Commentary

Integrated primary care organizations

The next step for primary care reform

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The story

Trish was a director in a regional health authority and she was worried. She had just had a teleconference with the province's new Minister of Health. The provincial government had been heavily criticized in the press following the deaths of several children from asthma in the past few months. The Minister had decided to make asthma a new health priority and during the teleconference had asked Trish to pilot a regional asthma control strategy. She thought she should form an expert group to help plan the strategy.

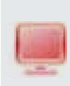
Within a few hours Trish had managed to get offers of help from the head of respiratory medicine and a senior manager from the regional hospital. But she was drawing a blank with family practice support. She knew of a few family doctors, but as far as she could work out nobody represented family doctors at a local level. If a strategy was developed, she could see herself needing to get a buy-in from each physician individually. She took a deep breath. It was going to be a long day.

Meanwhile, on the other side of town, Mary, a family doctor, had just finished a shift at the emergency department. Four children had come in with asthma, and none of them had used any controller medication since their last admission. Two of them did not have family physicians, and neither of the 2 that did had been able to get an appointment within the month since their last admission. She had met a few doctors in the area who had the same concerns about asthma in children and wondered what they could do if they approached the problem together.

The reality

Trish and Mary work within a health care system that lacks an organized link between government and primary care clinicians. Over the past decade Canada's primary care system has undergone substantial change. New models of interprofessional care have been piloted, blended payment schemes have been introduced, and practices have started to use electronic medical records. However, these changes have been confined to patients belonging to and practitioners working in individual practices. The new models of care have had minimal influence on horizontal integration—the part of the health care system that provides formal and informal links among primary care establishments (ie, offices or practices) in a given health region.[1]

Fragmentation has come to characterize Canadian primary care. Although some primary care providers work in hospitals, the remainder work in community agencies or, most predominantly, in small, independent practices. Patients receive duplicate tests, information is frequently unavailable at point of service,[2] and practices rarely interact among themselves or with other health care sectors—even when dealing with common problems. Confidence in Canada's response to a new influenza epidemic is undermined when one considers the tenuous links between primary care and public health.[3] Our lack of a stable primary care infrastructure means that temporary solutions need to be found for each new health care challenge.



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Experience in other countries

Trish's and Mary's difficulties would be eased if they worked in the United Kingdom, Australia, or New Zealand. In the past 2 decades, each of these nations has used primary care organizations (PCOs) to transform the primary care landscape. These PCOs have been defined as "organizations that seek to increase the influence of primary care professionals, and in particular general practitioners, in health planning and resource allocation."[4]

Although the objectives of PCOs vary, they fundamentally aim to forge links between activities at the micro level of care delivery (clinical care delivered by individual practitioners) and the macro level of care delivery (systems responsible for policy, funding, and infrastructure).[5] Although PCOs have had different forms in each nation, several features are common to all:

- Primary care organizations differ from professional organizations and are primarily funded by governments.
- They are regionally organized and are responsible for the needs of both the community and primary care clinicians.
- They have some responsibility for access, quality of care, and coordination of primary care activities within a geographic region.[6]

Australia's PCOs are called Divisions of General Practice. These government-funded, not-for-profit corporations were created in the 1990s following

an agreement among the federal government, the Australian Medical Association, and the Royal Australian College of General Practitioners. Divisions are designed to support general practices in providing better access and quality of care to communities.[6] They are governed by a board of directors (predominantly GPs) and managed and run by non-GP staff. Divisions do not have a clinical role but provide infrastructural support to practices in their respective regions and are the means by which population and public health initiatives can be translated to primary care.[5]

Although PCOs emerged spontaneously in New Zealand in the 1990s,[7] a national primary care strategy was followed by the implementation of community-governed, broadly represented primary health organizations (PHOs) across the country. Unlike in Australia, patients enrol in their PHOs through local GP clinics; the PHO is in turn responsible for carrying out primary care development and public health functions at a local level. Administered as part of the activities of district health boards, PHOs have an explicit requirement to include a broad group of health care providers in the decision-making process and to focus on access, care of disadvantaged groups, and population health.[8]

England's primary care trusts (PCTs) are a key part of the National Health Service. Their involvement in local health planning, primary care development, and a range of secondary and tertiary care purchasing[7] gives them a broader mandate than Australia's Divisions or New Zealand's PHOs.[9] Primary care trusts are responsible for the delivery of primary care, the commissioning of secondary care, and the delivery of public and community health services to as many as 250000 individuals. They assess local need and are responsible for close monitoring of access as well as integration of primary care services.[10]

The benefits of PCOs

These 3 PCOs differ in their activities, but all offer an infrastructure that is lacking in Canadian primary care. Australia, New Zealand, and the United Kingdom have found ways to make PCOs fundamental to health policy and management[7] while maintaining substantial physician participation and satisfaction. Access, particularly after-hours services, has improved, and PCOs have been the catalyst for innovative approaches to intermediate care.[11,12] They have helped optimize the use of electronic medical records and have facilitated quality assurance activities associated with the prevention and management of chronic diseases.[12] There is even evidence that their introduction (at least in the United Kingdom) has been linked to reductions in diagnosing and prescribing costs.[7]

Integrating Canadian primary care

We believe it is time to learn from international experiences and begin to develop PCOs in all Canadian provinces. Activities should be aligned with government priorities but be flexible enough to cope with regional and local needs. There are some early examples of moves toward primary care integration in Canadian primary care. Alberta has introduced primary care networks[13] and British Columbia has announced 3 prototype divisions.[14] In Quebec, networks are being formed that bring together certain models of primary care service delivery at a regional level.[15]

Given the move toward interprofessional health care delivery in other parts of the Canadian health care system, Canada's PCOs should actively seek to integrate nonmedical primary care professionals. A collaborative approach would be facilitated if the unit of membership was the practice rather than the individual provider. Governance could mirror the models used in hospitals throughout the country: a Board of Directors comprising primary care clinicians as well as health consumers, and administered by a Chief Executive Officer and support staff. Overseas experience suggests that it can be helpful to rehearse the process in a single small region before executing wider implementation.

Broad implementation of PCOs would require provincial funding based on patient population, rurality, and, possibly, the proportion of disadvantaged patients within a region. Funding would have to be predictable, linked to community need, and sufficient to cover costs for administration and delivery of activities. At a structural level, PCO boundaries should be aligned with those of regional health authorities. This initiative would benefit from a commitment of support, at the very least from the College of Family Physicians of Canada and the Canadian Medical Association. Added endorsement should be sought from the Canadian Nurses Association and key primary care professional groups.

Challenges

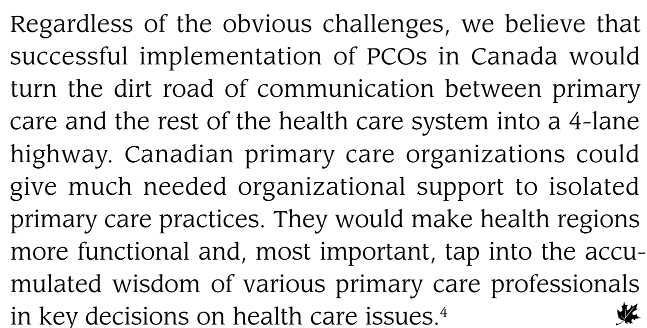
A Canadian family physician reading this commentary could well be thinking, "How much more change can I stand?" Primary care organizations are a big undertaking with substantial implications. Their introduction has not always been smooth: in the early days of implementation Australia's Divisions of General Practice were a hard sell, but by 2007 86% of the country's GPs were members and were soon joined by an increasing proportion of nonphysicians.[5]

More important, Australia's PCOs have had a long-term ability to pay GPs at agreed professional rates for time away from their practices attending meetings or handling other work. As it turns out the numbers of consulting hours "lost" have been offset by the efficiencies gained from working collaboratively, the provision of administrative support for individual practices, hospital-GP liaising, and innovative approaches to after-hours access.

Professional care organizations can lead to a reevaluation of the core business practices of large provincial or

national medical organizations.[16] With similar processes in place in Canada, professional colleges (such as the College of Family Physicians of Canada) might come to fully concentrate on setting educational standards, universities would be able to focus on teaching and research, and other professional organizations (such as the Canadian Medical Association) could occupy more of an industrial and representative role. These professional organizations will also have an important role to play as key stakeholders in the endeavour, providing input and supporting the changes required to effectively integrate primary care into the greater health care system.

Conclusion



Regardless of the obvious challenges, we believe that successful implementation of PCOs in Canada would turn the dirt road of communication between primary care and the rest of the health care system into a 4-lane highway. Canadian primary care organizations could give much needed organizational support to isolated primary care practices. They would make health regions more functional and, most important, tap into the accumulated wisdom of various primary care professionals in key decisions on health care issues.[4]

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Competing interests
None declared

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