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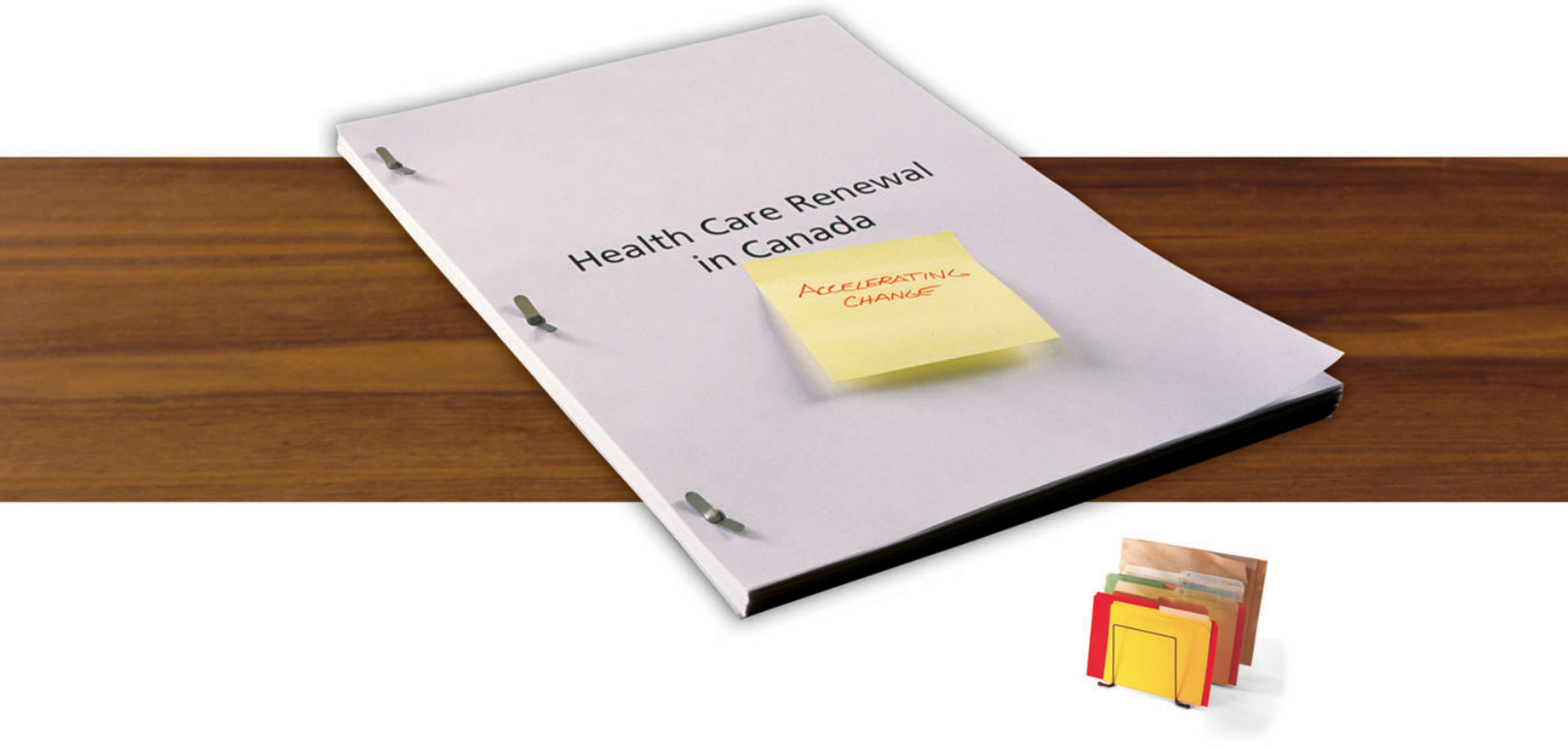
PRIMARY HEALTH CARE

A background paper to accompany
Health Care Renewal in Canada: Accelerating Change
(January 2005)



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Acknowledgements

The Health Council of Canada would like to acknowledge the following individuals for their contributions to this report. First, the members of the Council's Working Group on Primary Health Care: Ian Bowmer (Chair), Lyn Mcleod, Simone Geddry, Donna Hogan, Jean-Guy Finn and Bob Nakagawa. Bev Nickoloff and Fadi El-Jardali helped prepare the report, Amy Zierler edited it, and Brian Hutchinson provided insightful comments.

Please note that the information in this report was current as of November 2004.

Production of this report has been made possible through a financial contribution from Health Canada. The views expressed herein represent the views of the Health Council of Canada acting within its sole authority and not under the control or supervision of Health Canada and do not necessarily represent the views of Health Canada or any provincial or territorial government.

Contents

Purpose 3

Accord 2003: Federal, provincial and territorial commitments 4

Why is the issue of primary health care important? 5

What are the components of primary health care reform? 6

What do we know about what makes a difference in primary health care? 8

What is currently happening in primary health care in Canada? 13

What are the immediate issues and challenges in assessing progress? 16

Conclusions and recommendations 17

Next steps: Health Council activities for 2005/2006 on primary health care reform 19

References 22

Appendix 1: Definitions of primary health care 24

Appendix 2: Common strategies for advancing primary health care reforms 28

Appendix 3: Summary of primary health care initiatives by jurisdiction 33

Appendix 4: Summary of initiatives under the Primary Health Care Transition Fund 39

Purpose

The purpose of this background paper is to provide evidence and an informed analysis to support the Health Council's general observations on primary health care included in Council's first annual report (2005), *Health Care Renewal in Canada: Accelerating Change*. Specifically, this background paper highlights important findings on the progress of primary health care (PHC) reform in Canada and provides general observations on the following:

- The importance of PHC in Canada;
- What PHC reform means in Canada;
- Current progress of PHC reform in Canada;
- Current knowledge and evidence that show how PHC makes a difference;
- Gaps, challenges and barriers in PHC reform;
- Potential solutions to the barriers and challenges.

Canada's national commitments on health care renewal have identified that the system should be governed by the following principles:

- *Universality, accessibility, comprehensiveness, portability and public administration* for insured hospital and medical services as per the Canada Health Act;
- *Accountability:* a commitment to report regularly to Canadians on health status, health outcomes, and the performance of publicly funded health services, and the actions taken to improve these services;
- *Population responsiveness and acceptability:* the adaptation of services to key priorities and emerging needs of Canadians, and to meet their expectations for prompt, respectful and confidential services;
- *Equity:* ensuring access to health care and to quality services on the basis of health needs, not individual or social characteristics; this includes a specific commitment to collaborate with Aboriginal people, their organizations and communities to improve their health and well being.
- *Effectiveness:* the extent to which the outputs of an organization, policy, program or initiative make a positive contribution to the health and wellness of Canadians;
- *Quality:* the degree to which clinical procedures reflect current research evidence and/or meet commonly accepted standards for technical content or skill and are delivered with acceptable interpersonal skills.
- *Efficiency:* the extent to which resources are being allocated across initiatives, programs, or organizations in a manner that maximizes the values they are intended to produce, such as planned outputs; and
- *Sustainability:* the capacity to maintain a publicly funded program, with a policy direction and framework that is enduring over time.

Accord 2003: Federal, provincial and territorial commitments

The Council's starting point in reporting progress related to primary health care is the September 2003 First Ministers' Accord on Health Care Renewal. This Accord confirmed the agreement among First Ministers that there are four core components of an effective primary health care system (see Figure 1).

Figure 1: Core building blocks of an effective primary health care system

Improved continuity & coordination *… for care of the patient*	Early detection & action *… through primary health care teams*
Better information on needs & outcomes *… through better information technology & management*	New & stronger incentives to support adoption of new approaches *… to improve patient care and enable providers to work together*

First Ministers agreed that each jurisdiction would establish specific, verifiable multi-year targets to track progress of primary health care reform using the following:

- By 2011 at least half of their residents/potential users would have access to an appropriate provider 24 hours a day, seven days a week (24/7); and
- Residents/potential users will routinely receive needed care from multidisciplinary primary health care organizations or teams.

In preparing this paper, the Health Council has agreed that:

- The focus will be restricted to the specific aspects of primary health care as outlined in the 2003 Accord (i.e. core components, 24/7 access, and the use of multidisciplinary teams).
- The paper will make general observations based on an assessment of public information sources and self-reports provided by the jurisdictions (provincial, territorial, and federal governments) in response to a Health Council survey.

A key objective of this background paper is to lay an evidence-based foundation for reporting in future years by:

- Generating consensus around the meaning of key terminology (e.g. primary health care, 24/7 access, multidisciplinary teams[1]);

[1] Other terms used interchangeably: interdisciplinary team; inter-professional team; collaborative health care team; trans-disciplinary team, and trans-professional team.

- Providing evidence of the role of information technology and information management as key enablers of PHC reforms. Reporting will include how they are being incorporated into reforms; and
- Identifying key issues, barriers and challenges that affect reporting on progress and outcomes in the future.

Why is the issue of primary health care important?

> In many ways, primary health care is to the health sector as the three R's are to education. Just as reading, writing, and arithmetic are fundamental skills that open the door to further learning, primary health care services are the basic tools for health improvement and illness care, and are often the gateway to other health services.
>
> *Health Care in Canada 2003, CIHI*

Primary health care (PHC) is the foundation of Canada's health care system. It provides a critical entry point of contact to the health care system and serves as the vehicle for ensuring continuity of care across the system. Effective primary health care is community based, promotes healthy lifestyles as a pathway to disease and injury prevention, and recognizes the importance of the broad determinants of health. Primary health care programs develop strategies to advance individual and population health; they ensure that short-term health issues are resolved and most chronic conditions are managed.

In recent years, primary health care reform has been targeted as a key strategy for sustaining and revitalizing the health care system. It is believed that successful reform of PHC will:

1. Strengthen the continuity of care and achieve a more integrated health care delivery system;
2. Change the focus of health care from providers to the people and populations who receive health care services;
3. Make better use of highly qualified health professionals and result in a better team dynamic and partnership among providers;
4. Place a stronger emphasis on health promotion and disease prevention; and
5. Ensure appropriate access to specialized health resources.

Many of the activities being implemented to reform PHC systems in the provinces and territories build on initiatives that were initiated by the Primary Health Care Transition

Fund (PHCTF).[2] The common objectives of PHCTF, agreed to by federal, provincial, and territorial governments, are to:

1. Increase the number of people who will have access to primary health care organizations. These organizations are to be accountable for the provision of a clearly defined set of comprehensive health services to a defined population;
2. Increase health promotion, disease and injury prevention, and the management of chronic diseases for both individuals and communities;
3. Expand each person's 24/7 access to essential health services;
4. Ensure each person has the most appropriate health care, provided by the most appropriate professional. It is recognized that this will be best accomplished when delivered through multidisciplinary primary health care teams;
5. Ensure that each person's health care is coordinated and integrated with other health services provided by institutions and community and other government organizations.

Although not all of the PHCTF projects achieved all of their goals, they did provide useful lessons about the successes and challenges of undertaking primary health care reform (Mable & Marriott 2002). The impetus created by these projects also set the stage for the details related to primary health care reform included in the 2003 Health Accord.

What are the components of primary health care reform?

A key challenge in reporting on progress related to PHC reform initiatives is the lack of agreement on common terminology. Although every jurisdiction has embraced the importance of primary health care reform as a priority, there is no agreement on the actual meaning of the term primary health care. A review of provincial, territorial and federal strategies included in policy reports confirms that definitions of the term differ in important ways and are evolving in many jurisdictions (see Appendix 1). The lack of agreement on terminology has hindered debate about how best to measure and understand the progress of reforms.

The National Primary Health Care Conference held in Winnipeg in May 2004 confirmed the enormous challenge and importance of this lack of definition:

[2] In 2000, the Government of Canada established the $800 million Primary Health Care Transition Fund (PHCTF) to support the efforts of provinces and territories and other stakeholders to develop and implement transitional primary health care reform initiatives.

*The language of the [2003 Health Accord] reflects the aspirations, ambiguities, and tensions inherent in moving primary health care forward. It is at once transformative (multidisciplinary primary health care organizations or teams are more the exception than the rule in Canada) and cautious (8 years to ensure half the population has access to an "appropriate health provider" – not necessarily a primary health care team)… It also suggests that, like beauty, primary health care is in the eye of the beholder. Officially, everyone embraces it, but there is no consensus on what "it" is. The public, and many health professionals, are bewildered by the discussion and terminology, but the frustration should not end attempts at clarity. Words, terms and definitions matt*er. (Lewis 2004)

Most definitions share key concepts and elements: Primary health care is normally the first point of contact for individuals with the health care system; it enables entry to other components of the health care system and provides continuity of care across the system. Most definitions also recognize health promotion, disease and injury prevention, and strategies to address the broad determinants of health as essential components of a program to improve individual and population health. Any working definition must also recognize and value the role of a broad range of health care providers in the delivery of PHC services and be consistent with the four core building blocks of an effective primary health care system that were articulated in the 2003 Health Accord (see Figure 1).

Therefore the Health Council's Primary Health Care Working Group proposes that the following key concepts be adopted as a basis for any discussion or evaluation of primary health care reform:

Primary health care is the foundation of Canada's health care system.

- Primary health care ensures continuity of care for the individual as both the first point of entry into the health care system and the link to other specialized health and community care services.
- Primary health care is where health promotion and education efforts are undertaken, short-term health issues are resolved, and the majority of chronic health conditions are managed.
- Strategies to improve primary health care encourage the best ways for health care providers to deliver services — for the benefit of the provider and the individual being treated.
- Reform strategies also encourage the best use of health care tools such as information management.

Supporting terminology

The Health Council recognizes a significant variance in interpreting the Accord commitments in relation to primary care (such as 24/7 access and multidisciplinary teams). Once again, a clear definition and consensus on interpreting terms related to PHC are important in order to develop the right evaluation questions and indicators to measure progress. Below, we provide a description of supporting terminology.

First point of contact: The ease with which individuals can initiate contact with their health care provider/team.

24/7 access: Around-the-clock access to a health care provider who addresses the health need of the individual and ensures continuity of care and appropriate feedback to the individual's primary health care provider/team.

Continuity of care: An ongoing relationship between an individual and his/her health care provider/team. It implies coordination to facilitate seamless transitions among health care professionals and across the continuum of programs, organizations and levels of care.

Multidisciplinary teams: A broad range of health care providers who work interdependently in a collaborative partnership to deliver primary health care services with the patient as an integral member of the team.

Primary health care information management: The continuous improvement of health information management as an integral part of improving access to and quality of primary health care services. Priorities to advance work in this area within and across jurisdictions are focused on strategies that will result in more accurate diagnosis and treatment, better and safer patient care, and improved continuity of care.

Before meaningful evaluation and progress reporting can occur, the Health Council acknowledges the need for consensus on interpreting other supporting terminology such as: comprehensive primary health care, coordination and integration, appropriate provider, among others. In this regard, the Health Council supports the work that is currently underway to clarify and operationalize those terms as part of the National Evaluation Strategy for the Primary Health Care Transition Fund.

What do we know about what makes a difference in primary health care?

This section includes a review of literature on what makes a difference in primary health care reform and highlights possible models for reform from experience in Canada and other countries. Several elements of reform are covered in this section: multidisciplinary teams, information technology, chronic disease management, and education and training.

Multidisciplinary teams and information technology

In recent years, a growing body of research has begun to emerge about primary health care reform, including the evidence supporting underlying rationales, the relative pros and cons of different models of reform, and the barriers and facilitators impacting on reforms. For example, Shortt (2004) reviewed the clinical rationale for primary care reform in Canada. The paper identified the current evidence concerning the specific elements that can be shown to enhance quality of care and concluded that in many areas there is insufficient evidence available to determine whether primary care reforms measure up to the claims made by various provincial and national commissions. Results are summarized in Figure 2.

Figure 2: Key elements, clinical rationale, and assessment of evidence of primary care reform

Key element	Clinical rationale	Assessment of evidence
Multidisciplinary teams	Increased preventive care and health promotion counselling from nurse practitioners; redistribution of workload allows physicians to concentrate attention where skills are most needed.	Good evidence to support
Enhanced information technology	Enhances coordination of care between multiple providers; reduces chance of medical error.	Fair evidence to support
Non-fee-for-service physician payment (capitation plus)	Decreased volume incentives will lead to more appropriate care delivery.	Conflicting evidence; no conclusions
Rostered patients	Closer doctor-patient relationship leading to enhanced continuity of care, itself a key component in quality of care.	Insufficient evidence to judge
Enhanced access (on-call, tele-triage)	Increased continuity of care through decreased use of ERs, walk-in clinics.	Fair evidence against

Shortt's review draws attention to the relative merits of the different elements of PHC reform based on current evidence. It also raises important issues about the lack of current evidence to evaluate the potential of PHC reforms to achieve desired objectives. In fact, most of the conclusions of "fair" or "insufficient" evidence reflect the lack of current research. For example, the clinical effectiveness of tele-triage as a first line of encounter in after-hours primary care has yet to be established. Similarly, with the exception of nurse practitioners, there is a paucity of research that has been undertaken to support the relative effectiveness of integration for other types of providers in primary care delivery (Shortt 2004).

Emerging research suggests that the best and most cost-effective outcomes for patients and clients are achieved when professionals work together, learn together, engage in clinical audit of outcomes together, and generate innovation to ensure progress in practice and service (Borrill et al. 2001). In the UK, primary care teams have been reported to

improve health delivery and staff motivation (Wood et al. 1994) and to lead to better detection, treatment, follow-up and outcome in hypertension (Adorian et al. 1990). Jones (1992) reports on one US study in a primary health care setting showing that families receiving team care had fewer hospitalisations, fewer operations, more physician visits for health supervision and fewer physician visits for illness, compared to control families. Team working can also improve patients' access to primary care services. Marsh (1991) reported that team working can reduce the general practitioner's workload and thus increase the number of patients seen. Alternatively, a reduced workload can enable doctors to spend more time with individual patients, so they can provide a more patient-centred consultation (Hasler 1994). In addition, team working in primary care can improve the deployment of skills and expertise (Marsh 1991, Bradley 1996, Hasler 1994) and provide a more cost-effective service (Marsh 1991, Hacett et al. 1987).

With respect to information technology, there is growing body of research which argues that the use of information technology may benefit the practice of medicine in several ways. Specifically, it may reduce the demand on physicians' time, encourage shared care and collaborative practice, improve patient care and result in more knowledgeable patients. For instance, the electronic health record is shown to support decision-making that enhances the quality, safety and efficiency of patient care. The availability of complete patient health information at the point of care delivery can prevent many errors and adverse events (Institute of Medicine 2003). However, further research is required to test the assumption that electronic health records in particular can improve patient safety, support delivery of effective patient care, improve efficiency and facilitate management of chronic conditions (Institute of Medicine 2003).

Chronic disease management

Chronic diseases are the leading causes of death in Canada. Of the 215,669 deaths in Canada in 1997, more than 75 per cent were attributable to one of five chronic diseases: cancer, cardiovascular disease, diabetes, kidney disease, and respiratory diseases. More than half of Canadians with chronic conditions have three or more different providers and report that they often receive conflicting information from those providers; many undergo duplicate tests and procedures but may still not receive recommended care. In addition, physicians can have difficulty in coordinating care for their patients with chronic conditions. Chronic disease also contributes a major economic burden: 36 per cent of total health care costs in 1993 were attributable to cardiovascular disease, cancer, diabetes, and respiratory diseases, with a combined cost of $47 billion (Taylor 2002).

Good chronic disease management can make a real difference. According to a recent report by the UK Department of Health (2004b) entitled *Improving Chronic Disease Management*, there is growing evidence to suggest that good chronic disease management offers real opportunities for improvements in patient care and service quality, as well as cost reductions. The report highlights three program evaluations that demonstrate the benefits of good chronic disease management: the Castlefield Health Center (UK) pilot of active management of conditions; the Evercare model of case-management for elderly in US; and Veterans Administration (US). Interventions aimed at managing and preventing chronic disease in the primary and community care settings

have been shown to be effective. Furthermore, chronic disease management is not just a primary health care issue. Improving care and services for people with chronic conditions has a beneficial impact on secondary and emergency care, waiting lists, workforce, and other services. Multidisciplinary teams providing high-quality, evidence-based care, including the use of pathways and protocols, are one of the key approaches to effective management of chronic disease. (UK Department of Health 2004a).

What makes for good chronic disease management? Evidence from experience in other countries suggests that there are at least 10 essential components of chronic disease management:

- using multidisciplinary teams;
- using information systems to access key data on individuals and populations;
- identifying patients with chronic disease;
- stratifying patients by risk;
- involving patients in their own care;
- coordinating care;
- integrating specialist and generalist expertise;
- integrating care across organizational boundaries;
- aiming to minimize unnecessary visits and admonitions;
- providing care in the least intensive setting.

Education and training

Emerging research suggests that a need for more training and inter-professional education on how to work effectively in collaborative, multidisciplinary teams. According to Parsell & Bligh (1999), interdisciplinary education:

- promotes inter-professional collaboration;
- involves interactive learning between professional groups;
- develops knowledge and understanding of other professions;
- encourages professionals to learn with, from and about one another; and
- respects the integrity and contribution of others.

In the UK, an emphasis on community-based health care led to a number of collaborative models of delivery. Throughout the past three decades, many initiatives in inter-professional education were developed, covering a wide range of health issues. Government policies further reinforced the value of collaboration and thus the need for shared learning or joint training. The Center for the Advancement of Interprofessional Education (CAIPE) was founded in 1987 to provide a central resource to assist health

professional educators in exchanging and discussing new ideas to assist them in creating new initiatives (Watson & Wong 2005). Health Canada is leading an initiative entitled Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP), part of the Pan-Canadian Health Human Resource Strategy, to support and facilitate training in this area across all health care sectors. The overall goals of the initiative are to contribute to improved patient satisfaction, increased patient and provider satisfaction and, ultimately, improved patient outcomes.

Primary health care reform models

The relative benefits and outcomes of particular reform models is the subject of emerging research. A study reviewing the success of an integrated PHC system introduced in an Alberta health region showed that promoting more integrated delivery of primary care services had positive results.[3] The changes resulted in improved services; more efficient use of physicians, hospital and laboratory services; adoption of healthier lifestyles; use of fewer health services by residents; and high satisfaction with health care services (Hasselback et al. 2003). A Quebec study looking at accessibility and continuity of primary care concluded that primary care systems have been generally unresponsive to patient-centred care. There were, however, some important exceptions that provide guidance for future policies. The establishment of family medicine groups, increased clinic hours, nurse-physician work teams, and the provision of more comprehensive care through operational links with other health care establishments have been identified as positive features (Haggerty et al. 2004).

Among the models available from other countries, the UK National Health Service (NHS) and the US Veterans Health Administration have achieved remarkable results in reorienting their primary health care services. Patient outcomes improved in both systems when system reform focussed on improving access to a wider range of services, providing comprehensive disease management programs, supporting teams, and mandating measurement and accountability for quality. In both cases, targeted investments were made in expanding the workforce, supporting education and training, improving information systems, and redesigning pay scales for some health professions. For instance, the NHS has made significant progress in "liberating the potential of staff" so that every patient gets the right care in the right place at the right time. This is demonstrated by important changes in the way people, rules and regulations are organized. Examples of such changes are: pharmacists and their staff are integrated into the NHS primary care team; nurses and other health professionals have expanded roles as clinicians, practice partners and advisors; nurses and other health professionals are developing their skills and offering more specialist care in the community (UK Department of Health 2004a).

[3] The project set out to answer the following questions: Did the introduction of an integrated primary care system in the Taber region (Alberta) lead to improved primary health care? Were the changes successfully put into practice, and what factors affected this?

What is currently happening in primary health care in Canada?

In Canada, primary health care developed through public funding of individual doctors, usually family physicians. Other models of primary health care – such as community health centres, public health nurses, well-baby clinics and the integration of non-medical health care providers with a focus on health promotion – have come to be included. As the system grew, a number of concerns emerged:

- lack of access to primary health care providers;
- the disjointed way in which the various parts of the health care system worked with each other, often leaving patients moving between different providers and institutions;
- difficulties in integrating primary health care providers such as nurse practitioners, pharmacists, social workers or community health workers ;
- increasing evidence that Canadian primary health care practices focused on acute or episodic conditions, while individuals with chronic conditions such as diabetes, heart disease or hypertension required more comprehensive care;
- the recognition that increased use of multidisciplinary teams of providers could reduce clinical error, increase provider satisfaction, and improve patient outcomes in acute and chronic care settings.

The need for a new approach to primary health care has been acknowledged for more than a quarter of a century, beginning with the Alma-Ata Declaration of the World Health Organization in 1978. That landmark document identified health as being rooted in the community, and primary health care as the foundation of a comprehensive health system. Canada has featured prominently in the call for reform. The Lalonde Report of 1974 drew attention to the determinants of health, and in 1986 *Achieving Health for All* (Health & Welfare Canada 1986) reaffirmed these insights and endorsed the main principles of Alma-Ata. Numerous provincial and national reports throughout the 1980s and 1990s identified the need to reform the way primary health care services were organized and delivered. A consensus for change emerged with similar priorities for action identified in each jurisdiction. Appendix 2 provides examples of the strategies used. Common elements of these strategies are:

- *Improved continuity and coordination of care*:
  - greater access to providers 24 hours a day, seven days a week;
  - use of multidisciplinary teams and new ways to organize people to deliver primary health care;
- *Early detection and action*:
  - a stronger focus on health promotion and prevention;
  - a focus on chronic disease management;
- *Better information*:
  - the expansion of the electronic health record and telehealth technologies;

- *Incentives to change practice*:
  - the use of innovative funding models;
  - the integration of non-medical personnel;
  - innovative recruitment and retention strategies.

The 2003 Accord set a goal that by 2011, 50 per cent of residents will have access to an appropriate health care provider, 24 hours a day, seven days a week. Across Canada, there is considerable activity underway to meet this goal. (Initiatives are summarized in Appendix 3.[4]) Many different approaches are being tried, from testing of small pilot projects to implementation of larger ongoing programs. Several projects are designed to shift the patient's first point of contact to a nurse or nurse practitioner. However, most efforts focus on improving support for the family physician as the primary care provider. Decisions to pilot many of the reform initiatives have been based on two underlying beliefs. The first is that there is no single model of delivering primary health care services that will meet the needs of all communities. The second is that there is currently no definitive proof that any one model works better than others.

The need to implement change in primary health care delivery is also driven by the significant changes taking place in family medicine in Canada. Family physicians in practice today provide different services than their colleagues of 10 years ago (Chan 2002). They are providing more psychosocial counselling and less hospital-based care. Fewer deliver babies. Consistently, the rate of family physician participation in surgical services, anaesthesia and obstetrical care is declining and 13 per cent indicated in a recent survey that they plan to reduce their scope of practice within the next two years (CFPC et al. 2004).

Family physicians also report increasing concerns over workload and a feeling of burn-out. Younger physicians in particular report an unwillingness to continue the high workload of their predecessors (National Physician Survey 2004). They are spending less time on direct patient care than their counterparts did 20 years ago. They want more balance in their lives and more time for family and non-work related priorities. Female physicians have led the way in promoting the importance of work-life balance and now that approximately 50 per cent of medical school graduates are women, future practitioners will not provide as much service to as many patients as their predecessors did.

There are other worrisome developments. Historically, about half of all physicians were family physicians. Today, less than 30 per cent of medical students are interested in family medicine as a career. Sixty per cent of family physicians report that they take a limited number of new patients, or are not accepting new patients at all. Meanwhile, 14 per cent of the public report that they do not have a family physician. Rates are high even in large cities, where the concentration of physicians is greatest.

[4] In an effort to inform the debate and gain a better understanding of what is happening across Canada, the Health Council canvassed provincial and territorial jurisdictions and asked them to report on their progress in advancing the commitments articulated for primary health care as outlined in the 2003 Accord. The summaries in Appendix 3 were compiled based on responses to this survey.

While many physicians entering practice over the past decade have opted for group practice or some of the new models of care, few of the physicians in traditional practices are interested in moving towards new delivery models. The National Physician Survey (2004) indicates that in the next two years, only 2.7 per cent of these family physicians plan to move from solo to group practice, 3.1 per cent plan to change to a multidisciplinary model, and 6.7 per cent plan to become part of a practice network.

In summary, while it is not yet possible to evaluate or compare the success of primary health care reforms in Canada – due to the lack of an evaluation framework and consistent system level indicators – the following general observations can be made:

- Most of the activities being implemented at the provincial, territorial and federal levels build on strategies that were initiated under the Primary Health Care Transition Fund (PHCTF). (See Appendix 4 for a summary of the key projects undertaken through this fund.)
- Some progress is being made on implementing the commitments in the 2003 Health Accord. Some jurisdictions have established specific targets, particularly with respect to enhancing 24/7 care and testing new models of care delivery. Others have articulated broad statements related to the reform objectives.
- Enhancing 24/7 access is primarily being advanced in two ways. First, some initiatives are providing advanced training and physician support to address scope of practice issues – for example, nurses in rural communities are receiving training to enable them to screen patients for cervical/breast cancer and STDs. Second, after-hours telephone access to a nurse is being introduced and/or expanded. Some innovative extensions to telephone advice and triage services are emerging. For example, British Columbia has expanded service to provide after-hours pharmacist advice. The Atlantic provinces are collaborating in a project (Selfcare/Telecare) to enhance access to a tele-triage and health information service through various media including telephone, audiotape, e-mail and web access. Tele-Care NWT has been implemented as a toll-free family health and support line in the Northwest Territories. While the implementation of telephone triage services across jurisdictions is an important step toward providing 24/7 access, these services will only be truly effective in enhancing access to primary health care services if they provide a timely and effective link back to an individual's PHC provider/team. The Health Council's proposed definition for 24/7 access underscores the need for this linkage.
- The use of multidisciplinary teams and organizations is being enhanced through testing of a wide range of collaborative practice models. Some provinces begin with the family physician as the first point of contact and build other providers around the physician, whereas others start with a nurse or nurse practitioner and use medical resources at the next stage of contact. Many recent activities involve incorporating nurse practitioners and midwives into collaborative teams (supported by regulatory and/or legislative changes), and many are revisiting compensation/ funding models to promote team-based care. Current models

differ largely on funding approaches and how to fund non-physician providers. Some initiatives support separate funding streams for physicians and other providers; others recommend population/capitation funding to support team-based care.

- Other emerging successes focus predominantly on advancing the four core building blocks of PHC reform: improved continuity and coordination of care, early detection and action, better information on needs and outcomes, and newer and stronger incentives. Gains to advance work in these areas are also being achieved through common approaches and strategies as outlined in Appendix 2.
- The number and variety of activities underway provide an enormous opportunity to develop evidence on the effectiveness of specific models and to compare their strengths and weaknesses in action. Currently, however, there is no agreement on performance indicators and data sources to support measurement. As a result, it is difficult to evaluate the relative success of different strategies in meeting the objectives of PHC reform.
- Despite successes in testing a variety of new models and the apparent political and public support for reforms, implementing wide-scale reform is complex and overall progress is slow. The slow pace of change can be attributed in part to organizational challenges within the health care system. These are briefly described elsewhere in this paper.

What are the immediate issues and challenges in assessing progress?

Every jurisdiction in Canada has developed a policy framework (including a vision, specific goals, and priorities/actions) to guide reform of its primary health care systems. In a preliminary review of these reports, the Working Group has identified a number of specific challenges for those who are charting the course of specific primary health care reforms. These same issues also challenge the Health Council in addressing its task of monitoring and reporting on progress being achieved in this area. In particular:

- The absence of common indicators and/or a comprehensive evaluation framework has created a patchwork of progress reports on current reform initiatives. This fragmentation makes it difficult to assess what is really changing from a national perspective with respect to access, use of multidisciplinary teams, and achievement on the core building blocks of PHC reform.
- Assessing to what extent action within jurisdictions matches their stated visions and objectives is limited by a lack of clear evaluation reporting.
- Evaluating whether pilot projects have improved patient care and outcomes – a critical step in building knowledge on best practices – will continue to be difficult without a common framework for assessment.

- Even internationally, there is a paucity of evaluation literature on the relative merits of different primary health care delivery models and approaches. Planners have an abundance of literature on visions for primary health care reform to draw on but a relatively small body of reporting on actual implementation experience.

- Adding further complexity is the tremendous variation in practice associated with current reform initiatives across Canada. Many of the reforms experiment with a combination of approaches including new organizational structures, new working relationships and new methods of linking with other programs and services included as part of an expanded perspective of health.

These challenges are not new. Much has been written about PHC reform including analyses of different models, clinical/provider/patient rationales for pursing reforms in this area, specific challenges related to implementation of reforms, and experiences in implementing reforms both in Canada and other jurisdictions (Lamarch et al. 2003, Zelmer & Lewis 2003, Wilson et al. 2004, Atun 2004). In addition, a growing number of reviews have been recently undertaken by governments, academics and researchers with respect to the broad range of activities underway to support PHC reform across the country.

Conclusions and recommendations

In the absence of a nationally-accepted evaluation framework on PHC reform, the Health Council is limited in its ability to report on the impact, pace and relative success of renewal efforts across jurisdictions, However, it is clear that reforming primary health care is far from complete. The target of ensuring that 50 per cent of the population has 24/7 access to an appropriate health care provider by 2011 is modest and complicated by the fact that "appropriate provider" is not clearly defined. Based on the evidence to date, it appears that this target may not be achieved and further work is required to achieve the goals outlined by the First Ministers.

The Council believes that providing comprehensive care and improving individual access to an appropriate primary care provider will require changing the way people, money, rules and regulations are organized, as well the improving the flow of health information.

In order to accelerate change and help achieve the desired outcomes, the Council recommends the following:

1) Acceptance of common definitions*:* Different terms are being used to describe primary health care services and providers. This makes measuring progress more difficult. The targets articulated in the 2003 Health Accord must be supported by a common understanding of key terms. This report has proposed descriptions of common

terminology as the basis for generating agreement on the meaning of key concepts associated with the specific targets for PHC reform.

2) Collaborative forums to share experiences and to build on these experiences: Jurisdictions do not have many ways to share experiences. They want to stay abreast of innovation; know who is doing what (and with what results); build on others' work and not reinvent the wheel; know where the gaps are; and to build connections within and across the country to disseminate learnings and best practices.

3) New delivery models: Governments have been slow to support new delivery models even when they have proven successful. Positively evaluated innovations exist for organizations such as the Group Health Centre in Sault Ste. Marie, the Women's Health Centre in Winnipeg and some CLSCs (community health centres) in Quebec. These models generally match the stated intention of the 2003 Accord and should be pursued aggressively. Maintaining the status quo of family physicians working in traditional practices gets in the way of renewal.

4) Attention to well-known regulatory barriers and the slow pace of reforms: The barriers to implementing PHC reforms have been well documented and are generally consistent across jurisdictions. They include values and interests of all stakeholders including the public; health human resource issues including planning, training and supply; the roles and numbers of non-physician providers; the scopes of practice for each health care provider and the confusion around professional scope of practice when functioning in teams. Additional barriers include remuneration methods and financial incentives that are rooted strongly in the current physician fee-for-service system; medico-legal issues; the jurisdictional differences in the regulatory powers delegated to each profession; the need for more and better information about patients and information sharing between providers; the need to improve the quality of information systems, decrease duplication, and report on progress and key outcomes; and the lack of a systems approach to encompass the full spectrum of health care including, for example, services for mental health, long-term care and home care.

***5) Education and training models*:** If collaborative practice in multidisciplinary teams is the vision of the future, then the education and training system for health workers needs to reflect that vision. As well, it will be important for professional development programs for those already in practice to reflect the same philosophy.

***6) Information technology*:** Accurate patient information electronically transmitted in a timely fashion is a cornerstone of an integrated system. Efforts to wire the country need to be aggressively supported so that primary care providers can do their jobs – to help them share information and to support clinical decision-making.

7) Agreement on a framework for development of progress reports and measurement of outcomes: Deciding what needs to be measured and how it will be measured is critical. Some of the general questions that need to be addressed have been articulated in *Health Care in Canada* (CIHI 2003). These include:

- How is Canadians' use of different forms of PHC changing over time?
- How is this affecting the extent to which such care is integrated with other parts of the health care system?
- What effect are these changes having on health outcomes, access to care, satisfaction, and health care expenditures?
- How will current and planned PHC renewal initiatives affect population health, costs, patient and provider satisfaction, and quality of care?

Additional work on determining the right evaluation questions to monitor PHC reforms will also need to be developed. Over the next year, the Health Council will support and build into the work that is currently underway as part of the National Evaluation Strategy to develop evaluation questions, effective indicators and appropriate measurement tools.

Next steps: Health Council activities for 2005/2006 on primary health care reform

Over the next year, the Health Council will continue monitoring progress in PHC reform across Canada. The Council will develop a framework for identifying innovative practices and will showcase innovation. The Council is participating in efforts to develop a Best Practice Network on PHC, an initiative led by Health Canada. Likewise, the Council will participate in the Canadian Health Services Research Foundation's Primary Healthcare Network. The objectives of this network are: (1) to increase the dissemination of research evidence; (2) to facilitate mutual learning and support through linkage and exchange activities; (3) to provide collaborative and open forum for discussion; and (4) to build capacity for evidence-based decision making in PHC.

In the longer term, the Council will work with federal, provincial and territorial partners to articulate an initial set of indicators. These indicators will enable us to chart the progress of reform in terms of health outcomes and health system performance.

The work to identify a core set of indicators will be informed by the following assumptions:

- Monitoring the use of 24/7 access and the growth in multidisciplinary practice will require indicators that extend beyond readily available data. For example, provinces now report largely on physician-based services; to understand the pace of progress on the Accord commitments, we need better data on the use of services provided by other health professionals.
- Administrative or survey databases can support timely reporting on PHC reform.[5] Presently, these sources do not reflect the impacts of current reforms because of

[5] Key databases include Statistics Canada (Canadian Community Health Survey (CCHS)) and the Canadian Institute for Health Information.

delays in collecting data and publishing analyses. New information systems are needed to expand current data sources so that they can more rapidly collect and provide information related to key elements of PHC reform.

- There are opportunities to begin collecting this data through electronic health records, chart reviews (audits), and surveys of patients or their designated representatives. These efforts will also need to be supported through development of better information systems.[6]
- Outcome data are required to better assess the impact PHC reforms are having on patients. A patient-centred approach requires not only the technical measures of PHC quality but also evaluation of the patient's experience of care. Some important dimensions of quality of care that should be considered include:
  - *Access:* Access is not fully defined but includes concepts such as the ability to secure the services of a regular primary health care provider, specific 24/7 service availability (in person or by telephone) to a person who is linked to the person's PHC provider, same-day appointments, and timely availability of diagnostic and speciality services.
  - *Acceptability:* This refers to the patient's satisfaction with primary health care service(s); examples include adequate time spent with the appropriate health care provider, the ability of the appropriate health care provider to answer the patient's questions, and the patient's involvement in his/her own care and decision-making.
  - *Continuity and coordination:* Informational continuity is defined as all providers on the PHC team having access to clinical data as needed, in order to eliminate unnecessary tests and visits. Relational continuity is defined as the patient becoming known over time and the health care providers being aware of the social context (patients are able to see the same provider). Care coordination is defined as the coordination of care as a patient moves between providers and from primary health care, to acute care, to specialist care, to home care or to care in other community settings.
  - *Effectiveness:* While this has not been fully defined it includes concepts such as safety, efficiency, prevention and treatment.

In the interim, the Health Council will utilize published common PHC indicators for which data are available. The Council's work will feed into the larger process being undertaken by CIHI as part of a Primary Health Care Indicator Development Project funded through the national envelope of the Primary Health Care Transition Fund. This project is identifying consensus on a core set of existing and new PHC indicators by

[6] Developing better information systems was a goal re-affirmed in 2004 by First Ministers in their 10-Year Plan to Strengthen Health Care. Particularly with regard to primary care reform, First Ministers agreed "to accelerate the development and implementation of the electronic health record, including e-prescribing. To this end, First Ministers commit to work with Canada Health Infoway to realize the vision of an electronic health record through an ambitious plan and associated investment."

working from a set of evaluation questions for PHC renewal agreed to by the federal, provincial and territorial jurisdictions. The project will also provide advice to enhance the data collection infrastructure required for comparative reporting on the core set of new indicators. Developing a set of common indicators is crucial to evaluate primary health care reforms.

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Appendix 1: Definitions of primary health care

Federal / provincial / territorial definitions:[7]

FPT Vision 2000	The first level of care and usually the first point of contact that people have with the health care system. PHC supports individuals and families to make the best decisions for their health. It includes advice on illness and injury prevention, health promotion, individual health assessments, diagnosis and treatment of episodic and chronic conditions, and supportive rehabilitative care. Services are coordinated, accessible to all consumers and are provided by the health care professionals with the right skills to meet the needs of individuals and the communities being served. The PHC team works in partnership with consumers
Health Canada – Primary Health Care Transition Fund	Primary care, the medical model of response to illness, is part of the broader concept of primary health care. Primary health care recognizes the broader determinants of health and includes coordinating, integrating and expanding systems and services to provide more population-based, preventive and health promotion services through the best use of all care providers, not necessarily those provided only by doctors. (*Sharing the Learning: The Health Transition Fund Synthesis Series: Primary Health Care, 2002*).
Alberta	The first point of contact of individuals with the health system, -- that is, where health services are mobilized and coordinated to promote health, prevent illness and injury, care for common illnesses, and manage ongoing problems. (Adapted from the National Forum on Health, 1997)
British Columbia	The point at which a person enters the health care system and receives the health care services that meet most of their everyday needs. The first and most frequent point of contact with the health care system. Whether it is a visit to the family doctor or from a home care worker, a trip to the pharmacist, mental health counsellor or school nurse, primary health care is where new health problems are addressed, and where patients and providers work together to manage ongoing problems. The goal of primary health care is to keep people healthier, longer, by preventing serious illness and injury through education and timely treatment of short-term or episodic problems. It also works to help patients manage chronic health illnesses appropriately, so they don't develop unnecessarily into medical crises.
Manitoba	The first level of contact with the health system where services are mobilized to promote health, prevent illnesses, care for common illnesses, and manage ongoing health problems. PHC extends beyond the traditional health sector and includes all human services that play a part in addressing the interrelated factors that affect health. *Primary care* includes assessment, diagnosis, and treatment of common illnesses generally provided by family physicians and nurses. Primary care is one of the fore services provided by the PHC system. Other core PHC services include health promotion, illness prevention, health maintenance and home support, community rehabilitation, pre-hospital emergency medical services and coordination and referral.
Ontario	The foundation of the health care system with a sustainable, long-term relationship between the inter-disciplinary health care teams and patient. It refers to the first level of care and the initial point of contact that a patient has with the health system.

[7] Some sources are cited; in other instances definitions were accessed via provincial/territorial annual reports, business plans available via government websites.

Quebec	First point of contact between the patient and the health care system.
New Brunswick	First contact with the health system by patients. Is provided by clinicians who are responsible for addressing a wide array of health care needs and developing a long-term relationship with their patients. Changes to delivery of PHC will result in better, faster access to services, in the community and throughout the health system.
Newfoundland & Labrador	As a health services system philosophy and a strategy for organizing health services, primary health care is the first level contact with people taking action to improve health in a community. It is essential health care made accessible at a cost which the country and community can afford, with methods that are practical, scientifically sound and socially acceptable. (Adapted from WHO, 1998)
Northwest Territories	The term "primary health care" is used interchangeably with the term "primary community care" to reflect the health and social services environment. It is the first level of care and usually is the first point of contact clients have with the health and social services system - that is, in partnership with the client, services are mobilized and coordinated in response to client needs to promote wellness, prevent trauma and illness, build capacity, provide support and care for community health and social issues and manage ongoing problems to sustain functional independent at an optimal level. (Adapted from the 1997 National Forum on Health)
Nova Scotia	It is concerned with all the determinants of health as they apply to a given population, not just personal health serves. It is developed with the full participation of the people it services. It empowers people to take care of their own health and to take an active part in planning, policy-making and delivering health services in their community. It requires a strong foundation of community-based services that enable people to maintain and strengthen their health. (Adapted from the 1994 Task Force on PHC, and Health Canada's Taking Action on Population Health, 1998) Primary health care includes primary care, which is the first point of contact individuals have with the health care system and the first element of a continuing care process. Primary health care includes prevention, diagnosis, and treatment of common illness or injury, support for emotional and mental health, ongoing management of chronic conditions, advice on self-care, ensuring healthy environments and communities and coordination for access to other services and providers. Primary health care is about positively influencing the many factors that affect health. It includes a team-based approach to health care delivery, all day access to essential health services, and care for people of all ages and cultures in their communities, and the appropriate use of technology.
Nunavut	The level of care that meets most of the everyday health care needs of the population. It is the first contact point with the health care system and the place where basic services are provided.
PEI	It is a philosophy and an approach to health care based on the principles of accessibility, public participation, health promotion, illness prevention, appropriate technology and inter-sectoral collaboration.
Saskatchewan	A focus on care provided to individuals to address a particular problem or basic every day health need. It is care usually provided at the first level of contact with the health system - where people first enter the health system and where all health services are mobilized and coordinated.
Yukon	Point of first contact into the health care system.

Other definitions:

CIHI, Health Care in Canada 2003	The level of care through which individuals, families, and the community first come in contact with the health system. The term covers a range of essential health services and is often the gateway to other, more specialized care.
Canadian Medical Association, 1998	Defines primary medical care as a component of primary health care. Primary medical care consists of first contact assessment of a patient and the provision of continuing care for the wide range of health concerns.
Canadian Nurses Association, 2003	The focus of PHC is preventing illness and promoting health. It means being attentive to, and addressing, the many issues in people's lives that make them sick – from issues like diet, income and schooling to relationships, housing, workplaces and environmental toxins. PHC involves citizens and patients on an equal footing with professionals.
Charter of General Practice/ Family Medicine in Europe, 1994	Primary care is a system of care that provides accessible and acceptable care for patients; ensures the equitable distribution of health resources; integrates and coordinates curative, palliative, preventative, and health promotion services; rationally controls secondary care technology and drugs.
Fyke Commission, 2001 (Saskatchewan)	The first point of contact and provide the basis to address the main health needs of individuals and communities.
Health Services Restructuring Commission (Ontario), 2000	The first level of care, usually the first point of contact that people have with the health care system. Primary health care supports individuals and families to make the best decisions for their health.
Kirby Commission, 2002	A patient's first point of contact with the health care system. According to the Canadian Medical Association, primary medical care includes the diagnosis, treatment and management of health problems; prevention and health promotion; and ongoing support, with family and community intervention where needed.
Institute of Medicine, 1984	Community-oriented primary care is the provision of primary care services to a defined community, coupled with systematic efforts to identify and address major health problems of that community through effective modifications in both the primary care services and other appropriate community health programs.
Institute of Medicine, 1994, 1996	Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practitioner in the context of family and community.
Marriott and Mable, 2000	Primary care includes diagnosis, treatment and management of health problems with services delivered predominantly by physicians. Primary health care incorporates primary care, but also recognizes and addresses the broader determinants of health including population health, sickness prevention, and health promotion with services provided by physicians and other providers, often in multidisciplinary teams.
Medical Research Council, 1997	Primary care is first contact, continuous, comprehensive and co-ordinated care provided to individuals and population undifferentiated by age, gender, and disease or organ system.
National Forum on Health, 1997	The first point of contact of individuals with the health system, that is, where health services are mobilized and coordinated to promote health, prevent illness and injury, care for common illnesses, and manage ongoing problems.
Romanow Commission, 2002	The overall aim of primary health care is to significantly increase the importance of the first line of care and those who deliver these "first contact services."

World Health Organization, Declaration of Alma-Ata, 1978	The first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. Primary health care: • Reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience; • Addresses the main health problems in the community, providing health promotion, disease prevention, curative and rehabilitative services accordingly; • Includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs; • Involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular, agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors; • Requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate; • Should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need; • Relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

Appendix 2: Common strategies for advancing primary health care reforms

Building Blocks	Common Strategies
Improved continuity and coordination of care	**Enhancement of use of multidisciplinary teams and organizations** **Development and expansion of a range of primary health care organizations and models (e.g., physician health networks, family health groups, health service organizations, community health centres).** British Columbia has established a range of options for Health Authorities to choose the best approach for their population, including fee for service and blended funding models. Blended funding sites are funded according to the characteristics of the population served. Saskatchewan has mandated each Regional Health Authority to develop a network of care provider teams to deliver primary health care services and to provide case management to coordinate services. In Ontario, contracts between the Ministry of Health and Long-Term Care and Health Service Organizations, Community Health Centres, the Group Health Centre, Primary Care Networks, Family Health Networks, and Family Health Groups and other primary care models specify minimum numbers of office hours per week, 24/7 on call availability and a defined basket of services. In 2003, Ontario announced a commitment to establish 150 interdisciplinary Family Health Teams, as a new primary health care delivery model by 2008. These family health teams will encompass key elements of Ontario's Primary Health Care Transformation Strategy including: interdisciplinary teams; expanded access to care through extended hours and access to a province-wide telephone health advisory service; coordinated health care system access and navigation; health promotion; disease prevention; screening; acute care and chronic disease management guided by local health needs; active support for patients' self-care responsibilities; and, integrated clinical management systems. In Quebec, health and social services centres have been created by merging local community health centres, residential and long-term care centres, and general and specialized hospital centres. **Development of local primary health care proposals by Regional Health Authorities.** These plans build on provincial frameworks and focus on: • Expanding provincial or regional Telehealth systems. For example, 100 per cent of New Brunswick is served through the Tele-Care tele-triage service; • Enabling local priority-setting and decision-making related to implementation of the best primary health care practice models to meet community needs; • Establishing more collaborative teams to meet community needs; and, • Overseeing the development and implementation of an electronic patient health record.

Building Blocks	Common Strategies
Early detection and action	**Development of provincial chronic disease management strategies focused on high-risk populations and specific chronic diseases (e.g., diabetes).** For example, British Columbia has developed a Chronic Disease Management Toolkit for practitioners that offers a range of functions including web-based access to clinical guidelines for treating conditions such as diabetes, depression, and congestive heart failure. It enables practitioners to complete patient flow-sheets electronically – automatically integrating relevant clinical guidelines. British Columbia is also sponsoring the Electronic Medical Summary Project to develop the province-wide means to enable electronic exchange of patient information among practitioners when sharing the care of individual patients. Ontario has committed to establishing a chronic disease prevention and management framework in the next few years. In addition, key elements of Ontario's Primary Health Care Transformation Strategy are health promotion, disease prevention, screening, acute care and chronic disease management guided by local health needs and active support for patients' self-care responsibilities. Nova Scotia contracted Dalhousie University to work with partners to draft a long-term strategy to advise government on chronic disease prevention. Prince Edward Island is creating a set of best practice clinical protocols for use in Family Health Centres where teams of physicians and registered nurses practice collaboratively for chronic disease management. Nunavut has created a toolkit to be used by Community health representatives as front line staff in promoting community participation. This toolkit entitled *Engaging Nunavummiut: A Guide to Strengthening Community in Nunavut* is meant to encourage the emergence of more engaged citizens in Nunavut.
Better information on needs and outcomes	**Planning and implementation of shared electronic health record initiatives**. British Columbia has a comprehensive plan for the province wide implementation of the electronic health record. The implementation of the plan is governed by a provincial steering committee with representation from the senior executives of the health authorities, providers, chief information officers, and members of the Ministry of Health Services executive. The Alberta Electronic Health Record was implemented in 2004. It stores pertinent clinical patient information on-line that links physicians, pharmacists, hospitals, home care and other providers by computer. Quebec's information technology system, le Réseau de télécommunications sociosanitaire, links all public health services : hospitals; local community health centres; long-term care centres; rehabilitation centres; the 18 régies régionales; and, other services. Since January 2002, the Family Medical Groups can also access the system. Nova Scotia is implementing a province-wide hospital information system that supports a shared electronic health record across levels of care. The related Nova Scotia Health System Interoperability Project will allow primary health care teams to electronically link to client health information including lab and diagnostic imaging results.

Building Blocks	Common Strategies
Better information on needs and outcomes (cont.)	New Brunswick is implementing electronic patient records for Community Health Centres. Prince Edward Island has implemented a province wide Integrated Service Management information system linking community programs such as home care, mental health, diabetes education, child and family services to support continuity of care. **Federal and/or provincial research support to strengthen information related to primary health care reform strategies**. British Columbia has provided support to the Centre for Health Services Policy Research to build capacity for primary health care evaluation. The Centre has developed a primary health care evaluation framework and is developing an administrative database system that will provide profiles and information on primary health care from health authority, patient and provider perspectives. The Manitoba Centre for Health Policy is developing health indicators to support community needs assessments; health plans; performance agreements and deliverables. Manitoba is also piloting an electronic application in 21 communities for standardized client assessment and care planning. The Centre developed the Population Health Research Data Repository- a comprehensive database that holds records for all Manitobans' contacts with physicians, hospitals, home care, nursing homes and prescriptions. Administrative data from the database are being used to help physicians improve the quality of care they deliver based on assessment against a series of quality indicators. Through the e-Physician Project and improved clinical information systems, Ontario will become increasingly able to monitor needs and measure patient outcomes in the area of primary health care. Through its Primary Health Care Transition Fund, Ontario has funded a numbers of evaluation and planning projects that will provide guidance to the ministry on its primary health care strategies. Nova Scotia is enhancing its primary health care evaluation and research capacity through the development of an evaluation framework building on a February 2004 workshop. The First Nations & Inuit Health Branch, Health Canada is piloting an electronic application in 21 communities to standardized client assessment and care planning.

Building Blocks	Common Strategies
New and stronger incentives	**Development of new funding and remuneration methods including alternative payment plans for physicians such as contracts, rosters, or salaries**. In British Columbia, the 2004 Working Agreement with the BC Medical Association includes initiatives to support full service family practice, including chronic disease management, maternity care, improved access and quality of care for the frail elderly. $25 million has been allocated to support system-level primary health care renewal by providing funding for: change management or restructuring; development and implementation of new practice governance structures; training and skills development; and information technology enhancements. British Columbia has also developed a blended funding model based on the characteristics of the population served which supports interdisciplinary practice. In Alberta, an eight-year agreement has been signed by the government, the Alberta Medical Association and the regional health authorities to provide $100 million over three years to improve access to primary care services. Newfoundland and Labrador has developed a new model for family practice physicians - $70 million has been negotiated. **Exploration and implementation of changes to scopes of practice**. Some of these changes focus on changing incentives for providers to encourage them to work in a more seamless system of delivery by changing remuneration models for physicians and other practitioners to support a primary health care delivery approach. Nurse practitioners are now licensed to practice in New Brunswick and are working in various health care environments including physicians' offices and Community Health Centres. **Development of new recruitment and retention strategies**. Manitoba has developed an Office of Rural and Northern Health focused on development of a Primary Care Physician Recruitment and Retention Strategy and Nurse Practitioners Strategy. In Ontario, the Ministry of Health and Long-Term Care is increasing supply of human resources in health care by: ▪ Increasing the proportion of family medicine positions in the postgraduate medical training system from the current proportion of 38 per cent to up to 43 per cent; ▪ Working with medical schools to ensure that the family medicine training program is attractive and consistent with the skills and knowledge required to delivery comprehensive primary care; ▪ More than doubling the number of training positions for international medical graduates to 200 from 90 with an emphasis on positions in family medicine; ▪ Implementing return of service commitments for physicians who access ministry funded postgraduate training, which will include communities where Family Health Teams are to be located; ▪ Doubling the number of clinical education spaces for nurse practitioners to

Building Blocks	Common Strategies
New and stronger incentives (cont.)	150 from 75 spaces in three years; ▪ Increasing the number of postgraduate trained nurses needed for key faculty positions to educate more nurses; ▪ Removing barriers faced by internationally educated health care providers so they may practice in Ontario; ▪ Increasing the annual enrolment in pharmacy to 240 in 2005, which is double the 2000 enrolment level; and, ▪ Enrolling up to 60 new applicants in midwifery education programs in 2004 with a plan to be developed in 2004/05 for possible future expansion. As part of its primary health care strategy, Ontario is also committed to increasing the number of nurse practitioners, nurses, pharmacists and other health care providers working in primary care practices. A joint initiative of Nova Scotia, Prince Edward Island, New Brunswick and Newfoundland and Labrador delivers continuing professional education to primary health care providers.

Appendix 3: Summary of primary health care initiatives by jurisdiction

Jurisdiction	Priorities	Target date	Status
British Columbia	Engage 4,000 family practitioners via professional quality improvement process; implement primary health care structured collaborative	2006	In progress
	Implement four provincial chronic disease management collaboratives; support with IT and patient self management initiative	2006	Ongoing
	Pilot group patient clinical visits	2005	In progress
	Develop clinical practice guidelines	2005	Six complete; three under development
	Implement incentives for full service family practice	2006	Ongoing
	Establish Primary Health Care Transition Fund framework to provide regional health authorities with a range of new practice models	2003	Completed
	Enable 100% of population able to receive health information from registered nurses and pharmacists through phone access. (BC Nurseline)	2003	Completed
	Convert projects initiated as demonstrations to permanent primary health care organizations	2003	Completed
	Establish a blended funding model for primary health care organizations	1997 - ongoing	Established
	Create 11 primary health care organizations, five community health centres (sites owned by regional health authorities), four shared care initiatives (specialists and general practitioners managing complex patients together), one patient care network (practitioners are not in same site but share patient information, after hours care and on-call coverage)	2004	Established
	Expand midwifery by initiating a training program within the Faculty of Medicine at University of British Columbia	2005	First students to graduate in 2005
	Develop legislation for nurse practitioners	2004	Completed. Students to graduate in 2005
	Initiate training program for nurse practitioners in two universities	2004	First graduates in 2005
	Document successful nursing models for interdisciplinary care	2005	Under development
	Establish nurse managed care in six rural/remote communities.	2004	Under development
	Develop electronic medical summary	2006	Under development

Jurisdiction	Priorities	Target date	Status
Alberta	Develop province-wide access to telephone based health information	2003	Established
	Implement Alberta electronic health record	2004	March 2004 – 5,500 users are on line
Saskatchewan	Province-wide access to telephone advice	2003	Completed
	Develop a primary health care memorandum of understanding and model contract for physicians	December 2004	In progress
	Create health services networks and teams available 24/7 to 100% of population	2011	27 teams established covering a population of 18%. Registered nurse practitioners now licensable in Saskatchewan. Facilitators for team development in each Regional Health Authority
	All regional health authorities to develop primary health care plans.	2004	Completed. Each regional health authority has an identified director of primary health care and a multidisciplinary steering committee for primary health care
	Develop primary health care evaluation	2005	In progress
	80% of family physicians to participate in primary health care models	2011	In progress
Manitoba	Regions to develop primary health care plan based on provincial policy framework	2004	Completed
	Establish Health Access Centres		Ongoing. Two are established with additional centres in the planning stages
	Implement primary care physician recruitment strategy		Ongoing
	Establish office of rural and northern health		Established
	Expand Telehealth		More than 20 sites are in operation with planning underway for additional sites
Ontario	Implement nurse practitioner initiative		The most recent initiative funded 115 positions in small, rural and under serviced areas. The Ministry is exploring opportunities for nurse practitioners in Family Health Teams and other primary care settings. In total the ministry funds over 400 nurse practitioner positions. Upgrading 87 nursing positions to nurse practitioners and creating 34 new nurse practitioner positions in community-based settings

Jurisdiction	Priorities	Target date	Status
Ontario (cont.)	Implement Family Health Teams	2008	Plan to establish 150 Family Health Teams by 2008; 45 to be announced by March 31, 2005
	Align the following existing innovative primary care models along common elements: The Group Health Centre, Community Health Centres, Primary Care Networks, Family Health Networks, Health Service Organizations, Northern Group Funding Plans, and Community Sponsored Contracts		Over the next few years, Ontario will align existing primary care models along key common elements including extended hours of care; Telephone Health Advisory Service; interdisciplinary collaborative care; coordinated system access and navigation; health promotion; disease prevention; screening; acute care and chronic disease management guided by local health needs; active support for patients' self-care responsibilities; and integrated clinical management systems.
Quebec	100 family medicine groups to offer 24/7 services	2003	
	Community health centres to be open seven days a week for a minimum of 70 hours a week.	2003	In 2004, the community health centres were merged with residential, long term care and general and specialised hospital centres
Nova Scotia	Evaluate multidisciplinary health care teams	2003	Established four demonstration sites and completed evaluation
	Establish and support collaborative practice teams.	2006	Ongoing. Nurse practitioners already incorporated into teams in 14 communities
	Deliver training for primary health care providers	2006	Ongoing joint initiative of the Atlantic provinces to deliver continuing professional education modules to primary health care providers in all four provinces.
	Develop a Tele-Care phone line, interactive web site and audio tapes in partnership with other Atlantic provinces.	2003	Phase 1 underway. Implementation is targeted for 2005/06
	Implement a province-wide information system that supports shared electronic health record across levels of care	2005	Scheduled for completion in 2005/06
	Advance electronic health record initiative	2006	Ongoing
	Incorporate diversity and social inclusion in primary health care	2006	Ongoing

Jurisdiction	Priorities	Target date	Status
New Brunswick	Establish five Community Health Centres	2004	Community Health Centres established and operating in Saint John, Minto, Doaktown, Lameque & Riverside-Albert
	Establish four additional Community Health Centres	2008	Planning under way for the establishment of Community Health Centres for Plaster Rock, St-Quentin, Dalhousie & Caraquet
	Implement Tele-Care	1999	100% of New Brunswick served through Tele-Care tele-triage service; New Brunswick is also working with Atlantic partners on expanding this service on a regional basis
	Implement collaborative practices	2004	Individual collaborative practices (in physicians' offices) in place in Edmundston, Bathurst & Moncton; Collaborative practice clinic now in place for Fredericton
	Focus on interdisciplinary training	2006	Ongoing. Joint initiative of Atlantic Provinces to deliver continuing professional education to primary health care providers
	Engage nurse practitioners	2002	Nurse practitioners now licensed to practice in New Brunswick; working in various health care environments including physicians' offices and Community Health Centres
	Implement electronic health record for Community Health Centres	2008	Ongoing. To implement electronic patient record for Community Health Centres
	Enhance ambulance service		Ongoing. To enhance the capabilities and skills of ambulance attendants to improve access to health care
Newfoundland and Labrador	100% of residents to be registered with a primary health care network	2007	Ongoing. 25% of population will have access by 2005
	Develop a Tele-Care phone line and interactive phone line and audio tapes in partnership with other Atlantic provinces	2005	Phase 1 underway; implementation is targeted for 2005/06
	Evaluate a shared electronic health record across primary health care	2005	Ongoing
	Increase participation of family practice physicians in primary health care teams	2006	Ongoing. Full physician participation in eight projects

Jurisdiction	Priorities	Target date	Status
Newfoundland and Labrador (cont.)	Make available 24/7 primary care within 60 minutes to 95% of people	2007	Ongoing. 90% access as of 2004.
Prince Edward Island	Develop a Tele-Care business case with the other Atlantic provinces for tele-triage	2005	Phase 1 business case developed
	Create Family Health Centers with core staff of salaried physicians and registered nurses working collaboratively	2002 - 2005	Five of the six sites established and being evaluated
	Create a Healthy Living Strategy of 22 partner organizations that focuses on active living, healthy eating and tobacco reduction	2002-2005	22 organizations with social marketing plans
	Create local networks of community services that organize activities that promote the Healthy Living Strategy	2003 -2005	Four coordinators hired regionally to implement the local networks
Northwest Territories	Publish and distribute a self-care handbook to all households	2003	Completed
	Establish a 1 800 family health and social supports call centre	2004	Launched May 2004
	Formalize integrated health and social services delivery model and establish demonstration projects	2003	Plans are completed. Implementation to be phased in dependent upon resources and priorities
	Establish alternate service delivery teams	2010	
	Integrate nurse practitioners into primary care		New *Nursing Act* proclaimed Jan 2004 provides for regulation of nurse practitioners; nurse practitioners are to be placed in each community health centre and hospital emergency department (minimum 29 positions)
	Integrate midwifery services	2005	Coming into force of the *Midwifery Profession Act* January 2005
Yukon	Establish a Healthy Living Strategy	2006	Ongoing
	Support active living, including an ongoing walking program		
	Provide parenting information; implement a positive parenting social marketing campaign		
	Provide health information: • Yukon Health Guide - information book for all Yukon households • Web Access - link to on-line health information through British Columbia • Program Info - Improved on-line information on Yukon programs and		

Jurisdiction	Priorities	Target date	Status
Yukon (cont.)	services • Update disability handbook		
	Enhance information technology support: • Public Health information system • Mental Health information system • Client registry • Drug information system Strengthen information management as part of overall planning and coordination		
Nunavut	Use primary health care funds to promote multi-disciplinary approaches to health care delivery and to train Inuit service providers Focus on better integration of addictions and mental health services Develop and implement a toolkit entitled *Engaging Nunavummiut: A Guide to Strengthening Community in Nunavut* to be used by Community health representatives Develop: • Training materials for use by regional mental health training teams • Poster series on mental health awareness (anxiety, depression, post-traumatic stress disorder) Establish Mental health Worker Diploma Program Establish a pilot project to train Community health representatives in Nunavut for three months in dental and nutrition programs with the goal of awarding a diploma in Community Health Promotion Specialist in Dental Health and Nutrition Provide on-going training for Community health representatives in needs assessment and presentation skills	Ongoing	
	Establish the first collaborative family practice clinic in Iqaluit	2005	

Source: As reported by provinces and territories

Appendix 4: Summary of initiatives under the Primary Health Care Transition Fund

Initiatives under the provincial / territorial funding envelope:

Province	Key projects/ areas of focus
British Columbia ($74 M)	▪ Supporting a range of interdisciplinary practice models ▪ Developing an electronic medical summary ▪ Developing a chronic disease patient registry ▪ Establishing clinical practice guidelines for various diseases
Alberta ($55M)	▪ Implementing a province-wide telephone health information line ▪ Building capacity to better develop and deliver effective primary health care services
Saskatchewan ($19M)	▪ Building capacity to define core services, develop and set standards and establish performance indicators for primary health care services ▪ Building capacity of Regional Health Authorities for change management ▪ Establishing a telephone advice line
Manitoba ($21M)	▪ Expanding existing Telehealth system ▪ Enhancing emergency medical services and information technology ▪ Establishing and integrating collaborative practice training program for primary health care providers
Ontario ($213M)	▪ Supporting various initiatives leading to the integration of interdisciplinary providers in primary health care practices ▪ Developing information systems to support various health care practices ▪ Undertaking public and provider communications activities
Quebec ($134M)	▪ Establishing Family Medicine Groups
New Brunswick ($14M)	▪ Implementing several multidisciplinary community health centres ▪ Enhancing the capacity of their ambulance services
Newfoundland and Labrador ($10M)	▪ Implementing several Primary Health Care Networks, including the development of infrastructure to support these networks such as alternative physician funding models and pilot testing of an electronic health record
Nova Scotia ($17M)	▪ Enhancing information systems among primary health care providers in preparation for electronic health records ▪ Supporting the development of various primary health care models through Regional Health Authorities
PEI* ($7M)	▪ Implementing family health centres with a target of six by 2006 ▪ Developing a healthy living strategy and drug utilization strategies
Yukon* ($5M)	▪ Refocusing organizational structures and processes toward greater integration of services ▪ Emphasis on health promotion in the primary health care context ▪ Enhancing primary health care information systems
Northwest Territories* ($5M*)	▪ Providing public / staff education on primary health care reform ▪ Developing integrated primary health care teams and services ▪ Supporting improved women's reproductive health services ▪ Providing training for various health providers
Nunavut* ($5M)	▪ Implementing a change management process leading to integrated coordinated patient and community focused primary health care ▪ Developing an information management strategy

* These four small and/or remote jurisdictions each received supplemental funding of $4M in addition to their per capital allocations.

Initiatives funded under other PCHTF envelopes:

Funding envelope	Key projects/ areas of focus
Multi-jurisdictional envelope ($30M) *Supports collaborative initiatives undertaken by two or more P/Ts.*	Two initiatives involve the four Atlantic provinces: • development of Telehealth/ tele-advice services • curriculum and professional development for providers Two initiatives involve Western provinces: • common activities relating to tele-advice services • infostructure for chronic disease management One initiative involves British Columbian and Yukon: • substance abuse and concurrent disorders
Aboriginal envelope ($35M) and Official Language Minority Community ($30M) *Supports primary health care reform for targeted populations*	Nine initiatives are designed to renew and/or enhance the primary health care system in Aboriginal communities. Other initiatives are designed to improve access to primary health care services for official language minority communities, such as training of health interpreters and translation and distribution of materials.
National envelope ($67M) *Supports collaborative action to address common barriers to PHC reform.*	Examples of initiatives being supported include: • The development of a common set of indicators and instruments and tools to support the evaluation of various aspects of the primary health care sector; • Support for key national health provider associations to develop protocols and principles to support interdisciplinary team-based care; • Public and provider awareness activities such as provincial and national conferences and workshops; • Health care provider skill development (e.g. continuing professional development and faculty development initiatives); • Integration with other health care sectors such as home care and palliative care; • Initiatives that address access to primary health care by specific populations or for people with specific conditions; • The sharing of best practices (e.g. the latest evidence and innovative approaches); • Synthesis of the findings/results of each initiative.