Primary Health Care

*Primary Health Care* was a popular topic for debate and discussion in the Conversation on Health. Participants compared their visions of primary care, the administration of primary care and its facilities, how other countries manage primary care, and the need for patient advocates, navigators and case managers as a way of helping to maintain quality of care. Here is a selection of what British Columbians had to say on the subject of *Primary Health Care*.

Primary Care Models and Visions

Participants generally agree that primary care is an extremely complex subject area, and that the keys to improved population health and efficiencies in the health care system may lie in primary care. A number of participants praised the provincial governments’ Primary Care Charter.

Participants argue that, with pressures on the health care system such as chronic disease management and increasing demand on acute care, the focus should be on prevention, demand management and self-management. These are all part of an effective and efficient primary care system.

The vision of primary care that many participants share involves a system where the physician is not the only gatekeeper: nurses, nurse practitioners, chiropractors, naturopathic physicians and other practitioners could also play this role. They suggest, an effective primary care system focuses on maintaining and improving the health of the population. This means reaching out to all of the citizens to ensure they are receiving the social services and health supports they require to get and stay healthy. Patients are dealt with in an integrated team environment, where practitioners work together to provide the best possible care plan for each individual. Links to the community are important as it is through these links that participants see opportunities to focus on population health.

This vision would take the load off of the acute care system by providing more entry points to patients, focusing first on maintaining and improving health and self-care before turning to the more expensive acute care system. This new concept of primary care would also encourage greater integration among practitioners, resulting in more patient-centred care.
Participants warn, however, that movement to a truly new system of primary care will require some major systemic adjustments, beginning with a new approach to remuneration and incentives for physicians and a new societal attitude towards health and health care. This is a long-term change management process, which needs to be designed and managed effectively across government and communities with strong leadership in order to make it happen.

*Primary Health Care is a relatively neglected component of the health care system. Some of the most effective and lowest cost health systems are based on a 'primary care' foundation, supported by a thoughtful healthy public policy framework. This would represent a significant change for BC, but offers a chance to move from a position of conservative, timid change where the inefficient, inequitable, costly private health care alternatives is allowed to creep in by default. This is not a time to be timid, but to learn from evidence and to invest wisely rather than react to headlines.*

– BC College of Family Physicians, Submission

**Primary Care Administration and Facilities**

Facilities, funding models, and accountability structures were all explored in discussions around new models for primary health. One of the key areas of debate was whether primary care should be managed by health authorities. Some participants argued that moving primary care under the rubric of health authorities would provide a more holistic perspective on community health and the ability to better service the needs and demands of the population. Others argued that this approach would add bureaucratic inefficiencies and should be avoided.

Community health clinics came up frequently as a way of encouraging a health promotion ethic and incorporating new practitioners into the medical system. Most argue that these clinics should be publicly funded and easily accessible.

Some participants argue that a new approach to primary care will also require a new approach to funding models. There needs to be a way to compensate a physician for activities that support community-based disease prevention and health promotion. They argue that without new funding models, introducing new entry-point practitioners into the system would be difficult. One suggested model is to create salaried physicians who would serve a designated population. The physician would be responsible for the health promotion and prevention needs of that population, measured based on population health outcomes, as well as individual health outcomes. Participants also advocated for the inclusion of certain primary care health services that are not currently funded through the Medical Services Plan, such as preventive eye and dental exams and care.
International Models

A number of participants had experience in or knowledge of primary health care in other jurisdictions, and many recommend a better understanding of these systems in order to identify best practices, which could then be imported.

One example put forward was from New Zealand, where primary care has gone through an overhaul over the past decade, culminating in the implementation of a primary care strategy in 2003. New Zealand has moved to primary health organizations responsible for a defined population. Their focus is not just services, but preventive care and the reduction of health inequalities within their population. While expensive, New Zealand hopes that its investment will yield long-term savings through health promotion and disease prevention.

Patient Advocates and Navigators and Case Management

Participants describe the health care system as complex and challenging. Similarly, participants suggest the lack of continuing care affects the health of patients and creates more pressure on the acute care system. Many believe that patient advocates and navigators could help patients through the system dealing with both this complexity and the continuity of care. This would be particularly true for British Columbians with different cultural backgrounds and language barriers.

Many suggest a patient navigator could be very effective for older British Columbians living at home who may have a variety of practitioners and specialists as well as home care services. A navigator could help them understand the care they receive, and how best to take advantage of that care. An advocate could also push for different care and services when they feel it could improve patient outcomes and avoid expensive acute care intervention. Participants also suggested creating a patient ombudsman who would receive and follow-up on patient complaints within the system.

Navigators and advocates would help patients understand the system and the care they are receiving. This would encourage and empower patients ultimately to manage their own care.

In pushing for an integrated approach to patient care, participants believe that there needs to be a new way to manage care, and they often suggested case management as an effective approach. Through case management, all practitioners would be able to understand every aspect of the patient care and work together to make it most
effective for the patient. Similarly, participants advocate for improved discharge planning to coordinate services after a patient is released from hospital. Effective planning, they argue, will avoid hospital re-admission and secondary health ailments.

You need a better sense of a system of care into which a lot of senior’s care fits. What you need is a broad base of services, in an integrated and coordinated system of care, managed or facilitated through good quality case management so that there is a champion for each person that comes into the system of care. The components of the system see themselves as part of the system and therefore they also agree to conform to the general policies about accessibility and how you get in, and what kind of care you get. What this allows you to do is provide much more seamless care for individuals if you have this kind of integrated system.

- Focused Workshop Seniors and Aging, Vancouver

Conclusion

For most participants, a new vision of primary care focused on the health of populations. Integration of services and practitioners, continuity of care, and a focus on health promotion and disease prevention would all be supported by new facilities and funding mechanisms. Patient navigators and advocates, along with case management and discharge planning would all work towards keeping people healthy and helping them manage their own care. Participants argue that investments in primary care that work towards this vision will yield savings in the long-term.
Primary Health Care

This chapter includes the following topics:

**Primary Care Models and Visions**
**Primary Care Administration and Facilities**
**International Models**
**Patient Advocates and Navigators and Case Management**

### Related Electronic Written Submissions

- **Health Human Resources Responses**
  Submitted by the BC College of Family Physicians

- **Presentation to Conversation on Health**
  Submitted by Vancouver Coastal Health Authority

- **Family Practice Recommendations for British Columbia’s Health Care System**
  Submitted by the Society of General Practitioners of British Columbia

- **Physicians Speak Up**
  Submitted by the British Columbia Medical Association

- **Aboriginal Conversation on Health**
  Submitted by Vancouver Coastal Health Authority

- **Sunshine Coast Conversations on Health**
  Submitted by the Women’s Health Advisory Network, the Sunshine Coast Hospital and Health Care Auxiliary and the Seniors Network Advisory Group

- **HEU Submission to BC’s Conversation on Health**
  Submitted by the Hospital Employees’ Union

- **Submission to the Conversation on Health**
  Submitted by the BC Nurses’ Union

- **Submission to the Conversation on Health**
  Submitted by the BC Cancer Agency

### Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: **Access; Scope of Practice; Health Care Models and Collaboration in the System.**
Primary Care Models and Visions

Comments and Concerns

System Design and Vision
Entry-Points
Citizen- and Patient-Centred Care
Change Management

• Comments on system design and vision:
  
  • We need to define what success looks like from a medical system perspective (chronic and acute care), from a socio-economic perspective, and from all points of entry. Economic arguments are critical. The gatekeeper cannot be restricted to doctors.

  • The business model equates to short-term thinking as opposed to the primary health care mode, which is about long-term thinking.

  • I read the Primary Health Care Charter in the last couple of days and I am amazed at what is there and I would really encourage everybody to read it. It is a really good overview of where primary care should be going in the province.

  • Primary care is that continuum from prevention of disease through health promotion, healthy lifestyles, and also includes aggressive best practices management of chronic diseases.

  • Primary health care is complex, belying its secondary position in the health care system. Efficiency, safety and effectiveness warrant engagement of a range of skills; reliance on family physicians as the sole clinical resource is outdated.

  • Primary Health Care is a relatively neglected component of the health care system. Some of the most effective and lowest cost health systems are based on a primary care foundation, supported by a thoughtful healthy public policy framework. This would represent a significant change for British Columbia, but offers a chance to move from a position of conservative, timid change where the inefficient, inequitable, and costly private health care alternatives are allowed to creep in by default. This is not a time to be timid, but to learn from evidence and to invest wisely rather than react to headlines.

  • People living with heart disease, asthma, diabetes, depression and other chronic illnesses do much better when they have access to primary health services that include on-going support, education, nursing and outreach services along with health promotion strategies. Many of these services are funded outside doctors'
negotiated fee-for-service agreements. They can be provided by nurses, nutritionists, mental health outreach and community health workers.

- For the last ten years I have watched family practitioners and family practice just heading downhill and it looked like there was no future at all for family practice. And now that has been reversed with things like the Primary Healthcare Charter. It is really encouraging. When I saw that Primary Healthcare Charter originally, I put it aside because I wondered what the point was, and thought it was just more government stuff that they have in committees that I sit on. From my point of view, if there is no economic reason for family doctors to change, why would they change when they are already running as fast as they can and making about 40 per cent of what specialists do.

- There is a significant body of research out there demonstrating that a robust system of primary health care improves health outcomes and quality of life and reduces the burden on the acute care system, yet we have a growing shortage of primary health care providers in British Columbia.

- We need to do more to encourage family doctors back into the hospital. For economic reasons, they have fled the hospital. There are studies to show that hospitalists can get people out of hospital quicker than family doctors normally. But if the family doctor is involved they are discharged quicker still. So I think we need to have both the family doctor and the hospitalist involved in the hospital.

- The key piece of the primary care vision is to have coordination, collaboration, and a team facilitated by appropriate tools, like the electronic record, so that the primary caregivers have the time and space to coordinate their teams, communicate with each other and interact relationally with the people they are providing care for. It is that connection and relationship that helps us really deal with those lifestyle issues that were mentioned and with real preventive care to keep people out of the acute care system when they do not need to be there, and to provide efficient and effective care.

- Right now we have acute care as the foundation of the system and everything else is feeding into acute, and that is why patients that are unattached are going to the Emergency Departments. If we flipped it and said no, primary care is the foundation of the health care system and we are building the system to support primary care, then you ask how you provide access for these unattached patients. What are the social determinants that we need to look at? What are the social behaviours that we need to support? So there are huge significant questions in order to start challenging the design of the health care system.

- Primary health care covers many themes. The first theme is the capability of the people. The second theme is ecological, because health involves communities,
volunteer sectors and non-profits. The third theme was the systems, like the primary, secondary and tertiary systems and their integration. The fourth theme is healthy public policy.

· A primary health care model starts with the person in the centre and the relationship that that person has with the health care system and the players in the health care system. The circle around the person is the primary health care system and that that primary health care system is based on human needs, both the human needs of the patient and the human needs of the providers. The pentagram around the outside represents the players in the health system and their interaction, integration and relationship is really important. So the policy makers, the professionals and health care workers, the academics, the community, volunteers, non-government organizations and so on, and then health managers. There are relationships that need to be built between all of those different players. This is the lens that we would use to look at finding the solutions to some of the challenges we have in the health care system.

· The clinical practice approach needs to be based on health planning: planning people’s health and being proactive with call backs and care of the client.

· I prefer community-based and multi-disciplinary approaches to what I call the doc-in-a-box model of primary health care, which is just expanded overgrown family practices employing numerous doctors. The literature reviews do show that some chronic diseases, for example, have better outcomes when managed by nurses as opposed to physicians. So, I think we need to go where the evidence takes us.

· Current directions in primary health care talk about patients without mention of families and coordinating services.

· Health care should focus more on keeping people well, including, nutrition, getting additives out of food, chemicals out of the environment, and people off of drugs.

· We need better primary health care focused on preventative medicine. Education on root causes of poor health can improve the overall delivery of health care services.

· Primary care has to be linked to social determinants and tertiary care to create an integrated accessible system.

· You want to have good linkages. You want to be able to support the doctors and other practitioners.
The quality of care is far superior with the classic example of the family doctor who knows your medical history and is willing to engage in productive dialogue along with a proper examination.

Right now the two systems are working against each other. This is the critical divide and health authorities and Ministry of Health are strategically pushing this.

Physiotherapists and doctors can give opposite advice. A primary health care team could talk together and have patient conferences to develop a common approach to the particular ongoing problems of an individual.

There are some examples now where health authorities have set up primary care clinics. Our health authority set up one in Ladysmith when we shut down the hospital.

There is a population-based funding clinic called Spectrum Health and they have five doctors in there. They divided up their work and took leadership roles in a variety of ways and they were very innovative. They did not have to report to the health authority. They went out and got funding from other sources to bring in some other professions to work in the team. They are far more flexible and less limited by the bureaucracy.

Primary prevention has proven that it will save you money in the long run. Since we have attacked this problem from an acute care model for so long, and it is not getting anywhere, let us change our focus. Maybe we set up clinics. Maybe we set up something even within the acute care system. We have so many hospitals that probably have space that you could put the clinic in the hospital. So you are still gong to the hospital, but you are seeing a different practitioner there in a different environment. We have already made a major shift in how we deal with ambulatory care.

We have something called Care North. It brings nurses and physicians together to hold group appointments with patients. Patients will come in with other patients and have access to a variety of professionals.

The Ontario Health Services Restructuring Commission produced the best overall statement of what primary health care ought to look like. But what is happening in Ontario is just a consistent atrophying of the model into physicians and physician extenders.

Do not talk about primary health care: talk about prime disease management goals. Pick three sentinel conditions and set goals for how these should change in the population over time. This will drive the primary health care revolution more than all of the conversations that we have had up to now will.
• We take from acute care and put into primary health care to achieve risk avoidance. The idea is that if you spend a hundred million dollars more on primary care, then you save the system in laboratory costs and acute care costs that do cost a hundred million dollars. That does not mean a hundred million dollars comes out of the system, it means that as people age and people get more diabetes and everything, none of those people get turned away because you have now made some room in the system.

• We need an attractor for a collaborative model. Stage one is to fully develop the funding model, and then open it up for migration. We have to get it through the medical association. Phased uptake will be two to five years. You announce long term intent with phased implementation. Gradually establish the collaboratives in the regions that are interested early and move through the province over time. The speed of the uptake will be dependent on the algorithm that is created through the funding model: who will profit from it, and that is where your early adopters are going to be.

• The Primary Health Care Transition Fund contributed to the development of primary care offices in the newly reconstituted health authorities. These began to develop connections with community-based primary health care clinicians, developing some contracts for novel activities.

• The historical model of family practice had advantages. It offered much freedom for physicians: clinical freedom, freedom of styles of practice and hours of service, freedom from the need to negotiate. Many of these are as limiting as liberating. Some gradual co-location is occurring. Historically family physicians collaborated in after hours care, but with the breakdown of family physician involvement in hospitals, this has started to erode. Some family physicians joined together to work in walk-in clinics, chiefly on a fee sharing basis, but focusing on simple short-term, episodic health issues. Others have worked on a contract basis with health authorities, either in community clinics, or, increasingly in hospitals as hospitalists.

• Future planning for primary care should use advanced models for the health care system including the Results-based Logic Model for Primary Care, and the Clinical Microsystems model as organising frameworks. The latter has a great number of tools and management approaches directly relevant to care and care management.

• Primary health care reform in Canada is overdue and high on the public policy agenda. In the last decade the solution to the crises in health care has been to pass out more money. Recent efforts, most notably under the Primary Health Care Transition Fund, have been too narrowly defined since chiropractic and other
non-medical health care disciplines have not figured largely in these reform efforts.

- A pilot model in maternity care is the South Community Birth Program, which is a collaborative model with family physicians and midwives providing care in a team with nurses and postpartum support and doulas to a multi-ethnic, multi-lingual community and where the primary caregivers do not have all of those languages they make sure that there is doulas. They do group pre-natal care in a centering pregnancy model. It was funded with federal health transition money.

- The DEHACEM collaborative was a Vancouver Island Health Authority pilot with a group of ten doctors where the community home care nurse, instead of having a geographic region, was attending to that office of ten doctors no matter where the patients come from. Everything was dealt with through the collaborative, so the patient has got a home. They have got the lab and the pharmacy there: everything is there. The doctors are delighted, the patients are delighted. It took a lot to broker that with the union, changing that focus.

- We need to take staff from the health authority and match them with physicians throughout the area to create efficiencies.

- What we need is a government structure at the provincial level that brings in different people, is cross-sectoral, and has people that are very well respected. When you have a multi-stakeholder governance structure, you have to be more accountable because you are going to be caught out by different groups. That would provide some legitimacy and support for what we need in relation to the Ministry of Health. If you had a council that represented all of us, then it would be strong enough to make changes that would affect everyone, even physicians.

- **Comments on entry-points:**

  - We are talking about entry points rather than response points as if somehow there was an element of privilege in being able to get into the health system. So, do you need an entry point password to get past the gatekeepers?
  
  - Physicians are gatekeepers but patients do not always need that step.
  
  - Meals on Wheels are in a perfect position to do a quick visual scan of a senior’s residence and just see what is out of order. Are there medications sitting around that maybe are not being taken, for example. There are other interactions that many other people have with parts of the population you might want to track more carefully that we are not making use of.
• One of the challenges we have got is how to get people to understand their entry points. You have to be proactive and confident in managing your own health care, which many people are not equipped to do. We are taking people from picking up the phone and having the ambulance comes to their door to being proactive in managing their health care. People have been socialized to expect immediate response. How do we help people take control of their health?

• Emphasis needs to be shifted from the current mode of delivery where physicians are the only gateways into the system to a cheaper first line provider. This is already taking place to some extent with nurse practitioners and health hotlines, but this is the long term direction for health care.

• We need to see a system where a social worker refers clients to the health care system if they determine that part of your problem is a health or a medical problem. We are so far away from that. It works in clinics when you have social workers in the hospital or in clinics, but not in the community. That raises questions of how many sectors need to get involved, where does the health care system begin and end and how do you coordinate with everybody else about it?

• In urban centres most apartment buildings have more people than are found in many isolated communities. Why not have nurses assigned to these high rise apartments with their many hundreds of people as the first line of health care? Two nurses, sharing duty in a high rise apartment, could divert any number of people from the expensive and over crowded hospital emergency rooms. In this way real need cases would get to the emergency while others would be treated on site or held until the next day for a doctor’s appointment.

• Patients fear alienating doctors by seeking different entry points.

• Primary health care does not need to offer same day access to care unless it is an acute illness or emergency.

• Family physicians are central to British Columbia’s primary maternity care system. Midwives also function as primary maternity care providers with first-contact access, as nurse practitioners do in other areas of primary care.

• We need to think about how we unload the physician, how we surround them with services to help us manage some of these chronic diseases. We have set up the physician as a single point of failure! If we continue to put primary care doctors in the position they are in right now, then they are all going to quit. They should in fact quit because we are expecting them to do magic.

• Doctors of Optometry are primary care health care providers specializing in the examination, diagnosis, treatment, and prevention of diseases and disorders of the visual system.
• **Comments on citizen and patient-centred care:**

  - What we are really talking about is those services that citizens need that are provided in a coherent and consistent way across the system that is holistic. It comes back to redefining the services that we should actually include, and then rethinking that fundamentally.

  - Provide patients and caregivers with education. The system needs more engaged patients.

  - A primary clinic provides the whole context. What is the reason for someone's ankle sprain? If it was a kid who was not wearing appropriate protective gear on a skateboard, you could educate that child. You could educate that parent. If it is a senior who was a bit frail and lost balance and sprained her ankle that way, you can then look at all the circumstances and provide the information and assistance that person needs. A single family doctor usually does not have enough time to do this in their short visit.

  - If we have a patient focus, then the professionals come together better because they keep being driven to the patient needs. They would be able to put their provider silos away a little bit and not engage in so much turf war.

  - People say primary care systems are person-focused and not disease-oriented, but they can be stage-of-life oriented. If you have got people in that stage of life where they have got all of these chronic diseases flowing, then the disease focus comes.

  - To manage performance, you need to look at the balanced scorecard approach applicable to a team working to achieve outcomes collectively.

• **Comments on change management:**

  - Practitioners at the local level have to realize that they are not isolated players, but that they are members of the community in promoting health and not just part of the health care system.

  - Rural communities can really be a test bed for new models of care because it is easier to get your hands around it, test it, evaluate it and then expert it to the larger centres.

  - In 12 years, since we have been running low-cost sexual health clinics in the province, adolescent pregnancies have dropped 40 percent. These sexual health clinics are combined with school education in a lot of the communities. So this is an example of where a service that exists outside of the stamp of the institutional system actually can have an impact.
• If we want clinicians to be accountable for a practice, for a population of patients, then we are going to have to give them tools so they can actually manage a population of patients. Managing a population is as much about the patients who are not coming in as the people who are. You need to be able to look across your population of patients and say what are the unmet health care needs of this group of people? Who are the people who most need my attention? But also who are the people that have needs that could be met in an alternative way?

• The medical association needs to be really involved in building a vision for a new way of organizing primary care and an ultimately the health care system.

• There is a conflict of ownership as a result of vested interests engaged in primary care delivery.

• Because we are being a little bit more cautious and worried about the bottom line, we are encouraging doctors to first form together in a network and then co-locate and seek group funding. We realized that we could not do it without support of the Ministry of Health, and we could not do it without support from nurses, dietitians and social workers. Those three practitioners were critical to moving it ahead, getting doctors to interlink with them and allowing those practitioners into their offices.

• We need a greater focus and investment in primary care.

• We need to think outside the box and connect things that we think of as traditionally part of the health care system with the community and think about what health is, not just as it is defined necessarily by the Ministry of Health. We need to think about how those connections can be made.

• These models exist in Europe and the United Kingdom. They work perfectly well and yet we do not seem to have a true primary health care strategy. We have not changed the fundamental incentives to make it run appropriately. We have not asked: what do we want this picture to look like? How do we want people to work together? How should we pay them? How should we motivate them? We are not tracking them anyway, in terms of the data, so if they are actually delivering care according to guidelines, we are not able to track that and actually show that they are making a difference.

• We should act quickly. We are in a crisis right now in primary health care. Maybe the government actually has to look at some of the things that people are doing, politics aside.

• Creating effective clinical microsystems requires changing to an electronic medical record. There needs to be effective implementation through: time and support to plan personalized patient care (patient has their own cycles for testing
and patient care), a change in practice model, prompts to use the electronic medical record, knowledge about tools, and reminders to all key partners.

- You will have to persuade physicians to change their practice. Physicians now are working in solo practices with fee for service. There has to be a different way of compensating them. Maybe it would be capitation. Maybe it would be salary. There are probably some models to work on and just expand. If you have a number of folks building the model, or participating in it and understanding what is going on, then they can extract the pieces that will work.

- Start with where there is interest and gradually peel away and reconstruct from the related budgets over time. You are not going to flip a switch and all of a sudden one day everybody goes from operating totally one way and being funded one way to another.

- If you look at the hardest problems and you tackle something like the Aboriginal population, there is a huge economic development agenda there and you are probably talking about a generation to really make a difference. Look at the tobacco experience: there were significant changes as a result of the first round of legislative changes, then it flattened a bit and now there is another little drop. But it does take a long time. This is the idea of social marketing: it is a heavy marketing effort to actually engineer society the other way.

**Ideas and Suggestions**

**System Design and Vision**

**Entry-Points**

**Citizen- and Patient-Centred Care**

**Change Management**

- **Ideas about system design and vision:**

  - Ten years from now family physicians will manage people proactively and by exception. They will get to their desk in the morning and have a report that, for argument’s sake, has 80 names on it. They may be effectively doubling their existing capacity to manage people today. They will go through that report. It will have been compiled by an inter-professional team that, by the way, includes closely integrated mental health professionals as well as nurse practitioners, kinesiologists, registered dieticians and others, pharmacists, and so on. They will effectively be able to manage twice the number of people in a day than they do today. However, they will only see in a given day maybe ten or 12 patients. And
when they see those people they will spend the proper amount of time with them and they will achieve the outcomes that they are striving for professionally.

- A system of care based on the pillars of primary health care as delineated in the Romanow Commission must be implemented immediately: continuity of care; early detection and action; better information on needs and outcomes; and new and stronger incentives for health care providers to participate in primary health care approaches.

- Allied health care professionals could provide a mobile service to doctors’ offices for some of the more simple diagnostic tests and patient education.

- Develop an enterprise approach, bringing all of the pieces together, not as fragmented or silos, and including governance and needs and risk analyses.

- An effective primary health care centre develops strong links to the community and community based services.

- Primary health care should have an emphasis on health promotion, education and wellness, chronic and debilitating diseases, and mental health with a special program in non-pharmacological intervention.
• Challenge the assumptions on which the system is built. Do not move everything upstream into primary care on the backs of physicians.

• Keep a public system that decentralizes the delivery into manageable geographical areas by using a multi-team approach.

• Look at an integrated system of care including population health, palliative care and social integration.

• The framework should include case management, coordination and system navigation.

• Rebuild primary care: bring it into the accounting system.

• To maintain a strong public health care system we need transparency and accountability with a focus on primary care delivery (from acute care) and prevention in order to do a better job with the money we have.

• We need publicly funded, not for profit primary health care in integrated health care centres, administered at the community level and supported by documented evidence and in compliance with the Canada Health Act.

• The delivery model has to take account of available funding and the demand on that funding and develop a system that is inter-professional and collaborative.

• A new primary care system would have welcoming environments with integrated and convenient access. The attitude of professionals would be both positive and collaborative. The key outcome would be higher client satisfaction. This vision would include a values-based approach to training institutions and programs.

• The vision would be an innovative, integrated primary care and chronic disease delivery model, which is publicly funded and privately delivered.

• There should be a provincial framework which includes a case management and system navigation component, with government oversight and collaboration between agencies.

• Primary health care centres goals should be to improve the population health of the community and alleviate pressure on acute care.

• Create a publicly-funded and administered health center where family physicians, specialists, diagnostics, home care nursing and other resources are in one building.

• Success would look like no one would have to use a primary care centre. If you have ultimate success, then you have an extremely healthy population.
• We have to remove some of the disincentives because the notion of having general roster general practitioners and then having primary clinics sounds good, but the ethics of our communities is such that people believe that they have to see their own private doctor all the time for everything.

• Develop a model based on emerging best practices for primary care with remuneration based on a blended capitation and fee for service approach. Some of the features would be is a group of physicians and other health care providers working together in an integrated system of primary care with clear accountability. It would provide incentives for performance based on sound, evidence based, quality improvements and it would have flexibility for services based on community needs and desires.

• British Columbia needs community clinics like Ontario and Saskatchewan which focus on the team approach.

• Create ways to bring nurses, social workers, dieticians, mental health counselors and other helping professionals into networks with existing family practices to make it easier for family doctors to coordinate multidisciplinary services for their patients.

• Future planning for primary health care should explicitly address consideration of productivity within the context of safety and effectiveness.

• Government should fund a measurement-based study of primary health care models including piloting and evaluating different models with different cost structures. Government should look at existing programs, and politics aside, consider which ones to base pilots on.

• Our health is not just comprised of one or two things, but a multiple of disciplines. This should include, among other things, physiotherapy, dental, fitness, mental and so on, which all contribute to our wellbeing.

• **Ideas about entry-points:**

  • There should be multiple entry points (clinics, phone, and internet) designed with an understanding of who the patients are.

  • Include economic and social services organizations as an entry point (or as a pre-entry point).

  • Making the front end of medical care more responsive and efficient will doubtless require the introduction of reception cells, appropriate diagnostic machinery staffing, reducing set-up and set-down times among other tools for minimizing waiting times and waste.
• The provincial Ministry of Health should recognize all primary contact health providers on an equal basis to support the daily choices the public makes for necessary care. This will help to fully integrate primary health care and also acknowledge the public's right to choose who their primary care provider will be at their time of need. From the public's choice, regulated health professions are not alternative, supplemental, or complementary, but are mainstream, core services that support the public health care system.

• There should be formal recognition of minimal standards of primary eye care as a component of a comprehensive health care system, and parity in the scope of optometric practice across Canada.

• Develop a collaborative model of vision care services including optometrists, general practitioners and ophthalmologists.

• Embrace a primary care model that has a multidisciplinary approach with multiple access points.

• Develop health care clinics that encourage the devolution of power from physicians.

• There should be different points of entry into the health care system, including physiotherapists, nurse practitioners, chiropractors, naturopaths, and so on.

• We need to increase entry points into the health system. We need to change the conversation from a question of access to a primary care physician to access to primary health care, which could include nurse, practitioners and others. We need to look at appropriate primary care through different lenses, through evaluation research to look at what works and what is needed. We need to incorporate the notion of multi-disciplinary teams and multiple access points to primary care in medical school curriculums as well as public education.

• Clinical microsystems provide the most health care to most people. They include everything that goes into providing that care, from staff and technology to information and behaviour. The patient is at the centre of the clinical microsystem. The quality and efficiency of the patient care cannot exceed the quality and efficiency of the system providing that care.

• **Ideas about citizen- and patient-centred care:**

  • Shift to infrastructure changes and implementation strategies which are all about the patient.
• **Ideas about change management:**

  • Primary care should be a focus of the new model as the gatekeeper to the system: the current approach needs to change and we need to develop incentives to encourage that change.

  • We need a top-down prescribed strategy to create public confidence in the system. Leadership from the province can influence the federal government positively.

  • Challenge the normalization of Aboriginal health inequities in the province. Work with Aboriginal community partners. If they are not coming, then look at your process to ensure that the theory and mechanisms of health services deliveries (not just the outcomes) fit with local Aboriginal health knowledge and systems.

  • There are no reasons why Indigenous people should not be on hospital boards and management. There are no reasons why Indigenous people should not be involved in the management and delivery of mainstream or non-Indigenous specific primary health care services.

  • Government has lost the public relations battle and needs strategy for capturing the public's mind. The government does not fight back against malicious attacks. Can we assure decision makers that we will support them in making tough decisions? You cannot mandate change when there is sabotage.

  • Be careful about being pulled towards what we already do because it is comfortable. Look at different complementary medicine and therapies do not be afraid of test-driving some of that.

  • We need to be piloting and evaluating different models of primary health care.

  • Moving to a primary health care model requires a wholesale change. We have only just started.

  • We need an outrageous target for primary healthcare in British Columbia, like by 2010 we are going to have two hundred integrated health care clinics in place across the province in these communities.

  • No more pilots. Put the money in the bucket and do it. It is not a pilot, because in order to get this to work, you have to make a structural change. And that requires courage, and often governments do not have courage because they want to get re-elected.
• If one of the goals is to re-think primary care and move to more of a team-based approach, how do we go about motivating general practitioners and providing mechanisms that would enable them to be successful in that kind of a model? The physicians themselves want different things.

• General practitioner registers are closed off because they are so busy they cannot take more patients on, so there is actually no threat to them whatsoever. They can break down these scope of practice barriers and allow some other primary care practitioners to work much more closely alongside of them, taking off some of their workload. In fact, they may be much less stressed and still make pretty much the same amount of money, and maybe even more if there are new incentives to work around chronic disease management programs and so on, and to provide coordination and health promotion services.

• Ensure fundamental conditions and resources for health are available in communities where people live, work, play and invest.

**Primary Care Administration and Facilities**

**Comments and Concerns**

**Administration and Funding**
**Management and Accountability**
**Facilities**

• Comments on administration and funding:

  • While still small in number, midwives have the potential to increase the Province’s primary maternity care capacity. Yet right now the system is losing its capacity. Over the past nine years, the percentage of British Columbia births by family physicians has dropped from 59 to 45 per cent and there are 47.6 per cent fewer family doctors delivering babies right now. In the same period, midwifery numbers have risen from 29 registered midwives in 1998 to 106 currently. We have gone from providing care for about 1 per cent of deliveries to 7.3 per cent as of March, 2006. But that is not filling the gap.

  • How many physicians would there be? How many facilities in different areas and districts? How many clinics would it take? What kind of population would be served by one team? There are a lot of things to think about. You need to get the population data and determine what characterizes their health needs, and then tailor it, and then be willing to monitor that data over time because it will change.
It would be nice to have some baseline health data and follow outcome data over time. Before you were to launch these primary care centres, you would have to collect data and analyze existing data, and then tailor it to meet local needs.

- How would this look different in like an Aboriginal community? Most of them are quite small and so they have trouble sustaining facilities and infrastructure. Most want health care provided by their own people and their own health care system. But we are not going to have two systems. So we need to figure out what is going to work that will be okay for them, and have more health care workers who are Aboriginal. How about developing capacity to partner with neighbouring communities. Around Hazelton there are eight or nine different communities all trying to build a health service. How can we work together with the folks in those Hazelton villages to plan these resources together to make something bigger for all of us?

- There are some successful initiatives, and one of them in Vancouver Island is the collaborative for chronic disease. Using that as a framework, we could set up a system of clinics collaboratively-linked that would be able to provide services to our patients across the Island. This would require these individual clinics to work collaboratively: they would have regular meetings together, and they would share inter-professional advice and learnings to go on and improve, not only how they function, but improve patient outcomes as well.

- There is now a demand for family practice to do prevention counseling with their patients. We were told not to do it before. There needs now to be a shift in funding models that will accommodate this shift.

- Payment structures for physicians are historically rooted in the British Columbia Medical Association agreement. It will require some initial very strong, top-down, decision-making and commitment to re-structure certain aspects of the system. We need the political will and a plan that we will all invest in.

- Fee-for-service motivates physicians to spend as little time as possible with patients.

- There was an example in British Columbia of the development of the population-based funding model in 1998. Payments went to the group, not to the doctor, so each group had to determine how they would share the funding.

- Practitioners out there are ready for this. The medical organization may or may not be, but the practitioners certainly are ready to do this. Even if you went a small baby step in one health region and said, "You know what? If you are a family practitioner, you cannot practice here unless you have privileges in the region," you would have a battle royale. The gain would be a better system for looking
after the population. Let us say that the only way we can make this work is that we need contracts where health authorities perhaps tender the work they want done in primary care and we take all of the primary care money and put it in the health authority. You have got war. If we work with the existing money, how are you going to do it? Two billion dollars in doctor compensation in the last five years, and nothing is different. We need to be wise about it instead of doing it the way the medical association wants to do it. But if we do not do it the way the medical association wants to do it, we have got war.

- Physicians are part of a group of primary care physicians, and they would love to hire all sorts of other auxiliaries to rebalance the responsibilities, but they cannot do it in a world in which all the income has to come in to them as fees for their personal services.

- You really have to provide doctors an income that is equivalent to or better than what they have got at the moment. They still do not like the concept that we can give them at least what they are making now, and get them to work in a capitation model. They want the fee for service. And they have the power right now that they use to get the fee for service. They are reluctant to work in capitation models. Fee for service for physicians really represents their professional autonomy. There are individual physicians who are ready and they are interested in the model. But there seems to be a bit of a disconnect between the physicians and their medical association on this.

- If we implement it at a capitation blend model, using everyone to their maximum scope and capacity, the weight of utilization of physicians may actually drop through the use of teams. If you actually have a nurse that is working with you, you do not need two doctors.

- How do we resource the primary care system? 85 percent of British Columbians see a family physician every year, amounting to about 3.5 million contacts annually. A majority of it certainly is based in family doctors' offices, the funding for which is through their fee-for-service payments. In the United Kingdom it used to be that there was an allocation and an assessor would come around and look at the premises and the practices used, and then they will get assigned a reasonable payment for the premises. They also had innovation funds to upgrade the premises or put other mental health, community health nursing, physiotherapy, or occupational therapy services into practices depending on the needs of the population they serve.

- If we really think it is important to have a more team oriented approach, there needs to be a robust way of endorsing that at a practice level so that people do not actually face negative incentives. Physicians are not resistant to doing this,
but they are not stupid. They are not going to drive the practice into bankruptcy by hiring other people for whom they receive no recompense. The reason why physicians are all uptight often is not only just the fees, but their fees have to cover their overhead costs. The fees are structured around the fact that physicians are self-employed entrepreneurs, they get no benefits. So the fee is paying for their pension, their staff, their equipment, and their vacation. The difference when they are on salaries, they forget, although they might be getting less money, it is not actually costing them more. They have to factor in that they do not have to pay for the staff, the equipment, or the lease. So when you start talking physician reimbursement, look at the whole picture, not just the fee. When you go to a salary base, you will find their dollar is going to go down, but they will be ahead of the game because these other things will be added. Anytime we want people to change what they have been doing, change things that they care deeply about, you have to be prepared to make it attractive.

- Population-wide access to continuous primary care cannot be guaranteed under fee-for-service remuneration.
- There is evidence in the literature that inefficiencies and higher costs for care are associated with fee-for-service remuneration and smaller practices.
- In British Columbia, the majority of primary care is given by physicians working in doctor-only offices and remunerated by fee-for-service payments. Consequently these physicians have to provide all patient-related care, even that which does not require a physician's skill or knowledge, and have to see each patient in order to receive payment. Many of these practices are small, with one to three physicians working as a group.

- **Comments on management and accountability:**
  - A comprehensive approach to health care would improve the ability to measure cost and benefits.
  - If we are going to have health authorities, there needs to be a connection to primary care. Clarify who is responsible and accountable. In our current system, there is no accountability for primary care and no identification of success factors or clear outcomes and measures.
  - Currently the organization of primary care services is inefficient and excludes approximately 600,000 British Columbians from access to continuous primary care, thus putting them at risk of inadequate care and treating them inequitably.
  - All geographic health authorities do have a primary health care department program portfolio. We really appreciate the charter because it tells us this year and in years out some of the things that we can be doing to support primary
health care providers as well as patients in the community. What other roles would be helpful to patients and providers? We do not have a locus of control over primary health care, general practitioners, our independent business folk, community pharmacists, and community physiotherapists that are not funded by the health authority. Dentistry is also another key factor there.

- We do not have primary care organizations with flexibility to meet standards however they wish. We have micro regulation of who can deliver a particular service, and very little macro accountability about having outcomes from those particular services. Accountability is always better when it is more localized. If it is provincial, then there is always lots of red tape. The problem is that there is no organized locus of accountability for care for a patient.

- In Ontario they provide bonuses for being on call 24 hours a day. The statistics in Ontario demonstrate that there are about half a dozen phone calls to doctors per night. They are paying a huge bonus for this access, but they receive maybe six calls a night. But people want access 24 hours a day and seven days a week, and so they deliver. It is not worth the extra money for having doctors on call, because they do not get called.

- Comments on facilities:
  - The Saskatoon Community Health Clinic works well.
  - Primary care centres encourage the shift to a health promotion paradigm.
  - Implement paediatric walk-in clinics staffed by paediatricians and paediatric nurse practitioners.
  - I work in a health authority-run centre, and I would hate to see those replicated. They are terribly inefficient, bureaucratic and very expensive.

**Ideas and Suggestions**

**Administration and Funding**

**Management and Accountability**

**Facilities**

- Ideas about administration and funding:
  - Create a larger role for private delivery.
  - We should target the average time for the primary care visit being something like thirty minutes. It would mean that the primary care visit really has value.
• Reorient primary health care to help the public system perform better and more efficiently.

• Give them the framework and the system for collaborative care. The care providers are good at delivering the care. Set up the infrastructure.

• A database for certain chronic illness patients with specific relevant emergency treatment information and patient medical history could be designed to link with patient Care Card numbers. Or, the typing of a patient’s Care Card number could flag their patient file with a warning to check a dedicated database for treatment information.

• The evolving best practice model is one in which the practice rather than the practitioner is funded. There are groups of physicians cooperating with teams of other professionals. The practice is reimbursed by a combination of capitation and fee for service. Capitation implies that the practice is responsible for a defined group of people. You do not want the practice to be able to select the least cost patients, which is why the reimbursement will be based partly on capitation. It has got to be adjusted for the characteristics in that population. It will be partly based on fees for the performance of procedures, which have been well established to be effective as prevention.

• Primary eye care should be explicitly recognized as an essential component of general preventive health care. The components of primary eye care (refractive status, binocularity, and ocular health) should be recognized as an integrated suite of data that should not be fragmented.

• Consider a health co-op model, owned cooperatively by practitioners and the community, and offering an integrated service setting with a number of different practitioners under one roof. With the co-op approach we share the costs, so it helps the consumer but it also helps the provider. That is one of the things we think is important in primary care: the provider gets some benefit out of this as well as the consumer. If you banded together and worked out some way where you could share the overhead, provide extended hours that would improve access, provide an expanded scope of services, and share the workload, you would be doing it for yourselves and your patients. The other dimension is the opportunity to open doors for delivery of other community and private services. The co-op provides more potency for getting that network in place than a single practitioner might achieve.

• Government should develop a standard approach administratively and clinically to do collaborative care and it should fund multiple disease prevention management centres.
• The government should explore the potential of making individual practitioner-based patient population health profiles available to family physicians.

• The successful models out there are all a blend of some sort of capitation, combined with some element of fee for service. That seems to be the most successful model out there. The contract has to be held with a group of people so that there is a clearly identified group who is responsible. The objectives of primary care must be stipulated in the contract. If it is fee for service-based, it can be based on outcomes or the service level. You want capitation because that defines the population for which this group is responsible but you want a fee for service component because that is the lever for improved population health.

• Make doctors employees of health authorities.

• Physician compensation should be salary based.

• Eye care services that are deemed essential to a comprehensive health care system should be covered equally under the publicly administered program regardless of whether they are provided in a clinic or a hospital, by an appropriately trained and equipped optometrist, general practitioner, or ophthalmologist.

• In addition to workload based incentives, the Ministry of Health should consider health gain based incentives for the primary health care system.

• Physicians are provided funding through either the health authority or the government for an interdisciplinary provider and/or team that is required to meet their patient population. Each physician’s group practice has a nurse, at a minimum, funded not by that physician. It is paid for by somebody else, because the return on investment back to the health system would be quite significant in terms of reduced acute care utilization, and so on.

• The Government should fund physician practices through the health authorities, and a significant portion of that funding should be tied to the number and characteristics of the population registered with the practice.

• **Ideas about management and accountability:**

  • Implement a new funding model for primary health care that combines outcome and performance payments with fee-for-service and population-based payments. Create the appropriate governance and policy supports for team-based care for identified populations. This will require increased transitional costs and supports for change management. A key element is effective use of a robust electronic medical record by the primary health care team to manage delivery of care and promote health.
• Primary health care must be locally controlled and management, and appropriately linked to secondary services such as training and education.

• Increasing practice size would lead to economies of scale and higher incomes for family physicians, without any additions to the available amount. The need for locum services may be reduced in a practice where there are enough physicians to manage the workload when one member is away.

• **Ideas about facilities:**

  • Create publicly funded urgent care facilities which are open 24 hours a day and seven days a week.

  • If hospitals are about health care, there should be one wing with a free Naturopathic Doctor, herbalist, acupuncturist, osteopath, massage therapist, Chiropractor and so on, and a free fully equipped fitness center open 24 hours a day, seven days a week.

  • We need nursing clinics: a physician would be in charge, and minor health concerns can be addressed; ongoing injections can be administered, such as allergies, B12, flu shots, and so on; routine dressings can be changed and monitored; and, many other services can be provided by a Registered Nurse.

  • Create more holistic care facilities in a community clinic model and setting which are publicly funded.

  • There should be more inter-disciplinary birthing centres.

  • Put primary care services in malls.

  • Provide mobile primary health care services.

  • We need more non-profit clinics like Read and Mid-Main who operate in a team environment with a global budget and a prevention and health promotion angle.

  • The primary care system should capitalize on technology.

  • Implement primary health care centres, but continue to fund and support walk-in clinics where family general practitioners continue to practice.

  • Mall facilities would have nurse practitioners, nutritionists, and counselors. They would provide advice and information on support programs, vaccinations, exercise programs, pharmacists, and outreach services.

  • An inter-disciplinary health care centre is needed in the Interior.

  • Centralize cancer care.

  • An investment in community health centres would be one key positive allocation that could be made from the Ministry of Finance’s Health Innovation Fund for the
2007-08 fiscal year. These centres have a proven record in helping prevent illness and keeping people out of hospital. They have been touted as a critical reform to make medicare work as far back as the Hastings Commission of 1971, and again by Roy Romanow in 2002.

**International Models**

**Comments and Concerns**

- When I lived in Australia, we had community based health centres that were open 24 hours per day and staffed with salaried physicians and nurse practitioners. These centres were multi-disciplinary, had lab and X-ray ability, and during the day offered out-patient physiotherapy and massage therapy. Access was free with your medicare card. The emergency room at the hospital was the place for ambulances and emergent situations like a heart attack or trauma.

- In the United Kingdom, physicians set up health care trusts and can be paid for the full range of services that are being offered. It does not matter whether the physician is offering the services of a nurse practitioner, a pharmacist, a dietician, a physiotherapist, and so on. All of a sudden some of the reasons for feeling very protective about the turf start to evaporate and there is an incentive to want to create the team. It is funded through a contract to provide services to a known group of people. This is the same within the Health Maintenance Organization (HMO) in the United States. But the satisfaction levels reported by people enrolled in those Health Maintenance Organizations and the National Health Service is low, because patients do not like it. Arguably it is more effective because it is cheaper: you have a single fixed rate contract with someone who is providing a full range of services to a known population, and they in turn make all the decisions about what personnel they are going to employ. In Britain they have cut their wait lists, and our patients are furious about wait lists. So basically we have to choose which problem we fix because on some level it will be a trade off.

- The concept of primary care in Japan, Taiwan and Korea is really quite different. Most primary care physicians in Korea and Taiwan hold specialty qualifications. Public and private providers, community providers and hospitals compete fiercely for patients in all three of these countries and that is because patients bring with them all-important social insurance money.
• I lived in the States for a number of years before I moved to Victoria. We never saw our doctor. We had the clinic, and we had a really solid cross-section of practitioners. And, generally speaking, we saw the nurse practitioner in triage. Once I was shown what a nurse practitioner was, that was not an issue.

• Look at the Swedish primary health care example.

• In New Zealand, what the government attempted to do with its primary care strategy in 2003 is build on general practice organizational developments of the 1990's by establishing what are called primary health organizations. We now have about eighty of these primary health organizations covering the country and they are capitation funded, they require an enrolled population and they should feature a range of primary care providers. They are governed by provider and community representatives and they must aim to provide preventive care and to reduce inequalities, especially among Indigenous Maori people and Pacific people. There has also been additional funding for services to improve access for care plus initiatives and for health promotion programs. Now the concentration on primary care has not been cheap, it has been around six to seven percent in addition to existing health care funding. However, the seeds have now been sown for a strong primary care system and numerous quite exciting initiatives have resulted. The implementation path has been far from straightforward though.

• One of the features of both the United Kingdom discussion and the New Zealand discussion is the notion of reimbursing practices rather than particular individuals.

• In the United Kingdom we actually have a contract with the general practitioner practice, not with the individual physician. It may be a practice of four people to provide a range of services. We have actually made it so that it is the physician is responsible for the practice and they can provide the service in whatever way they see is right, provided again it meets our quality standards. So what you have seen in recent years is a big increase in the number of nurses and others who are employed in general practitioner practices. There have been some studies which show now that general practitioners are doing something like twenty percent of the direct hands-on work that they used to do and it is the top end. There is an awful lot more that is now being passed on. The chronic disease management system run by a specialist nurse may actually be a much better way of providing the service than periodic meetings with the doctor. So it a focus on the practice and getting rid of the professional barriers that say that only a doctor can do this.

• In New Zealand there is a nationally agreed primary health organization contract which was negotiated across all the various different primary health organizations representative groups and that includes the medical association and various other associations that work in primary care. It says that if you become a primary health
organization, you will provide a range of primary care services. You will include a range of primary care providers in your organization. You will be responsive to certain communities and groups who suffer from particular conditions and so forth. It says that you will also be eligible for additional funding if you can provide a plan for services to improve access. That is very broadly defined so it is up to the primary health organization to come up with a plan for how it might improve access to, for example, new migrant groups or groups of patients who have never ever been seen by a general practitioner in the last fifteen years, or groups of people who are perhaps morbidly obese and need a nutrition plan and an exercise plan and so on. So it is quite flexible and the financial incentive is definitely also within that contract because people who are not members of those primary health organizations are not gaining access to the money that the primary health organizations do have. General practitioners these days are doing much less work than they once did, they are also still very busy people, but they are working much more collaboratively with a range of different primary care providers.

Ideas and Suggestions

- The government could come up with some scholarships for leading medical professionals to travel to countries that already have similar kinds of arrangements, like New Zealand. New Zealand has been going through this major reform of primary care over the last ten, and especially the last five years. The doctors are really behind it and totally into it. It would be quite good for some Canadians to go down there and visit some of them.

Patient Advocates and Navigators and Case Management

Comments and Concerns

- System Navigation
- Patient Advocates
- Case Management and Discharge Planning
- Continuity of Care

- Comments about system navigation:
  - Navigating the system is challenging and daunting.
  - People have difficulty navigating the system because there are too many services under one ministry.
• System navigators help us move through a very complicated system, because even on equipment assistive devices we are looking at 17 programs in five ministries. Imagine.

• Increased understanding of the differences between Canada’s health care system and those of other countries would enhance cross-cultural understanding between health professionals and the clients they serve. Frustrations around access to health services are, in part, due to an immigrant’s limited understanding of how to navigate the Canadian health care system. Health education workshops delivered in the first language of immigrants are required.

• I think the healthcare system performs really badly in terms of being responsive to client needs and navigation.

• It is not unreasonable to ask for convenience in terms of access, information and navigation.

• Services are unevenly divided resulting in fragmented care and isolated decisions.

• A successful Service Canada initiative involved placing staff into community service (non-government) offices for ethnic communities providing service in their own language for a day or a period of time.

• In a team approach, patients will want one person that would be the leader, someone in charge. They will not want to be the coordinator of all these people.

• When you have got, for example, mobile health services, home care, or community health nurses, you have got all these disintegrated services each doing something for the patient, each doing maybe their own care plan, each working on different standards of care and all with different information. That is one of the biggest concerns about primary care, aside from the access. You have total fragmentation with the patient in the middle either trying to navigate all the services or trying to understand what everybody is saying and doing and that is an incredible duplication. It is inefficient and ineffective.

• The public is confused about the cancer agency and cancer foundation. We need identification of what the different organizations do.

• Cancer patients are almost helpless to find their way into the loop: they are diverted by the professional jealousies of assorted health practitioners.

• **Comments about patient advocates:**

  • Conceive of the advocacy as empowering people to be self advocates, and empowering the profession of carers to be better advocates. With self-advocacy you can do a lot of work in a year by talking to people about the concept of self-advocacy, putting material on the web, and putting material in handouts. We can
do that in a year at minimal cost. With respect to empowering providers to become more advocates, that is a longer timeframe. You can work with them to develop those concepts. You can talk about remuneration. You can provide information or continuing medical education.

- There is an important role for patient advocates and organizations to work and partner with health authorities and the Ministry of Health to raise the profile of patients' needs.
- There needs to be a place to go to provide advocacy. There should be a process within each health authority to specifically deal with roadblocks.

- **Comments about case management and discharge planning:**
  - Early case management of problems can prevent hospital admissions.
  - There is inconsistent discharge planning.
  - Do most people assume the primary care physician is supposed to coordinate services? That is not the right person, particularly when we are looking at having more gatekeepers in the system.
  - There is quite a bit of work in Australia around care coordination, particularly with general practitioners or primary care physicians. Family physicians are the worst because they do not know the other parts of the system, so they are very bad at coordinating, and not very interested in it.
  - Part of the problem is we are really set up for people who have a specific problem. In that context the health care system works pretty well. But when we are dealing with a population with significant risk factors, the system works very badly. That is when we look at good case management. There is a real person with a real face who has some responsibility for care coordination.
  - Case management and care coordination are not things we have invested in.

- **Comments on continuity of care:**
  - The available medical literature suggests that interpersonal continuity of care is associated with significant improvement in at least some care outcomes with the strongest evidence of such an association (being) for those outcomes that have been most frequently studied: preventive services and hospitalization.
  - Patients value continuity. They focus not only on the family physician, but on other members of the team.
  - There is very solid evidence that having a consistent provider improves personal satisfaction. There are a variety of continuities: informational continuity, personal
continuity, geographic continuity and so on. But if you have personal continuity, working with the same person or persons, people's satisfaction is certainly much higher. Usually it is higher still if you select the person.

- Each patient has to have a primary provider. That primary provider would provide the continuity of care and some coordination of services.
- All future planning for development of primary health care in British Columbia should explicitly focus on actively supporting continuity in care, in all domains.

**Ideas and Suggestions**

- **System Navigation**
- **Patient Advocates**
- **Case Management and Discharge Planning**
- **Continuity of Care**

**Ideas about system navigation:**

- To assist patients in navigating the system there could be a two-pronged approach: a passport for patients and one for care providers. You could have the dementia road map, kidney road map, cancer road map, or palliative care road map.
- There is an advocacy role that serves two purposes: helping people enter and navigate the system; and helping the health care professionals go to the right health care solution.
- A system navigator helps the person through the health and social systems. It does not have to be a person. You could set up a central information system or a general referral system.
- We want to avoid the word system navigator because we do not want to elevate it to too high a professional level, we would like to it to be mostly lay people.
- The potential exists also for saving money, because if you have care coordinators presumably the patient outcomes will be better faster. You will reduce the need for ad hoc services, visits to emergency rooms and so on.
- A requirement of the care coordinators is that they have the skills and perhaps cultural ethnicity to match the population they are working with.
- People need to be well trained to do this job.
- You need people who know the whole system, instead of somebody phoning 15 different places and still trying to figure out who to call. It is a single entry system
so you do not have to find all these services yourself. If you are admitted you have got somebody working with you who really knows the system and the linkages to other services. It is really their job to match the best possible set of services that they can, to the needs that you have and to check on you every so often to make adjustments as appropriate.

- Care coordinators do not have to be separate: they can be your doctor, your pharmacist and so on. It is a philosophy. There are community based organizations that do these kinds of things too. There is a difference between advocacy and navigation. Advocacy is about representing someone's interests. A navigator provides you with information and shows you how to get from point A to point B, and what sort of stops you might want to make along the way. They are not advocating for you. They are providing you with tools so you can do something yourself. They empower you to do something. Some people require both.

- We need to improve care for foreign or other language speakers.

**I ideas about patient advocates:**

- We need a well-informed, paid individual to act as advocate, ombudsman and liaison for seniors. They should have nursing or social work training.

- Patient advocates are needed and valued.

- Professional health advocates are needed to facilitate access to care, assist with referrals, and improve access to education and information.

- Actions taken to address ethno cultural health needs be done in partnership with members of the communities themselves, and with community service agencies.

- Create a medical ombudsman to provide a place for individual cases to be heard and information to be distributed.

- First Nation and Aboriginal liaison workers are needed in hospitals and in the community.

**Ideas about case management and discharge planning:**

- You need a better sense of a system of care into which a lot of senior's care fits. You need a broad base of services, in an integrated and coordinated system of care, managed or facilitated through good quality case management, so that there is a champion for each person that comes into the system of care. The components of the system see themselves as part of the system and therefore they also agree to conform to the general policies about accessibility and how you
get in, and what kind of care you get. What this allows you to do is provide much more seamless care for individuals if you have this kind of integrated system.

- There should be better communication between doctors, specialists and patients regarding diagnosis.
- Primary care coordinators could be catalysts for innovation in the system.
- Vancouver General Hospital orthopaedic surgery has top-notch quality of care and integrated case management.
- In Montreal they focused on case management and developing a very strong personal relationship. You could call this person anytime and they would be there. So if you ended up in emergency, your case manager would come in to you and they were responsible for fitting in all the services. You did not have to schedule your appointments. They found that overall satisfaction was up and hospital visits were down, but costs were about neutral because they used a lot more physiotherapy and other services.

- **Ideas about continuity of care:**
  - We need preplanning for visits to the doctor which involves a physician review of a number of components of patient care including: past assessments; promotion, prevention and management issues; prearrangement of tests; assignment of provider(s) according to needs; and the duration and nature of physician encounter related to needs and choices of the patient. Each task is provided by the least expensive provider with appropriate training. Understand when the patient may be able to manage tasks themselves, with a view to enhancing engagement in their care.
  - A Medical Intuitive should be assigned to all patients. Medical Intuitives could be used in hospitals to assist patients seek out different healing modalities rather than the pharmacological modalities within the hospital setting. The Medical Intuitives would also quickly identify any problems. The use of Hands-on Healing, Therapeutic Touch, Meridian work, Chakra clearing, Auric cleansing, Homeopathy, and the use of non-pharmaceutical vibrational medicines should be priorities, while the use of pharmaceutical drugs (including vaccines) should be reduced to a minimum. All medicines should be assessed for the individual patient using Dowsing and Kinesiological methods. The Ministry of Health must not be dominated by members of any one modality to the detriment of other modalities.