Primary Care Reform & Insights

An international perspective from across the pond

Lumos Symposium 2024

Ray Messom, Nous Group Principal & Canadian Health Practice Lead

Oct 9, 2024

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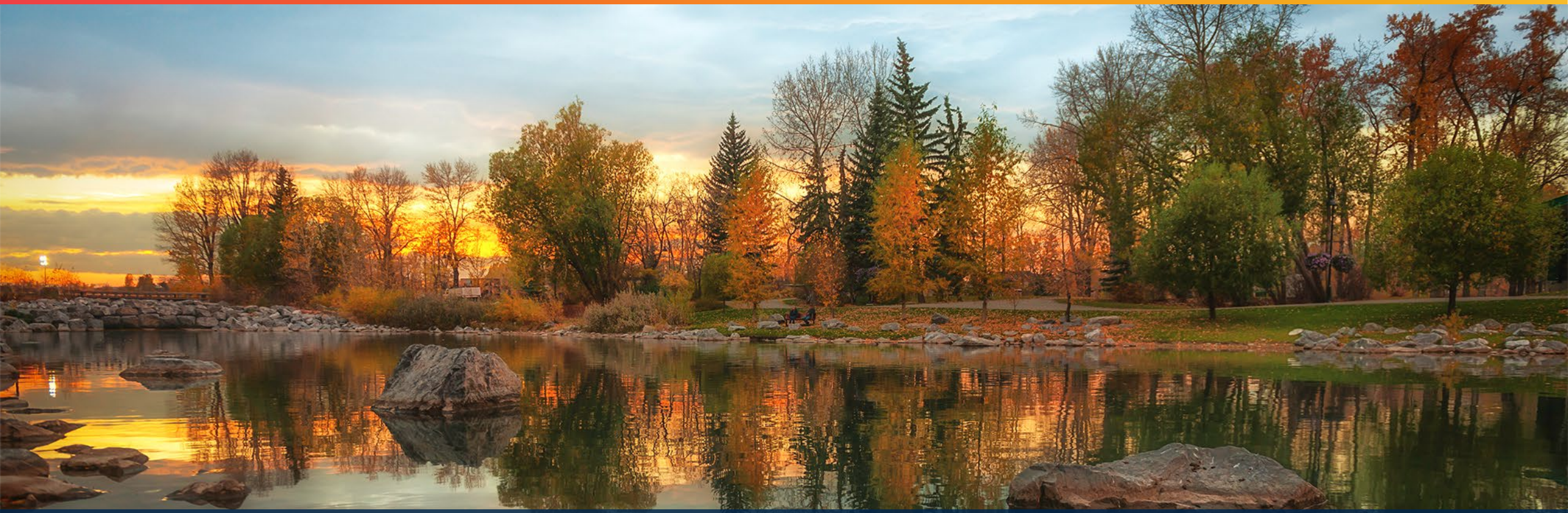

Land Acknowledgement

In the spirit of reconciliation, I acknowledge the traditional, ancestral, unceded territory of the Musqueam, Tsleil-Waututh and Squamish First Nations on which I am presenting from, learning and working today.

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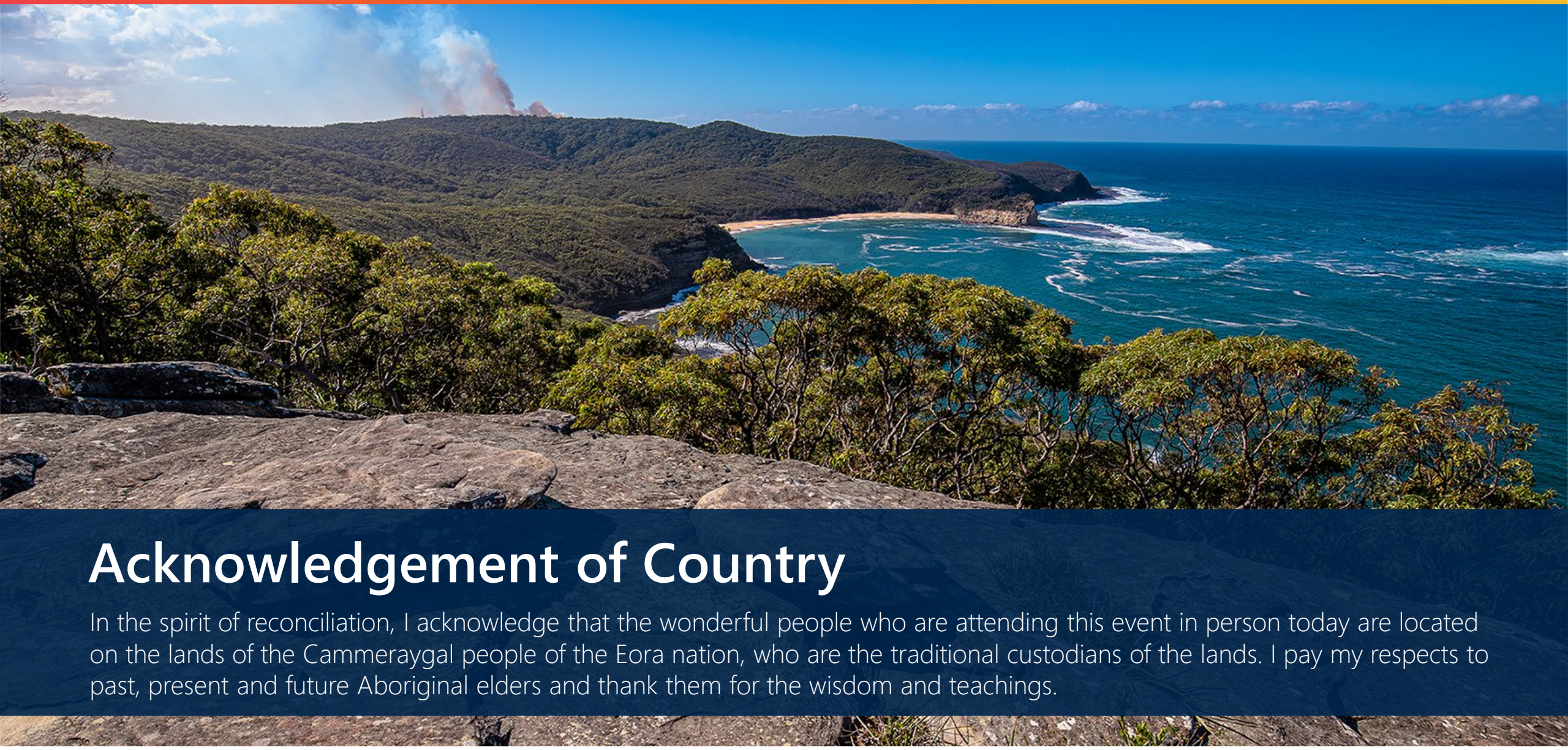

Acknowledgement of Country

In the spirit of reconciliation, I acknowledge that the wonderful people who are attending this event in person today are located on the lands of the Cammeraygal people of the Eora nation, who are the traditional custodians of the lands. I pay my respects to past, present and future Aboriginal elders and thank them for the wisdom and teachings.

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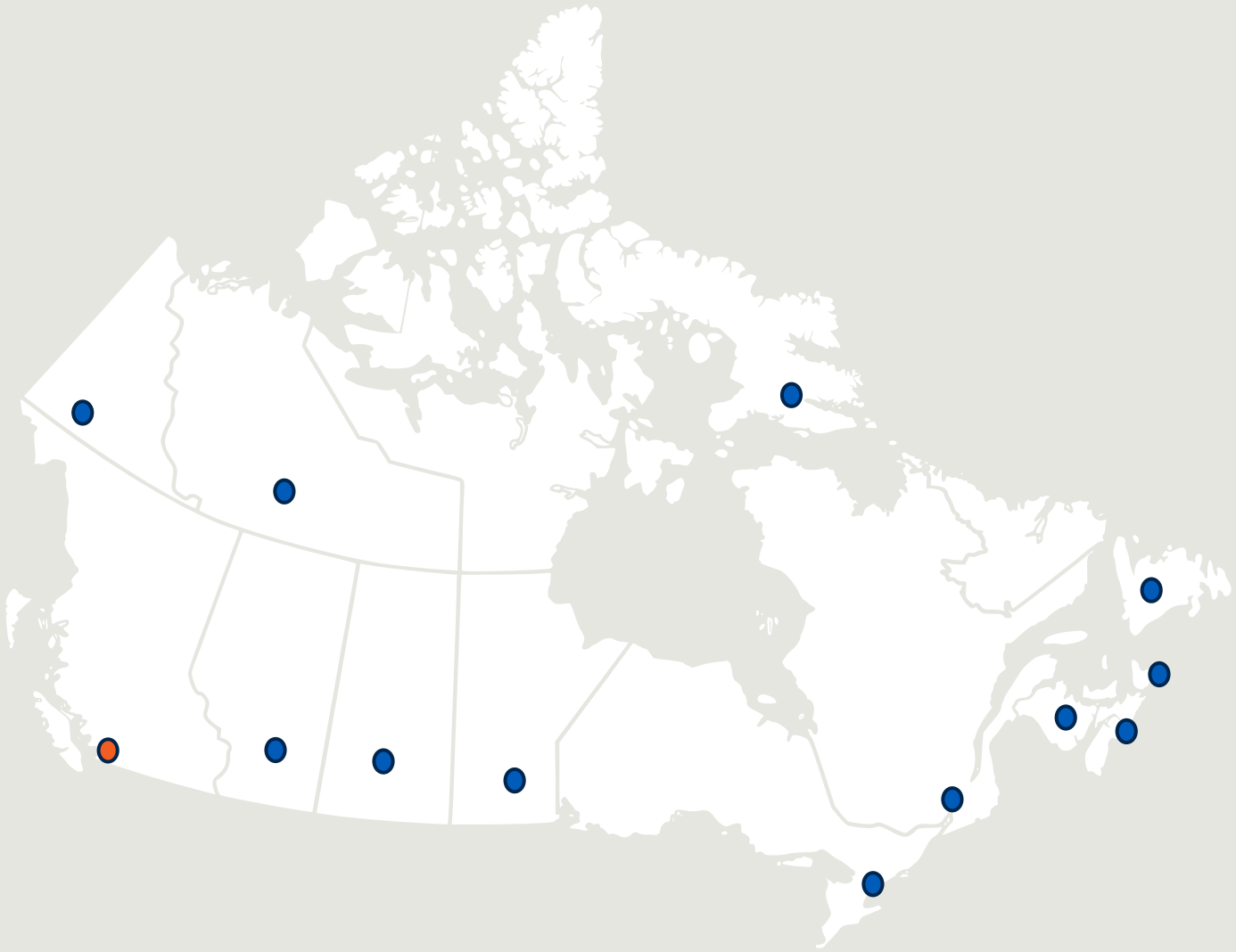
Presentation Agenda

- KEY FEATURES OF THE CANADIAN HEALTH SYSTEM
- PRIMARY CARE REFORM & INSIGHTS
  1. Governance
  2. Funding
  3. Data Sharing & Insights
- QUESTIONS

Canada has 13 health systems, delivering care for 40 Million Canadians across 10 Million square kilometres.



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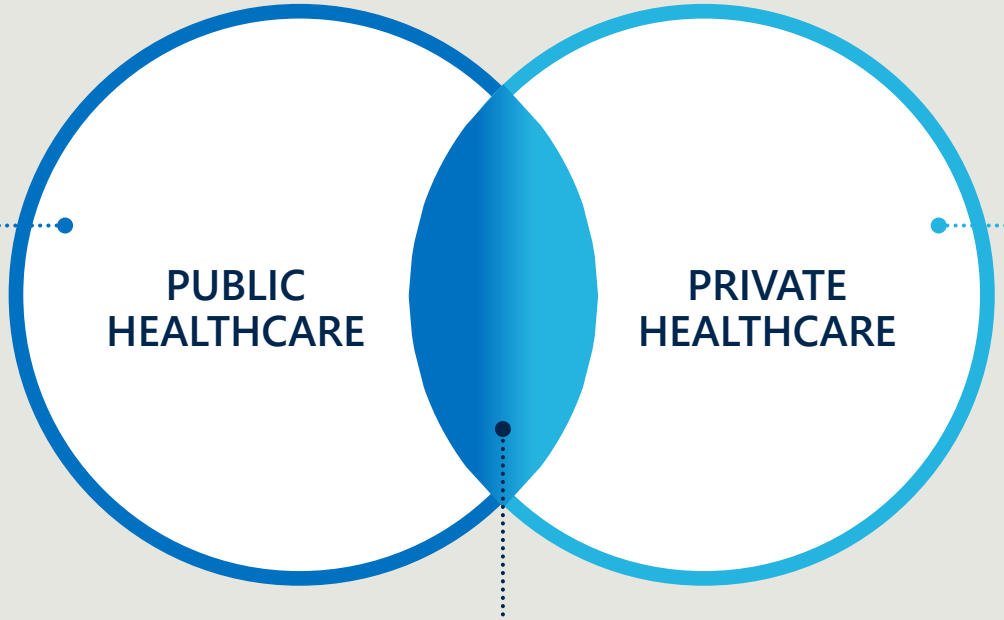
Canada has a universal medical system, but like Australia healthcare is delivered by a mix of public, private and not-for-profit organisations.

Hospitals

Physicians

Diagnostics



Many Drugs

Allied Health (Physio, Phycology, rehabilitation, etc.)

Nurse-Led Clinics

Dental

PUBLICLY FUNDED, PRIVATELY DELIVERED

Urgent Care Centres

Day Surgeries

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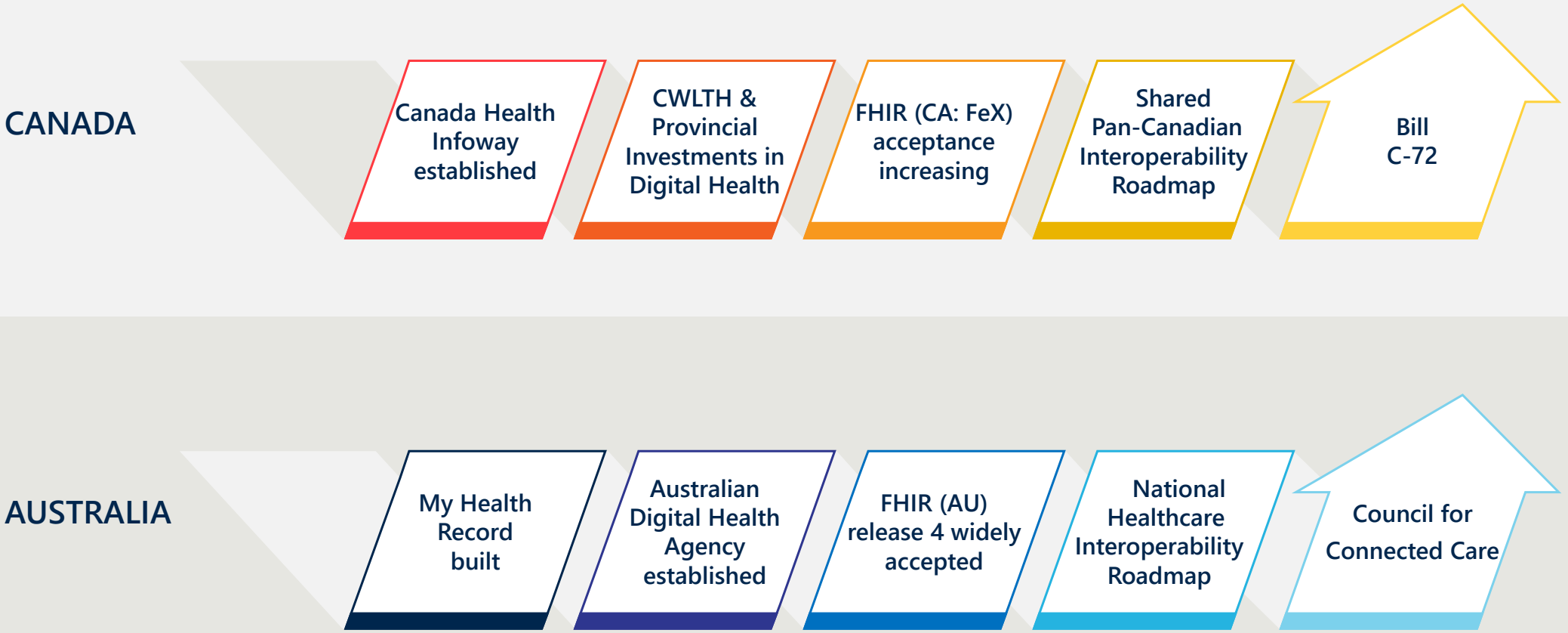
Canada and Australia are moving together toward interoperability, data sharing, primary care reform and new models of integrated care.



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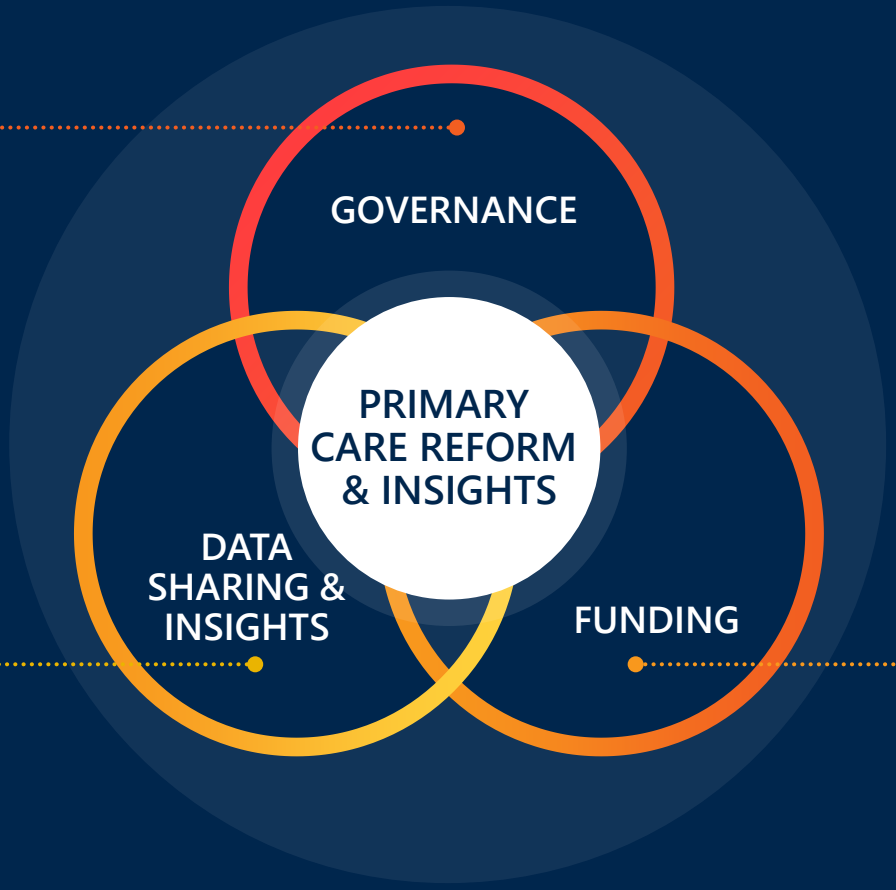
Now let's consider some perspectives on primary care reform & insights through some examples.

1. Comparing and contrasting Ontario Health and NSW Health system roles and responsibilities



3 An inspiring future is ahead - exploring the Lumos equivalents in Canada

2. Showcasing primary care funding reforms of British Columbia and Alberta – the art of the possible

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Comparing and contrasting Ontario and NSW health system roles & responsibilities

Governance

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Let's reflect on Ontario and NSW systems and reflect on the key roles various actors play in each.

	POLICY	PROVINCIAL/STATE SYSTEM LEVEL PLANNING AND FUNDING	REGIONAL SYSTEM LEVEL PLANNING AND FUNDING	INTEGRATED SERVICE DELIVERY
NEW SOUTH WALES	• Ministry of Health (NSW) • Department of Health & Aged Care (CWLTH)	• Ministry of Health (NSW), eHealth NSW, Pillars, etc. • Department of Health & Aged Care (CWLTH), NSW PHN CEO Forum	• Local Health Districts (LHDs) • Primary Health Networks (PHNs) • Integrated care partnerships/Collaborative Commissioning	• Health Pathways • Hospitals, community health centers, general practices, community providers, etc. • Healthcare Neighborhoods
ONTARIO	• Ministry of Health (Ontario) • Federal government influence through transfer payments (CWLTH)	• Ministry of Health • Ontario Health (Ontario)	• Hospitals & Health Services • Primary Care Networks (PCNs) • Ontario Health Teams (OHTs) assuming ownership of integrated care planning and funding	• Integrated Clinical Pathways • Hospitals, Family Health Groups/Teams, Primary care physicians, Community Health Centres, Nurse-Led clinics, etc. • Healthcare Neighborhoods

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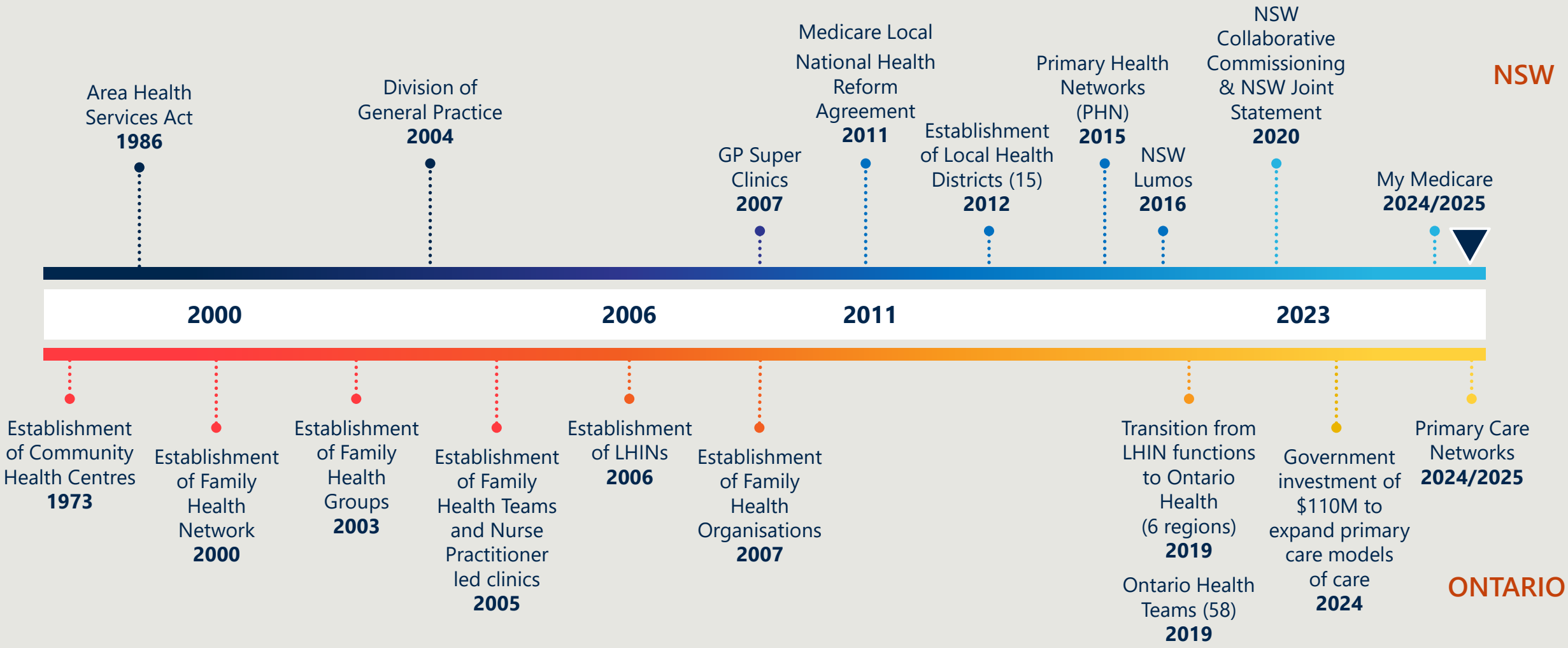
It is important to acknowledge where we have come from – NSW and Ontario are on similar journeys.



Showcasing British Columbia's & Alberta's primary care funding reforms

Primary Care funding reform

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British Columbia is leading the way in increasing attachment (registration). They are also moving to more flexible funding.

Primary Care Networks

Empowering physician leadership and community connections, Strengthening team-based care, creating opportunities for innovative PCN clinic models, and strengthening supports for patient attachment

Models of Care within Primary Care Networks

Patient Centred Medical Homes, Urgent Care Centres, Community Health Centres, Nurse Practitioner Led Clinics, Health Connect Registry

Primary Care Initiatives

Attachment (registration), Virtual Care, After Hours Program, Pharmacist Scope of Practice, Nurse in Practice Program, Walk-in Clinics

Primary Care Funding Reform

The Longitudinal Family Physician Payment Model supports family physicians by compensating for time, patient interactions, and the number and complexity of patients attached to their practice.

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Alberta leads primary care funding reform in Canada, blending payments for physicians operating across a range of settings and capacities.

FEE FOR SERVICE

Fee-for-service (FFS) is a payment method in which physicians are paid for each service performed.

The Schedule of Medical Benefits (SOMB) lists all the health services that physicians are able to bill for their services and the rules that govern billing.

CLINICAL ALTERNATIVE RELATIONSHIP PLAN

Compensates physicians for providing a set of clinical services at defined facilities to a target patient population. Clinical ARPs can help to align physician compensation incentives with overall health system objectives. For some physicians, simply being paid differently can enable them to deliver services in a manner better suited to them and their patients.

BLENDED & CAPITATIVE MODEL

Alternative to traditional FFS, blending patient-based capitation payments and volume-based payments through FFS.

The goal of the Blended Capitation Model (BCM) is the advancement of the Patient's Centred Medical Home and delivering a quality care experience to patients through improved access, continuity and comprehensive team-based care.

ACADEMIC MEDICINE AND HEALTH SERVICES PROGRAM (AMHSP)

The mission of the AMHSP is to improve health by providing outstanding clinical, education, research and leadership services.

Currently, there are 14 AMHSP Arrangements with a combined total of over 950 participating physicians.

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Exploring the Lumos equivalent in Canada

Data Sharing

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Grass root partnerships are shifting the landscape and yielding fascinating insights.

The Canadian Primary Care Sentinel Surveillance Network operates across Canada

ACHIEVEMENTS

1.8M patient records

1,300 practices

15 years of R&D

- Strong partnerships with universities and college of family practicians (150+ publications)

CHALLENGES

- Use for quality improvement (consent model and legislative framework)
- Ongoing government funding

Alliance for Healthier Communities

ACHIEVEMENTS

- Primary care clients are registered to a physician or nurse practitioner.
- There is wide variation in geography and needs of patients.
- MDT care central – GP, nurse, social worker, dietician, counsellors, community health worker.
- Linked data using unique ID.

CHALLENGES

- Data on individuals who received services but are not registered as ongoing primary care clients with a physician or nurse practitioner at these 73 CHCs is not included in the analyses.

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Three key features of Canadian Data Linkage to be aware of before we look at some example insights.

1 STANDARD LINKAGE

Deterministic using a person's health insurance unique identifier

Includes FFS information for primary care

2 ENHANCE LINKAGE

Deterministic but currently only available for commissioned services or those managed by public sector entities

3 FUTURE LINKAGES

Making enhanced linkage possible for all primary care providers, private sector providers and for a broader purpose

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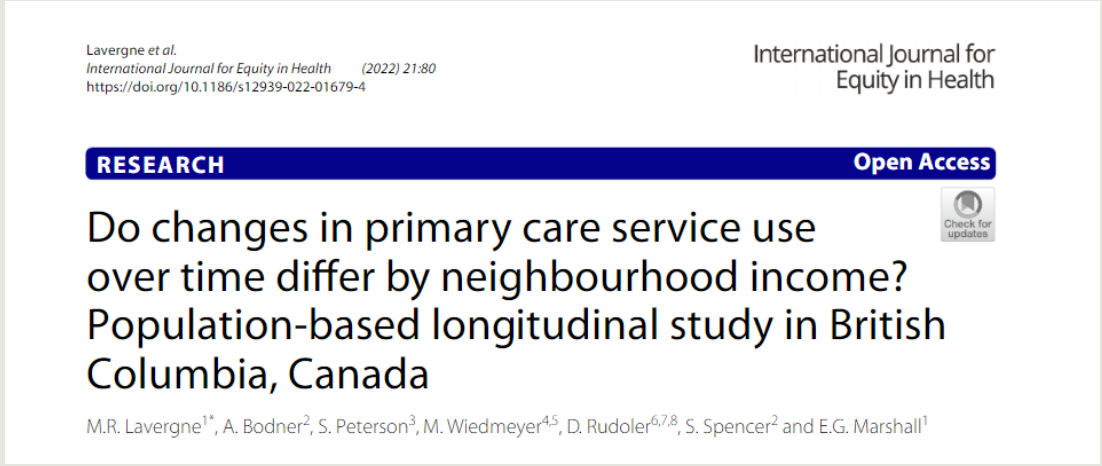
Health policy settings between 2000 & 2017 saw reduced equity in BC primary care access. This adversely affected priority populations.

Goal: Sought to determine if changes in primary care service use between 2000 and 2017 differ by neighbourhood income in British Columbia.

Results: Average number of primary care visits per person, specialist referrals, and continuity of care fell in both urban and rural settings, while ED visits and prescriptions dispensed increased. Over this period in urban settings, primary care visits, continuity, and specialist referrals fell more rapidly in low vs. high income neighbourhoods. The percentage of physicians who provide the majority of visits to patients in neighbourhoods in the lower two income quintiles declined from 30.6% to 26.3%.



Lavergne *et al.*
International Journal for Equity in Health (2022) 21:80
https://doi.org/10.1186/s12939-022-01679-4

International Journal for Equity in Health

RESEARCH Open Access

Do changes in primary care service use over time differ by neighbourhood income? Population-based longitudinal study in British Columbia, Canada

M.R. Lavergne[1*], A. Bodner[2], S. Peterson[3], M. Wiedmeyer[4,5], D. Rudoler[6,7,8], S. Spencer[2] and E.G. Marshall[1]

Applicability: Policies that tailor patterns of funding and allocation of resources in accordance with population needs, and that align accountability measures with equity objectives, are needed as part of further reform efforts.

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Interventions to increase attachment (registration) in Quebec between 2014-2016 improved access and continuity of care.

Goal: To evaluate changes in access to and continuity of primary care associated with attachment to a family physician through Quebec's centralized waiting lists for unattached patients.

Results: The number of primary care visits increased by 103% in the first post-attachment year and 29% in the second year ($p < 0.001$). The odds of having all primary care visits concentrated with a single physician increased by 53% in the first year and 22% ($p < 0.001$) in the second year after attachment. At the practice level, the odds of perfect concentration of care increased by 19% ($p < 0.001$) and 15% ($p < 0.001$) respectively, in the first and second year after attachment.

BMC Prim Care. 2022; 23: 238.
Published online 2022 Sep 16. doi: 10.1186/s12875-022-01850-4
PMCID: PMC9482231
PMID: 36114464

Improved access to and continuity of primary care after attachment to a family physician: longitudinal cohort study on centralized waiting lists for unattached patients in Quebec, Canada

Mélanie Ann Smithman,[1] Jeannie Haggerty,[2] Isabelle Gaboury,[1] and Mylaine Breton[✉1]

Applicability: Our results show an increase in patients' number of primary care visits and concentration of care at the family physician and practice level after attachment to a family physician. This suggests that attachment may help improve access to and continuity of primary care.

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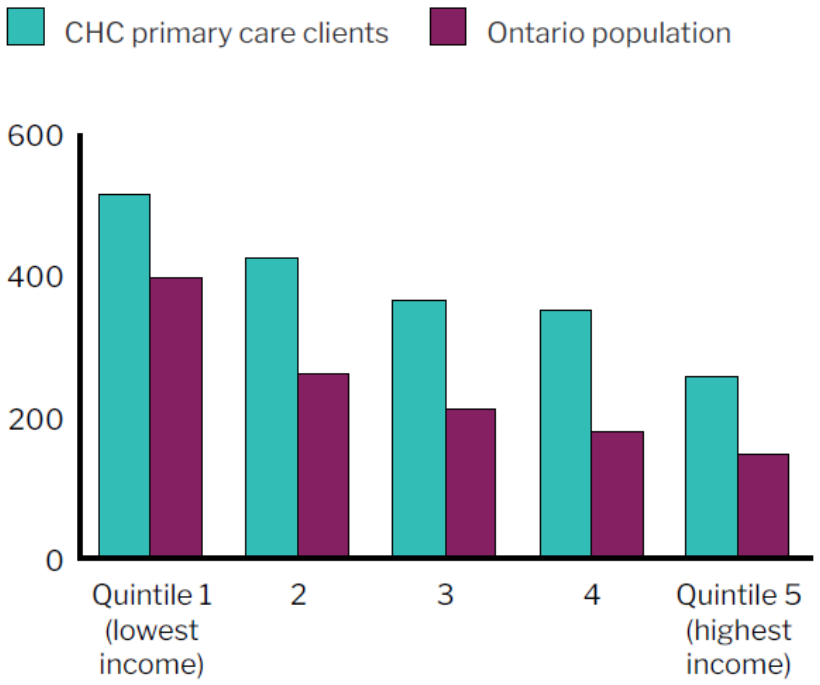
The prevalence and use of acute care for Ambulatory Care Sensitive Conditions (ACSC) suggest significant opportunities for CHCs in providing high-value care.

Age-standardised rates of hospitalisation for ACSCs per 100,000, by neighbourhood income quintile, CHC primary care clients and Ontario population, 2021-2022



Inequality measure	CHC primary care clients	Ontario population
Income rate ratio	1.9	2.6
Potential rate reduction	38	37

Source: Primary Health Care and Discharge Database, 2021-2022, Canadian Institute for Health Information and Postal Code Conversion File Plus (PCCF+), Statistics Canada

- **CHC primary care clients had the highest rate of hospitalizations for ACSCs**, living in the lowest-income neighbourhoods
- **Health disparities** were seen among primary care clients at CHCs and in the Ontario population.
- If all income quintiles in both populations (CHC primary care clients and Ontario) had the same ACSC hospitalization rate as the rate for the highest-income neighbourhood, **the overall rate would be reduced by 37–38% in both populations.**

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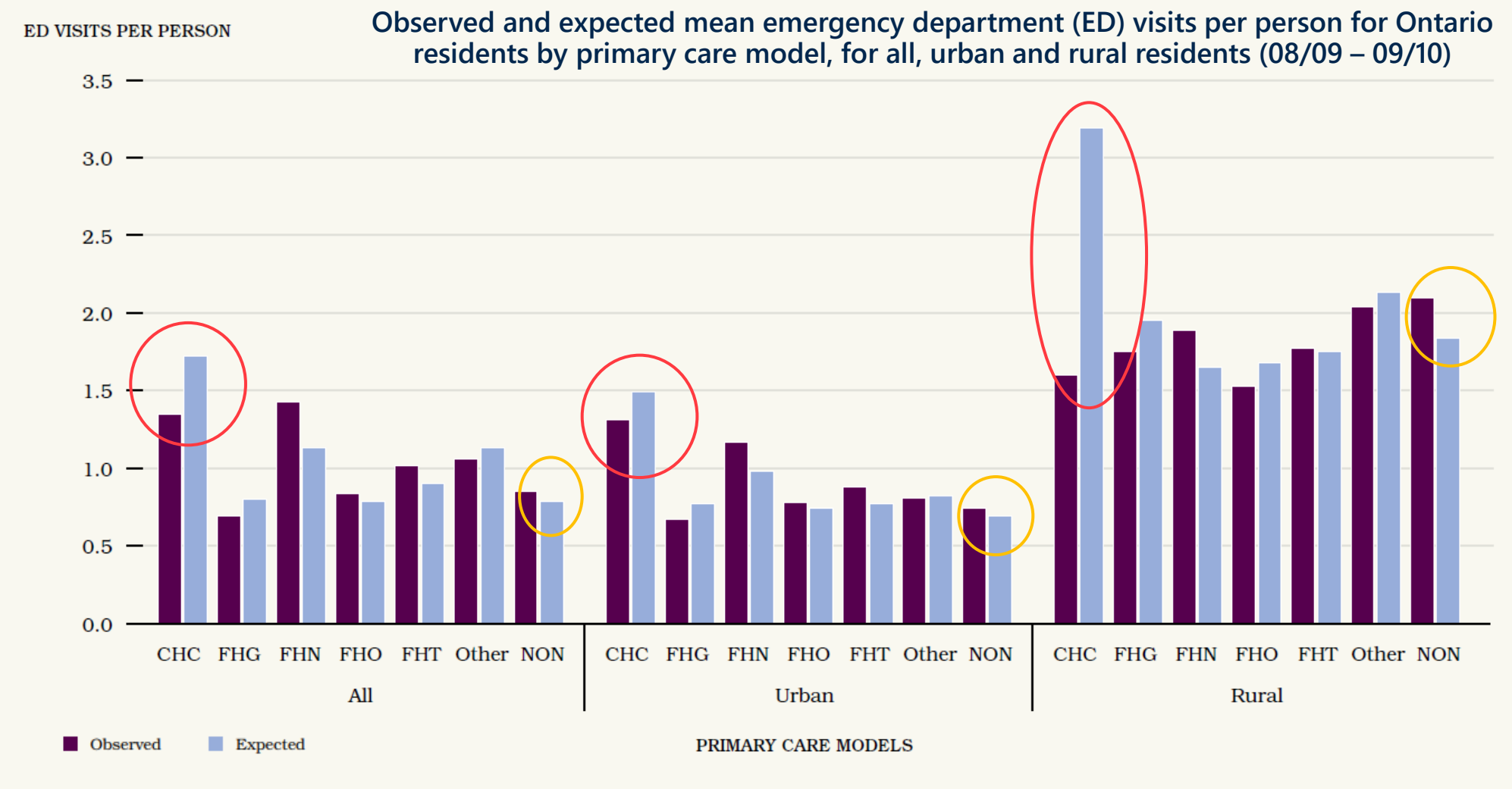
Community Health Centres delivering primary care lead MDT models were the most effective in reducing ED person in metro and rural areas.



Source: Glazier RH, Zagorski BM, Rayner J; Institute for Clinical Evaluative Sciences. Comparison of Primary Care Models in Ontario by Demographics, Case Mix and Emergency Department Use, 2008/09 to 2009/10. 2012

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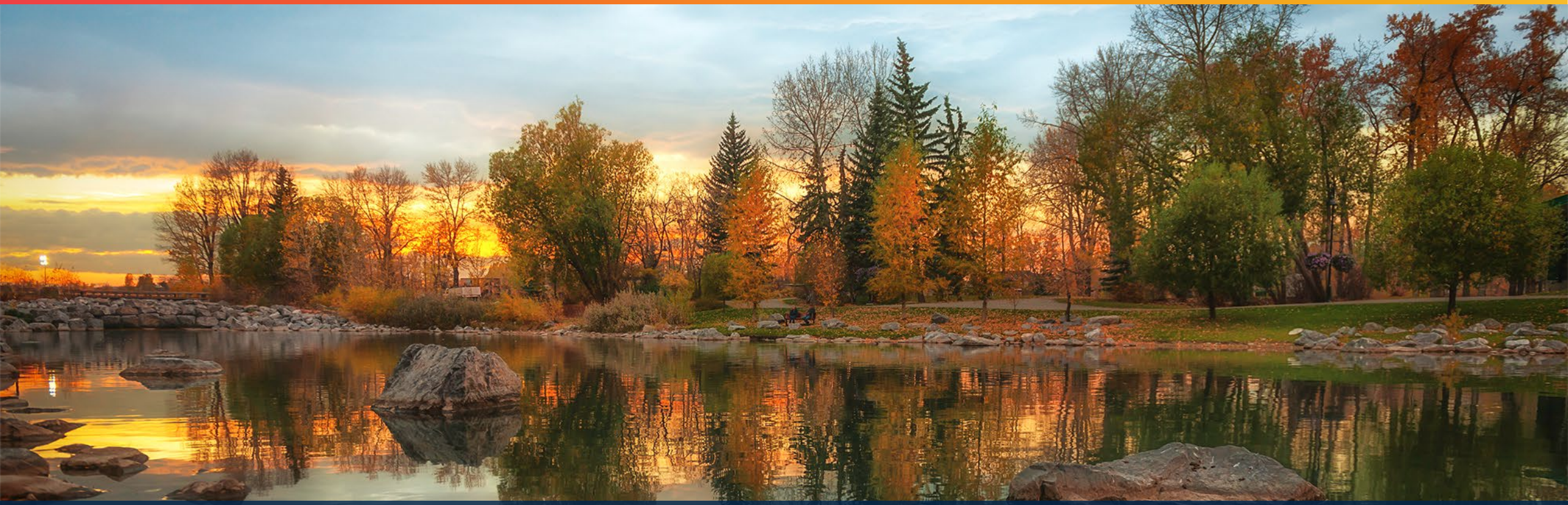

Questions?

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A bigger idea of success

Nous Group is an international management consultancy operating across Canada, Australia and New Zealand, the United Kingdom and Ireland.

We are inspired and determined to improve people's lives in significant ways. When our strengths complement yours and we think big together, we can transform businesses, governments, and communities. We realise a bigger idea of success.

750
PEOPLE

5
COUNTRIES