PRIMARY HEALTH CARE TRANSITION FUND II

CASW ACTS
Canadian Association of Social Workers
Association canadienne des travailleuses et travailleurs sociaux

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

CANADIAN NURSES ASSOCIATION
ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA ®

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

RECOMMENDATION:

The federal government, in concert with provinces and territories, establish a targeted fund in the amount of $1.2 billion to support a new time-limited Primary Health Care Transition Fund that would build on the success of the fund launched in 2000 with the goal of widely introducing a sustainable medical home model across jurisdictions. This would include the following key elements:

- Age-sex-weighted per capita allocation across the provinces and territories (PTs);
- Joint governance of the FPT governments with meaningful stakeholder engagement;
- Respect for the Canada Health Act principles;
- Common objectives (e.g., modeled on the College of Family Physicians of Canada Patient's Medical Home framework);
- Operating Principles specifying eligible/ineligible activities;
- Reporting provisions and agreed-upon metrics; and
- Sustainability plans.

The goal of this fund would be to ensure that care provided across Canada meets the needs of the patients today and in the future. By shifting away from episodic care toward an approach of continuous prevention and management, Canada can achieve better health outcomes for all.

FEDERAL SUPPORT FOR PRIMARY CARE: A BRIEF HISTORY

In 1978, the World Health Organization (WHO) launched the *Declaration of Alma-Ata*, which set out a definition of primary health care (PHC) with an emphasis on multi-disciplinary teams.[1] WHO has reaffirmed this approach in the 2018 Declaration of Asthana, stating that "PHC is a cornerstone of a sustainable health system for universal health coverage".

Beginning in the mid-1990s, the federal and provincial/territorial governments (FPT) have provided sustained leadership in promoting and supporting the transformation of primary care in Canada.

In September 2000 the First Ministers concluded the first of three Health Accords, in which they agreed to promote the establishment of primary health care teams. This was supported by the $800 million Primary Health Care Transition Fund (PHCTF) that was intended to go beyond pilot projects to achieve lasting change. The PHCTF was funded by the federal government, but jointly governed. The fund was divided among five envelopes and the PT envelope was allocated on a per capita basis. There were five common objectives to the fund and every project has to support at least one. They were:

- to increase the proportion of the population with access to primary health care organizations which are accountable for the planned provision of comprehensive services to a defined population;
- to increase the emphasis on health promotion, disease and injury prevention, and chronic disease management;
- to expand 24/7 access to essential services;
- to establish multi-disciplinary teams, so that the most appropriate care is provided by the most appropriate provider; and
- to facilitate coordination with other health services (such as specialists and hospitals).

The final summary of initiatives under the PHCTF catalogued numerous projects at the PT, cross-jurisdictional and national levels. The PHCTF resulted in large-scale sustained change in primary care delivery models in three jurisdictions; Ontario, Quebec and Alberta.

Ontario initiated a series of new primary care models, starting with Family Health Networks in 2001, which involved three or more physicians working as a group, patient registration and blended capitation. In 2006 Ontario introduced Family Health Teams (FHTs). FHTs are interprofessional teams involving family physicians, nurse, nurse practitioners, social workers, pharmacists and others. Since 2005 Ontario has established 184 FHTs that have enrolled more than 3 million patients in over 200 communities.

In 2002 Quebec launched the first Family Medicine Groups (FMGs) in which groups of family physicians collaborate with nurses to provide care for registered patients through an arrangement with a Local Community Health Centre. The government also has a program of financial support for other professionals associated with FMGs, including nurse clinicians, social workers, pharmacists, nutritionists and others. As of September, 2017 there were 314 FMGs in Quebec with just under 4.6 million enrolled patients.

In 2003 Alberta established Primary Care Networks (PCNs). PCNs are groups of family physicians working collaboratively with other professionals to provide service to registered patients. Initially the PCNs were provided capitation funding in the amount of $50 per registered patient per year to purchase the services of non-physician providers, since raised to $62. There are now 41 PCNs involving more than 3,800 physicians and the full-time equivalent of more than 1,000 other health care providers with almost 3.6 million registered patients.

Even in these three provinces it is clear that the job is far from finished. Considering the figures above in relation to Statistics Canada's most recent population estimates the following proportions of the population in team care models are observed:

- 21% of Ontarians are enrolled in FHTs;
- 54% of Quebeckers are enrolled in FMGs; and
- 84% of Albertans are enrolled in PCNs.

Across Canada, access to primary care is challenging for many Canadians. There is a persistent shortage of family physicians. In November, 2018 there were almost 2,000 advertised positions for family physicians, not including part-time and locum positions. According to Statistics Canada's Canadian Community Health Survey (CCHS), in 2017 4.7 million Canadians aged 12+ reported that they did not have regular health care provider. Even those who have a regular provider experience wait time issues. The 2017 CCHS found that just under four in 10 persons with a regular provider could get an appointment either the same or next day when they needed one. It is also the case that many Canadians do not have access to team-based primary care. Of those Canadians with a regular health care provider in 2017, just four in 10 (40%) reported that there were one or more nurses working with their family physician/nurse practitioner, and just under one in 10 (9.5%) reported that health professionals other than doctors and nurses such as nutritionists worked in the same office where they obtained their regular care. Similarly, a 2018 Pollara survey found that while nine in 10 (89%) Canadians with chronic conditions reported that they consulted a physician for their condition, just one in 10 (11%) reported access to a health care professional team.

Other jurisdictions are interested in adopting team-based primary care delivery models. In 2017 New Brunswick introduced *Family Medicine New Brunswick* a blended capitation model that will comprise groups of family physicians, nurses and medical office assistants with patient registration. There are currently 34 physicians practising in this model at 6 locations.

THE PATIENT'S MEDICAL HOME

There has been wide interest in primary care models since the development of the College of Family Physicians of Canada's (CFPC) vision document *Family Practice: the Patient's Medical Home* (PMH), initially launched in 2011 and recently re-launched. The model is founded on 10 pillars that are depicted in the Figure below.

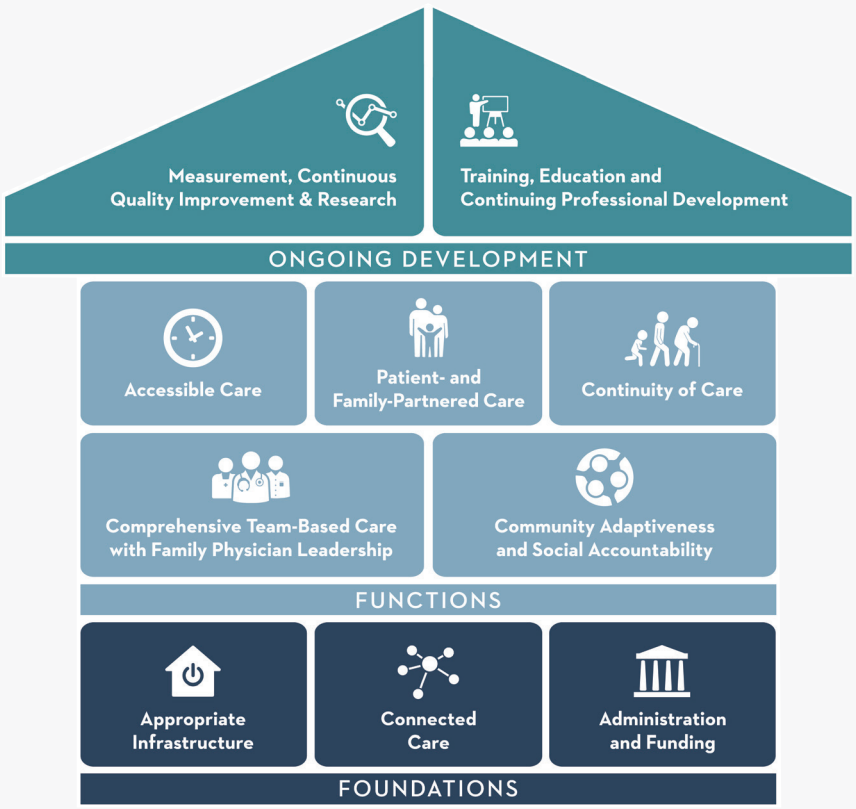

FIGURE 1. THE PATIENT'S MEDICAL HOME, 2019

The updated model places increased emphasis on team-based care and introduces the concept of the patient's medical neighbourhood that sets out connections between the primacy care practice and all delivery points in the surrounding community.

Since its initial release in 2011 the PMH model has been widely embraced by the PT Chapters of the CFPC, other medical organizations and governments.

While comprehensive baseline data are lacking, it seems safe to conjecture that far from a majority of Canadians are enrolled in a primary care model that would measure up to the 10 pillars of the CFPC PMH.

As noted above there is room for greater population coverage in the three provinces that have made large-scale advances in implementing new models over the past decade.

In terms of outcomes, while the Alberta PCNs and Ontario FHTs are still relatively new to have been definitively evaluated there is a considerable literature on the primarily U.S. experience with the Patient's Medical Home model. A 2017 synthesis of 115 articles showed positive results for reduced ER visits and hospitalizations, improved preventive care, quality of care, access and patient satisfaction as well as cost savings.

A PATIENT'S MEDICAL HOME FUND – PHCTF II

Based on the foregoing there is a case to be made for a new time-limited PHCTF II that would build on the success of the first one with the goal of widely introducing a sustainable medical home model across jurisdictions. The amount of $1.2 billion is proposed which reflects the $800 million of the 2000 fund adjusted for inflation. This would include the following key elements:

- Age-sex-weighted per capita allocation across the PTs;
- Joint governance of the FPT governments with meaningful stakeholder engagement;
- Respect for the Canada Health Act principles;
- Common objectives (e.g. modeled on the College of Family Physicians of Canada Patient's Medical Home framework);
- Operating Principles specifying eligible/ineligible activities;
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- Sustainability plans.

While, like most targeted funds, the original PHCTF was distributed on an equal per capita basis, population-based (capitation) funding models generally incorporate some dimension of need. The only readily available and current data that can be used to develop a weighting scheme and applying it are the age-sex specific estimates of health spending that are produced by the PT Ministries and compiled by the Canadian Institute for Health Information (CIHI) and the age-sex population estimates produced by Statistics Canada. In 2016 for example, CIHI estimates that per capita health expenditures for a person aged 20-24 were $475.85 compared to $2,505.00 for a person aged 80-84.

In addition to the resources that the CFPC has developed to support the PMH model, other comprehensive resources have been developed. CIHI has developed indicators and survey tools that address primary care practice at the organization, provider and patient levels. Health Standards Organization has an accreditation standard for primary care services. Health Quality Ontario has developed indicators for reporting on primary care performance in Ontario. Hence, there is no shortage of tools that can be deployed to ensure accountability under the new fund.

June 8, 2019

ENDNOTES

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