Thank you for the opportunity to contribute to the dialogue.

The following comments are a response to and supplement to the document prepared for the Primary Health Care Workshop of June 13th. Comments here should be integrated with those in the comments on the Health Human Resources document. These issues need to be seen in a coherent whole; one illuminates the other.

**The Current Realities**

The context for any consideration of forward development of Primary Health Care must include:

- Recognition that increasing family physicians in a society:
  - extends the populations longevity and
  - reduces overall health costs and
  - improves the equity of healthcare
- Recognition that many British Columbians do not have a family physician (estimated at ~15% or more)
- Recognition of the aging population, which has an established need for more primary care
- Recognition of the need to increase the focus on Chronic Disease Management (CDM)
- Recognition of the need to address preventive health issues more comprehensively
- Recognition that many family physicians are moving into more limited practice fields. This is important as family physicians might be considered the ‘stem cells’ of the medical system – with a broad clinical education, they can respond to needs for skilled service in many important areas: Emergency Medicine, GP Anesthesia, GP Obstetrics, Hospitalists, Sports Medicine, regional cancer care, Palliative Care, GP Geriatrics/ Resident Care, etc. While adding additional services, this also reduces the capacity for comprehensive generalist care.
- Recognition that the family physician workforce is aging
- Recognition that in the face of increasing complexity of Family Medicine, continuing prejudice regarding the value of Family Medicine and the skills of Family Medicine specialists, growing student debt, societal forces affecting the demographics of medical students, other societal changes and prominently, an income gap which is growing in dollar value between Family Medicine and other specialists, there is a declining enrollment in Family Practice Residency Programs
- Recognition that the younger workforce
  - Do not establish new practices as historically has been the case
  - Prefers other payment approaches than the traditional and currently predominant FFS payment system
  - Is moving to be predominately female rather than male
  - Sees fewer patients daily, especially so for women
- Recognition that mid career family physicians are leaving practice
• Recognition that forty years of expert reports have supported the value of collaborative, interprofessional delivery of primary care services, with recent reports including Romanow, Kirby and Fyke. Recent research and practice innovation with a focus on quality outcomes have reconfirmed this in practice, and emphasizes a new set of skills in organisation and communication required to develop and sustain a focus on quality outcomes across the broad range of primary care components. While BC is beginning to recognise this evolution, there are very few examples and no comprehensive support for such development

• Recognition that Primary Health Care is an undervalued and underfunded component of BC’s health care system. Despite serving ~84% of the population in any year, including the majority of obstetrical care, palliative care, residential care, Mental Health care as well as general office based care, the entire family practice infrastructure, including facilities, staff, equipment and family physicians themselves receives only about 7% of the healthcare budget

Access to the Healthcare System

• Access to the health care system should not be dispersed. There is a strong literature base supporting the positive impact on health of Continuity, a fact which has an inherent reasonableness. Untrained, unskilled (or not trained/skilled in the context of a scientific, evidence-based background) personnel will only create greater inefficiencies and costs. Effective strategies are available and it is towards these that investments should be targeted

• Many approaches to improving Access to care are available and some are being adopted in BC, though there is great room for greater integration and innovation.

• Collaborative, interprofessional care in group practice settings, well resourced with space and electronic medical records should provide the core of support

• Patients will welcome and use a practice internet portal to make appointments, to access their health record, to contribute to their health record and to access health information tailored to their health conditions

• Patients welcome the opportunity to address many health issues over the phone, a very efficient and more traditional approach, but one not often funded, and eagerly adopt Email correspondence. As with much office-based care, much of this can be provided with other health professionals, such as nurses.

• The Nurse Line is totally not integrated with the rest of the health system. In part this is because the IT infrastructure for Primary Health Care is years slower in development than other jurisdictions, so the information is not available to the nurse on line. However, neither is there any effort to convey the nature of the call and recommendations shared with the family physician. None of the investigations or hospitalization information is available (some good work is afoot with the CareConnect project). For this reason, it is not appropriate for the Nurse Line to initiate referrals. This is but another instance of neglect of a highly educated and experienced, and efficient component of our system – the family physician. Too commonly already, great waste(to the system, but at considerable gain to the hospital-based specialist)
occurs in hospitals due to inappropriate cross-consulting for problems often well known to and certainly well-managed by the family physician. Further waste occurs when the known character of the patient, past experience managing similar or even the same problem, is neglected. On discharge, the care in hospital is poorly communicated to the family physician, creating further inefficiency

- New facilities outside Emergency rooms are not needed.
  - The Open Access, or same day appointment approach, widely adopted elsewhere, is being explored in BC. Along with the opportunities to address health concerns by phone and email, providing a prompt response to a health care concern and obviating a need for a visit, same day access facilitates continuity (value noted above) and eliminates the need for high cost ‘emergency rooms’ for low intensity problems.
  - Any resources which might be targeted to meet such a scheme should instead be used to facilitate the development of group practices, responsive teams, non-visit alternatives, innovations such as same day access, etc.

- Staffing for such hypothetical centres would ‘steal’ from an already depleted HHR component (see the other document) and, as noted, detract from the efficient Similar social policy decisions will be necessary to address the sustainability of our society in the face of impacts from use of fossil fuels, land use policies and practices and others on the world’s climate

- Inattention to widespread chemical use in the society is increasingly gaining attention – from lawn fertilizers and insecticides, to additives in many other products, to pharmaceutical wastes in drinking water
  - Societal determination has dramatically altered the situation of tobacco use in our society, saving great numbers of lives. With dramatically increasing societal obesity and consequent serious negative health impacts on the order of those caused by tobacco, a comparable approach will be necessary. As with tobacco, it took some time to acknowledge the links between the cause and the effects and then a determined societal effort to overcome the integration of care

**Social Determinants of Health**

The BC College of Family Physicians strongly endorses this understanding of persons in community. Along with building a more robust, team-based, IT supported Primary Care practices, health has to be seen in a societal and community context. Elements which need to be considered, in light of strong research understanding include:

- There is a strong gradient of health in association with income, with itself correlates with education. Interestingly, but significantly, population health is worse (at all population income levels) when there is a greater disparity between the lowest income earners and the highest income earners. Canada’s status in this regard is deteriorating.
• Lack of appropriate housing is a major determinant of health. This challenge particularly affects those with Mental Health problems already. Not surprisingly, very low incomes lead to poor(er) nutrition, also leading to poorer health
• Social policies which foster personal motor vehicles over public transit lead to reduced activity and increased pollution – causing many deaths per year. In addition, motor vehicle accidents correlate with numbers of automobiles and their use, whereas injuries and deaths are less with increased public transit
• Social policy decisions will determine the shape of our built environment, its density and mix, among others, which impact on personal wellbeing and activity – contributing to societal health
• commercial interests which supported the status quo. It is likely that a similar societal response will be necessary to respond to this new ‘plague’

Chronic Disease

The BC College of Family Physicians has welcomed the opportunity to lead an innovative approach to supporting Self-Management for patients with chronic disease. Much more needs to be done.

• The BC College of Family Physicians subscribes to the full ‘chronic disease model’ concept
• To effectively and efficiently address chronic diseases, actions need to be taken at many levels, and these actions need support
  o A robust information infrastructure – not just an EMR, but an appropriately designed one, used with great skill and consistently to support service delivery, and outcomes analysis, using a PDSA approach. Unfortunately all of the elements are in very short supply and perhaps none are truly integrated yet in BC settings
  o Key elements of this include active creation of patient ‘registries’ of patients with or at risk for a range of health conditions
  o An interprofessional, highly communicating, well informed, proactive Primary Health Care team which knows its capabilities, plans for efficiency, and constantly evolves to improve the quality of care
  o Active review of elements of evidence-based chronic health risks and status with individual active communications and support for interventions
  o Informed patients, who might have access to their records online, who can participate in group visits (which integrate care with patient responsive, ongoing education in the context of the care visit, not staff determined educational ‘sessions’), seek help from different staff members according to need and preference and who are communicated with using the ‘Self-Management’ approach. For remote areas, this might be linked via teleconference or telemedicine technologies
  o All of this must be supported by healthy public policy, not least a public policy which endorses and supports the development of such teams
Prevention and Health Promotion

The BC College of Family Physicians considers prevention and health promotion as core elements of Primary Health Care. The last three decades has seen considerable development of this domain, in the form of evidence-base, analytical tools and resources and communication (e.g. include the Cochrane Collaboration, the Canadian Task Force on the Periodic Health Exam, the U S Task Force on Preventive Health Services, etc). Nonetheless recent research shows that only about 50% of evidence supported health care and preventive interventions are implemented. Fundamental responses to this current reality include:

- Support for and implementation of a robust EMR with a deliberate focus on supporting preventive/ health promotion assessments and reminders
- Funding for prevention
  - Funding for services directed to prevention/ health promotion. This could be on a population basis, FFS, pay for performance, achievement of targets, or a combination
  - Funding for support staff. Remarkable strides have been made by using staff directed to managing and reviewing the registries, calling in or connecting with those needing assessment or interventions (based on individualized assessments of evidence-based risk), arranging follow-up testing, and with non-physician staff providing a range of relevant services – follow-up care for hypertension, COPD, DM, CHF, and many others, with referral on to medical involvement only in selected cases – efficient, effective, comprehensive, reliable care!
- As noted in the previous section, a broad based focus on social policy and responses is crucial to address a broad range of issues

Conclusion

The BC College of Family Physicians welcomes the opportunity to review some of the suggestions made to the Conversation on Health and to contribute our own views.

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.

The BC College of Family Physicians looks forward to being a partner with the Ministry, Health Authorities and other professional disciplines in further developing a robust, efficient, effective, equitable, engaged health system.

Thank you.