ENHANCING INTERDISCIPLINARY COLLABORATION IN PRIMARY HEALTH CARE

AMÉLIORATION DE LA COLLABORATION INTERDISCIPLINAIRE DANS LES SOINS DE SANTÉ PRIMAIRES

Canadian Policy Context: Interdisciplinary Collaboration in Primary Health Care

EICP

PRIMARY HEALTH CARE
A Framework That Fits

ACIS

LES SOINS DE SANTÉ PRIMAIRES
Une cadre qui réunit tous les morceaux

Professionals: Working Together to Strengthen Primary Health Care

The Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative focuses on how to create the conditions for health care providers everywhere in Canada to work together in the most effective and efficient way so they produce the best health outcomes for their patients and clients.

Canadians know that health care providers on the front line are there to respond with care and skill to their health care needs. Primary health care providers are not only committed to caring for their patients directly, they also facilitate access for patients to other specialized services. But, more and more Canadians are expecting better co-ordination between those providers and they want to optimize their access to the skills and competencies of a range of health care professionals. As much as they want to be treated for illness, they want health promotion advice and information about preventing disease and illness, too.

The EICP Initiative, funded through Health Canada's Primary Health Care Transition Fund, is designed to follow-up on the research evidence that interdisciplinary collaboration in primary health care has significant benefits for both patients and health care professionals. The Initiative spotlights the best practices and examples that show that collaboration is "value-added" for our health care system. The Initiative's legacy will be a body of research, a consultation process that will engage health care providers and get them thinking more about working together, and a framework for collaboration that encourages change and more co-operation.

The EICP Initiative will deliver:

- A set of principles and a framework that will enhance the prospects and options for more collaborative care in settings across the country;
- Research about best practices and the state of collaborative care in Canada;
- A toolkit to help primary health care providers work together more effectively; and
- Recommendations that will help the public, provincial/territorial governments, regional health authorities, regulators, private insurers and educators embrace and implement the principles and framework. With the leadership of some of the key players in primary health care in Canada, the EICP Initiative will capture the very best of what is being achieved in interdisciplinary collaboration in this country and will help us learn from it.

EICP Partners include:

- Canadian Association of Occupational Therapists
- Canadian Association of Social Workers
- Canadian Association of Speech-Language Pathologists and Audiologists
- Canadian Medical Association
- Canadian Nurses Association
- Canadian Pharmacists Association
- Canadian Physiotherapy Association
- Canadian Psychological Association
- College of Family Physicians of Canada
- Dietitians of Canada
- Canadian Coalition on Enhancing Preventative Practices of Health Professionals

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Foreword

Research is at the heart of the Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative. The Initiative has a mandate to take a hard look at the trend toward collaboration and teamwork in primary health care, both through a broad consultation process with key stakeholders in primary health care, and through commissioned research reports that target elements critical to the implementation and sustainability of interdisciplinary collaboration in primary health care.

The EICP Initiative research plan is designed to:

- Provide an overview of interdisciplinary collaboration in primary health care in Canada, including a literature review;
- Examine the three core elements that affect interdisciplinary collaboration in primary health care nationally:
  - the policy context
  - the responsibilities, capacity and attitudes of individual providers and health service organizations
  - public health and social context;
- Build a case for interdisciplinary collaboration in primary health care;
- Assess readiness for interdisciplinary collaboration in primary health care in Canada; and
- Develop recommendations to enhance interdisciplinary collaboration in primary health care.

The First Wave of EICP Research

The first wave of EICP research is comprised of four distinct research reports, and captures domestic and international data about the workable options associated with collaboration.

The reports are:

1. Enhancing Interdisciplinary Collaboration in Primary Health Care in Canada
2. Individual Providers and Health Care Organizations in Canada
3. Canadian Policy Context: Interdisciplinary Collaboration in Primary Health Care
4. Public Health and the Social Context for Interdisciplinary Collaboration

The research findings from these reports, along with input from the extensive EICP consultation sessions, will lead to a more complete understanding of the gap between the current state of primary health care in Canada and a possible future where interdisciplinary collaboration is encouraged and well-managed, so that it delivers benefits to patients/clients and health care providers.

These research reports are posted on the EICP web site.

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Executive Summary

Canadians take great pride in their health care system and are concerned about its future. Having a sustainable public health care system has become a top priority for many Canadians. Among the policy and practice communities, it is widely recognized that a strong primary health care (PHC) system is needed to address the challenges of an aging population, and to meet the needs of the increasing proportion of people who experience chronic health conditions. A strong PHC system improves the level and distribution of population health services, buffers the effect of socio-economic factors on health and attains these outcomes at a lower cost than health systems that rely more extensively on secondary and tertiary care. As a result, primary health care renewal has been identified in Canadian policy as a key ingredient in a sustainable health care system. The purpose of this report is to identify elements of the policy context that are likely to facilitate, support or affect the nature of interdisciplinary collaborative teams in primary health care in Canada, and the extent to which these elements are used.

In order to make the transition to new models of delivery, a number of requirements are necessary, including recognizing the need for change, a vision for renewal, developing champions for change, as well as supportive structures and activities. This report begins with an overview of historic circumstances and current contexts, in order to identify barriers to this transition and opportunities to make progress. The next section reviews predominant and emerging modes of organizing PHC, before assessing how change is taking place in Canada. The conclusion discusses the extent to which primary health care in Canada will be able to make the transition to more interdisciplinary collaborative care.

All is not well with primary health care in this country and the need for change is widely recognized. Family physicians are unhappy with their workloads, fewer medical students are choosing a future in family medicine, younger family doctors carry lower workloads than their predecessors, and recent reports indicate that family doctors are restricting access by new patients. At the same time, Canadians are frustrated both in their ability to make first contact with doctors and to see their family physicians for routine care. Journalists report dismay among providers and their patients. Canadians strongly support the idea of collaborative care, and the majority of people would prefer that their family doctor work as part of a team. The experiences and expectations of patients and health care practitioners has commanded the attention of policy-makers.

Between 1997 and 2001, the Health Transition Fund launched pilot and evaluation projects in primary health care across Canada to test new modes of delivering PHC. At that time, only four provinces required physicians to work in groups and to work in multidisciplinary teams, as a precondition for funding. While the Fund's investments spawned innovation, there was no national vision for renewal, no policy framework to guide change and little momentum to alter the predominant way of delivering primary health care. But, at the September 2000 meeting of the First Ministers, federal, provincial and territorial leaders agreed on a vision for renewal. In response, the government of Canada announced the Primary Health Care Transition Fund (PHCTF), which established a policy framework to guide the investment of $800 million over five years, in support of implementing large-scale, primary health care renewal initiatives.

Interdisciplinary collaboration was explicitly mentioned as a goal of the PHCTF, the First Ministers' Accord in 2003 and the First Ministers' Meeting on the Future of Health Care in Canada in 2004. All provincial governments now include interdisciplinary collaboration as one of their goals and objectives. Some provinces established committees or commissions in the late-1990s or early 2000 to seek advice on how to renew primary health care. These provinces were able to quickly establish the need for local change and a vision for renewal, and to advance their efforts to achieve that vision, with the help of the PHCTF. In comparison, provinces that did not affirm the need for local PHC renewal were not able to create a unified vision for change, nor did they establish champions for change. Overall, they seem to have progressed more slowly on the path to PHC renewal.

In response to growing political interest, policy activities and more investment in primary health care, a number of professional associations and unions have defined the role of their practitioners in delivering primary health care. However, few of these groups have made specific recommendations about the policy, management, practice and education that might help to create more interdisciplinary collaborative teams in PHC. The College of Family Physicians of Canada is one notable exception. In this report, it is argued that the absence of a coherent vision for renewal and policy recommendations from professional groups indicates that practitioners have not reached agreement about how they would like to see PHC teams funded, what they think of different regulatory frameworks, and what their needs are for new legal structures and educational systems that support interdisciplinary collaboration. Until there is a clear vision for interdisciplinary collaboration, national policy recommendations to guide transition to this type of care, and champions for change among professional associations, it will be difficult to synchronize the health policy, regulatory and legal frameworks that are necessary, and practice communities will be limited in their ability to move ahead on their own. Recently, 10 national professional associations and one coalition have joined forces to review the state of interdisciplinary collaboration in primary health care in Canada, and to establish a shared vision of what they can do to make it a reality.

Professional champions alone cannot create the critical mass for a transition. Such a change will also require supportive structures and focused activities. These structures include legislative, regulatory and legal frameworks; adequate financing and appropriate funding; and new models of education. Analysis of the current context suggests that while there are focused activities in these areas, a great deal still needs to be done to align these puzzle pieces. Momentum for change seems to be emerging in the areas of legislative and regulatory frameworks and, more recently, professional education. Current legislative and regulatory frameworks are not conducive to interdisciplinary collaboration, though some activities, particularly in nursing, show promise. In order to ensure that interdisciplinary collaboration gains momentum in the short term and is able to maintain it, universities are engaging in activities to enhance inter-professional education and governments are investing in these efforts.

Non-physician providers are predominantly financed from private, rather than public, sources. New investments by governments in these health professions—through health authorities, group practices or other intermediaries—will be required to facilitate their alignment with publicly funded, private practice family physicians. Most governments have no explicit vision or mechanism to effectively fund interdisciplinary collaborative primary health care. Current methods seem to rely on public payments to physicians (or their organizations) through per capita, or blended,

funding mechanisms. Yet, few jurisdictions pay capitation rates that are high enough to allow physicians to hire other providers. Therefore, it is unlikely that current financial arrangements will spawn interdisciplinary PHC teams or be part of the glue that holds them together.

The predominant model for PHC in Canada is the "professional contact model," in which private practice physicians work alone or in small groups. Despite recommendations for increased interdisciplinary collaboration in PHC service delivery, there is currently no formal mechanism to facilitate co-ordination of services among various PHC providers, between PHC and secondary/tertiary health care sectors, or the adoption of an interdisciplinary mix of providers. Most jurisdictions are now moving to a "professional co-ordination model" in which comprehensive and continuous services are delivered by physicians and other providers, particularly nurses or nurse-practitioners.

Across the nation, there appears to be a convergence of public and provider views about the need for change, champions for change in policy and practice communities, and supportive structures and activities fed by government funding. At this point in time, the recipe for success in moving toward interdisciplinary collaboration includes:

- Public consultations revealing dissatisfaction with the current mode of delivery, and the demand for the transition to interdisciplinary collaborative teams and integrated delivery to take place. Though the Commission on the Future of Health Care in Canada attempted to understand the perspectives of Canadians on primary health care, only a few provincial governments have actually engaged in this activity and, therefore, many policy-makers still do not understand what people in their own regions want from primary health care.
- Public dissatisfaction with access to family physicians, coupled with family physicians saying they are unhappy with their workloads, and the willingness, on the part of providers and patients alike, to pursue new modes of service delivery. While there is strong evidence of these factors at the national level, local understanding of regional variation in issues of access and workloads among family physicians continue to be a stumbling block. Where voices for change are louder, reform is more likely.
- A vision for renewal at the national, provincial and local levels. While the First Ministers have established core principles of PHC renewal, each jurisdiction needs to coalesce around goals and objectives for PHC renewal that include interdisciplinary collaboration. Provincial policy frameworks need to address regional issues and signal tolerance for diversity in implementation. When this happens, local leaders become champions for change.
- The support of health care professionals, as well as their associations and unions. Without them, provincial policy frameworks and implementation activities are unlikely to have traction. Health associations and unions, in turn, must be attuned to the perspectives and expectations of their members, if they are to effectively lead PHC renewal and be champions for change.
- Champions among government and the health professions must target structures that support or thwart interdisciplinary collaboration, including regulatory and legal contexts, financing and funding issues, and provider education. Much work needs to be done to align these puzzle pieces, so that they support interdisciplinary collaboration in primary health care.
- New PHC organizations, owned and operating by regulated providers, which receive funds from provincial governments or health authorities, and pay collaborating health care professionals to deliver an array of PHC services.

- New money, directed to PHC organizations, with guidelines that stipulate the expected processes (i.e., interdisciplinary collaboration) and the outcomes of such investments. Expenditures on interdisciplinary PHC teams must exceed current investments in primary medical care. The degree to which this is the case will indicate the degree to which governments want non-physician PHC providers to be integrated with Medicare.

When one or more of these ingredients is in short supply at the provincial or local level, stagnation or "incrementalism" in transition occurs. In the mid- to late-1990s, health care committees and commissions across the country recommended "big-bang" changes to funding, organizing and delivering PHC. Few were aware of the broad array of policy levers, synchronization of effort, and sustained energy required to facilitate system-level change in this sector. Over the last five years, policy, administrative and practice communities have developed a more mature understanding of what it takes to steer the PHC sector—levers such as public and provider consultation to establish the need, a common vision for renewal and champions for change, and the alignment of structures to support the transition to interdisciplinary collaborative practice, including legislation and regulation, legal foundations, financing and funding decisions, and professional education.

Current funding pressures in the secondary and tertiary care sectors continue to vie for the public's attention and for new investments by governments. A strong PHC system can reduce the demands on the secondary and tertiary care sectors. Although Canadians widely support renewal, investments to date have been insufficient to achieve the core aspects of the PHC system they expect, including interdisciplinary teams of providers. The policy and practice community would be wise to engage Canadians and providers in a dialogue about the importance of renewing primary health care through new government investment in interdisciplinary collaboration. This would effectively turn up the volume on these calls for change and make it possible for champions of change to do their work. This is what is needed to trump political pressure on governments about wait lists for secondary and tertiary care, a path that will only lead them to spend new money in old ways.

Introduction

Primary health care—the foundation of Canada's health care system—contributes to increased knowledge about health and health care among the population. It reduces risk, duration and the effects of acute and episodic conditions, as well as reducing the risk and effects of continuing health conditions.[1] PHC involves activities targeted to individuals, populations and sub-populations, and includes clinical services, health promotion and education activities to improve the level of health among Canadians.[2] Dietitians, nurses, occupational therapists, physiotherapists, pharmacists, psychologists, physicians, social workers and other professionals deliver primary health care.

Primary medical care, on the other hand, is primarily focused on clinical activities for common medical conditions and the management of illness. Primary medical care has been described as the "level of a health service system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and co-ordinates or integrates care provided elsewhere or by others."[3] For most people, primary medical care is their first point of contact with the health care system, often through a family doctor.

It is widely recognized that a strong primary health care system is needed to address the challenges of an aging population and to meet the needs of the increasing proportion of people who experience chronic disease, complex co-morbidity, and/or functional disability.[4] A strong PHC system improves the level and distribution of population level health, buffers the effects of socio-economic variables on health and attains these outcomes at lower cost than health systems that rely more extensively on secondary and tertiary care. [5, 6, 7]

Unfortunately, all is not well with PHC in Canada. Across the country, family physicians are unhappy with their workloads and increasingly, restrict access to new patients.[8] Fewer medical students are choosing a future in family medicine,[9] and younger family doctors carry lower workloads than their predecessors.[10] At the same time, Canadians are frustrated both in their ability to make first contact with doctors and to see their family physicians for routine care.[11] Journalists report dismay among providers and their patients. Evidence accumulated over the past few years suggests that Canadians strongly support the idea of collaborative care[12] and the majority of people would prefer that their family doctor work as part of a team.[13] Many professional associations argue for increased integration of PHC providers from different disciplinary backgrounds. Family physicians are increasingly practicing in groups,[14] but few share office space with non-physician providers.[15]

Following a decade of fiscal restraint and restructuring of the acute care sector in Canada, health care policy-makers, administrators and practitioners have turned their attention to investment and renewal of the primary health care, home care and pharmaceutical sectors. However, from the perspective of Canadians, neither cuts to health services, the acute care sector reforms of the 1990s, nor the massive re-injection of public funds in the late-1990s have led to better system performance—though they acknowledge that some efficiency gains may have occurred. "Citizens are insisting there is much more to do…the restructuring of the 1990s has had relatively little impact on the everyday services used by the majority of Canadians."[16] It could be argued that hospital restructuring did not increase Canadians' sense of confidence that the system is well managed and on a sustainable course, because few people are ever admitted to a hospital, and therefore, do not have the

opportunity to see evidence of change. By comparison, roughly 80 per cent of Canadians visit a medical doctor each year for first contact care[17] and the mode of primary medical care service delivery has undergone little change over the past decade.

The current system is heavily reliant on family physicians. The transition to new interdisciplinary, collaborative models requires support at the policy, health care management and clinical levels. Interdisciplinary teams demand that health care providers from different disciplines collaborate and function interdependently to assess, plan and deliver comprehensive and co-ordinated care, and to evaluate outcomes according to the needs of clients, families and communities.[i] Team members determine who will assume leadership and co-ordination roles, and work in a complementary fashion to use their resources most effectively and efficiently.[18]

The purpose of this report is to identify elements of the policy context that are likely to facilitate, support or have an impact on the nature of interdisciplinary teams and the extent of collaboration in primary health care in Canada. In order to make the transition from current to new models of delivery, a number of requirements will be needed, including: recognizing the need for change, setting a vision for renewal, developing champions for change, and creating supportive structures and activities. This report offers an overview of historic circumstances and current contexts in relation to these requirements, in order to identify barriers to this transition and opportunities to move toward interdisciplinary collaboration in primary health care. The next section reviews predominant and emerging models of organizing PHC in order to assess the degree to which change is occurring in Canada. The conclusion appraises the extent to which primary health care in Canada is likely to successfully make the transition to more interdisciplinary collaborative care.

Recognized Need for Change

Citizen Experiences and Societal Expectations

Over the past decade, Canadians have undergone a traumatic shift in perception of the performance of their health care system. Ten years ago, only 3 per cent of Canadians identified health care as the most important issue confronting the nation and its leaders, but by 2000, that number had risen to 50 per cent. In 1991, 60 per cent of Canadians thought the system was excellent or very good; an additional 25 per cent thought it was good. By 2000, only 29 per cent indicated it was excellent or very good and 34 per cent considered it was only good.[19]

In 1989, only 2 per cent of people who had used health care services in the previous year reported that they were unable to obtain such services when needed. By 2001, that proportion had risen to 15 per cent.[20] Between 1995 and 2000, Canadians became increasingly concerned about quality of care, and by 2000, access and quality were tied, in terms of their level of importance to Canadians.[21] Today, fewer Canadians are satisfied with access to care in the community (48 per cent) and the timeliness of access (43 per cent).[22] While most Canadians (86 per cent) report having a family physician, some (16 per cent) report difficulty accessing first contact care, and others (13 per cent) report difficulty accessing routine care.[23] Many (51 per cent) now rank improvements in the quality of care as a top priority for new health care investments.[24]

[i] Given that there is no consensus, as yet, regarding differences between the terms “interdisciplinary” or “interprofessional,” we have chosen to use them interchangeably.

In recognition of the need to ensure that Medicare remains aligned with the values of Canadians, the Commission on the Future of Health Care in Canada engaged in a dialogue with citizens in 2001 and 2002 to better understand societal expectations. They concluded that Canadians "have reached a mature, settled public judgment, based on decades of experience, that the Canadian health care model is a good one that should be preserved."[25] Yet, people are ready for new models of service delivery to improve or sustain the current level of care.[26] When asked to assess various options to sustain their health care system, Canadians recommended interdisciplinary teams to provide more co-ordinated PHC and that the teams be supported by a central information system. Observers of these deliberations reported that "citizens are far more open to change in the delivery of health care services than most politicians imagine."[27]

In September 2004, half-day forums were held in three cities across the nation with Canadians who had experience with interdisciplinary PHC.[28] The forums enabled citizens to reflect on their experiences and share their perspectives. Participants indicated that communication and prevention activities were diminishing, providers were pressed for time, and the lack of an electronic health record resulted in duplication of practitioner efforts. Key themes that emerged from citizens' visions for the future of PHC included:

(a) Expanded coverage of pharmaceuticals, dental care, prevention services and rehabilitation;
(b) Single, co-ordinated point-of-service delivery in one location by an adequate number of providers who work collaboratively;
(c) Holistic, responsive, high-quality, patient-focused care;
(d) Access to PHC, 24 hours a day, 7 days a week; and
(e) Readily available information to understand service availability and to support self-care.

Evidence accumulated over the past few years suggests that Canadians strongly support (70 per cent) the idea of collaborative care, defined as "a team, including a doctor, nurse, pharmacist, or other health care provider who would collectively provide care."[29] The majority (74 per cent) of Canadians would prefer that their family doctor work as part of a team, rather than practice on his/her own.[30] People report that they would be satisfied with seeing a general or specialized nurse who works with a doctor, for routine health care services (e.g., ear or throat infections, immunizations), to manage diabetes, monitor high blood pressure or to check progress on a surgical wound.[31]

Canadians are attracted to the idea that PHC teams would not only provide more co-ordinated, cost-effective care, but also would have a greater incentive to focus on wellness, prevention and patient education. They understand that to achieve this will require changes in the behaviour of patients, providers and governments.[32] Canadians see the team approach, led by doctors, as the "centrepiece of the health care system," because it would be "responsive to individual needs, structured to emphasize wellness and prevention, and would offer integrated and co-ordinated care through a team of various professionals."[33]

Finally, Canadians identify interdisciplinary teams as the solution to the current challenge of finding a family doctor, and "some hoped that a supportive and collegial team would reduce the burden on doctors, prevent burnout, and encourage health professionals to locate and stay in rural and remote areas." Through teams, Canadians expect professionals to share, criticize and use data and information, and thereby attain efficiency gains in the health system.[34] The majority of Canadians believe that collaborative care would improve quality of patient care (73

per cent) and expedite access to care (69 per cent). However, Canadians are not clear on how collaborative care will change the cost of service delivery. Thirty per cent believe that it will cut costs, 21 per cent foresee no change, and 37 per cent believe it will increase the cost to taxpayers. There were regional differences in opinion. In the Atlantic provinces, 25 per cent oppose a change to collaborative care: their concern is that this model of delivery will increase costs.[35] Policy-makers have taken note of temporal shifts in the experiences and expectations of citizens.

Practitioner Circumstances and Desire for Change

During the early- to mid-1990s, both federal and provincial governments focused on deficit reduction, and the health care sector and people who worked in it operated under conditions described as "fiscal duress."[36] Real per capita health expenditures began to decline in 1992, reached a low in 1995 and 1996, but rapidly recovered in the following years.[37] Between 1992 and 1996, real per capita health expenditures declined 2.2 per cent, representing dramatic slowing of public investment, relative to previous decades. Since hospitals represented one of the largest publicly funded sectors at that time, the acute care sector faced declines in budgets for the first time, and the pursuit of redesign held the attention of health care workers, media and the public. Between 1992 and 1996, real per capita investments in hospitals declined 9.3 per cent.[ii] Hospitals were merged or closed, hospital bed days and lengths-of-stay were reduced and outpatient services increased. In Winnipeg, for example, the rate of adult in-patient surgery declined by 31 per cent during hospital restructuring between 1991 and 1997. But, the rate of adult outpatient surgery increased by 42 per cent, and the number of patients who had specific procedures such as coronary bypass, knee replacements and removal of cataracts increased dramatically over this period—by as much as 169 per cent, in the case of knee replacements.[38]

Transformation of acute care services during the 1990s occurred at a time when most facilities had already moved to strengthen the role of interdisciplinary teams through the use of functional organizational models. Previously, most hospitals were organized by disciplinary departments and professional staff reported solely to managers from within their discipline. The shift to same-day surgeries and outpatient services seemed to strengthen the focus on interdisciplinary teams in the secondary and tertiary sectors—each team led by program managers, rather than disciplinary leaders. During this period, however, there were few contextual forces to substantively change the nature of interdisciplinary collaboration among professionals in community-based settings.

Fiscal duress during the 1990s fuelled conflict between federal and provincial governments, strained relations between governments and health care providers, and challenged medical and non-physician regulated health professional associations to manage internal conflict. "Nurses, physicians, other health professionals, and hospital administrators across Canada have done a remarkable job of transforming practices…their tolerance for change, however, has been sorely stretched by the pace, scope and scale of institutional downsizing."[39]

As the nation entered the new millennium, governments acknowledged that citizens were increasingly unsatisfied with access to care and providers needed a reprieve from restructuring of the acute care sector. Governments began to reinvest in health care. Real per capita health expenditures increased in 2001 by 5.7 per cent—a higher level than any fiscal period since 1975. Increases in per capita health expenditures are expected to be 3.3 and 3.7 per cent in 2002 and

[ii] Real per capita growth in the hospital sector in 2001 was 4.6 per cent, and is expected to be 4.3 and 5.6 per cent in 2002 and 2003, respectively.

2003, respectively.[40] Results of the First Ministers' Meeting on the Future of Health Care in September 2004 indicate that this level of investment will continue for years to come.[41]

In more recent years, there has been growing consensus among providers, policy-makers and Canadians that there are significant and growing shortages of health care professionals, and family physicians, in particular.[42] The result: expansion of a number of medical schools and fast-tracked policies intended to increase physician supply.[43,44] Paradoxically, current perceptions of family physician shortages come close on the heels of perceptions of surpluses, at least in urban centres, and reductions in medical school enrolments only 10 years ago. Between 1993 and 2001, there was a 5.1 per cent decline in physician supply and a 7.0 per cent increase in workloads among family physicians in Canada.[45] It has been argued[46,47] that this modest magnitude of change is unlikely to fully explain headlines and evidence[48] that many family physician practices are increasingly restricting access to new patients or why these doctors are unhappy with their workloads.

The family physician workforce and its capacity to deliver PHC services have been influenced by unexpected temporal shifts in the practice patterns of practitioners. For example:

- Across the country, family physicians are reducing the comprehensive array of services they deliver, since they are less likely to deliver babies or care for patients in hospital. Though there appears to be an increase in family physicians who work solely in hospitals,[49] a decline in the proportion of the workforce who visit in-patients reduces the degree to which in-patient and primary medical care are integrated and the degree to which family physicians are linked with interdisciplinary in-patient teams.
- There have been important and dramatic temporal shifts in how family physicians of different ages practice. In Winnipeg, for example, younger family doctors are providing many fewer visits, while their older colleagues are providing many more visits than their same-age predecessors did 10 years ago—a finding independent of physician sex. By 2000–01, family physicians between 30 and 49 years of age (64 per cent of the workforce) provided 20 per cent fewer visits per year than their same-age peers did 10 years previously. Conversely, family physicians 60 to 69 years of age (11 per cent of the workforce) provided 33 per cent more visits per year than the corresponding group a decade earlier.[50] The trends reported in Winnipeg are similar to temporal analysis of national survey data indicating the hours family physicians of different ages spent providing direct patient care.[51]

Given these trends, the current focus on increasing the number of doctors will not help in diagnosing or treating the issues of supply and access to primary medical care—at least in the short term. Many family physicians report unhappiness with their workloads. Indeed, "rather than protecting turf, many family doctors are looking for people to share it."[52] In some jurisdictions, therefore, governments have ramped up efforts to train non-physician PHC providers, such as nurse-practitioners, and to establish interdisciplinary teams to more efficiently use scarce physician resources. For example, in 2002, the Government of Ontario announced that more than 300 nurse-practitioners would be added to the province's health care system over the next two years, with funding available for their educational preparation.[53] In May 2004, the College of Physicians and Surgeons of Ontario released a discussion paper, *Tackling the Doctor Shortage*, which called for the government to pilot a project that would allow international medical graduates to qualify and work as physician assistants in supervised practice settings, and to

ensure that liability insurance was made available for this professional group.[54]

Over the past decade, many non-physician regulated health professionals moved from working in institutional- to community-based settings. They took with them skills in interdisciplinary collaboration learned in acute care settings, where complex team dynamics, as well as collaborative activities and decision-making, are common. However, many of these providers now work in private practice settings and receive funding outside of Medicare—a topic discussed in a subsequent section of this report. By comparison, most family doctors in Canada have spent their careers in small private practice settings and have little experience working in the same setting with other health professionals with whom they deliver interdisciplinary collaborative care. Policy-makers have taken note of temporal shifts in the experiences and expectations of providers.

A Vision for Renewal and Champions for Change

Political Leadership and Policy Framework

When public investments declined in the mid-1990s and rebounded thereafter, governments sought guidance from a variety of health care committees and commissions to assist them in the process of restructuring and reinvestment. The most noteworthy undertaking in the mid-1990s, in terms of guiding reinvestments in PHC, was the National Forum on Health, whose deliberations led to the establishment of the Health Transition Fund. In 1997, the National Forum recommended moving toward more integrated health care delivery with primary health care as a foundation. Key elements of the recommendations included funding mechanisms tied to patients (capitation), rather than volumes of services provided by physicians (fee-for-service), the use of pay to promote a continuum of care from prevention to treatment, and encouraging the use of multidisciplinary teams.[55]

Between 1997 and 2001, the Health Transition Fund provided funding for approximately 140 pilot or evaluation projects across Canada—65 of which were in primary health care. Interestingly, only four provinces (British Columbia, Ontario, Nova Scotia and Newfoundland) required physicians to work in groups and to move toward multidisciplinary teams as a precondition for funding. Lessons learned from these projects, vis-à-vis interdisciplinary collaboration, include:

- That the process of bringing physicians who are used to operating in isolation to work in groups takes time;
- Joint undergraduate, post-graduate and continuing education opportunities among health professions facilitate progress toward collaborative practice;
- Evolving scopes-of-practice require professional acceptance in all groups; and
- There is a need to harmonize new and existing legislative frameworks and legal underpinnings across jurisdictions.

"Barriers to collaborative practice include jurisdictional issues, flawed regulatory and funding mechanisms, a lack of policy development in nursing and medical associations and regulatory bodies, and medical–legal issues that prevent practitioners from collaborating as much as possible."[56] Policy levers and barriers (i.e., education, scopes-of-practice, legal contexts) are addressed in a subsequent section of this report.

What emerged during the mid- to late-1990s were "big bang" recommendations from political and policy communities for PHC renewal—many of which focused on shifting from fee-for-service funding to mechanisms thought to support interdisciplinary practices, groups or networks. While Health Transition Fund

investments spawned innovation at the margin, there remained little momentum toward changing the predominant mode of delivering primary health care. For example, the following documents released before and during the Health Transition Fund era did not gain widespread policy traction at the time:

- In 1994, the provincial Deputy Ministers of Health commissioned a paper that outlined the "policy options for changing physician payment and delivery systems," focusing on "approaches to physician remuneration other than fee-for-service."[57] The proposed method of payment suggested capitation with risk-adjusted rates, and supplemental payments or performance awards. In 1995, the Federal/Provincial/Territorial Advisory Committee on Health Services also proposed a model for reorganizing primary medical care that included capitation with performance rewards.[58]
- In 1999, Ontario's Health Services Restructuring Commission recommended the establishment of provider teams comprising physicians, nurse-practitioners and other professionals, as needed—to be called PHC group practices.[59] PHC physicians would receive base salary and benefits, plus financial rewards for meeting quality targets. The Commission was silent on the method of funding other providers.

  Interestingly, this Commission was established shortly after Ontario's Provincial Co-ordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR) completed its work in July 1996.[60] In July 1997, Ontario's Advisory Group of Interprofessional Practitioners issued a report recommending interdisciplinary primary care agencies (IPCAs) be established to provide team-based services to improve access, quality, continuity, patient and provider satisfaction, and cost-effectiveness of services for rostered populations. The minimum provider team would include a "nurse, FP [family physician], and nurse-practitioner team, psychologist, chiropractor/physiotherapist team, dietitian, consulting pharmacist, and additional providers, according to the needs of the rostered population…Linkages to services outside of those directly funded by the IPCA will be secured by formal agreements on behalf of rostered patients."[61]

Toward the end of the Health Transition Fund era, it was evident that a national policy framework and additional investments were needed to kindle and sustain widespread momentum toward PHC renewal. At the September 2000 meeting of the First Ministers, federal, provincial and territorial leaders agreed upon a vision for renewal —*Action Plan for Health System Renewal*—that included, among other things, additional investments to catalyze PHC. Many argued that the time for small-scale demonstration had passed. The First Ministers agreed, saying, "improvements to primary health care are crucial to the renewal of health services. Governments are committed to ensuring that Canadians receive the most appropriate care, by the most appropriate providers, in the most appropriate settings."

In response, the Government of Canada announced the Primary Health Care Transition Fund (PHCTF), which established a policy framework to guide the investment of $800 million to "support the transitional costs of implementing sustainable, large-scale, primary health care renewal initiatives."[62] Such initiatives, in bringing about fundamental changes to the organization, funding and delivery of PHC services, are expected to result in improved access, accountability and integration of services. Among the objectives of the PHCTF are to "establish interdisciplinary primary health care teams of providers, so that the most appropriate care is provided by the most appropriate provider," and to establish collaborations among these teams to "facilitate co-ordination and integration with other health

services, i.e., in institutions and in communities." Though PHCTF funding was slow to hit health regions, it is being used to realize part of the vision declared by provincial commissions, committees and policy-makers across the country.

The provinces that established committees or commissions in 2000 or later, in order to obtain advice on methods of renewing PHC, were able to quickly establish the local need for change, a vision for renewal, and move forward to champion renewal efforts, using PHCTF funding. For example:

- In 2000, the Premier's Health Quality Council was established in New Brunswick to make recommendations to government on renewing the province's health system. One of the vision statements of the Council is that health services will be easily accessible and "provided by interdisciplinary teams of health professionals working as a single unit."[63] By 2002, the Council had recommended the creation of a network of Community Health Centres that would use a team approach to delivering individual-focused, community-based services, 24 hours a day, 7 days a week. In 2003, five Community Health Centres were established and an additional two have been announced for future development.[64]
- In 2001, the Saskatchewan Commission on Medicare recommended the establishment of Primary Health Service Networks—organized and managed by health districts—that would contract or employ physicians and nurses, as well as providers from mental health, rehabilitation, public health and addiction services. Teams would be "co-located whenever practical and feasible, to promote a positive environment for integrated practice" and would "work collaboratively with each other."[65] PHC became a key component of *The Action Plan for Saskatchewan Health Care* in December 2001, and today, interdisciplinary collaboration is a major principle in the PHC strategy for this province. [66]
- In 2001, the Clair Commission in Quebec issued a final report calling for Family Medical Groups (FMGs), networks of multidisciplinary teams to facilitate the integration of services, and strategies to strengthen regionalized hospital and community structures.[67] The Clair report acted as a catalyst for PHC reform and today, Quebec has 76 FMGs in 16 socio-health regions, with a range of organizational approaches. Among the PHCTF evaluations being conducted in that province, one is designed "to understand how, and to what extent, interdisciplinarity has been instituted in FMGs," and "to describe interactions between players involved in implementing these FMGs and their influence on changes in professional practice."[68]

In comparison, provinces that have not confirmed the local need for change, set a vision for renewal that all stakeholders can agree upon, and established champions for change seem to have progressed more slowly on the road toward PHC renewal.

Any momentum for interdisciplinary collaborative PHC created by the policy framework and fiscal support of the PHCTF was fuelled by a vision for renewal that emerged from two key deliberations in 2002: the Standing Senate Committee on Social Affairs, Science and Technology (Kirby Committee) in April, and the Commission on the Future of Health Care in Canada (Romanow Commission) in November. The Romanow Commission, for instance, noted that 1.5 million people worked in health care and social services in 2000: nurses represented 35 per cent of the health workforce, doctors made up 8 per cent and a range of providers accounted for the remaining 57 per cent. "The multiplicity of health care providers is both a tremendous resource and a challenge, in terms of sorting out

new models of PHC, new roles and responsibilities, and more collaborative ways of working together," said Romanow.[69] The prominent nature of the Romanow Commission and the Kirby Committee, and their recommendations for the creation of PHC teams/networks and new approaches to the education and training of health professionals, gave explicit endorsement of PHC renewal initiatives in these areas.

In February 2003, the First Ministers' Accord on Health Care Renewal reaffirmed a national vision for PHC renewal and established goals, objectives and requirements for federal transfer payments under the newly established, five-year, $16 billion Health Reform Fund.[70] These investments were intended to cover primary health care, home care and catastrophic drug coverage. In the Accord, the First Ministers declared, "The ultimate goal of PHC reform is to provide all Canadians, wherever they live, with access to appropriate health care providers, 24 hours-a-day, 7 days-a-week," and they agreed to ensure that at least 50 per cent of residents have access to this type of service within eight years. The Accord also included a health human resource strategy to promote inter-professional education to advance collaborative care, and in September 2004, the nation's leaders renewed their commitment to support interdisciplinary training and credentialing at the First Ministers' Meeting on the Future of Health Care.[71]

Interdisciplinary collaboration is explicitly mentioned as a goal of the PHCTF, the First Ministers' Accord and the First Ministers' Meeting on the Future of Health Care; all provincial governments also include this as one element of their goals and objectives statements for PHC renewal. Appendix A summarizes the vision for interdisciplinary collaboration of each provincial government, as of October 2004. These include:

- In the Northwest Territories (NWT), the approach is "to focus on clients realizing that sole care providers can rarely meet the complex needs of people in the NWT. Care providers have opportunities to work in multidisciplinary settings to collaborate for integration of services and continuity of client care. Not only does this facilitate comprehensive co-ordinated client services, but it also ensures human resources are used wisely, health working environments are strengthened and a stable northern workforce is developed."[72]
- In Saskatchewan, the government has declared that, "a defining characteristic of PHC [is] that interdisciplinary teams will engage in all the elements of prevention and management of chronic diseases. Integrated, interdisciplinary, multi-services networks of providers will provide a comprehensive range of co-ordinated health promotion, prevention, primary curative care, rehabilitation, supportive and palliative services."[73]
- Both the Alberta and Manitoba governments have declared a broad vision for PHC that extends beyond the traditional health care sector. One of two principles identified for primary health care by Alberta includes the use of community development approaches and local intersectoral co-operation, and "an interdisciplinary team approach, including collaboration with volunteers and other agencies, and the use of non-traditional and alternative health workers as appropriate."[74] Manitoba also indicates that, "one of the key principles of PHC is its intersectoral/interdisciplinary nature—to adequately address the determinants of health, the skills and services of numerous sectors and disciplines will be required. Formally integrated and co-ordinated teams of service providers must be developed."[75]

Between 1997 and 2008, there have been, and will continue to be, substantial federal investments dedicated to supporting provinces in improving the delivery of PHC in Canada. The

Health Care Transition Fund, the PHCTF, the First Ministers' Accord and First Ministers' Meeting on the Future of Health Care in Canada all include financial commitments to support projects or initiatives designed to inform (e.g., Health Transition Fund), catalyze (e.g., PHCTF) and sustain (e.g., First Ministers' Accord, First Ministers' Meeting) interdisciplinary collaboration in primary health care. Momentum for reform has been building and is likely to continue for the foreseeable future. Most provinces have now made the transition from a period of fiscal duress to strategic investment and action on the PHC front.

Provider Leadership and Policy Framework

In the early 1990s, the College of Family Physicians of Canada (CFPC) expanded its mandate to include contributions to a primary medical care reform agenda on behalf of its members. In 1992, CFPC proposed a blended funding mechanism to family doctors. The proposal had four components: base salary and benefits, compensation for overhead, compensation for non-clinical professional activities and volume modifiers based on resource-based relative value fee units. In 1995, CFPC fast-tracked membership participation in public policy, when it discovered that 87 per cent of its surveyed members were very concerned over current and proposed reforms. This concern may have been a reaction to the September 1995 Federal/Provincial/Territorial Advisory Committee on Health Services discussion document proposing a model for reorganizing primary medical care, which included capitation with performance rewards, and/or a 1995 public opinion poll showing that 43 per cent of Canadians favoured a flat salary system for paying primary medical care doctors, while 24 per cent supported capitation and 24 per cent favoured fee-for-service.[76]

In 1995, CFPC released a discussion document—*Managing Change: The Family Medicine Group Practice Model*—in which it recommended that remuneration should occur through the 1992 proposed blended funding mechanism and that family physicians commit to providing continuing and comprehensive care 24 hours a day, 7 days a week for defined populations. The group practice model put forward would include a number of family physicians, who would "associate" or develop "affiliations" with a multidisciplinary team. The patient–doctor relationship, based on trust, was seen as the fundamental unit of care delivery. Pilot projects to explore "front-line purchasing" (a budget for hiring other health care professionals) was recommended. The family physician was identified as the lead co-ordinator of patient care, though "this does not imply sovereignty over other members of the team."[77]

In 2000, CFPC hosted a major summit on the future of family medicine and PHC in Canada, which culminated in another discussion paper—*A Prescription for Renewal*. The College proposed Family Practice Networks that would commit to providing continuing and comprehensive care 24 hours a day, 7 days a week. However, prior recommendations for rostering and blended funding were relaxed. More emphasis was given to the recommended transition to collaborative interdisciplinary teams, in which family physicians would generally be responsible for taking the lead role in providing and co-ordinating medical care, and nurses would provide and co-ordinate a range of nursing services. Depending on geographic location and patient demographics, team members might include nurse-practitioners, nurses, midwives, dietitians, social workers, psychologists, physiotherapists, occupational therapists and pharmacists.

In recent years, a number of other associations for health care professionals have defined their roles in delivering PHC in response to growing political interest and policy-related activities at federal and provincial levels. Appendix B

summarizes the vision for interdisciplinary collaboration of each of these associations, as of October 2004. However, these professional associations make no specific recommendations as to which policy, management, practice and educational levers they support (or not), as the best means to creating and sustaining interdisciplinary collaborative teams in PHC. CFPC seems to be the only exception.

It could be argued that the absence of a vision for renewal and national policy recommendations from the professional associations suggests that these groups (and their members) have not yet reached agreement about their policy preferences for funding, tolerances for different regulatory frameworks, and the need for new legal structures that support interdisciplinary collaboration. If professional associations had undertaken to engage members on these issues, they could have established a vision for PHC renewal that specified conditions under which interdisciplinary collaboration could be supported. They might also have championed change initiatives designed to support members who engage in this type of practice. Consider that, for example, many professional associations still lack national policy frameworks to guide the development of scope-of-practice regulations in each jurisdiction. They have not actively engaged in a dialogue with members to learn about their concerns regarding the legal liability of collaborative care, nor have they hosted continuing education activities to dispel myths in this area.

The absence of a clear vision for interdisciplinary collaboration, national policy frameworks to guide the transition to this type of care, and champions for change among professional associations has an array of potential consequences. Low levels of activity in these areas make the work of health policy, regulatory and legal communities more difficult. The result:

(a) Policy-makers may design renewal strategies that do not reflect the expectations of practitioners (e.g., recommend physician-owned and led PHC groups that hire other providers as employees, despite unease among non-physicians for this type of organizational structure).
(b) Regulatory bodies are not provided with national policy frameworks to guide their decision-making, and therefore are likely to rely on the perspective of local constituents or implement policies that are not harmonized in various jurisdictions.
(c) Legal counsel is unable to establish the degree to which the professional sanctions apply (or not) to a specific scope-of-practice.
(d) Individual providers do not clearly understand their own profession's position on the issues and may, for example, be less likely to delegate work to other PHC team members.

Most recently, 10 national professional associations and one coalition[iii] have joined forces to review and support interdisciplinary collaboration in PHC in Canada.[78] Five national associations participating in the Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative do not have a specific statement on interdisciplinary collaboration available on their website, although they may have statements on PHC. The five include the Canadian Association of Occupational Therapists, Canadian Association of Speech-Language Pathologists and Audiologists, Canadian Psychological Association, Dietitians of Canada and the Canadian Coalition on Enhancing

[iii] Canadian Association of Occupational Therapists, Canadian Association of Social Workers, Canadian Association of Speech-Language Pathologists and Audiologists, Canadian Medical Association, Canadian Nurses Association, Canadian Pharmacists Association, Canadian Physiotherapy Association, Canadian Psychology Association, CFPC, Dietitians of Canada, and Canadian Coalition on Enhancing Preventive Practices of Health Professionals.

Preventive Practices of Health Professionals. Three national associations—the Canadian Medical Association, Canadian Nurses Association, and Canadian Pharmacists Association—have issued a joint statement on scopes-of-practice that includes a specific section on interdisciplinary collaboration. By comparison, the College of Family Physicians of Canada (CFPC) provides the most detailed statement about interdisciplinary collaboration; it includes which providers could be considered part of a team and how these providers might be remunerated. The benefits of these professional associations collectively reaching a consensus on the vision for interdisciplinary collaboration in PHC would be significant.

In September 2004, 13 one-day forums with health care professionals were held across Canada to enhance understanding of perspectives on interdisciplinary collaboration in PHC.[79] Participants indicated that they expect collaborative care will increase the quality of life for providers and patients. Yet, a key theme that emerged was the need for leadership at the provincial government and institutional levels. As one participant in New Brunswick said, "Governments must be willing to change." Providers indicated that leadership must be independent and non-biased, must establish vision and goals, set guiding principles, have strong managerial skills and allow collaboration.

Forum participants had clear recommendations about inter-professional education and regulatory scopes-of-practice. For example, participants suggested that health professionals:

- Should engage in courses to encourage interdisciplinary collaboration. They suggested that core inter-professional education material should include the development of knowledge and skills in conflict resolution, and how to establish and maintain collaborative teams. All forums expressed the common need for team members to listen to each other and be accepting, respectful and trusting of other health professions.
- Need greater clarity in defining each team member's scope-of-practice. They believe that, in order to work as part of a team, providers need greater understanding about the scope-of-practice for different health professions and the liability frameworks for patient-centred care.
- Support the establishment of interdisciplinary practice councils that would develop standards of practice recommended by providers.

Supportive Structures and Activities

Legislative and Regulatory Action

The legislation and regulation of health care in Canada is predominantly a provincial matter: each jurisdiction defines its own scopes-of-practice, standards of education, core competencies, ethical frameworks and systems of accountability in all health care professions. The historic absence of a national framework to guide provincial action has resulted in variability among regions, which creates confusion among different health professionals, students and the public.[80] Consider the scopes-of-practice for nurse-practitioners: in Ontario, it is limited to PHC services and described in specific guidelines and a list of actions that they can perform.[81] In Nova Scotia, the legislated scope-of-practice includes primary and specialty care, with no limits on location.[82] In comparison, legislation in Alberta limits the use of nurse-practitioners to areas underserved by physicians.[83] The Canadian Nurses Association website provides a comprehensive comparison of nurse-practitioners' scope-of-practice in various provinces.[84]

Jurisdictions differ in the regulatory powers delegated to each profession. While each regulated profession has a scope-of-practice, the legal effect of the scope-of-practice varies, depending on the applied model of regulation (i.e., licensure, certification or controlled acts). The legislation prohibits all unlicensed individuals from providing the services that fall within the scope-of-practice. Certification prohibits others from using the title of the regulated profession, but recognizes providers qualified to deliver a specific type of care (e.g., critical care certification for registered nurses). Legislation under the controlled acts model prohibits anyone from performing any of a list of controlled acts unless he/she is a member of a regulated profession authorized to perform that act.[85]

Jurisdictions also differ in the legislative structure of their regulatory systems. In three territories, four Atlantic provinces and two Prairie provinces, the legislative framework is limited to various statutes that have been incrementally passed for each health profession. These statutes may also be supplemented by regulations, bylaws and codes of practice. By comparison, in Quebec, Ontario, Alberta and British Columbia, there is a unique law for each profession, supplemented by a secondary level of law. The latter is considered an omnibus, or "umbrella," law; it establishes that institutions can, to varying degrees and in different ways, establish, govern and administer the general system of regulation that includes each self-regulating profession.[86]

Health care professionals are also self-regulating, in terms of assurance to the public about levels of educational preparedness to practice and codes of conduct. While there are benefits to self-regulation, such as peer review and audit, many have argued that current structures for professional self-regulation, including the legislative ability to prescribe scopes-of-practice, often serve as a barrier to integrated health care systems and to interdisciplinary practice.[87,88,89] Furthermore, regulators tend to place their professional interests in control of a scope of occupational "turf" ahead of their obligation to serve the broader public interest.

Testimony made to the Standing Senate Committee on Social Affairs, Science and Technology (Kirby Committee) led members to strongly believe that revisions to scope-of-practice rules and other regulations were necessary to promote greater flexibility and encourage collaboration among health care professions. The Kirby Committee further recommended that the federal government continue to work with provinces and territories to reform PHC delivery in ways that lead to the creation of multidisciplinary teams. The Committee argued that the variation in legislation across provincial and territorial jurisdictions was a barrier to inter-professional collaboration.

Others have also argued that a national framework defining scopes-of-practice is increasingly necessary to realize inter-professional collaboration, since regulation can be used to support (or thwart) transition to new modes of practice.[90] Traditional scopes-of-practice are changing. For example, Bill 90, introduced in 2002 in Quebec, authorizes certain health practitioners, such as nurses and pharmacists, to perform particular "medical" services, which have traditionally been performed by physicians in well-defined practice settings.[91]

Strategies for law reform have also been suggested.[92] It has been proposed that regulatory bodies have specific statutory accountabilities for facilitating, enabling and supporting the development of interdisciplinary collaborative practice and for reporting on their progress. There would be a general adoption of the controlled acts model that would increase

flexibility in the regulatory framework of each province and maintain consistency throughout the provinces. One possible alternative to adopting the controlled acts model would be the widespread adoption of certification, supplemented by a "harm clause,"[93] which prohibits all treatment and advising by unregulated persons, when it is "reasonably foreseeable" that serious physical harm could result.

If interdisciplinary collaboration is to become institutionalized and sustainable in the PHC sector, legislative flexibility needs to be enhanced, as it relates to the regulation of health professions. Such flexibility could ensure that regulatory matters are subject to appropriate safeguards of transparency and accountability. Flexibility can also be increased by the ways that statutes are structured and administered.[94] For example, in Nova Scotia and New Brunswick, the legislation delegates decisions about which drugs nurse-practitioners can order and administer to a diagnostics and therapeutics committee, composed equally of nurses, physicians and pharmacists.[95,96]

In September 2004, the First Ministers committed to continue and accelerate their work on health human resource planning, including, among other initiatives, inter-professional education, investments in post-secondary education and credentialing of health professionals. The First Ministers also agreed to establish a "best practices network to share information and find solutions to barriers to progress in PHC reform such as scope-of-practice."

Legal Context and Activities

To promote interdisciplinary collaborative practice in PHC, boundaries between various health professionals and their respective scopes-of-practice will need to be adjusted, made more fluid and perhaps blurred. Interdisciplinary collaboration will expand the scope of liability among team members. An important question that has been posed is: "Will the courts redirect too much accountability towards non-physician providers because of the view that they are doing doctors' work?"[97] Conversely, physician groups have argued that family physicians open themselves to litigation by offering non-physician services in their practice. In accordance with the traditional physician-centred model, the standard of care is applied to physicians, in terms of assessing their responsibility over the entire course of care. Thus, when liability is assessed, liable physicians are often appointed a greater proportion of damages than other liable providers.[iv] Traditionally, malpractice litigation (e.g., negligence) is typically highly individualized, when the ultimate findings of liability are linked to specific individuals, rather than to any relevant group. One concern about the move to inter-professional practice is that the courts will read the new situation through the old lens, not recognizing or accepting that roles and responsibilities have been adjusted on the basis of the needs of a clinical case.[98]

The case of *DeJong versus Owen Sound General*[99] represents the first substantial attempt by a Canadian court to deal with the issue of liability in interdisciplinary collaboration. In this landmark case, the patient (the prosecution) was admitted to a psychiatric ward of a hospital, where an interdisciplinary team structure was in place (the team included a psychiatrist, a psychologist, nursing staff and a social worker). The patient was injured when he broke through the window of a room and was subsequently

[iv] In *Fandle versus MacKenzie* [1990], B.C.J. No. 2341 (C.A.), a sponge was left in the patient's hip during a bone graft operation. The nurses were held negligent for failing in the execution of their task (e.g., ensuring the retrieval of the sponge). However, the doctor was also held negligent for not ensuring the nurses did a formal count, failing to search the incision himself and to conduct a subsequent investigation. The doctor was held 80 per cent liable and the nurses, 20 per cent.

involved in a traffic accident. In the final judgment, the psychiatrist, psychologist and a number of nurses were all found to be negligent. The court found that observation of the patient was critical during one phase of treatment, and that observation period had not been properly implemented or charted by a nurse. The court specifically stated that "there was no designation of a specific team member to make the sightings in accordance with the level of observation; nor was there was any requirement or practice that the person making the sightings, sign a docket verifying the fact, as well as the time, of the sighting." The trial judge was open to evaluating the inter-professional collaboration, while making clear that each team member would be subject to individual liability on the basis of how the team performed.

Another issue is the potential for direct liability of institutions (e.g., regional health authorities, hospitals or PHC groups, teams and networks), if they administer or provide a setting for interdisciplinary collaborative care. Policies and procedures that provide guidance and co-ordinate personal roles and responsibilities are needed. Record-keeping must be stringent and thorough to indicate the role and functions of each provider, the decision-making process and actions taken. All of this will be required to enable the courts to accurately discover how a course of treatment proceeded.

Adequate Financing

Financing involves issues of how revenues (from whom and by whom) are raised to fund PHC services. Public financing of PHC services has predominantly focused on funding physicians, rather than practitioners from other disciplines. In this section, we review historic trends in financing and implications for an increased interdisciplinary mix of PHC providers in Canada.

Analysis of national health expenditure trends[100] (Chart 1) suggests that:

- Over the last 10 years, total expenditures for health care services outside of hospitals increased, but the magnitude of growth for public versus private financing varied by sector.
- There have been real increases in expenditures on physicians and non-physician regulated health care providers (i.e., dentists, chiropractors, massage therapists, physiotherapists and psychologists), due to the increasing number of these providers and the rise in their incomes.
- Real increases in expenditures on non-physician regulated health care providers have occurred through private, rather than public, sources. Non-physician regulated health care providers have been, and continue to be, predominantly financed through private sources. By 2001, private financing accounted for 84 per cent of expenditures on non-physician regulated health providers. Of the 16 per cent financed by governments, the number and type of non-physician regulated health providers who deliver publicly funded PHC is unknown.
- Public investment in non-physician regulated health care providers has remained stable over the period.[v]
- Physicians have been, and continue to be, predominantly financed through public sources.

[v] Between 1991 and 2001, the size of the non-physician regulated health care workforce increased primarily due to government investments in publicly funded education, but the incomes of this expanded workforce have increasingly been financed through the private sector. Arguably, only those people who have private insurance or are able to afford to pay for health services have realized the benefits of a publicly financed expansion of the non-physician regulated health workforce.

These temporal trends reflect historic policy commitments to financially support a mix of different types of PHC providers. It is important to acknowledge, however, that the current financing situation and the latitude for public policy decision-making in this area are heavily influenced by legislative legacies in Canada. Consider that, in 1966, the *Medical Care Act* enshrined public payment for private medical practice,[101] and in 1984, the *Canada Health Act* required public investments in medically necessary hospital and physician services. This legislative focus on medical need and physician services may explain why the professional practice model of PHC is predominant in Canada and why physicians are almost exclusively the providers of primary medical care. No corresponding legislation exists to commit governments to invest in an interdisciplinary mix of primary health care providers.

Canada's legislative framework has enabled cash-strapped governments to limit public funding of non-physician PHC providers during times of fiscal duress. In some jurisdictions, pressures on government budgets in the 1990s resulted in de-listing—that is, services were changed from universal, first dollar coverage to either public subsidy for eligible enrolees, or to the realm of private financing.[102] In 2001, Ontario, for example, de-listed some rehabilitation services. Also in 2001, British Columbia restricted access to physiotherapy, chiropractic, naturopathy, massage therapy and optometry services, by requiring residents to meet eligibility criteria. Ministry restrictions on direct funding of these services resulted in health professionals seeking employment opportunities from health authorities/districts, or entering into private practice arrangements supported by private (e.g., Workers Compensation Boards) or public financers (e.g., health authorities).

Though de-listing has occurred on the fringes of Medicare, it has been particularly influential in the financing of particular non-physician regulated health professions, such as rehabilitation services. Between 1991 and 1999, the proportion of the physical therapy workforce employed in private practice in British Columbia, for example, increased from 33 to 44 per cent. In comparison, the proportion of the occupational therapy workforce employed in private practice increased from 5 to 22 per cent.[103]

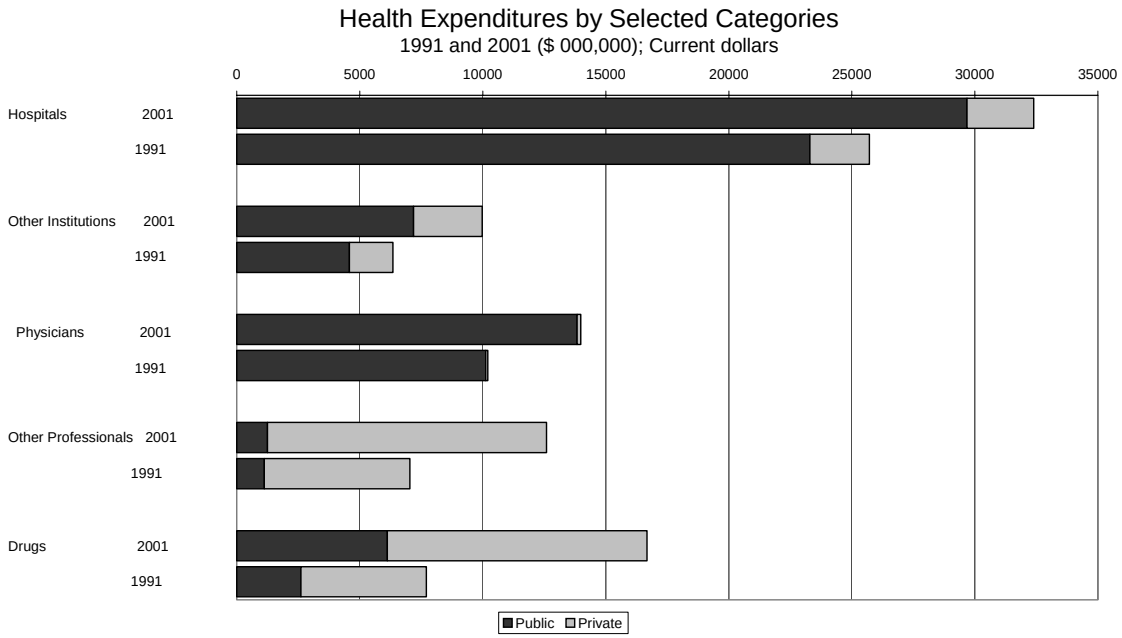
In 2002, the vice-president of the Canadian Association of Occupational Therapists (CAOT) board of directors wrote, "As we moved into the 1990s, health reform directly impacted our daily practice and every aspect of the profession. We again witnessed a surge of occupational therapists depart from traditional settings to public and private sector community-based practices…"[104] In 2002, the executive director of CAOT reported that provincial governments increased the number of seats in occupational therapy education programs—the number of active practitioners rose 62 per cent between 1991 and 2000. Practitioner-to-population ratios increased 21 per cent between 1996 and 2000. But, by 2002, 50 per cent of the profession received funding from a private payer for their services.[105]

Chart 1 and the brief analyses presented here suggest that Canada has the health human resource capacity to increase the number of professional health disciplines delivering publicly funded PHC services. This presumes, however, that:

(a) Governments or health authorities are interested and able to make these financial commitments.
(b) Non-physician regulated health providers are willing to switch to publicly financed positions.

Though Canada has entered an era of reinvestment in which real spending on health care is increasing, there are pressures on

Chart 1



Data Source: Canadian Institute for Health Information (CIHI). National health expenditure trends: 1975–2003. Ottawa: CIHI, 2003.

decision-makers to invest new funds in expanding universal coverage of health care products (e.g., pharmaceuticals) and services (e.g., to reduce surgical waiting lists) outside of primary health care.

Ultimately, public investments in non-physician PHC providers during times of fiscal duress or reinvestment will depend upon at least two key ingredients. First, there must be convincing evidence that the use of such practitioners will reduce demand for or expenditures on hospitals, nursing homes, physicians and/or pharmaceuticals. Second, policy-makers and administrators must be convinced that investment in non-physician PHC providers is more beneficial, in terms of improved health outcomes, than alternative public investments.

Cost pressures in the health care system have resulted in considerable debate about the current mix of public and private financing and whether a sustainable system can only be achieved by increasing the private share. This is despite the fact that the proportion of public financing in Canada's health care system registers at the lower end of the range among Organisation for Economic Co-operation and Development (OECD) countries. Furthermore, it has been convincingly argued that Medicare is sustainable from a public affordability perspective.[106]

Yet, should the public's fear about the financial sustainability of public funding of their health care system continue, there is likely to be little objection to the de-listing of non-physician providers. And, if physicians and hospitals continue to exert pressure for more money and more doctors, the availability of public funds to invest in a broader mix of interdisciplinary PHC

providers will be negated. Should price inflation, increased demand and patterns of drug use in the pharmaceutical sector remain unchecked, pressure for enhanced coverage and more public investment will be tremendous. It would appear that the only forces able to counter these competing interests are the public's interest in interdisciplinary PHC, a unified advocacy voice among health care professional associations to support interdisciplinary collaboration, and the support of family physicians who seek the assistance of other professional groups to deliver PHC.

Appropriate Modes of Funding

Funding health care involves deciding how funds are allocated to (and among) organizations and providers and how services are allocated to a variety of prospective populations and patients. "PHC reform, as commonly understood in the current Canadian context, involves not only a change in the nature of the delivery of care, but also in how professional practices and the individual providers within them, come to be reimbursed. Primary health care reform is, thus, inextricably linked to questions of resource allocation and purchasing arrangements."[107]

There are a number of different approaches to funding PHC services delivered by organizations or individual providers: namely, fee-for-service (FFS), salary, capitation and blended mechanisms. Each method of payment is compatible with any level of expenditures that society considers appropriate to spend on publicly funded PHC. But the methods used to distribute these funds send explicit and implicit messages to providers about who will be paid and what behaviours will be rewarded.[108] For example, funding based on service volume is likely to result in an increase in services. Different approaches to funding send different "signals" to providers, and insofar as financial incentives influence behaviour, financing schemes may have an impact on the degree to which PHC services are encouraged to use interdisciplinary teams and collaborative practice.

The predominant form of service delivery—the professional contact model—relies primarily on fee-for-service remuneration by provincial ministries for the medically necessary services of physicians. Fee-for-service focuses on payment of throughputs (volume and service type) and can be used to fund primary health care organizations, small groups or solo practitioners. Some jurisdictions allow other approved providers (e.g., physiotherapists and optometrists) to bill ministries directly for their services. However, these non-physician billing arrangements are becoming rare, as provinces de-list services not considered to be medically necessary.

The professional contact model in Canada has historically entailed some salary or sessional remuneration for primary medical care doctors and nurses who work in, for example, rural jurisdictions. This method of payment focuses on inputs—health care providers are compensated, based on the amount of service time and degree of their expertise. Salary or sessional payments can only be used to fund individual practitioners, either directly via provincial ministries, or indirectly, through intermediaries, such as health authorities, Family Health Networks (FHNs), Family Medical Groups (FMGs), or similar organizational models. In theory, both fee-for-service and salary remuneration could be used to compensate interdisciplinary collaborative teams of primary health care providers. In practice, these payment methods require organizational entities (e.g., health authorities or group practices) that would either establish fee-for-service contracts with an array of providers, or employ salaried providers to deliver primary health care. Such organizational entities have not traditionally existed in Canada, or, like the health authorities, have been responsible for hospital

and/or community-based care, rather than primary medical care.

The community models of PHC in Canada largely rely on organizations to deliver services to geographic populations. These organizations serve as intermediate entities between government payers and individual health care providers, and receive lump sum payments for managing the delivery of primary health care services. These lump sum payments can come from global budgets, capitation or blended funding. Capitation and blended funding models are being used more and more to fund physician-led PHC group practices. However, the vast majority of these new practice models do not seem to receive enough funds to afford to purchase the services of providers from other disciplines.

Capitation refers to a method of payment in which the amount of funds paid to a health care organization is determined prospectively, on the basis of the characteristics of a defined, or rostered, population. This approach to financing shifts the risk associated with insuring health services from governments to organizations that assume the responsibility for the unpredictable nature of illness and health service use. Rostered populations may represent a sample of individuals from the community (i.e., enrolment-based rostering) or all of the people who reside in a specific region (i.e., geographically defined rostering). When the process of rostering is explicit, as in Ontario's FHNs and Family Health Groups (FHGs), enrollees are fully aware that a specific health organization is responsible for providing their care. They become aware of the rostering process and the responsibilities it entails for patients and physicians, by reading and signing documentation. The process of rostering is implicit, as in British Columbia's PHCOs, when not all enrollees are aware that a specific organization has been assigned responsibility for their care. Implicit rostering involves assigning patients to practices based on where the majority of their care was received; provincial governments analyze administrative data generated by physicians to track patterns of PHC use by the population and assign patients.

Recently, it has been argued that comprehensive PHC reform should entail explicit expansion of the scope of services offered by an integrated team of health care professionals, called Primary Care Groups (PCGs). PCGs would be owned by regulated health care professionals and receive risk-adjusted capitation funding to deliver primary medical care, in-home continuing care, prescription drug coverage for seniors and other vulnerable populations, and possibly, diagnostic and laboratory services.[109] Evidence emerging from British Columbia suggests that there is a complementary relationship between investments in home care and primary medical care across geographic areas in that province. In addition, capitation funding for primary medical care, combined with home care, can more readily be risk-adjusted to account for regional variation in population health status than for either sector in isolation.[110]

It is important to acknowledge that proposals supporting services integration in areas other than physician and hospital services, requires substantial new public investments beyond that required by the *Canada Health Act*. Yet, provincial governments have been given guidelines as accompaniments to new federal money to spend under the Health Accord 2003 and First Ministers Meeting 2004. Whether governments comply with these guidelines has not yet been determined—Canadians now wait on the Health Council of Canada to be vigilant and account for provincial government investments in primary health care, home care and pharmaceuticals. Though the country has entered an era of reinvestment in PHC, pressure from secondary and tertiary care sectors, as well as inflation in existing publicly financed

pharmaceutical programs, vie for attention and new money.

Linking Financing and Funding Decisions for Interdisciplinary PHC

Many health care committees charged with making recommendations for PHC renewal suggest a move to blended funding mechanisms that combine capitation for enrolled populations with fee-for-service for specific services. Capitation is simply a method of partitioning "the pot of gold" to distribute it among PHC provider organizations. So, whether the shift to blended funding of PHC in Canada leads to interdisciplinary collaborative teams, likely depends more on the size of the pot than the method of funding. Consider that Canada has a single payer system and places limits on extra billing by physicians; therefore, current expenditure on primary medical care equals the aggregate income of doctors who deliver this type of care. The size of the pot determines the aggregate physician income. Therefore, if current expenditure on primary health care remains relatively unchanged in Canada, but instead, is distributed to teams that include non-physicians, then physician income would decline. It is for these reasons that newly created physician-led organizations that receive blended funding are unlikely to be able to afford to hire non-physician providers, and physician associations have argued that PHC reform needs "new money."

It could be argued that the appropriate use of non-physician providers will free up scarce physician resources and thereby, save money. Yet, it is unlikely that decision-makers would reduce current physician expenditures on primary medical care to "save money" because of pressures from physician interest groups. Since the number of physicians is relatively stable, reduction in expenditure to save money translates into reduced income among doctors. Therefore, arguments have been made that real opportunities for the appropriate use of non-physician providers would free up scarce resources to allow doctors to engage in more cost-effective activities, and would resonate more loudly with policy and physician communities. The creation of publicly funded interdisciplinary teams will require additional public investments, since many non-physician providers are currently funded by private sources.

Funding interdisciplinary collaborative teams will require the creation of intermediary organizations as go-betweens for providers and governments/ health authorities, since governments are unlikely to want to employ a huge number of new people on a salary or fee-for-service basis. These new intermediary organizations, whether they are called Family Medical Groups or Primary Care Groups, are unlikely to be exclusively financed on a fee-for-service basis, for all these reasons. They are more likely to receive blended funding, coupled with contractual obligations about services expectations and accountability mechanisms. In Ontario, for example, it appears that new Family Health Teams may serve as this type of intermediary role and will be financed with substantive new investments in primary health care.

New Models of Education of Health Professions

Canada has a tradition of educating its health care professionals in silos, and then calling on them to work together after graduation.[111] It has been argued that, when health care professionals are expected to work and function collaboratively as part of inter-professional teams, they should be prepared to engage in these activities through undergraduate education, clinical training and professional development.[112,113] While a systematic review determined that the effect of inter-professional

education on clinical practice is inconclusive,[114] inter-professional education, practice and research is a global movement.[115] A number of recent commissions, committees and policy documents in Canada identify the importance of reshaping educational preparation and the professional training of health care professionals,[116,117,118] and the need for more effective use of the skills of the full array of health human resources.[119]

In order to support inter-professional education, post-secondary institutions must surmount a number of legislative, fiscal and cultural barriers. For example, the legislative framework established by the *University Act*[120] in British Columbia gives authority for the finances of a university to a board of governors, vests the responsibility for academic programs in the Senate, and establishes the roles and responsibilities of faculties. The authority to establish course curricula and to assign instructional responsibilities is within the jurisdiction of faculties; therefore, inter-professional education initiatives require approval from each faculty. At the University of British Columbia, the number of students in courses within a faculty determines the dollars allocated to fund full-time instructors within that faculty. By definition, inter-professional education in provinces such as British Columbia requires different faculties to share curricula, instructional and funding responsibilities.[121]

Post-secondary institutions also face fiscal barriers to making inter-professional education for the health professions a viable alternative to established disciplinary curricula. The development and implementation of inter-professional curricula are expensive new undertakings. An inter-professional course can cost at least $24,000, just to pay for faculty from different disciplines.[122] When student fees are applied to fund inter-professional education programs, funding formulas become increasingly problematic, since fees are increasingly being differentiated among various health disciplines.[123] Inter-professional courses are typically the first to be cut during times of budget constraints at post-secondary institutions, since they are courses outside a specific disciplinary boundary.

In addition to the reluctance of health profession programs to channel dollars to inter-professional curricula, there are other barriers within universities, including:

- Curricula within professional programs are developed to maximize specific disciplinary education and research; one reason for this is that one school (e.g., pharmacy) cannot make demands on the resources of another school (e.g., dentistry).
- Many requirements are imposed on professional programs by accrediting and licensing authorities that have no interest in accommodating mandatory inter-professional education.
- Accrediting and licensing authorities pay insufficient attention to the practice interaction between professionals, allowing opportunities for inter-professional education to fall through the cracks.[124]

The current disciplinary emphasis also means that instructors who engage in inter-professional education activities do so at their peril, since promotion, tenure and merit adjustments are predicated on service to a single department or discipline. What is needed is a model of inter-professional education that pays for release time to the home department of a faculty member who is participating in an inter-professional team-taught course. Inter-professional education courses must also become part of an evaluated curriculum within each health discipline; otherwise, students will not engage in or value inter-professional education.

Despite the legislative, fiscal and institutional cultural barriers, there is a movement in post-secondary institutions across Canada toward providing more inter-professional education. Cook[125] outlines a continuum of inter-professional education ranging from no specific instruction on inter-professional health care teams or the development of team skills, to specific instruction in inter-professional education that involves most teaching faculty from different professions. A number of universities in Canada have active inter-professional programs at different points on this continuum. For example:

- The University of British Columbia's College of Health Disciplines has organized a major development in inter-professional education, from team-building workshops to developing a series of inter-professional courses available to health sciences students. There is also the Inter-professional Rural Placement Program of British Columbia, with community placement sites hosting groups of students from different professions.
- The University of Alberta has a certificate program in inter-professional health, which requires both a didactic course and an inter-professional clinical placement.
- At the University of Saskatchewan, the Health Science Colleges/Program is a new inter-professional college that will offer curriculum that promotes social accountability and fosters partnerships with the public, health regions and community-based organizations.
- The University of Toronto has a number of programs (e.g., Centre for Health Promotion, Collaborative Program in Aging and Life) that offer inter-professional study opportunities, as well as some inter-professional clinical placement sites (e.g., Toronto Rehabilitation Institute).
- The University of Ottawa offers a Ph.D. program in the area of population health that brings together the insights of social, biological, clinical, organizational and political sciences, and the strengths of quantitative and qualitative methods.
- McMaster University's Division of Rehabilitation Studies makes an inter-professional course on HIV/AIDs available to health science students.
- Memorial University of Newfoundland hosts a series of inter-professional team challenges that are particularly relevant to the community. The case studies involve clinical issues such as eating disorders, health in schools, problems of rural seniors, mental health, Aboriginal health, and occupational and environmental health.

Recent policy statements from the federal government, underscored by investments, are intended to support and expedite the transition to inter-professional education in post-secondary institutions. In 2003, the First Ministers' Accord included a health human resource strategy to strengthen the evidence base for national planning, promote inter-professional education to advance collaborative care, and ensure the supply of needed health providers, including nurse-practitioners, pharmacists and diagnostic technologists. In 2004, the First Ministers renewed their commitment to ensuring an adequate supply and mix of health care professionals, and initiatives to support inter-professional training, post-secondary education and credentialing of health professionals. These events have led Health Canada to develop a Canadian Health Human Resources Strategy. Although the strategy has not yet been released, Health Canada indicates that one component is the Inter-professional Education for Collaborative Patient-Centred Practice strategy. This initiative is to provide advice on how to achieve inter-professional collaboration. The ultimate goal of the multi-year initiative is to support the development and implementation of various facets of inter-professional education for collaborative patient-centred practice in all health sectors in Canada.[126]

Though interdisciplinary education is currently in its infancy in Canada, with the commitment of governments, post-secondary institutions, and the different health professions, interdisciplinary education and subsequent inter-professional collaborative practice may become a more predominant characteristic of PHC.

Models of Primary Health Care in Canada: Evidence of Change

In this section, predominant and emerging models of organizing primary health care are assessed to determine the extent of transition to interdisciplinary collaborative practice in Canada. Following a review of the literature, Lamarche and colleagues[127] identified two professional and two community models for organizing, financing and delivering PHC. We use Lamarche's framework to review the models of PHC in Canada, to describe the extent to which these models support or thwart interdisciplinary collaboration and to assess how these emerging models will alter the characteristics of PHC in Canada.

Professional Models

Professional models of care are designed to deliver medical services to patients who seek care or first contact with the health care system. The professional contact model includes private practice physicians, psycholgists, physiotherapists, chiropractors, optometrists, etc., who work alone or in groups; these practitioners may associate with other health care professionals, including nurses. In this model, there is no formal mechanism to facilitate continuity of care, or co-ordination of services among various PHC organizations, or between PHC and secondary/tertiary health care sectors.

The professional contact model is exemplified by private practices and walk-in clinics—the predominant means of delivering primary medical care in Canada. Few studies have assessed the degree to which there is interdisciplinary collaboration in family practice settings in Canada. We do know that 25 per cent of family physicians work as sole practitioners and 7 per cent practice in settings with a nurse-practitioner.[128] We do not know the extent to which family physicians liaise with PHC providers who work in other settings. We do know that family physicians who work in large group practices rarely share patients, and people who receive their care from these groups tend to see the same physician.[129] We do not know the extent to which shared care should occur among family physicians in the same group practice, or the degree to which some primary medical care services can more appropriately be provided by other professionals, to extend scarce physician resources.

In comparison, the professional co-ordination model is designed to co-ordinate a range of health care services and follow-up with patients to facilitate continuity of care. The predominant providers include physicians and nurses, with payments to physicians (or their organizations) through per capita or blended funding mechanisms. The professional co-ordination model has been adopted in initiatives being undertaken in a number of jurisdictions in Canada. For example:

- In British Columbia, primary health care organizations (PHCOs) have been established to support interdiscipinary teams, in order to strengthen access to comprehensive, co-ordinated primary health care through integrated patient health record data and educational programs for both practitioners and patients. PHCOs are expected to be integrated with community-based services. A blended funding formula consists of capitation (age, sex and morbidity) for core services and fee-for-

service funding for non-core services, such as obstetrics and anaethesia. Seven PHCOs were established under the Health Transition Fund and additional PHCOs are being established under the PHCTF. A recent review of six of the original PHCO sites suggests that these practices vary in size from 2.4 to 5 full-time equivalent physicians, with most doctors co-locating with nurses. Several PHCOs include dietitians, pharmacists and professionals from other disciplines. But case-conferencing was not in place in half of the sites.[130] The province admits "the full potential of interdisciplinary practice has yet to be realized in British Columbia."[131]

- In Ontario, FHNs and FHGs were established to support "groups of family physicians who work together with other health care professionals to provide accessible, co-ordinated care to their patients and create a better working environment for themselves." FHNs and FHGs guarantee after-hours care by offering extended office hours and after-hours telephone health advisory services.[132] By the end of 2003, more than 1,800 doctors in FHNs and FHGs served more than 2.5 million Ontarians,[133] but few of these organizations included non-physician providers. In September 2004, the Ontario government announced that it would be creating 150 Family Health Teams, in which family physicians will receive new money to practice in interdisciplinary groups with nurse-practitioners and pharmacists.[134,135]
- In Quebec, Family Medical Groups (FMGs) have been established to support "groups of family physicians who work in close co-operation with nurses to offer family medicine services to registered individuals…and work closely with other health care professionals in CLSCs (Centres locaux de services communitaires), hospitals and community pharmacies to complement the services they offer." The intent of FMGs is to improve access, follow-up and continuity of general medical care. The Minstrère de la Santé et des Services Sociaux established 76 FMGs by April 2004,[136] and intends to register its entire population in 300 FMGs by 2005.[137]

Community Models

The two types of community models are designed to improve health and promote the development of geographic populations through the provision of health promotion, disease prevention, diagnostic, curative, rehabilitative and palliative care services. These delivery models require a governance authority that includes public representatives and interacts with the community. The authority receives a lump sum to allocate resources, purchase services and organize the delivery of care. Interdisciplinary teams provide medical, health, social and community-based services; these providers are paid on a sessional or salaried basis.

The integrated community model promotes the continuity and co-ordination of care among PHC providers, and between PHC providers and secondary/tertiary organizations that serve the same population. This integration occurs, for example, through the use of community health information systems. Due to the complementary nature of providers in these networks, they are able to offer a comprehensive array of services and make services available 24 hours a day, 7 days a week.

Some of Quebec's CLSCs follow an integrated community model of delivering PHC in rural jurisdictions, but most CLSCs in urban settings are not well-integrated with other health service sectors. However, recommendations from the Clair Commission and other recent activities in that province, involve enhancing the degree of integration between CLSCs and other health sectors.

There are a number of Primary Care Trusts (PCTs) in England and Wales that are approaching an integrated community model. PCTs hold responsibility and funding for purchasing or providing all health services for rostered populations. They use electronic information systems for enrollee registration, prescribing and patient recall. Hospital laboratories can also download results directly into electronic records held at PCTs.[138]

The non-integrated community model lacks specific integration mechanisms and is characterized by less continuity or co-ordination among PHC providers and between PHC providers and secondary/tertiary organizations. Because providers are not part of collaborative networks, they are less likely to offer services 24 hours a day, 7 days a week.

Ontario's Community Health Centres (CHCs) and Community Care Access Centres (CCACs) exemplify the non-integrated community model. In 2004, Ontario's 54 Community Health Centres offered PHC services to "individuals, families and communities to stengthen their capacity to take on more responsibility for their health and well-being" and to "contribute to the development of healthy communities." CHCs are governed by a community-elected board of directors.[139] Ontario's 43 CCACs offer in-home professional and support services, including nursing, physiotherapy, occupational therapy, speech-language therapy, dietitian services, social work, personal support and homemaking. CCACs also assess, authorize and arrange services for special needs children in schools; manage admissions to Ontario's long-term care facilities; and provide information and referrals to the public about other community agencies and services.[140]

The Optimal Model of Primary Health Care

The four models of organizing and delivering primary health care services can and do co-exist in any one jurisdiction, and vary in the degree to which they support interdisciplinary teams. The optimal performance of a PHC system, in fact, depends on the co-existence of alternative models, since each model differs in its impact on the process and outcome of care.

The predominant model in Canada, the professional contact model, is least supportive of interdisciplinary teams. Indeed, a number of prominent committees and commissions have identified this situation as a challenge to PHC reform.[141] By comparison, community models of primary health care require interdisciplinary collaboration and, thereby, attain better outcomes than the professional contact model in equal access, effectiveness, continuity, quality and cost reduction. But community models perform less well than the professional contact model in important aspects of accessibility (e.g., ease or difficulty in contacting care) and responsiveness (e.g., the extent to which services meet expectations and are deemed satisfactory).[142]

The question then becomes: What is the optimal combination of models and the appropriate mix of models for Canada? The answer, if one asks Canadians, or looks at activities already underway to renew primary health care, is expanding the professional co-ordination model through the increased use of nurses and reducing our reliance on the professional contact model. Though some jurisdictions signal the intent to include other disciplinary practitioners in the emerging professional contact model, there appears to be little concrete activity in this area.

Using Lamarche and colleagues' conceptual framework, this type of a transition would likely result in:

(a) The maintenance of current levels of accessibility, responsiveness, equity in access, effectiveness and quality (including appropriateness); and
(b) A reduction in current levels of continuity of care and total use.[143]

Yet this is at odds with the generally stated aims of current renewal efforts, which are to ensure that the most appropriate provider delivers care to citizens and that there is increased accessiblity, comprehensiveness and continuity of care. Evaluative efforts associated with enhancements to interdisciplinary collaboration through the professional co-ordination model should therefore, assess, at a minimum, the intended and unintended effects of this approach.

Conclusion

Momentum for the renewal of primary health care services has been building and will continue to build for some time. Over the last three years, most provinces have moved from fiscal duress to strategic investment and from stagnation to action on the primary health care front. This paper documents that the policy community and health professional associations now recognize a need for transition to interdisciplinary collaborative teams to respond to the views of citizens and practitioners. Though the vision for PHC renewal established by government-sponsored advisory bodies in the mid-1990s was grandiose and had little policy traction at the time, many provinces have now established a clear vision and policy frameworks that have been informed and harmonized by the First Ministers. All have championed change through focused investment.

Unfortunately, the health professional associations (other than the CFPC) have only recently engaged their membership in establishing a realistic vision for primary health care renewal. Until there are champions for change among the associations and activities designed to support transition to interdisciplinary practice, the work of policy, regulatory, legal and practitioner communities in all provinces will not be synchronized and the pace of change is likely to be slow.

Change requires champions, but also supportive structures and focused activities. Current legal and regulatory frameworks are not conducive to interdisciplinary collaboration, though emerging activities, particularly in the area of nursing, show promise in supporting the transition. Clearly, the financing of non-physician providers is predominantly from private, rather than public, sources. New investment in these health professions by governments—through health authorities, group practices or other intermediaries—will be required to facilitate alignment with publicly funded, private practice family physicians. Governments have not explicitly established a vision for funding interdisciplinary collaborative care. Until methods of funding are established, public investment in non-physician providers is not possible. Therefore, it is unlikely that financial arrangements will spawn either PHC teams of publicly funded family physicians and privately funded non-physician providers, or be part of the glue that holds them together.

Legal and regulatory frameworks, as well as adequate financing and funding, are necessary to support the shift to interdisciplinary collaboration in PHC in the short term. In order to ensure that interdisciplinary collaboration gains momentum in the short term and maintains it in the longer term, universities have engaged in activities to enhance inter-professional education. Governments are making a focused investment in supporting these undertakings.

Across the nation, achievements seem to be fuelled by a convergence of public and provider views on the need for change, champions for

change in policy and practice communities, and supportive structures and activities, fed by government funding. The recipe for success in shifting to interdisciplinary collaboration in PHC, therefore, includes:

- Public consultations, revealing dissatisfaction with the current mode of delivery, and calls for transition to interdisciplinary collaborative teams and integrated delivery. Though the Commission on the Future of Health Care in Canada tried to understand the perspectives of Canadians on PHC, only a few provincial governments have engaged in this activity and, therefore, many policy-makers do not understand what citizens in their own regions want from their PHC system.
- Public dissatisfaction with access to family physicians, coupled with family physicians voicing unhappiness with their workloads and their willingness to pursue new modes of service delivery. While strong evidence has emerged at the national level, there seems to be regional variation in issues of access and the workloads of family physicians. Where access and workloads are issues and family physicians make themselves heard, reform is more likely.
- A vision for renewal that recognizes the need for change and provides future direction. While the First Ministers have established core principles of PHC renewal, each jurisdiction requires goals and objectives that include interdisciplinary collaboration. Useful provincial policy frameworks address regional issues and show tolerance for diversity of implementation. In developing appropriate policy frameworks, local leaders become champions for change.
- The support of the health care professionals, as well as their associations and unions, since provincial policy frameworks and implementation activities are unlikely to have traction without them. Health associations and unions, in turn, must be attuned to the perspectives and expectations of their members in order to effectively lead PHC renewal and become champions for change.
- Champions among government and the health professionals must target structures that support or negate interdisciplinary collaboration, including regulatory and legal contexts, financing and funding issues, and provider education. There is much work to be done to align these factors, so that they support interdisciplinary collaboration.
- New PHC organizations, owned and operated by regulated providers, which receive funds from provincial governments or health authorities, and pay health care professionals who collaborate to deliver an array of PHC services.
- New money, directed toward PHC organizations, with guidelines stipulating the expected processes (i.e., interdisciplinary collaboration) and outcomes of such an investment. Expenditures on interdisciplinary teams must exceed current investments in primary medical care. The degree to which new expenditures exceed current investments will signal the degree to which governments want non-physician PHC providers to be integrated with Medicare.

When any one or more of these ingredients is in short supply at the provincial or local level, stagnation or "incrementalism" in transition toward interdisciplinary collaboration occurs. In the mid- to late-1990s, health care committees and commissions across the country recommended "big-bang" changes to funding, organizing and delivering primary health care. Few were aware of the broad array of policy levers, synchronization of effort, and sustained energy required to facilitate system-level change in this sector. Over the last five years, policy, administrative and practice communities have developed a more mature understanding of what it takes to steer the PHC sector—factors such as

public and provider consultation to establish the need, a vision for renewal and champions for change. In addition, structures need to be aligned to support the transition to interdisciplinary collaborative practice—legislation and regulation, legal foundations, financing and funding decisions, and professional education.

Current funding pressures in the secondary and tertiary care sectors continue to vie for the public's attention and for new, government investments. A strong primary health care system can reduce the demand on secondary and tertiary care sectors. Although Canadians and health care practitioners widely support renewal, until now, investments have been insufficient to achieve the core aspects of the PHC system required by Canadians, including interdisciplinary teams of providers and significant changes in service delivery. The policy and practice communities would be wise to engage Canadians and providers in a dialogue about the relative importance of renewing PHC through new investment in interdisciplinary collaboration. This is what is needed to turn up the volume on calls for change and to enable champions of change to have sufficient time to conduct their work. This will be necessary to trump political pressure on governments to respond to waiting lists for secondary and tertiary care, which will only lead them to spend new money in old ways.

Appendix A – Provincial and Territory Governments' Vision of Inter-Professional Collaboration

Province	Vision: Inter-Professional Collaboration	Reference web site
British Columbia	"As with other Canadian jurisdictions, British Columbia is facing challenges in finding health professionals willing to work in rural or remote areas of the province. While successful training, recruitment and retention strategies have the potential to increase the supply of providers in these areas, they alone will not address the availability and access problems faced by providers and patients alike. Innovative ideas and strategies, such as telemedicine, nurse first call and shared care, are needed to overcome the barriers to patient access to primary health care providers." "Interdisciplinary practice allows clinicians to develop and strengthen the natural links existing between family medicine and other health professionals such as nurses, social workers, pharmacists, occupational and physiotherapists, etc. Patients needing any or all of these services would benefit from a coordinated, comprehensive approach to their care. Although the full potential of interdisciplinary practice has yet to be realized in British Columbia, other Canadian jurisdictions (such as Saskatchewan) have integrated nurse practitioners working in concert with family physicians to provide primary health care in rural or other under-served areas." "As one of the characteristics of a Primary Health Care Organization, an interdisciplinary team approach to primary health care delivery (in which each health care provider contributes to patient care according to their competencies and skills) to strengthen patient access to comprehensive, coordinated primary health care."	http://www.healthservices.gov.bc.ca/phc/pdf/renewphc.pdf
Alberta	Two principles of PHC are: • "1) that it focuses on the specific needs, strengths, resources and issues facing a community in deciding what services are to be offered, how many services are required, who will make up the team of providers, where and when services are to be offered; and • 2) uses multiple strategies to address individual and population health issues. This includes community development approaches and local intersectoral cooperation. It also involves an inter-disciplinary team approach including collaboration with volunteers and other agencies, and the use of non-traditional and alternative health workers as appropriate." A key element of PHC is that it is "Integrated and coordinated – involves a wide range of multidisciplinary service providers, use of community staff, and co-ordinated services to avoid duplication and make the best use of available resources."	http://www.health.gov.ab.ca/about/phc/resource/discussi.pdf

Province	Vision: Inter-Professional Collaboration	Reference web site
Saskatchewan	"The Saskatchewan Action Plan for Primary Health Care is about a primary health care system that expands on primary care by focusing the delivery of services to include a holistic approach, a continuum of services, inclusion of a range of health providers, involvement of the public, and a recognition that health is influenced by many factors." Primary health care will include the "proactive and collaborative approach to chronic management disease: interdisciplinary teams will be engaged in all the elements of the prevention and management of chronic diseases." "Many health care professionals provide basic services such as the public health nurse who visits schools and new moms, the family doctor who sees patients in his or her office, the nutritionist who provides education on diets for people with diabetes, the home care worker who provides personal care, such as bathing, in people's homes. All of these professionals work very hard to meet people's basic health needs." A defining characteristic of primary health care is: "Integration and co-ordination of services – A comprehensive range of co-ordinated health promotion, prevention, primary curative care, rehabilitative and supportive services will be provided by integrated, interdisciplinary, multi-service networks of providers with care co-ordination for each high-risk client or family. This will involve further development of group medical practices and a continuous client record." "Each Regional Health Authority (RHA) will develop a network of providers to deliver primary health care services. The network will consist of teams to deliver the service and provide case management to co-ordinate the service. There will be a variety of team structures within each network (RHA). The most common team would consist of a group family physician practice, primary care nurse practitioner, home care, public health nursing, therapies, and mental health. Other team members might belong to more than one team (e.g., dieticians, pharmacy, social work, speech and language pathologists, and psychologists) where a full-time person is not required on the team. A team would be situated at (or around) a central location and could serve a number of communities." "Access to health care services will be achieved through the following ways: 1. Establish access standards for primary health care services: 2. Provide access to basic services (physician and/or nurse) 24/7; 3. Establish a 24-hour telephone advice service; 4. Improve co-ordination of referrals to other primary health care services, diagnostic services, and tertiary services; and 5. Improve referrals to primary health care services by hospitals and emergency rooms.	http://www.health.gov.sk.ca/ps_phs_services_over.html *Note*: For a clearer overview of the types of providers who participate in these multidisciplinary teams, see the section under program, central, and satellite teams.

Province	Vision: Inter-Professional Collaboration	Reference web site
	Primary health care networks throughout the province will offer a full range of core primary health care services. Primary health care networks and team structures will vary depending on the geographic or social needs of the population. Teams will vary in size and complement depending upon the assessed needs of the community and availability of resources. The team further extends to include representatives from the community and other human service sectors such as Education, Social Services, Justice and Municipal Government, as well as the public." "Program Teams: Program teams form part of the network. There may be one or several of each program team in a Health Region depending on the population served. Some examples of these teams may be mental health, specialized programs, public health (population based, i.e., Medical Health Officer, nutritionist, etc.), emergency response teams, and chronic disease management teams (e.g., diabetic management team). These teams would link to all teams in the network. Teams would exist in institutions as well. Much of what happens in a hospital or Emergency Room is considered primary health care. The management of many medical conditions involves some time in hospital. The hospital and emergency room teams must be linked to the community teams. Further, most of the health care needs that are being met in special care homes are primary health care services. Teams that provide service in special care homes should function on primary health care principles. Central Team: A central team is envisioned to have at a minimum a group of 3-4 physicians and a primary care nurse practitioner serving a population of approximately 5,000, including satellite and visiting locations. In urban areas physician groups may be larger, with 5-10 physicians and with 1 or 2 primary care nurse practitioners, and therefore serve a larger population. Although co-location may be desirable for all team members in most cases, this may not be immediately attainable. At a minimum, the nurse practitioner should be co-located with the physician group. An urban centre may have many central teams serving different communities within the urban boundaries. A central team may provide visiting services to satellite and visiting locations and provide needed support to smaller teams. An urban centre may have several central locations and team members may be by way of a virtual team. The key idea is that the core team members know each other well and can share the responsibilities of clinical management, proactive care, or health promotion and injury prevention. Satellite Teams: The satellite team will be connected to a central team and receive visiting services from the central team. A satellite location is envisioned as a community where resident staff or visiting staff offers health promotion and prevention services, clinical services and access to emergency services. A range of basic services is delivered to meet the health needs of the individual, family and community closer to home.	

Province	Vision: Inter-Professional Collaboration	Reference web site
	A satellite location will at a minimum have the following services on site: • a primary care nurse practitioner; and • a primary care physician (visiting). The following services would be offered by visiting staff: • laboratory (specimen collection abilities) visiting or part time services; • public health; • home care; • therapies; and • emergency services based on geographic needs."	
Manitoba	One of the key principles of PHC is its "intersectoral/interdisciplinary nature – to adequately address the determinants of health, the skills and services of numerous sectors and disciplines will be required. Formally integrated and coordinated teams of service providers must be developed." One of the goals and objectives of primary health care reform includes: **Goal 2**: "Enable PHC service providers to deliver services in ways that reflect PHC principles. **Objective 2(a)**: Increase the proportion of existing and future PHC providers who are appropriately trained for practice in an integrated, interdisciplinary setting."	http://www.gov.mb.ca/health/primaryhealth.html
Ontario	One of the five essential features of primary health care recommended by the Health Services Research Commission (HSRC) in Ontario is: "the provision of service by inter-professional provider teams. The HSRC believes that primary health care is most effectively delivered by an inter-professional group of providers who share common goals, contribute in a coordinated manner according to their competencies and skills, and respect the functions and distinctive contributions of others. **Benefits of Inter-Professional Providers** • Quality of care increases since the consumer receives services from the professional who is best qualified to provide the care the consumer needs. For example, family physicians can diagnose and treat consumers with complex medical problems; nurse practitioners can advise on health promotion and disease prevention, and diagnose and perform comprehensive health assessments; pharmacists can advise on medication issues; and psychologists and social workers can play an active role in case management and mental health counseling). • Coordination and continuity of care improves as consumers' needs are met through provider collaboration and teamwork. • Maximizing the skills and recognizing the expertise of different health care professionals, especially those whose skills have been underused in primary care, increases quality of working life of all members of the PCG.	http://www.health.gov.on.ca/hsrc/phase2/rr_phc_final.doc

Province	Vision: Inter-Professional Collaboration	Reference web site
	• Capitalizing on the skills of health professionals in addition to physicians, improves the utilization of these professionals and access to comprehensive primary health care especially in underserviced areas of the province. • It is cost effective to use the skills of a variety of health professionals in addition to physicians, to provide primary health care. The inter-professional team approach to care has been successfully used in many settings (e.g., hospitals and community health centres) and its value recognized. For example, inter-professional care providers are a key feature of community health centres, and some health service organizations include nurse practitioners. The OMA pilots recognize the contribution of nurse practitioners, and the Ontario College of Family Physicians endorses an enhanced role for nurses recognizing that other professionals also have a role to play in primary care. There is a great deal of evidence from other jurisdictions to support the safety and quality of care of non-physician providers, particularly nurses with advanced training, and midwives. There is also evidence of their cost effectiveness. The use of nurses and other health professionals will enable physicians to maximize their skills and work to the full extent of their qualifications, training, and scope of practice. There is evidence that a substantial proportion of the current activities of family physicians could be done equally well by nurse practitioners. In Ontario, the top five physician billing codes that accounted for approximately 69% of the total amount billed by primary care physicians in 1996/97 ($1.2 billion) included intermediate assessments/well baby care, general assessments, minor assessments, individual psychotherapy and counseling. Many of these services may well be provided by nurses and other health professionals. This would free up physicians to work to the full extent of their training. Many jurisdictions regard advanced practice nurses (which includes nurse practitioners) to be appropriate providers of many primary health care services. These include health-screening evaluations, post-surgical hospital care, chronic care, long-term care and services to 'special needs populations' (e.g., homeless, those with high care needs such as persons with AIDS). In addition to being lower cost providers, nurse practitioners typically spend more time with individual patients than can physicians, and explore and present a broad range of treatment options. **Core Team** The HSRC believes that primary care physicians and primary care nurse practitioners should form the *core team* in each PCG and collaborate in a group practice setting. There should be at least one nurse practitioner in each PCG.	

Province	Vision: Inter-Professional Collaboration	Reference web site
	Although the key function of the primary health care physician and nurse practitioner together is to provide routine and urgent primary health care to the enrolled population, their roles will be determined by their training and scope of practice. Physicians and nurse practitioners will work as equal partners, recognizing, however, that each plays a distinct role and brings particular skills and approaches to health care. The different skills and philosophies offered by nurse practitioners and primary care physicians are complementary and when combined, will provide enrolled members with improved primary health care services. Along with other members of the PCG, the core team will oversee the provision of primary health care services to a defined, enrolled population and will ensure optimal quality of care, efficient use of resources and high levels of patient satisfaction. The members of the core team will appoint or elect a member of the core team as team leader. **Additional Clinical and Administrative Support Functions** Additional support functions will work with, and increase the capacity of, the core team to extend the range of care provided in PCGs. Adding capacity to a PCG allows the group to care for a larger total number of patients at lower cost. For example, a midwife who provides prenatal care and attends deliveries for all group practice members will free up the time of primary care physicians and nurse practitioners. This will support a system of high quality, accessible and efficient care within each PCG. Additional support functions include midwifery, walk-in primary health care, demand management, case management and mental health care. (See the section, *Establishing the Primary Health Care Group* for a discussion of these functions.)" The HSRC recommends that: "All Primary Health Care Groups be organized as groups of inter-professional primary care providers. Primary care physicians and primary care nurse practitioners should form the core team, with other clinical and administrative support functions added to meet the care needs of the enrolled population for comprehensive primary care." "Education is an essential mechanism to support the development of PCGs and help them to meet the needs of their enrolled consumers. Benefits of Education • The HSRC's strategy is supported with a sufficient number of providers with appropriate skills. • Quality and continuity of care is enhanced with training on establishing effective group practice. • Health care providers are supported to work to the full extent of their scope of practice through enhanced skills training. • Consumers benefit from education on how to stay healthy.	

Province	Vision: Inter-Professional Collaboration	Reference web site
	Educating a Sufficient Number of Providers to Support the Primary Health Care Strategy A review of current health care human resources in relation to the HSRC's primary health care strategy indicates that: • There seems to be a sufficient number of primary care physicians to meet the province's need for primary care, which requires the training and expertise of physicians. These primary care physicians, however, are unevenly distributed throughout the province. A recent study indicated that there were 7.9 active GPs/FPs per 10,000 population in 1997/98. The distribution of these physicians ranged from a high of 10.0 per 10,000 in Toronto to a low of 5.8 in Essex/Kent/Lambton. • There are an insufficient number of primary care nurse practitioners who are qualified to practice in Ontario to implement the recommendations in this report. The lack of training, funding and job opportunities for nurse practitioners have had a negative impact on attracting students to this program. • Current training programs in Ontario do not adequately prepare nurse practitioners to provide the full scope of services required for effective group practice. Appropriate training programs must be planned and implemented immediately if Ontario residents are to enjoy the full benefits afforded by the addition of nurse practitioners in the core of primary health care groups. • Midwifery and nursing are two distinct professions with separate training programs, their own regulatory colleges and distinct legislative requirements. As a result, cross-training between midwifery and nursing does not occur, nor is an environment created that encourages professionals to develop and use both midwifery and nursing skills. For example, nurse practitioners in Ontario are not authorized to perform obstetrical acts. Smaller communities that could benefit from and support a professional with both sets of skills, may not be able to attract and maintain both a nurse practitioner and a midwife. The HSRC's primary health care strategy is achievable. It will require some redistribution of current primary care physicians, increased training opportunities and funding support for primary care nurse practitioners, and opportunities for cross-training between midwifery and nursing, including accrediting courses taken in one program toward qualifications in the other. The HSRC supports the Ministry of Health's efforts to encourage the redistribution of physician resources through the use of incentives. The HSRC believes that establishing PCGs, enrolling the Ontario population in groups and supporting telehealth initiatives will attract physicians to practise in areas that are underserviced, as well as provide employment opportunities and financial support for nurse practitioners, midwives (and those dually-qualified) and other health professionals. The HSRC recommends that: **R9** An education task force be established to identify education initiatives that will support the primary health care strategy. The key priority of the task force will be to develop: • strategies to increase training opportunities for primary care nurse practitioners; and	

Province	Vision: Inter-Professional Collaboration	Reference web site
	• a plan to support cross training of midwifery and nursing to encourage professionals to develop both sets of skills. **R10** The Ministry of Health invest stable and ongoing funding immediately to support the education of nurse practitioners in Ontario. Academic health science centres and the other universities and colleges that train health professionals have a role to play in advancing an inter-professional approach to primary health care and health care practice in general. For example, integrated teaching programs would give students an appreciation of the expertise of their colleagues and highlight opportunities for collaboration between professionals. A collaborative education experience would help prepare professionals to work in the inter-professional environment of PCGs. The HSRC recommends that: **R11** The Education Task Force develop strategies to support collaborative education opportunities among the health professions. **Educating Providers to Meet the Needs of Their Consumers** Once PCGs are established, health care providers must be supported with education appropriate to meet the needs of their enrolled consumers. Currently, the training of health care professionals is the responsibility of quite separate faculties where the emphasis is on mastering professional skills. Too little attention is paid to inter-professional teamwork, understanding the skills and potential of other health care professionals, and how to capitalize on a combination of professional contributions to the provision of care. Education is required on how to work effectively in group practices and settings, as well as with a range of professionals. Individual professions should work to the full extent of their scope of practice. To achieve this may require training to enhance skills as well as 'refresher' courses to sharpen skills (e.g., training in advanced cardiac and trauma life support, training in telemedicine technologies). This training will help result in more appropriate use of health professionals, including primary care physicians and nurse practitioners, specialists and other professionals. Since PCGs will also be expected to play an important role in educating the public on how to maintain health, professional members of PCGs must have the skills and knowledge to play an effective role in public education.	

Province	Vision: Inter-Professional Collaboration	Reference web site
	The HSRC recommends that: **R12** The Education Task Force develop and recommend: • educational and training programs on how to work effectively in groups of inter-professional providers; • educational and training programs to enhance the skills of health care providers so they practise to the full extent of their scope of practice; and • strategies on how PCGs can educate enrolled consumers to maintain health." "**Members of the Core Team** The core team will include primary health care physicians and primary health care nurse practitioners with extended certificate of registration. *Primary Health Care Physician* will provide primary medical care or consulting services to: • patients with uncomplicated or complex acute and chronic medical care needs, including ambulatory and acute inpatient hospital services; • patients with emergent needs for life or limb saving medical care; and • patients with uncomplicated obstetrical care needs, including vaginal delivery. *Primary Health Care Nurse Practitioner* will provide primary care services to: • patients with uncomplicated acute and chronic care needs, including ambulatory and acute inpatient hospital services; • patients with emergent needs for life or limb saving medical care; • It is anticipated that the primary care nurse practitioner will be trained in the future to provide services to patients with uncomplicated obstetrical care needs, including vaginal delivery. **Number of Providers in the Core Team** The number of providers in a group is directly related to the size of the enrolled population. There is limited empirical evidence to suggest an optimal size for either the number of providers in a single primary health care group or the enrolled population. Size estimates for group practices are available in the OMA pilots, the Ontario College of Family Physicians' model and elsewhere. The OMA pilots are based on the maximum enrolment of 2,200 people per full-time physician. An additional 800 consumers are allowed for each nurse practitioner. For HSO physicians, currently a maximum of 2,500 people for each full-time physician is allowed. The Ministry has planned for pilots to include 15-20 physicians but has approved smaller units. The Ontario College of Family Physicians has suggested that practice networks comprise between 7 and 30 family physicians. Based on an estimate of 2,000 enrolled consumers per full time physician, according to the College's recommendation each network would serve a defined population of 14,000 to 60,000 people.	

<table>
<tr><th>Province</th><th>Vision: Inter-Professional Collaboration</th><th>Reference web site</th></tr>
<tr><td></td><td>PCGs must be large enough to provide the resources needed to meet the health goals of the population and the full range of agreed-upon services. They must conduct both clinical and administrative work.

It is critical for the members of the core team to develop a true group practice to support comprehensive and coordinated care. To achieve this, the HSRC believes that the core team should have from four to a maximum of eight providers. This allows for optimal group dynamics to create the effective group interaction required for the peer review necessary to improve quality and efficiency. The minimum size of four allows for a reasonable on-call schedule of every fourth day for the core team physicians and nurse practitioners. It facilitates achieving economies of scale and permits sharing of financial risk. The upper limit of eight minimizes the risk that the core team will break down into sub-groups and lose some of the positive small group dynamic interactions that are being sought. It also permits effective informal communication among the provider members and avoids the administrative expense necessary in larger groups.

Wide disparities exist in Ontario with regard to geography, transport, population density and availability of health care resources. The size of PCGs must reflect the province's population distribution. Consequently, three models for PCGs were developed – urban, rural and remote.
• Urban: This model will apply in cities and towns that have a population of at least 15,000 within the immediate surrounding areas.
• Rural: This model will apply in smaller towns where a PCG is in one physical location and can be reached within an hour by its enrollees; the number of possible enrollees must be at least 5,000.
• Remote: This model applies in all other situations not covered by the other 2 models.

The number of primary health care physicians and nurse practitioners comprising the core team differ in the three models."

<table>
<tr><th></th><th>Urban</th><th>Rural</th><th>Remote</th></tr>
<tr><td>Core team</td><td>8 providers
• 6 physicians
• 2 nurse practitioners</td><td>4 providers
• 2 physicians
• 2 nurse practitioners</td><td>4 providers
• 1 physician
• 3 nurse practitioners</td></tr>
</table>
</td><td></td></tr>
<tr><td>Quebec</td><td>New institutions known as health and social services centres are found at the heart of each local services network. The health and social services centres were created by merging local community health centres (CLSCs), residential and long-term care centres (CHSLDs) and general and specialized hospital centres (CHSGSs). This new type of institution results from the adoption of the Act respecting local health and social services network development agencies (Bill 25) in December 2004.</td><td>http://www.msss.gouv.qc.ca/en/reseau/lsn.html</td></tr>
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Province	Vision: Inter-Professional Collaboration	Reference web site
	"The creation of health and social services centres at the heart of the local services networks means that a hierarchy of services must be established to guarantee better complementarity and make it easier for people to move through the primary (general medical and social services), secondary (specialized medical and social services) and tertiary (highly specialized medical and social services) services offered by the entire local services network and all its partners. Each health and social services centres must ensure the population on its territory has access to medical services, general and specialized hospital services and social services." "The implementation of health and social services centres at the heart of local services networks will improve patient follow-up since each of the local networks will essentially become a hub where the public will have easier access to all of the services offered. Actors in a local service network: • general and specialized hospital centres; university hospital centres. • community pharmacists • education and municipal partners • community organizations • non-institutional organizations • youth protection services • private resources • rehabilitation centres • family medicine groups and medical clinics • social economy enterprises In short, the objectives of health and social services centres are the following: • to promote health and well-being • to bring together the services offered to the public • to offer more accessible, better coordinated and seamless services • to make it easier for people to move through the health and social services network • to ensure better patient management, particularly of the most vulnerable users." "A family medicine group is a group of family physicians who work in close cooperation with nurses to offer family medicine services to registered individuals. Family physicians who are members of FMG will also work closely with other healthcare professionals in local community health centres, hospitals, community pharmacies, etc, to complement the services they offer."	

Province	Vision: Inter-Professional Collaboration	Reference web site
Nova Scotia	A defining characteristic of primary health care renewal is that it is: "**Integrated, collaborative and innovative.** This means that: • Health care services are coordinated and integrated in a way that ensures care is provided to individuals and families in the optimal setting, and assists individuals and families in navigating with ease through the system. • Linkages are made and maintained with organizations, agencies and government departments whose contribution is essential to the improvement of individual, family and community health status. • Collaboration within and outside the primary health care system results in creative, innovative and effective approaches to the delivery of health care services and to the implementation of activities that promote health. • Collaboration among primary health care professionals, other care providers, community organizations, individuals and families is supported by structures that foster trust, support for shared decision-making and respect for professional autonomy." As part of the Nova Scotia Action Plan, teamwork is a focus: "Many health care providers and community professionals can work together to meet the primary health care needs of individuals and communities. • There are many examples of informal types of integration taking place in Nova Scotia's health care system today, but the primary health care system is still not well coordinated and integrated. This results, for example, in gaps in care, lack of coordination between levels of care, and redundancies and duplication in the care process. • There is not enough collaboration among government departments, the private sector, and community organizations in primary health to ensure Nova Scotians are offered and have access to health services and activities close to home. • The links made with community-based organizations are not often formally planned or supported. • The current system relies heavily on family caregivers and volunteer organizations that are not well supported or integrated within the health care system." "The core team would include the family physician, family practice nurse, pharmacist, nurse practitioner, social worker, dietitian, the appropriate public health provider(s), and midwife."	http://www.gov.ns.ca/health/phcrenewal/vision.htm#top
Newfoundland and Labrador	"Primary health care, as a level of health services, is the first point of contact with the health services system. At the primary health care level, teams work in collaborative partnership with clients/patients to determine the most appropriate health service providers to meet their needs in the initial and continuing team/client/patient relationship. Within this relationship, health service providers will be supported and	http://www.gov.nf.ca/health/matterofhealth/primaryhealthcare.htm

Province	Vision: Inter-Professional Collaboration	Reference web site
	enabled to fully use their knowledge and skills, and clients/patients will be enabled to take control of their own health. The community, as a client, will be supported by the team in building capacity to improve the health of the community population." Primary health care renewal in Newfoundland and Labrador will reflect the following principles: "Teams and networks of health professionals will work in partnership with patients/clients to provide a continuum of services including health promotion, illness prevention, health protection, emergency transportation, management of acute and chronic diseases, rehabilitation, and end of life care; primary health care teams will have established linkages with health and community services programs, and secondary and tertiary health services to support a continuum of service and care delivery; and primary health care teams will adopt a population-based, community development and intersectoral approach to health services planning, implementation, and evaluation." "Primary health care teams will provide interdisciplinary services, with the appropriate infrastructure for population health approaches within the team structure… Members of the primary health care team can include general practitioners/family practitioners, nurses (including nurse practitioners, and public and community health nurses), and other practitioners (e.g., paramedics, dentists, pharmacists, physiotherapists, occupational therapists, social workers, administrative personnel, etc.). This team of professionals will work together to promote health and wellness, provide comprehensive primary health care services and, within available resources, respond to the health needs of the population. The teams will be composed of existing primary health professionals working for institutional, integrated, and community boards, plus the voluntary integration of independent family physicians. Team members who currently provide provincial and regional services and programs, and legislated and/or group services, will continue to do so. Some team members would be associated with specific sub-regions as part of the teams, and will provide services based on provincial/regional direction and the specific needs identified in the sub-region. Dependent on the size of the population for which the team provides service, these team members may be part of the core team or the network. Though it may be preferable for teams to practice from a common site, it is also possible for teams to practice from multiple sites. Where teams practice from multiple sites, it is very important to develop a co-ordinating and supportive structure to ensure effective and efficient delivery of services. Primary health care teams are the principle route for access to all primary level health and community services for the defined population. Primary health care teams are also the principle route for access to secondary level health and community services. Teams are to establish effective linkages within community health, secondary and tertiary services in a region to ensure appropriate and timely client/patient referrals, and provide support for continuity of service/care. This would include continued service in the institutional setting as appropriate, and placement in long term care. Teams will develop	

Province	Vision: Inter-Professional Collaboration	Reference web site
	innovative ways to meet their community needs, and will be encouraged to lead innovations that create healthy communities." "The primary health care team and network will provide a wide professional skill mix, allowing an appropriate distribution of workload and team members to work to their maximum scope of practice. This will provide a more enriching professional life, maximize the effectiveness of all team members, make the best use of the most expensive human resources, and make the model of primary health care more sustainable." "Formalized team building processes will be required to develop teams to work collaboratively toward a common client/patient focus, allow providers to work within their full scope of practice, and provide the skills to deal with challenges such as building trust and conflict resolution. An important aspect of team building will include integration of health promotion and prevention of disease practices for all provider roles. **Conflict Resolution Processes** Contracts will provide mechanisms for formal consultation, followed by mediation, and then arbitration to deal with dispute resolution. Professional practice dispute issues will be resolved through internal conflict resolution processes, with self-governing bodies involved as appropriate. Other types of disputes will be resolved through step-by-step internal and external organizational conflict resolution processes. **Interdisciplinary Teaching** Interdisciplinary teaching allows providers to share common experiences and encourages them to enhance their knowledge base. This can have a positive impact on the service delivery to the public and worklife of professionals. **Professional Development** Providers will have the support for ongoing professional development to facilitate a best practices direction for care and services. They will also be provided the opportunity to learn new and innovative skills that are required to bring needed services to the community. This will assist with reducing the need for patients to travel to distant sites and improve accessibility of health care services. Collaborative relationships within the medical and professional schools will be proactively pursued to support professional and team development, at both the team and student levels. **Collaborative Practice** Working as teams allows each provider to offer services at the higher level of their scope of practice. In doing so there is greater opportunity to avoid duplication of services, provide efficient services, and enhance worklife satisfaction for providers."	

Province	Vision: Inter-Professional Collaboration	Reference web site
Northwest Territories	"Primary community care and primary health care are considered interchangeable. 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 promotive services through the best use of all care providers, not necessarily those provided only by doctors. An element of the NWT primary community care approach is the most appropriate provider: The NWT approach is to focus on clients realizing that sole care providers can rarely meet the complex needs of people in the NWT. Care providers have opportunities to work in multi-disciplinary settings to collaborate for integration of services and continuity of client care. Not only does this facilitate comprehensive coordinated client services but it also ensures human resources are used wisely, healthy working environments are strengthened and a stable Northern workforce is developed. A team approach helps to avoid overlap and duplication of effort, makes the best use of available resources, adds flexibility to continue core program delivery and can respond more quickly to changing conditions. The number and composition of Primary Community Care teams will vary depending on the target population, community, and available infrastructure. Adequate orientation, ongoing training and clear mechanisms for referral and consultation enhance quality of care and will do much to improve the retention of our providers. Lack of ongoing training can lead to provider stagnation, development of poor working habits and a system that does not foster new practice ideas. All health and social services professionals are accountable and responsible for their own practice. A professional's scope of practice encompasses the activities for which the professional is educated and authorized to perform; and is influenced by the setting in which they practice, the requirement of the employer and the needs of the clients. When professionals work in an interdisciplinary primary community care environment, they find areas of overlap that exist between their respective scopes of practice." The NWT approach to action includes: **Sustainability of Programs** Objective - Using the most appropriate provider - Promote capacity building Task - Clustering of professional service providers - Develop necessary skills in workforce to address the needs within the community - Create healthy teamwork environments	http://www.hlthss.gov.nt.ca/content/Publications/Reports/PrimaryCare/PCCFrameworkAug2002.pdf

Province	Vision: Inter-Professional Collaboration	Reference web site
	Responsibility: DHSS - HSS Authorities - Providers - Public Results - Recruitment and retention issues diminished - Increased provider satisfaction - Increased client satisfaction - Increased community capacity **Integration and Coordination** Objective - Providing services in the best setting in a timely manner by the appropriate provider - Integration of appropriate technology with care Task - Developing mechanism for co-ordination of primary community care - Coordination of referral services - Linkages to existing and emerging HSS strategies - Linkages to NGO programs, other sectors - Best practices for interdisciplinary teamwork Responsibility: DHSS - HSS Authorities - Providers Results - Integration and coordination of services - Integrated case management - Components of 5 types of care (promotive, preventive, curative, rehabilitative, supportive/palliative) available to clients - Technology is adapted to the community's social, economic and cultural development." The NWT recognizes the need for legislative and regulatory reform: "In order to succeed, appropriate legislative and regulatory frameworks need to be established to support primary health care renewal. Legislation created in the past may no longer address the evolving roles of health and social services providers needed in the NWT. This would include legislation, policy and memoranda of understanding to define the roles and responsibilities of the Department and health and social services organizations that create the working environment for providers."	

Province	Vision: Inter-Professional Collaboration	Reference web site
Yukon	"In May 2003, the Department of Health and Social Services brought together 100 delegates from across the Yukon for two days of talks about priorities for primary health care in the territory. These people represented government, non-government agencies and organizations, direct service providers, and members of the public. All had one common goal—to recommend changes to improve health care in the Yukon." One of the key themes from the forum was: "**cooperation and collaboration**—improving our ability to work together within the health and social services community and other sectors. Forum participants believe that by working together, we will strengthen our health care system. They recommended that professionals share case information to coordinate care for individuals. They also want programs that work together to avoid duplication of services and identify gaps."	http://www.hss.gov.yk.ca/phctf/report.pdf

Appendix B – National Associations' Vision of Interdisciplinary Collaboration

Associations	Vision: Interdisciplinary Collaboration	Reference web site
Canadian Association of Occupational Therapists (CAOT)	CAOT does not talk directly about the role of interdisciplinary collaboration within the context of PHC; however, in a "Position Statement on Primary Health Care (2000)," the Association states that it "believes in a comprehensive view of health and supports attempts to integrate primary health care, health promotion and disability prevention to address the health issues of Canadians…Occupational therapy has a critical role in primary health care; working collaboratively with the client to identify conditions that limit performance of occupation. Occupational therapists apply their professional expertise and philosophy by providing direct service, consultation, education, research and policy analysis in numerous sectors. These sectors include but are not limited to health, education, housing, employment, leisure and recreation, transportation, environmental design, health promotion and injury prevention, and community development." CAOT's position paper is available on-line at: www.caot.ca/index.cfm?ChangeID=2&pageID=188	http://www.caot.ca/default.asp?pageid=188
Canadian Association of Social Workers (CASW)	The CASW statement on preventive practices and health promotion (1998) includes the principle of working in partnership with other professions: "The benefits of working in partnerships with other professions are many. The combination of different strengths and skills of the partners enhance the possibility of creative solutions, while successful partnerships drastically lessen the possibility of turf wars. There is also more chance of securing funding, simply because of strength in numbers. Collaboration is particularly effective in complex or ambiguous situations. The most important benefit is, however, to the health of Canadians, where partnerships can be very effective in helping clients take control of their own health. Collaboration involves using to the full the different expertise of various disciplines. It does not mean one discipline being replaced by another. Social work is well fitted to work in partnerships. When ownership of issues is developed by the client groups, collaboration is most likely to succeed. This means working with people rather than doing things for them or to them; it means mutual respect and an equal voice for all participants. It includes self-help/mutual aid models and natural community 'helpers.' It may involve accepting different outcomes from what the professionals recommend, when communities espouse different values. It recognizes the strengths and barriers of language and culture, as well as the effect of racism. These are all social work values and established ways of working that were pioneered by the profession."	http://www.casw-acts.ca/

Associations	Vision: Interdisciplinary Collaboration	Reference web site
Canadian Association of Speech-Language Pathologists and Audiologists	The Canadian Association of Speech-Language Pathologists and Audiologists is the single national body that supports the needs, interests and development of speech-language pathologists and audiologists across Canada. There is no information on their website that describes their philosophy regarding interdisciplinary collaboration. There is a link to the "Enhancing Interdisciplinary Collaboration in Primary Health Care" website, which indicates their involvement in this initiative.	http://www.caslpa.ca/english/index.asp
Canadian Medical Association	"Collaboration and cooperation: in order to support interdisciplinary approaches to patient care and good health outcomes, physicians, nurses, and pharmacists engage in collaborative and cooperative practice with other health care providers who are qualified and appropriately trained and who use, wherever possible, an evidence-based approach. Good communication is essential to collaboration and cooperation."	http://www.cma.ca//multimedia/staticContent/HTML/N0/l2/where_we_stand/2003/JointScopes03.pdf
Canadian Nurses Association	"Collaboration and cooperation: in order to support interdisciplinary approaches to patient care and good health outcomes, physicians, nurses, and pharmacists engage in collaborative and cooperative practice with other health care providers who are qualified and appropriately trained and who use, wherever possible, an evidence-based approach. Good communication is essential to collaboration and cooperation." The Canadian Nurses Association also has a joint policy statement on "An Interdisciplinary Approach to Continuing Care." The statement reads: "An interdisciplinary approach in continuing care requires health care providers from different disciplines to collaborate and function interdependently to meet the needs of health care consumers and their families in the home, the community, or within health facilities and agencies. An effective way to manifest this interdisciplinary approach is to establish a team of caregivers….The interdisciplinary team assesses client needs, plans, and delivers comprehensive care, and evaluates outcomes. The composition of the team and the roles of team members are determined in keeping with the needs of consumers and their families." The action needed in order to achieve an interdisciplinary approach in continuing care includes the specific objectives of: "encouraging institutions that educate health care providers to provide interdisciplinary education, and to include in the curricula opportunities for collaboration and shared decision making, and exposure to models of effective interdisciplinary practice; encouraging facilities, agencies, and professional associations to support individual health care providers in increasing their effectiveness as members of interdisciplinary teams by providing access to continuing education opportunities for skill development in practice settings, and by fostering interdisciplinary networking."	http://www.cna-aiic.ca/_frames/policies/policiesmainframe.htm

Associations	Vision: Interdisciplinary Collaboration	Reference web site
Canadian Pharmacists Association	In 2004, the Canadian Pharmacists Association published a report calling for action "to recognize and integrate pharmacists as members of the primary health care team, and thus optimize health care." *Pharmacists and Primary Health Care* explores the role of pharmacists in primary health care and the need for system change, and advocates for interdisciplinary training as "one of the necessary next steps if Canadians are to maintain a vigorous health care system. In order to ensure the best care for their patients, providers must develop new ways or working and interacting with each other. The creation of wider multidisciplinary teams will lead to the re-alignment of existing skills and the development of new ones." The report acknowledges that while the public, health professionals and governments accept that the system must be updated, there continue to be barriers to implementing change. For pharmacists, the barriers include: • "**Underutilization of pharmacists' skills, education and services**. A growing body of evidence demonstrates that full utilization of pharmacists' skills and services will help contain drug costs, reduce pressures on more expensive areas of the health care system, and reduce costs. • **Outdated compensation schemes**. Currently, pharmacists are paid a fee for each prescription dispensed. The fee-for-service model of payment discourages collaboration with other providers and the expansion of pharmaceutical care. • **Lack of access to the full patient record**. Community pharmacists have inadequate access to diagnosis, medical history and laboratory values of their patients; this is not the case in hospital settings. • **Professional shortages**. There is a shortage of pharmacists in Canada impacting on patient care in both the community and hospital settings. • **Necessary changes to legislation and practice models**. Governments must make changes so pharmacies can become health consultation centres." To overcome these barriers to change, the report makes the following recommendations. • "Pharmacists must be recognized as essential members of the primary health care team in order to ensure optimal drug use. • Pharmacists are the most accessible members of the primary health care team and should be positioned as first contact provider whenever possible and appropriate. • Pharmacists must become medication managers in patient-centred practices. • Pharmacies must become health consultation centres. • Pharmacists must work with government and other providers to clearly define the services to be included and paid for in primary health care. • Protocols and outcome measures for quality pharmacy services in primary health care services need to be developed.	http://www.pharmacists.ca/content/about_cpha/who_we_are/policy_position/pdf/Scopes_of_practice_jt_sm_CMA-CNA-CPhA.pdf

Associations	Vision: Interdisciplinary Collaboration	Reference web site
	• Payment methods for pharmacy-focused primary health care services need to be developed. • Governments and providers must work towards the provision of fully integrated primary health care. Communication must be enhanced between pharmacists and the rest of the primary health care team." *Pharmacists and Primary Health Care* is available on-line at: http://www.pharmacists.ca/content/about_cpha/whats_happening/cpha_in_action/pdf/primaryhealth2a.pdf	
Canadian Physiotherapy Association	The Canadian Physiotherapy Association has a position statement on "Health Promotion and Disease Prevention." According to the statement, "Physiotherapists also participate in interdisciplinary team approaches to health service delivery. Interdisciplinary teams allow for a broader understanding of the client by incorporating a greater understanding of the determinants of health from multiple perspectives."	http://www.physiotherapy.ca/pdfs/healthpromo.pdf
Canadian Psychological Association	The Canadian Psychological Association (CPA) addresses the issue of interdisciplinary collaboration in the paper "Strengthening Primary Care: The Contribution of the Science and Practice of Psychology," (Mikail, McGrath, and Service, 2000). The paper uses the World Health Organization's definition of health ("not merely an absence of disease but as a state of complete physical, mental and social well-being") to make the case for "interdisciplinary delivery models." This definition, says the paper, "clearly points to the multi dimensionality of health, and includes biological, psychological, social, and cultural components. An effective primary care delivery system must address each of these indicators of health." "Governments work diligently to address the factors that contribute to ill health. To date, the delivery of health care in Canada has revolved around primary care, that is, health care that is directly accessed by consumers through contact primarily with family physicians as well as psychologists and other health professionals." However, continues the paper, "Extensive research shows that expanding the base of primary care to more comprehensively include psychological care yields impressive benefits to individuals and society." The paper shows evidence of psychological factors in health, including: • Thyroid and adrenal disorders are generally associated with high rates of psychological symptoms. • There is now a clear association between infection produced by the human immunodeficiency virus and psychological issues.	http://www.cpa.ca/contents.html

Associations	Vision: Interdisciplinary Collaboration	Reference web site
	• Neuropsychology is critical to the effective management of disorders such as Alzheimer's, dementia, and those that result from closed head injuries. • Cancer management is significantly enhanced by psychological interventions. • Patients experiencing depression following a myocardial infarction have higher mortality rates than non depressed patients. • In excess of 25% of patients with a medical condition fulfill diagnostic criteria for serious psychological maladjustment. • Smoking is a leading cause of death and health care spending. Psychologists have developed effective smoking cessation programmes that can contribute to improved health and decreases in health care spending. • Developmental disorders and learning difficulties are addressed by psychological assessments and treatments. Despite the evidence of psychological factors in health, "family physicians are being sought out for services that are more appropriately provided by primary care psychologists. This points to a serious limitation in primary care. Specifically, our failure to create and implement a system of primary care that meets the needs of its consumers has led to improper use of current health care services. This results in economic and human resource inefficiencies and contributes to frustration and lack of satisfaction for consumers and health care providers alike. Research shows that every $1 spent on psychological services yields a savings of $5 in medical costs." The paper offers several solutions to the improper use of current health care services: • Canadians need access to quality psychological health care. • The economic viability of the Canadian health care system is dependent on a restructuring that recognizes the need to integrate physical and psychological health through viable interdisciplinary models. • Interdisciplinary community-based primary care remains the most cost effective and efficacious means of delivering health care services. • Psychologists have the training and skills required to work in a coordinated manner within a primary care team. They offer assessment, consultation, treatment and program evaluation services. "Strengthening Primary Care: The Contribution of the Science and Practice of Psychology," is available on-line at: http://www.cpa.ca/primary.pdf	

Associations	Vision: Interdisciplinary Collaboration	Reference web site
College of Family Physicians of Canada (CFPC)	"Under the FPN [Family Practice Network] model, family physicians, nurse practitioners, nurses, midwives and other health care professionals would work in interdisciplinary, integrated teams. While this is already the case in a number of family practices across Canada, the CFPC recommends that this approach be more strongly encouraged and supported to help foster the kind of comprehensive, integrated care that our patients will increasingly require in the future. Teamwork involving a broad spectrum of health care professionals, with patients at the centre, is essential to the provision of high-quality care. The spectrum of care required by patients will be provided for them by their family physicians working together with nurse practitioners, nurses and other health care professional members of FPN teams. The number of family doctors, nurse practitioners nurses, and others required to participate as part of an FPN will vary from practice to practice depending on geographic location and patient demographics. Besides nurse practitioners, nurses and midwives, other professions, which could also be part of integrated teams, include dieticians, social workers, psychologists, physiotherapists, occupational therapists, and pharmacists. While the specific roles of each provider may vary from one FPN to the next, generally, family physicians would be responsible for taking the lead role in providing and coordinating medical care, and nurses would provide and coordinate a range of nursing services. A collaborative practice approach based on mutually supportive roles for doctors and nurses would facilitate the delivery of a comprehensive scope of primary care services for patients within FPNs. As described by Way, Jones, and Busing in their paper *Collaboration in Primary Care – Family Doctors and Nurse Practitioners Delivering Shared Care* (May, 2000) 'Collaborative practice involves working relationships and ways of working that fully utilizes and respects the contributions of all providers involved.' Their article also states that in a collaborative practice, 'Nurses practice nursing, physicians practice medicine.' While it is recognized that in some parts of Canada, nurses with advanced training (i.e. nurse practitioners or extended-practice nurses) may now perform some acts previously restricted to physicians, generally, nurses are not licensed to carry out independent medical practice. The CFPC supports expanded roles for nurses with advanced training but maintains that all licensed providers of medical diagnosis and treatment in Canada should be required to meet the same high standards of education and training.	http://www.cfpc.ca/English/cfpc/communications/health%20policy/primary%20care%20and%20family%20medicine/default.asp?s=1

Associations	Vision: Interdisciplinary Collaboration	Reference web site
	It will be important for governments to provide appropriate funding to support interdisciplinary teams. Currently, remuneration for office nurses is usually provided by family physicians from their own earnings. This has resulted in many private practices finding it difficult to include nurses as part of their professional staffs. Continuation of this approach will likely rule out the appropriate inclusion of nurses as key players in FPNs. The CFPC therefore supports government funding being offered as an option for remuneration of nurses, nurse practitioners, and other health care professionals working within FPNs. To encourage maintenance of competence, governments should also support continuing professional development for family physicians and other members of the FPN team. The CFPC also recommends that each provider on an FPN team be accountable for his or her own professional practice and be responsible for securing his or her own liability coverage." "The CFPC [College of Family Physicians of Canada] supports integrated models of education and training for all health care professionals (family physicians, specialists, registered nurses, etc). We believe providing shared experiences during both undergraduate and postgraduate training will enable those preparing for different health care professions to learn to work together and enhance their understanding of one another's roles." "Many of the concepts forwarded in the FPN model will require further deliberation, communication, and study as they are being addressed and implemented, including: • The supports needed to establish and sustain the model; • The roles and relationships of nurses and other health care professionals within FPNs; • Studies to be carried out to measure the pros and cons of formal patient registration; • Studies to measure the impact of FPNs on patient care and health system outcomes; • Strategies to ensure accountability of providers, patients, and governments. "Collaboration, which includes all key players – physicians, nurses, patients, other health care providers, and governments – will be critical to the ultimate success of this vision."	
Dietitians of Canada	In a paper entitled "The Role of the Registered Dietitian in Primary Health Care (2001)," the Dietitians of Canada include mention of "interdisciplinary group practices…Team-based delivery of primary health care is recognized around the world as the most effective	http://www.dietitians.ca/news/downloads/DC_corporate_profile.pdf

Associations	Vision: Interdisciplinary Collaboration	Reference web site
	way to deliver everyday health services. Recent evaluation of PHC demonstration projects indicates that collaborative group practices facilitate consultation, case management, coordination and continuity of care, as improved consumer satisfaction. It has also been suggested that interdisciplinary team-based PHC is more efficient and cost-effective that that of a solo practitioner." This paper is available on-line at: www.dietitians.ca/news/downloads/role_of_RD_in_PHC.pdf Additionally, a report outlining the Dietitians "corporate profile" indicates that they have three ongoing projects supported by the Primary Health Care Transition Fund to enhance "interdisciplinary collaboration in Primary Health Care and in Mental Health Services and will demonstrate ways to improve integration of nutrition services within primary care settings."	
Canadian Coalition on Enhancing Preventive Practices of Health Professionals	No web page available.	

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