

Reflections on Ontario's Primary Healthcare Journey



COMMENTARY

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ABSTRACT

Despite the prevailing opinion and consensus around how primary healthcare systems should be changed, there is very little agreement on how this should happen and a surprising paucity of research and evaluative evidence related to both system organization and mechanisms for change. The authors reflect on Ontario's experience with primary healthcare renewal and provide insight into lessons learned.

DR. HUTCHISON HAS provided a thoughtful work that challenges us to reflect on what we have achieved and why certain paths have been chosen, and to question ourselves on future directions and opportunities. Despite the prevailing opinion and consensus around how primary healthcare systems should be changed, there is a surprising paucity of research and evaluative evidence related to both system organization and mechanisms for

change. The lack of evidence and descriptive information on the experiences across Canada has hampered our ability to learn from our own successes and mistakes and to understand and learn from each other. We are moving quickly, adapting to changing priorities and reflecting on what supports or impedes change, and we must become more systematic about evaluating and tracking our progress against clearly stated objectives and goals.

It is our belief that while we have made substantial progress, we must continue our efforts and refine our focus on creating a sustainable foundation in the emerging primary healthcare “system.” The reality is that our healthcare system changes every day in response to the needs of those it serves, the cultural environment and the interests and skills of those who work in it. As a result, there are significant areas that require ongoing attention, such as bringing the elements of a new system together; providing the types of supports needed to maximize the effectiveness of the new organizations; expanding to a greater number of communities; and leveraging what exists to make even greater gains in system performance, care access and elevation of clinical outcomes.

Measuring change and progress is essential and requires a commitment to performance measurement, evaluation, data collection and transparency. Ontario has made some progress in these areas, but much still remains to be done; at this point in time, we are largely measuring process items and beginning more comprehensive evaluations to collect the evidence needed to support refinements and system changes.

There are two basic approaches to a change of the magnitude being undertaken with primary healthcare renewal – *revolution* and *evolution*. The approach taken in Ontario has deliberately been one of evolution or iterative change – where opportunities are taken as they arise in the political, societal and economic environments, and mid-course corrections are made based upon learnings from each previous step. Even with this approach, we have learned some significant lessons: that change takes time, that it can occur in steps or phases and that asking for too much too fast runs the risk of overwhelming and discouraging your champions as well as destabilizing an important sector

of care. For Ontario, this meant developing a menu of choices for physicians and, more recently, communities and providing appropriate compensation and reward for the effort taken to make the substantial practice and service changes these choices would entail. We did not learn this easily or quickly, and it has not been without concerns about whether the majority of physicians are now “stuck” at a point in the change and not likely to move on.

Primary healthcare renewal is somewhat unique in that there is little disagreement about what should be done but significant differences of opinions around how it should be done. In this case, the *how* has become much more important than the *what* in shaping the change agenda.

Change can start and be championed from almost any part of the system. Perhaps none is more important than the role of local leadership and champions. It is always those who have their peers’ respect and trust and who are considered to have credibility who make the best champions, and the importance of finding these leaders and supporting them cannot be underestimated. At the same time, there must be leadership provincially to stay the course when the inevitable bumps in the road are hit, and to be clear about the vision for the future.

If you accept our contention that “carrots” and incentives work better in most circumstances than disincentives and sticks, then it is important to consider how to choose the incentives and how to determine the degree of the incentive and the method by which it might be applied. In Ontario, we have developed a menu of choices of blended compensation models for physicians; this itself begs the question, assuming incentives work, beyond what point does the added complexity become a disincentive to participation?

One of the biggest enablers of change occurs when partnerships across organizations

and individuals can be forged, allowing for the building of trust and the focusing of energy around meeting patients' needs, regardless of the setting in which care is provided. When a primary healthcare system is organized so that there are groups of providers engaged in planning and working to develop improved referral and coordinated care mechanisms, patients' healthcare experience can be improved. Why can't home care services be co-located and integrated with primary healthcare? Why shouldn't physicians follow their patients in residential long-term care settings as they move to a new stage of their life? How can organized primary healthcare work with local hospitals to enhance access to outpatient and diagnostic services? How can local providers work together to improve access for unattached patients? What programs and services can primary healthcare teams provide or coordinate with public health units or local mental health agencies? These are all questions that couldn't even be asked a few years ago when the predominant mode of delivery of primary care was through solo physician practices. Now is the time to build on the foundation created and to begin a new journey to build public confidence. A focus on results achieved and accountability agreements is a must.

A constant theme that arises is family-centred care and care that is focused on the needs and preferences of the individual within this context. We are moving to team-based care, and patients may identify with and seek out the care of one provider more than another, depending on their needs and preferences. Should consideration be given to expanding this concept further? Should walk-in clinics or other regulated health providers beyond physicians and nurse practitioners be seen as key providers, depending upon the choice of the individual?

In all jurisdictions, dialogue continues around the role of the family physician and

whether sub-specialization into areas of practice such as hospital medicine, sports medicine, palliative care and student health services addresses care issues. This quickly leads to broader discussions about who is the right provider for specific services and whether that provider or provider-team mix varies by geography due to the realities of scale and size. These are not easy issues to resolve, but they are fundamental to any health human resource planning efforts. As stated earlier, this drives us to evaluation and measurement; with ongoing attention to access and the distribution of health human resources, the answer to these issues will start to materialize.

Over time, we will see more organization in care teams for defined populations and increased attention to formal evaluation and outcome measurement. This includes the integration of specialists into the primary care team as consultant advisors as well as members to develop programs and services. Pediatricians, psychiatrists, internists and cardiologists are already beginning to link to the organized primary care models, and we anticipate that this will become an increasing trend. Another area where there is significant potential is maternity care – the involvement of midwives, family physicians, obstetricians, nurses, nurse practitioners and dietitians as part of an integrated care team could improve access and outcomes.

In closing, committing to the evaluation of clinical outcomes and patient experiences has the added benefit of targeting the focus for the future on what you are trying to achieve; it serves as a reinforcement of vision, goals and objectives. Bottom line, there is *no* status in the quo.