If you wish to read further into this

subject, you might try the following:

Shah CP. *Public Health and Preventive Medicine in Canada*, 4th ed. Toronto: University of Toronto Press, 1998. Chapter 15, Community Health Services, pp 385-9, and Chapter 17, Canadian Health Care into the 21st Century, pp 447-8. (The standard Canadian reference work.)

Povar GJ. Primary care: questions raised by a definition. *J Family Practice* 1996: 42: 124-8.

Starfield B. Is primary care essential? *Lancet* 1994; 344: 1129-33. (Two theoretical works.)

Rachlis M, Kushner C. *Strong Medicine: How to Save Canada's Health Care Services.* Toronto: HarperCollins, 1994. (Especially chapters 9, 10, 11. A popular, leftish analysis of the Canadian situation.)

For more information on the Ontario Family Health Network:
www.ontariofamilyhealthnetwork.gov.on.ca/english/about.html

EVALUATION:
Short-answer questions on examination at end of Block.

NOTES

1. Primary Health Care

Primary health care is first contact care that deals with the majority of health problems. It is the foundation of any health care system: systems with strong primary care seem to work much better than those without. International thinking on primary care is based on the WHO declaration calling for Health for All by the Year 2000 (HFA2000, introduced in First Block):

> "The main social target of governments and of WHO should be the attainment by all the people of the world by the year 2000 of a level of health which would permit them to lead a socially and economically productive life."

The WHO determined that the way to achieve HFA was through primary health care, defined as:

> "... the essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at each stage of their development, in the spirit of self-reliance and self-determination."

In developing countries this includes many services that in North America are provided by public health units (maternal and child health, environmental hygiene).

The Draft Charter of General Practice/Family Medicine in Europe (WHO-EURO 1998) lists 7 characteristics of primary care:

1. general (deals with unselected health problems of the whole population)
2. continuous
3. comprehensive

4. coordinated
5. collaborative
6. family-oriented
7. community-oriented.

2. Primary Health Care in North America

In North America, "primary care" generally refers to services provided by physicians and closely associated professionals. In Canada, this means family physicians and a decreasing number of general practitioners (primary care physicians who are not certified in family medicine), while in the USA primary care is also provided by internists, paediatricians and obstetricians. The Canadian College of Family Physicians has enunciated four **principles of primary care**:

- The doctor-patient relationship is central to what we do as family physicians.
- The practice of family medicine is community-based
- The family physician is a resource to a defined population
- The family physician must be a skilled, effective clinician.

Other important attributes of primary care include:

- first contact care
- accessibility
- continuity
- case-management (responsibility for coordinating all the care that a person needs).

In Ontario the EFPO project (Educating Future Physicians for Ontario) defined the roles that the public expects doctors to fill, with emphasis on primary care. The Royal College of Physicians and Surgeons of Canada has defined a very similar list of physician roles in its CanMEDS project:

EFPO	CanMeds
• medical expert/clinical decision maker	medical expert
• communicator/educator/humanist/healer	communicator
• collaborator	collaborator
• gatekeeper/resource manager	manager
• health advocate	health advocate
• learner	professional
• scientist/scholar	scholar
• person	

3. Settings for Primary Care in Canada

Solo practice and small *partnerships* (usually *fee-for-service*) are the dominant forms of practice in Canada. They provide the physician with maximum autonomy, maximum individual responsibility and minimum support. Fee-for-service payment gives the physician an incentive to work hard, but this can mean seeing too many patients and providing too many services. It tends not to reward "talking" services as well as "doing" services, and thereby discourages prevention and a more global approach to the patient (including social and psychological interventions).

Group practice (also usually fee-for service) is growing slowly and is more common in the West. It has obvious advantages for the doctor: colleague support, sharing of expenses and call duty, reduced capital costs. It has some advantages for patients as well, in terms of one-stop provision of medical care. There does not appear to be much difference in hospital utilization or in the total costs of care per patient. Similarly, and somewhat surprisingly, there is little evidence of higher quality of care in physician-sponsored group practice than in solo practice. All of this suggests that governments' hands-off attitude towards conventional (doctor-sponsored) group practice is appropriate.

Health Maintenance Organizations (HMOs) combine a group practice with a funding arrangement. They were developed mainly in the USA (e.g., Kaiser-Permanente Health Plans and the Health Insurance Plan of New York); Canadian examples are the Community Clinics in Saskatchewan and the community-sponsored Group Health Centre in Sault Ste. Marie, Ontario. The American examples feature a prepayment plan combined with a group practice offering an unusually wide range of specialties and ancillary services; some plans even own their own hospitals. The plans provide their subscribers with comprehensive health services for a fixed amount per month (capitation); patients who go outside the plan for services that the plan provides must pay for them privately. Capitation has the huge advantage of linking people to their doctors (or at least to the plan). It provides an incentive for the doctor to keep the patient healthy, and thus in principle it encourages prevention (in practice, this may not work out). Critics claim that it encourages the doctor to slack off, telling people to go to the emergency department. The original community-sponsored plans have been able to provide comprehensive health care for at least 20% below the usual costs, primarily by using less hospital and surgical care (critics ascribe the savings to exclusion of sick people from membership in the plans). The low hospital rates are encouraged by the wide range of laboratory and other ambulatory services provided, and (in the case of Kaiser) by a monetary incentive: savings in the hospital sector can result in substantial bonuses for the salaried physicians. There is no evidence that technical quality of care suffers in the community-sponsored plans, and some evidence that it is higher, although Kaiser is sometimes criticized for being factory-like. In the 1970s and 1980s, US authorities came to believe that HMOs could control health care costs while requiring only a minimum of government involvement, and hence encouraged their formation. Naturally, provision had to be made for commercial sponsorship, and the resulting tremendous growth of *"managed care"* has become dominant in US health care, leading to a bewildering array of acronyms, all aimed at increasing efficiency, most resulting in loss of doctors' autonomy and patients' choice, and the whole combining to give a good approach a bad name.

The concept has been less successful in Canada than in the United States, where the existence of universal health insurance means that everyone has the same coverage at the same cost, so the HMO-type plans cannot compete on price. Furthermore, the Canadian plans do not own their own hospitals, and their proponents claim that they have not received full benefit from reducing hospitalization rates. Some plans were established in centres already well supplied with physicians. Finally, the profession was hostile for a long time, and governments generally unsupportive - a problem in view of the high start-up costs. Despite these obstacles, there is

(disputed) evidence that the Canadian clinics practise more prevention and have hospitalization and surgical rates about 25% lower than conventional practice.

The experience of the early Canadian plans led to the appointment of The Community Health Centre Project, which reported in 1972, recommending the development of a significant number of such centres in Canada, but warning that they could flourish only in a re-organized health care system. Neither the expansion nor the reorganization happened, except in Québec, where it took a somewhat different direction.

Ontario's response took the form of *Health Services Organizations (HSOs)* and *Community Health Centres (CHCs)*, which together provide less than 5% of all primary health care in the province. HSOs are paid by *capitation* and are mostly doctor-sponsored; the payment arrangements were eventually found to be too generous and expansion of the program is currently on hold. Local examples are the Civic Hospital Family Medicine Centre and the Ste Anne's Clinic in Lowertown. CHCs are community-sponsored clinics on *global budget* payment, with *salaried* physicians working beside a range of social services to care mainly for disadvantaged populations. For decades, the Ontario government proclaimed its support for these clinics, but it showed little tangible evidence of that support until the late 1980s; there are now 6 CHCs in Ottawa-Carleton (Centretown, Sandy Hill, Somerset West, Pinecrest-Queensway, Carlington, Southeast Ottawa).

Québec has gone further than the other provinces in reorganizing and rationalizing its health care system, following the recommendations of several commissions. Its *Centres Locaux de Services Communautaires (CLSCs)* now cover the entire province, providing a range of medical, public health and social services (similar to the WHO concept of primary health care), although their primary medical care role has not developed to the extent originally envisaged.

Hospital emergency departments (various funding arrangements) provide a considerable amount of primary care–much more than they would like.

Drop-in (Walk-in) clinics (fee-for-service) have grown apace: patients appreciate the convenience of being able to drop in without an appointment, and physicians appreciate the flexibility they provide. But these clinics provide little in the way of continuity of care, and tend to skim off the "easy" (and remunerative) patients, leaving the older, multi-problem patients to family physicians and making family practice less financially viable.

4. Primary Care Reform

In several respects, Canada's health care payment system (Medicare) provides a supportive setting for primary care:

- there is a fairly good supply of trained family physicians (although no longer enough)
- family physicians can usually obtain hospital privileges, so are not isolated from specialists and hospitals (in fact, family doctors are increasingly withdrawing from hospital practice

on the grounds that they cannot afford to do it).
- there are few direct financial barriers to prevent patients from seeking care.

But the structure of our health care system has several less favourable implications for primary health care:
- The patient is not administratively linked to the physician. Instead, patients are free to "shop around", with resulting damage to continuity, and physicians have limited accountability to them.
- Physicians still have considerable freedom to establish their practices wherever they want, rather than where they are needed.
- Limited support is available for family physicians, who must often deal with complex medical and social problems while working alone. There is little provision for payment of other health care professionals, making it hard to establish a health care team.
- There is little linkage to public health, despite the overlap in responsibilities.
- The fee-for-service payment system discourages prevention and thorough care.

Other problems are not linked to the structure of the system, like the growing complexity of care and the changing lifestyle of doctors.

There is accordingly a great deal of discussion regarding *"primary care reform"*, which is seen as fundamental to addressing issues like increasing costs of care, increasing specialization, and failure of the system to provide personal care (as illustrated by complaints and the growth of alternative medicine). Three prominent proposals are:
- Various forms of *Comprehensive Health Organizations (CHOs)* on the HMO model, paid by capitation and responsible for providing or purchasing all health services (including hospital care) for a defined group of patients. The variant popular in the late 1990s was *Integrated Delivery Systems (IDSs)*, but this very comprehensive approach was never implemented and may now be dead.
- The Home Hospital, an attempt to integrate primary and in-patient health care, based on a family practice model.
- The *Ontario Family Health Network*: networks (virtual clinics) of family physicians assuming 24-hour responsibility for defined populations and paid by capitation. Several pilot projects underway in Ontario, with over 170 physicians and 250,000 patients enrolled, and the government hopes that this will become the dominant mode of primary care organization within a few years.

Principles of Primary Care

(Canadian College of Family Physicians)

- **The doctor-patient relationship is central to what we do as family physicians**
- **The practice of family medicine is community-based**
- **The family physician is a resource to a defined population**
- **The family physician must be a skilled, effective clinician**

Characteristics of Primary Care

Draft Charter of General Practice/Family Medicine in Europe (WHO-EURO 1998)

1. **General** **(unselected health problems of the whole population)**
2. **Continuous**
3. **Comprehensive**
4. **Coordinated**
5. **Collaborative**
6. **Family-oriented**
7. **Community-oriented**

CanMEDS Roles

(Royal College of Physicians & Surgeons of Canada)

- **medical expert**
- **communicator**
- **collaborator**
- **manager**
- **health advocate**
- **professional**
- **scholar**

PROBLEM 3

MS. SHARON SMITH

A thirty-five year old woman has a febrile illness with cough, malaise and pain in the chest that is aggravated with each breath. She admits that she has been drinking more heavily since her boyfriend was killed in a drug dispute.

Settings For Primary Care

Private solo practice	**(fee-for-service)**
Private group practice	**(fee-for-service)**
Health Services Organization	**(capitation)**
CHC / CLSC	**(global/salary)**
[Nurse-practitioner	**(salary)]**
Emergency department	**(sessional, ffs)**
Walk-in clinic	**(fee-for-service)**
Specialist practice	**(fee-for-service)**
Primary Care Network	**(capitation)**
Compr Health Organization	**(capitation)**
Integrated Delivery System	**(capitation)**