NOTES FOR AN ADDRESS BY

Dr. Susan J. Hutchison
Chair, General Practice Forum

PUBLIC HEARINGS ON PRIMARY CARE REFORM

Presentation to the Standing Senate Committee
on Social Affairs, Science and Technology

Ottawa, Ontario
May 22, 2002

ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

A healthy population…a vibrant medical profession
Une population en santé…une profession médicale dynamique

ASSOCIATION MÉDICALE CANADIENNE

CANADIAN MEDICAL ASSOCIATION

Mr. Chairman:

Good afternoon and thank you for the opportunity to present to you today. My name is Susan Hutchison and I am a practicing family physician. The perspective I am presenting to you today comes from the chairs of general and family practice of the divisions and territories of the CMA.

As noted in Dr. Barrett's presentation the "primary medical care system" forms the basis for the delivery of medical services in Canada. Family physicians, working collaboratively with their specialist colleagues, form a virtual network care continuum. This network of professionals, work cooperatively with allied health professionals to deliver an array of services in a variety of settings from the most complex institution to the home. This system has formed the basis of a universal health care system that is world renowned.

The Committee has asked the CMA to address a list of questions framed around the primary care issue. These questions have formed the basis for this presentation. It is important that we consider what is primary care reform as a first step in responding to these questions.

Primary care reform is an amorphous term. It has been associated with "efficiency planning" which is another word for economic cuts. In other areas it is used to introduce alternative providers and in yet other areas it is coined to serve as the curative panacea for the ills of our current system. The language of reform is a source of confusion and needs to be clarified.

If primary care reform means providing the same or more services for less, it is a non-starter. If it means finding ways to provide more comprehensive care to patients while maintaining the quality Canadians deserve then there is common ground from which to begin the challenging work of looking at alternatives to the current system and studying these alternatives through pilot projects.

Physicians are supportive of changes to the system that are evaluated prior to their implementation. It is necessary to evaluate the outcomes of alternatives to the current system on patient care. Adopting untested changes to the current system may negatively impact on patient health outcomes. Primary care pilot projects have been the focus of Health Canada's health transition fund. The synthesis report on the pilot projects is due to be released in a few weeks and will include some outcomes measures of alternative models of care delivery. There are challenges in interpreting these reports however. There are no valid and reliable baseline data sets to compare the changes to. In light of the short time frame of the HTF it is unlikely that they have true patient health outcomes measures. This makes conclusive interpretation of any initiatives difficult. Physicians need to be integral to the reform process as they have the domain knowledge which is required for accurate interpretation of the results of pilot projects.

This evaluation process takes time and resources to complete, both are in scarce supply. This makes the reform process slow. Taking the time to consider options carefully is necessary. The delays do not belong to the profession, the delay is characteristic of the time it takes to evolve a complex system.

Anecdotal reports from pilot projects, however, tell us one thing for certain; is clear that the alternatives are more costly than the current system.

Primary care reform options have considered primary care teams to include family physicians, nurses and other allied health professionals, but it does not ask what other skills are required to serve the needs of the patient. Most reform proposals consider the inclusion of nurse practitioners despite the current nursing crisis. Other options could be explored. The Canadian Military's use of medical assistants is one option. In the public sector, the emergency medical technicians who staff our emergency response teams are another way to extend medical expertise to patients where and when they need it. Nurse clinicians have a special skill set and can function in many other roles in addition to the primary care setting such as in specialized clinics for cardiac patients and diabetes for example. The systems reform options must consider where best to commit scarce resources.

Delays in the reform agenda are a function of the funding and human resource challenges. The other major challenge to the reform agenda is the delay in the creation and implementation of information technology. The technology must be designed so that it is the servant of the system. Systems programmers have been working for years to achieve this objective. The introduction of the technology is time consuming and the use of the technology is an additional component of the system which will need additional resources. The major delay in the progress in this area is cost. Applying technology to the practice of medicine is an expensive though necessary proposition. In the short term, the implementation of information technology will cost the system significantly more in terms of human and financial resources. There is the expectation that such an investment will eventually save time and money. While this potential exists, we cannot simply assume either will be the case. Therefore, it is more prudent to discuss information technology it terms of its enabler benefits to the system and less on the potential savings it may provide.

There are many models of primary care reform which include different payment options alternatives. We have learned that no matter what the payment method, if the funding is adequate the outcome will be positive. Physicians appear to be most satisfied with a blended form of payment which include a fee-for-service component as well as a sessional or salary component.

Services to be included in the models can vary. In general, however, it is not possible to include previously unfunded services into the current funding without an additional resource commitment, this will result in a failure of the reform initiative.

You have asked whether we can envisage primary care in Canada as teams acting as purchasers of care on behalf of their patients? Off the top, it would be imperative to avoid the perverse incentives of the managed care system in the U.S. to provide less than optimal care. As a start I think you should have to take a close look at the U.K. experience of fund holding which I understand it has had a "mixed success."

Considering the scopes of practice, what we know is that physicians are concerned with training and liability as well as legislative issues and that these processes take considerable time. Physicians have worked collaboratively with nurses for years. In the office setting, many physicians used to hire nurses but can no longer afford to maintain this practice model as nurses were paid from their fee for service billings. Many physicians have voiced their desire to return to their prior collaborative practice models. Ways to fund these initiatives should be supported.

The mix of health care providers varies based on the needs of the population. There is no ideal mix. What works best is adequate human resources to meet the needs of the population. The mix of providers is dictated by the services required to address the patient needs. The ideal range of services for a given "team" would depend on the needs of the population and the available mix of providers. There may be considerable variability between the needs of a given population as is the case in the aboriginal populations.

Primary care reform, if it includes the medical care continuum, adequate funding and realistic human resources plan, inclusive governance structures, information technology infrastructure with appropriate connectivity has the potential to improve the quality of care delivered to patients. More resources may be committed to illness prevention and health promotion if the resources are adequate. This would have the potential to further improve the population's overall health status. The cost of reform initiatives will be significant and will depend on the elements to be included.

Whatever alternative system is proposed, physicians need to be able to retain their autonomy and role as patient advocate.

Medical care is a continuum. Reform options must support the medical care continuum. Reform options must be evaluated prior to implementation and evaluation must include measures of patient health outcomes. There must be a plurality of payment options and service delivery models to serve the needs of the population; there is no onesize fits all solution. Physicians must be directly involved in the planning and implementation of the reform options. Physicians must retain their autonomy in clinical decision making and retain their role as patient advocates. Physicians should be supported in their practices by physician assistants. Scarce resources should be used carefully.

The only reform that will be successful is reform that is grass roots and comes from the bottom up. Imposed, unilateral reform would most likely critically destabilize an unstable and fragile system.

With regard to methods of remuneration we know that no matter what the method, the funding must be adequate. We know that when adequately funded all payment options have their place in a system for different reasons.

Thank you for the opportunity to address the committee. We recognize the importance and enormity of the task you have taken on and wish you well in your continued efforts to consider this fundamental system which has served Canadians well.