A THOUSAND POINTS OF LIGHT?

MOVING FORWARD ON PRIMARY HEALTH CARE

A **SYNTHESIS** of the key themes and ideas from the

National Primary Health Care Conference

Winnipeg, Manitoba

May 16-19, 2004

TABLE OF CONTENTS

THE LONG JOURNEY: FROM ALMA ATA TO WINNIPEG TO THE FUTURE 3

THE CONFERENCE: IDEAS, SUCCESSES, AND CHALLENGES 9

- Determinants of Health, Public Participation and Building Communities 9
- Integration: Putting the Pieces Together 11
- Improving Primary Care: Better Service, Better Value 13
- Information Management (IM) and Information Technology (IT) 14
- Accountability: The Next Frontier 17

OPTIMISM TINGED WITH FRUSTRATION: A FINE BALANCE 17

- Of Politics, Doctors, Dollars and Teams 18
- IM and IT: A Surprising Consensus 19
- Explaining What We Mean and Where We're Going 19
- Harnessing the Passions to Move PHC Forward 20
- An **'N of 1'** Forever? The Perpetual Uniqueness of Sault Ste. Marie 21

PASSING THE TORCH: PHC CONFERENCE 2006? 23

APPENDIX I: CONFERENCE THEMES AND DEFINITIONS 25

- Determinants of Health 25
- Information Management 25
- Community Perspective/Community Capacity/Citizen Participation 25
- Accountability 25
- Integration 25

PLEASE NOTE:
THE CONTENTS OF THIS SYNTHESIS REFLECT THE VIEWS OF THE PARTICIPANTS IN THE NATIONAL PRIMARY HEALTH CARE CONFERENCE, NOT NECESSARILY THOSE OF THE ORGANIZERS/SPONSORS/GOVERNMENTS.

EDITORIAL COMMITTEE:
Jeanette Edwards
Sue Hicks
Marie O'Neill
Lynda Corby
Linda Kulkarni
Barb Wiktorowicz
Juliette E. Cooper

WRITER:
Steven Lewis

CONFERENCE NEWSLETTER TEAM:
Janine Harasymchuk
Jack Altman
Lillian Bayne
Steven Lewis
Patricia Martens
Jennifer Zelmer

CONFERENCE EVALUATION COMPILER:
Crystal Gaudry

STUDENT REPORTERS:
Allison Bailey
Kelly Lynn Bekar
Charyle Crawley
Sherry Dow
Marilyn Dupré
Ruth Hadden
Sara Larson
Alexandria Simms
Judy Marvin
Nancy Ryan-Arbez
Sherri Wiebe
Lenora Moerland
Nancy Renwick

THE **LONG JOURNEY:** FROM ALMA ATA TO WINNIPEG TO THE FUTURE

For four days in May 2004, Winnipeg brought together the Canadian primary health care (PHC) universe. The conference became a reality in the typical Canadian way. The federal government, with the blessing of the provinces and territories, established the $800 million Primary Health Care Transition Fund (PHCTF). Part of the fund was reserved to support innovations that transcend the borders of individual jurisdictions. Recognizing the need to create a community of understanding across Canada on the nature of and prospects for PHC, Manitoba Health approached the PHCTF with the idea of a major conference. The idea won rapid approval, and dozens of volunteers set to work. The Manitoba organizers enlisted Saskatchewan Health as a close partner given its leading role in the Fund's national PHC awareness strategy development. The planning committee set its sights high—an action-oriented, state-of-the-art forum for discussing and debating current realities and future prospects for PHC. For good measure, they seasoned the Canadian mix with healthy dollops of international experience to enlighten and inspire.

It takes a Canadian sense of humour to mount a huge conference on a topic that has proven difficult to define clearly, and whose meaning is often a source of confusion. For example, the Health Accord of 2003 identifies PHC as the cornerstone of tomorrow's health system:

"The key to efficient, timely, quality care is primary health care reform. …First Ministers agree to immediately accelerate primary health care initiatives and to make significant annual progress so that citizens routinely receive needed care from multidisciplinary primary health care organizations or teams. First Ministers agree to the goal of ensuring that at least 50% of their residents have access to an appropriate health care provider, 24 hours a day, 7 days a week, as soon as possible and that this target be fully met within 8 years."

The language of the accord reflects the aspirations, ambiguities and tensions inherent in moving PHC forward. It is at once transformative (multidisciplinary primary health care organizations or teams are more the exception than the rule in Canada) and cautious (8 years to ensure half the population has access to an "appropriate health provider"—not necessarily a PHC team—is about the same time it took to put a human on the moon). It also suggests that, like beauty, PHC is in the eye of the beholder. Officially, everyone embraces it, but there is no consensus on what "it" is. The public, and many health professionals are bewildered by the discussion and the terminology, but the frustration should not end attempts at clarity. Words, terms and definitions matter. Some confusions are avoidable, and others may be deliberate.

The classic definition of PHC is from the World Health Organization Alma Ata meeting held in 1978:

"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community

and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process."

This formulation is both straightforward and extraordinarily ambitious. It is worth noting that it arose from concern about health problems in developing nations, although proponents recognized that many people in prosperous countries faced similar circumstances. The key element is the linkage of the achievement of health for all to social and economic development. Its emphasis on participation connects PHC to inclusion and citizenship.

People are understandably weary about rehashing the difference between primary care and primary health care, but the difference is real. Primary care deals mainly with the prevention and treatment of sickness. It is what Canadians think of as front-line care, traditionally in the form of a visit to a family doctor. Primary care may involve immunization, preventive advice (stop smoking, get some exercise), diagnosis and treatment of illness, but it stops short of a comprehensive, intersectoral approach to producing or enhancing health. Perhaps most importantly, primary care is focused on individuals and families, but not the community as the unit of intervention.

"…I still hear at this conference the synonymous use of primary care/ primary health care. But …people are hearing the inappropriate [use] of terminology, [which] undermines and lends confusion to those of us who strive to lead and shed light…. We can't move forward if people are unclear re: PC and PHC."

The fact of the matter is that there are two almost-identical terms—primary care and primary health care—that share considerable but not total conceptual space. No wonder there is confusion, not only among the public, but also among people working in the system. Compounding the problem, some use the terms interchangeably, as if they were synonyms. For example, in the UK:

"The Department of Health defines primary health care as all those health services provided outside hospital by:

Family health services, which are administered by FHSAs, and include the four practitioner services:

- GPs
- Dental practitioners
- Pharmacists
- Opticians

Community health services, which include:

- Community doctors
- Dentists
- Nurses, midwives and health visitors
- Other allied professions such as chiropody and physiotherapy" [1]

From the Canadian Health Services Research Foundation:

"At its core…primary healthcare is defined as a set of universally accessible first-level services that promote health, prevent disease, and provide diagnostic, curative, rehabilitative, supportive and palliative services."[2]

From the Health Canada Web Site:

"Primary health care is our first contact with our health system. It often takes place in physicians' offices or community health centres. Primary health care is the most common experience Canadians have with their health care system. A regular checkup with a family physician, a phone call to a health information line, a visit from a public health nurse, advice given by a pharmacist – are all examples of primary health care. It is the first step in the continuum of care, emphasizing health promotion and illness prevention, and links individuals or patients to more intense or specialized care provided in hospitals when these services are needed for the management of acute or chronic illness." [3]

These definitions have adopted the vocabulary of PHC but their substance speaks mainly to primary care. In a sense they "define primary health care downwards"—they narrow the meaning of the term in an attempt to provide a clearer and more concrete basis for policy and practice. Many argue that this narrower definition marks a retreat from the "true" PHC vision, but it does have the virtues of clarity and pragmatism. Primary care is an easier concept to digest, and something that the health care system is willing to be held accountable for. PHC's breadth and long-term time horizons are less well-suited to the way governments organize ministries and budgets.

Does it matter in the end? In one sense, yes, in another, no. Primary care and PHC are not mutually exclusive; every definition of PHC includes the elements of primary care. Primary care is the traditional core of health care systems and over 90% of Canadians have contact with these services annually. It came of age in the last century, when scientific knowledge grew at an astounding rate and the hope was that science and ingenuity would eventually triumph over disease irrespective of their causes. In the last twenty-five years, research has identified the importance of the non-medical determinants of health and shifted some of the focus from individuals to populations and communities. This more recent understanding created greater interest in PHC in recognition that even the most sophisticated and expensive health care systems cannot on their own overcome disparities in health status, and deal with health problems rooted in complex social and environmental circumstances. Primary care does not disappear under PHC; it is an essential subset of PHC. They are complementary, and neither can be effective or efficient without the other.

Where the distinction does matter is in the values and goals that underlie various approaches and models. PHC is a comprehensive and egalitarian idea. It connects health and health care to social and economic organization. It is organized to meet the needs of everyone, but particularly disadvantaged populations. It strikes a balance between health promotion and health care; health and social services; individuals and communities. It entails the transfer of power from professionals to citizens, and breaks down many of the traditional hierarchies within health care. These are radical notions; there is no point pretending they aren't.

In Canada, there appears to be consensus that primary care should be reinvigorated and to some extent, reorganized. But it is not so clear that there is universal interest in pursuing PHC in its expansive definition. The specific commitments in the Accord enumerated after the term "primary health care" describe primary care. In prosperous countries, most people are preoccupied with primary care: their "determinants of health" are for the most part unproblematic. To put it starkly, those near the bottom of the socio-economic spectrum in Canada stand to benefit greatly from PHC, while most others' needs can be largely met by high quality primary care. And those at the bottom are precisely those whose voices struggle to be heard in debates about how programs should be organized and resources allocated. Hence the real question is the extent to which public policy should focus exclusively or mainly on primary care, or expand to include PHC.

Neither primary care nor PHC are ends in themselves; they are instrumental to solving two main problems. One is the overall quality of front-line health services. The more we know about current levels of quality, the more compelling the need to change. An American study published in 2003, potentially as important for primary care as the landmark To "To Err is Human" was for patient safety, revealed serious gaps in service quality. McGlynn et al. reviewed thousands of charts to ascertain the extent to which patients with various conditions receive evidence-based care. Typically, people get only 50% to 60% of recommended care. For instance, only 45% of people with diabetes received the recommended follow-up and testing. Only 68% of people who had suffered heart attacks

were on the appropriate medications. Those with alcohol dependency received only 10% of recommended care[4]. A Manitoba study—the first of its kind in Canada—found similar results, albeit with a smaller set of indicators and conditions and relying on administrative data only for its analysis[5].

Primary care is more effective for certain groups than others. For example, higher socio-economic status (SES) groups are more likely to use some preventive services, e.g., Pap test and mammography screening. Lower SES groups are less likely to adopt preventive measures[6 7] even when recommended by primary care providers[8]. They tend to have more complex and serious health problems, and at the same time are less likely to have a continuous source of care and providers familiar with their needs[9]. Comprehensive care is important to identify multi-faceted needs, ensure access to care teams able to address complex problems, increase adherence to recommended therapies, and improve quality of life and functional status[10]. Relatively few Canadians have access to this range of care in a single, coordinated centre.

The second problem is health disparities. SES strongly predicts health status. A few statistics remind us of how great the differences are in Canada. Only 47% of Canadians in the bottom income quintile report their health as excellent or very good compared to 73% in the top quintile. People in the bottom fifth are 5 times more likely to rate their health as fair or poor as those in the highest. Aboriginal people are 1.9 times as likely to report fair or poor health status than non-aboriginal people, even when their incomes are the same.

For those facing health problems of this magnitude, the PHC vision is essential to improvement. PHC connects primary care explicitly to actions on other fronts in order to address both the illness itself, and the determinants of health. It acknowledges that health care alone cannot eliminate health status inequalities. It builds on an increasing body of knowledge that points to the importance of community, work, inclusion, participation, and a host of other factors—not least of which is income—in producing and maintaining good health. PHC is a "hand up" for disadvantaged people, whose circumstances put them at risk of poor health, and whose poor health creates a major barrier to full participation in economic and social life.

All of these conceptual and real-world issues inspired the conference organizers to choose the themes under which the presentations and posters were organized. These are (definitions of each can be found in Appendix I):

- **Determinants of health**
- **Information management**
- **Accountability**
- **Community perspective/ community capacity/citizen participation**
- **Integration**

Given the deluge of abstracts and the attendance, these themes obviously struck a chord across the country. There were presentations to suit everyone's intellectual needs, from theory to practice, organization and delivery, local and national, health promotion to curative medicine. The conference was quite literally a PHC bazaar where anyone seeking interesting ideas and people to talk about them was sure to find some treasures.

As such, it proved to be a showcase and unifying event for the PHCTF.

"The PHCTF is intended to support the transitional costs of implementing sustainable, large-scale, primary health care renewal initiatives. As a result of such initiatives, it is expected that fundamental and sustainable change to the organization, funding and delivery of primary health care services will result in improved access, accountability and integration of services." [11]

The Fund supported many of the projects presented at the conference and was the major funder of the conference itself.

THE **CONFERENCE:** IDEAS, SUCCESSES AND CHALLENGES

Delegates at the Winnipeg Conference

Ideas and exchanges flowed in abundance during the conference. No synthesis could hope to do them all justice. This section provides vignettes and highlights from the plenary and concurrent sessions, organized by theme. Needless to say, it is not an official proceedings, but a distillation designed to convey the breadth and flavour of the event. We summarized many sessions and presentations in the daily conference newspaper, *Forward Reflections*, both editions of which are posted on the conference Web site at www.phcconference.ca. Also on the Web site are conference posters and papers, as well as the abstracts whose authors provided permission to post them, arranged by theme.

DETERMINANTS OF HEALTH, PUBLIC PARTICIPATION AND BUILDING COMMUNITIES

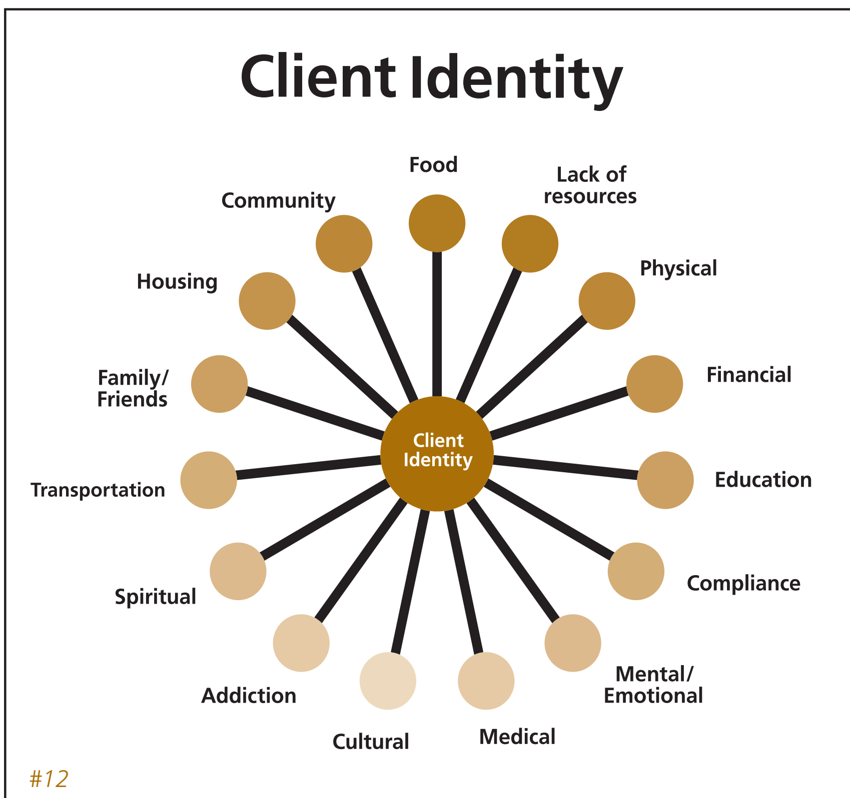
The PHC vision is a reality in several communities. Linda Young and Janice Silver described the **Youth Health Centres (YHC)** operating in Halifax County schools. A partnership between the Capital District Health Authority and the Halifax Regional School Board, the centres are designed to deal with student issues and concerns in a holistic and comprehensive fashion. The joint steering committee that runs the program includes four students, as well as principals, guidance counsellors, YHC coordinators and public health personnel. Sexuality, mental health, drugs,

alcohol and dropout rates are high-priority topics. The centres have established links to community agencies, and almost as many students are referred to non-health care agencies as to health care. They face the typical challenges of sustainability, particularly in light of the unexpectedly high use of the services. Early evaluation points to student and administrator involvement and peer-to-peer learning as keys to success.

"Semester after semester we saw students drop out because of a lack of appropriate, immediate and ongoing support systems …. The YHC had almost an immediate impact on meeting many of these needs to help support kids to keep them in school."

Janice Ristock of the University of Manitoba and Brenda Comaskey of Health Canada presented their overview and evaluation of **An Empowerment Approach to Community-Based Programming for Children**. The Community Action Program for Children (CAPC) was launched in 1993 as part of the federal government's Child Development Initiative to deliver a wide range of family, parenting, and children's programming. Its goal was "to improve the health and development of children (0-6) and their families, living in conditions of risk." Its guiding principles included flexibility, equity, accessibility, and a focus on children first. Comprised of 14 projects—seven in Winnipeg and seven elsewhere in Manitoba—the program adopted a variety of models responsive to local needs and circumstances, often involving participants in design and delivery. A main emphasis was to integrate parents into their communities and overcome the sense of isolation that can adversely affect family life and child development. Using a theory-based qualitative evaluation framework that linked personal empowerment to effective parenting resulting in healthy children, the authors conducted 28 focus groups involving 143 program participants, staff, and an evaluation working group. The CAPC is a classic example of the broad understanding of PHC, working with at-risk populations from a long-range perspective and building on the knowledge of the determinants of health. It combines both individual-level and community interventions, and among its successes are testimonials from program "graduates" who no longer need the services because they have taken control of their lives.

"For participants, CAPC changed their lives, improved self-confidence, made them better parents, gave them better skills, increased their support networks, made their children happier, changed their children's behavior and attitudes and had a positive impact on their home life."



Working with hard-to-reach groups is no stranger to Suzanne Stelmack and colleagues at the **Calgary Urban Project Society Community Health Centre**. Their shared care mental health program works with mentally ill homeless people. Needless to say, this is a very difficult and complex group of people whose needs cannot be met in isolation. The interdisciplinary team has experienced some understandable growing pains as workers define roles and approach problems from different perspectives. But the struggles have been worth it: assessments are more complete and holistic, communication is better, morale is better, professional isolation is reduced, and clients have better access to appropriate services. A central message was the inevitability and value of continuous change, united by a desire to serve clients better.

Regionalization has been the centrepiece of Canadian health reform for a decade, and it creates opportunities for developing PHC. In **A Community Development and Public Participation Framework: A Practical and Comprehensive Approach**, Jeanette Edwards and Val Austen-Wiebe outlined the PHC vision for the Winnipeg Regional Health Authority (WRHA). This framework includes three components; organizational capacity building, intersectoral networking and locality development, all of which are essential if community development and public participation are to be meaningful in PHC. Examples of regional initiatives such as workplace wellness, housing strategies and Aboriginal employment initiatives are well underway. It recognizes that communities are defined in many ways, from geographic neighbourhoods to health care users to the entire population. The key to the Winnipeg strategy is people participating in the design of their programs and services and intersectoral agencies addressing issues and problems in concert.

Jeanette Edwards and Val Austin-Wiebe

In a similar vein, Madeline Boscoe's **Advancing Primary Care: Models of Women-Centred Care in Canada** described strategies for developing programs that respond to the particular needs and circumstances of women. Among the elements of successful programs are involvement and participation; women's patterns and preferences in obtaining health care; gendered research and evaluation as well as a gender-inclusive approach to data; and collaborative and inclusive work environments. The Winnipeg Women's Health Clinic has incorporated these principles into its operations, and its concerns extend to social justice and recognition of inequities in power and status. It has a healthy public policy focus that acknowledges that socio-economic and other societal factors determine health status to a greater extent than lifestyle choices.

INTEGRATION: PUTTING THE PIECES TOGETHER

Integration is another concept that is unchallenged in theory but diverse and elusive in practice. PHC is about unity: bringing together disparate disciplines, services and programs on the needs of people and communities. Whether through regionalization of health care or at a more local level, integration is fast becoming a reality in many Canadian communities.

"The concept [PHC] is so ingrained in my mind that I can't help but think about it and integrate it into practice."

A commonly identified barrier to integration is that students learn in silos but are expected to practice in teams, and graduate from programs heavily oriented towards medical knowledge and health care while being asked to adopt a broader, community-based PHC model. In Prince Edward Island, the nursing education program has begun to walk the talk of PHC. It is based explicitly on the Alma Ata definition of PHC. The four year program demands an increasingly broad range of experiences and interactions with the community and other sectors, built around the four core components of person, health, environment, and nursing. Clinical placements range from women's shelters to correctional centres and church youth groups.

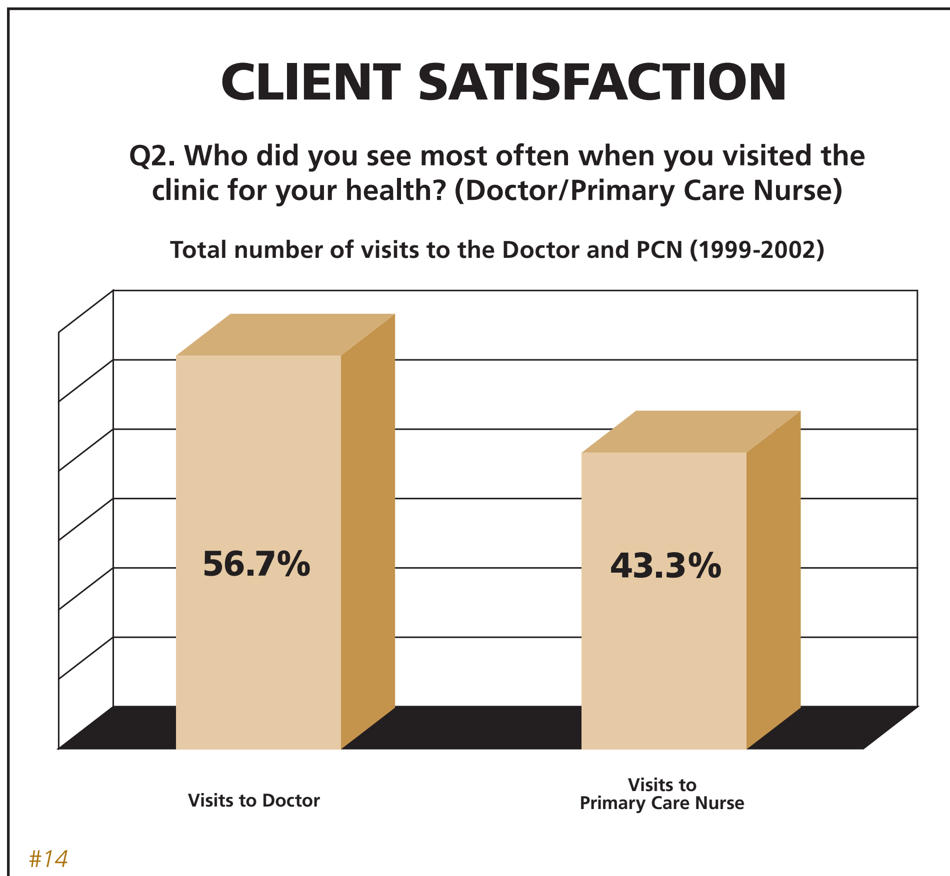
Does it produce a different kind of nurse? About 90% of graduates report they are able to apply PHC principles in their practice. A majority believe they practice differently from graduates of other programs because of the exposure to PHC theory and practice. Seven of 12 employers surveyed indicated that UPEI graduates were better prepared for nursing than graduates of other programs.

Beginning in 1995, **Dilico Ojibway Child and Family Services** in the Thunder Bay-Algoma area of northwestern Ontario has evolved into a fully integrated service network serving 13 First Nation communities. Its vision is "Balance and well-being for Anishinabek children, families and communities." The range of services has

expanded to include addictions, children's mental health, home and community care, primary care with a special focus on nurse practitioners, home and community care, and tele-psychiatry. The holistic approach integrates health care services from primary care to specialist consultations, and health and social services. The program embraces the principles of community governance, collaborative practice, and a focus on quality.

The Saskatchewan Action Plan for Primary Health Care was released in June 2002 and called for an integrated system of services to be organized through Regional Health Authority managed networks and teams. Gill White outlined **Team Development and Implementation in Saskatchewan's Primary Health Care Sector**. The plan recognized that teams would not jell automatically simply by virtue of being under the same roof. There had to be a sound theoretical base, supported by investments in team-building. The process included regional focus groups; a three day team development skills program for regional facilitators and selection of demonstration sites.

Team-building is, among other things, a change in workplace roles, relationships and culture, and the Saskatchewan initiative was not without its challenges. Team facilitators underestimated the scope and magnitude of the project and the time and energy needed to effect the change. They expressed a need for "booster sessions" to reinforce learning and its application to practice.



The nurse practitioner (NP) concept—first shown to be effective in primary care in the early 1970s in Canada[13]—is often conceived as a cornerstone of PHC, and a link between the two. Saskatchewan has gradually integrated NPs into a growing network of practices since 1997. In her presentation **Integration of Nurse Practitioners Into Interdisciplinary Primary Health Care Teams in Saskatchewan: Reflection Upon the Process and Lessons Learned**, Primary Health Care consultant Vivian Krakowski traced the evolution of the program and the results of evaluations to date completed in 10 of the 20 existing sites. Amendments to the Registered Nurses Act passed in 2001 allow nurses with advanced education to *"diagnose and treat, prescribe, perform minor surgical and invasive procedures and order diagnostic tests for common medical conditions."*

Overall, 80% of people visiting the centres report they are very satisfied (51%) or satisfied (29%) with the services received; another 14% are somewhat satisfied. Two-thirds are satisfied with the time spent on discussing ways to improve health. The NPs practice very independently—only 2% to 5% of patients are seen by both NPs and physicians during the same visit. On a 4-point Likert scale, staff rated team cohesiveness at 2.9, which is quite positive. The province plans to expand the network to 95 central teams and 45 satellite teams, most of which will serve rural areas.

IMPROVING PRIMARY CARE: BETTER SERVICE, BETTER VALUE

Primary care—the daily provision of service to people, some sick, some worried, some with simple needs, some with complex problems—is fundamental to an effective and efficient health care system. Roy Romanow made the case that primary care is central to meaningful reform in both his report, and in his keynote address at the conference. Good primary care is, in his view, the bedrock of a high quality, sustainable system. There has been a quiet revolution in primary care in many parts of Canada, and the results are compelling. However, as Romanow noted, the pace has been frustratingly slow, and since PHC underpins other proposed changes, there is increasing concern that the realization of his and others' goals for Medicare will flounder.

Nick Kates and Anne Marie Crustolo's **Integrating Specialised Services in Primary Care: Lessons Learnt** reviewed the impact of incorporating mental health and nutrition services into the practices of 38 Health Service Organizations with 77 physicians and 170,000 rostered patients in Hamilton, Ontario. People are referred to dietitians, counsellors, or psychiatrists, depending on their needs. The program has been a success on many levels. Health status has improved; for example, among those with diabetes, 95% have decreased sugar consumption and 74% have lost weight. Utilization of hospital services has declined: inpatient psychiatric admissions have dropped by a third, and outpatient hospital visits by about 90%. Both provider and patient satisfaction is high. There are plans to expand the program to include palliative care and treatment of congestive heart failure.

REFFERALS TO MENTAL HEALTH SERVICES
(first 13 practices - 45 physicians)

Service	92-93	94-95	2000	2003
Out-patient clinics	203	75	73	82
HSO mental health team	-	2532	2180	2255
Total referrals	203	2607	2252	2337
Referrals/phys/year	5	58	53	57

#15

Kates and Crustolo believe the program is more efficient because of early intervention, reduced overhead, and cheaper costs per episode. However, there are also added short-term costs due to increased case-finding, but over the long haul this should pre-empt costs later on. The availability of specialized services has increased the confidence of physicians to deal with a wider range of issues. Just over half the physicians in Hamilton are satisfied with mental health services in the community compared with 86% of those in the integrated program.

INFORMATION MANAGEMENT (IM) AND INFORMATION TECHNOLOGY (IT)

If there was consensus on one issue at the conference, it was that the achievement of the PHC vision and quality improvement in all facets of care is highly dependent on good information. A highlight of the event was the John Bibby/ Ghislaine Young plenary presentation on **Accountabilities and Primary Heath Care: The United Kingdom Experience**. The physician-nurse practitioner duo traced the evolution of PHC in the UK over a twenty year period, using North

John Bibby and Ghislaine Young

Bradford as an illustration. They described the evolution of the primary care team and the changing division of labour. For example, nurses do almost all chronic disease management. A core innovation has been the electronic health record (EHR), which among other things creates a database that not only describes a patient population in a primary health trust or geographic area, but also allows managers and practitioners to assess the appropriateness and quality of care. With a few keystrokes the authors produced epidemiological, process and outcomes data that Canada can match in only selected locations. The EHR is considered a vital system component, not an optional increment, and the NHS funds both the implementation and training.

There are Canadian success stories in IM and IT. In British Columbia, Rosemary Gray and Michael Li identified the steps in **Implementing an Information System to Support Chronic Disease Management**. Their system had to develop in the absence of an EHR, but it has proven very useful in spite of these broader limitations. It began with 3,000 to 4,000 patients with congestive heart failure, diabetes, or depression and records about 12 observations per person. It creates recall protocols and both individual-level and summary analyses and charts. Described as a toolkit, it has the capacity to be used across the province. Doctors believe it works because the supports built into the system—clinical practice guidelines and protocols—are evidence-based, and the system responds to actual practice conditions and gaps. They also like being part of a collaborative.

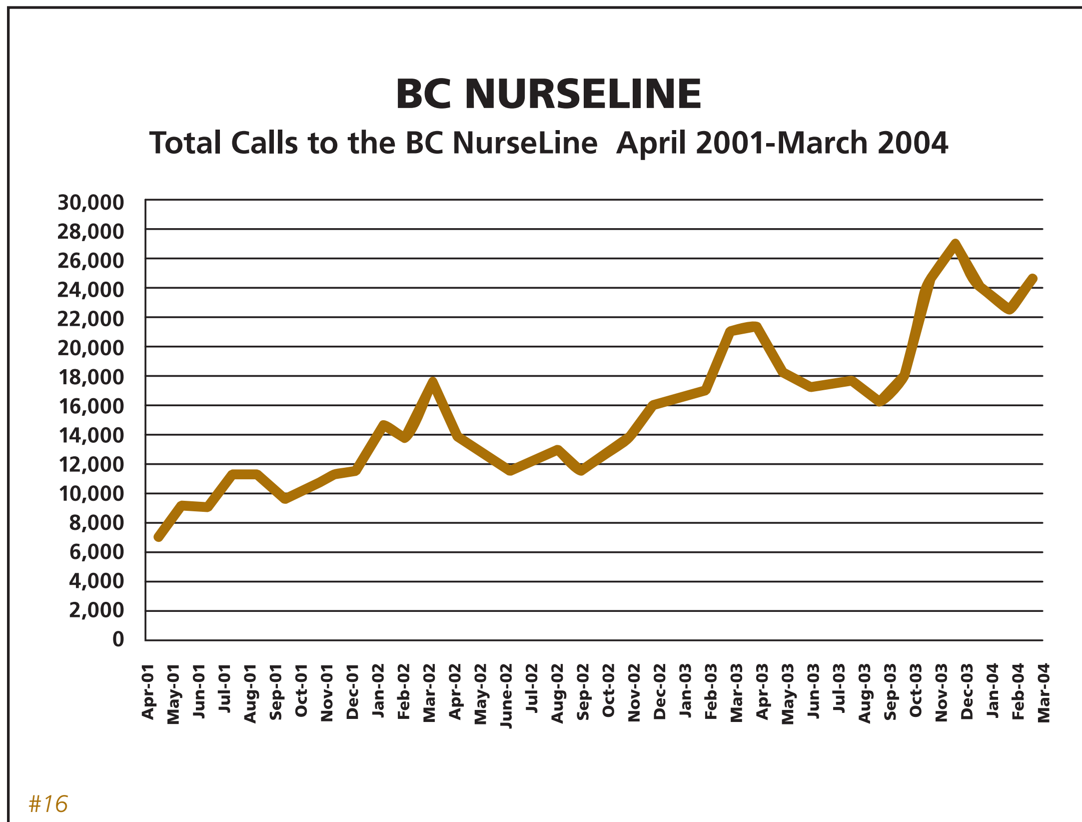
"It [the IM system] aready made me a better doctor."

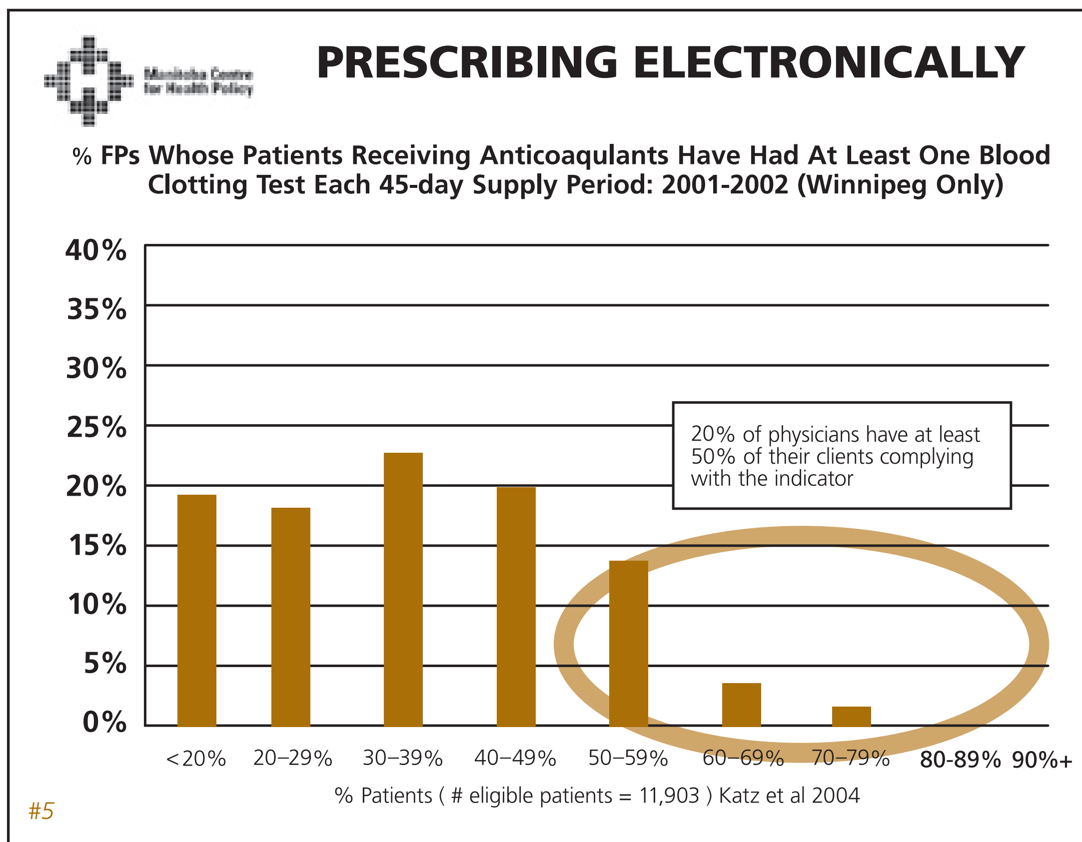
"It has changed the way we work."

"Patients love it."

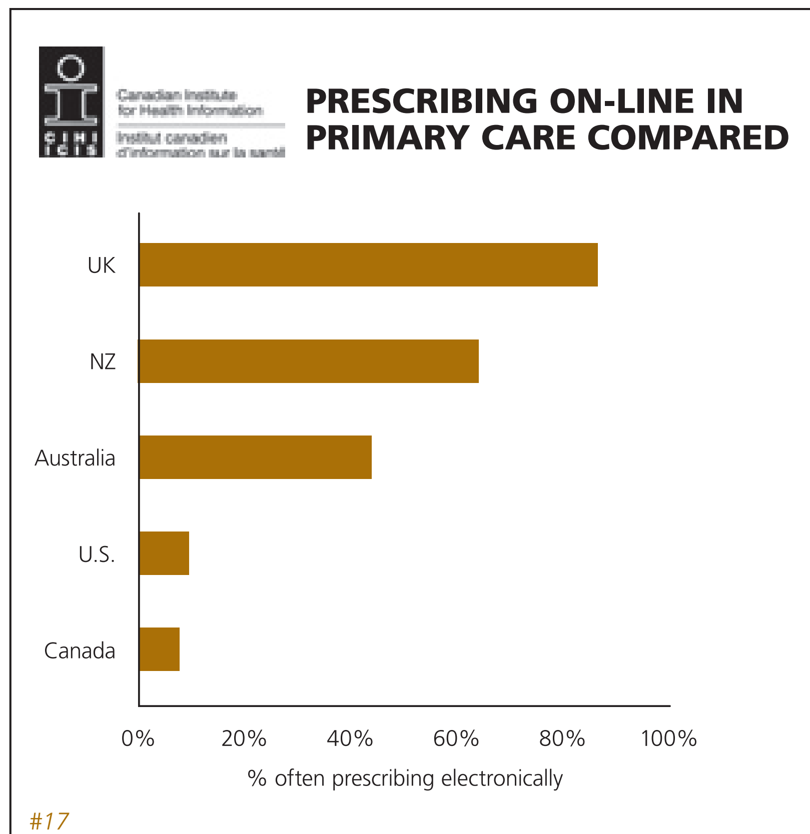
Roy Romanow calls delegates to action

Another BC project is BC NurseLine, a major element of BC HealthGuide. Lori Halls presented highlights of the **BC HealthGuide Statistical Summary** to show the utilization and impact of NurseLine to date. In its first three years the service received 560,000 calls. The service has pre-empted 36,000 visits to physicians or emergency rooms. Three-quarters of callers are advised to seek either immediate or non-urgent care. Its NurseLine Pharmacist Service, an enhancement that began in June 2003, receives about 100 calls a month triggered by adverse drug reactions. These data suggest that the public views on-line services as valuable access points for the system, and use them as both ports-of-entry to care and sources of health information.





Pat Martens and Jennifer Zelmer knit this theme together with presentations on how using research-based evidence both enlightens practitioners and policy-makers and has the capacity to influence decisions. In **Information Management and Primary Health Care**, Martens showed some of the capabilities of the Manitoba Centre for Health Policy (MCHP) resources, which she described as a constellation of databases clipped together to produce a rich source of geographically-based analysis. Now in its second decade, the MCHP produces reports on topics ranging from health status on reserves to indicators of performance in primary care. The key design feature that facilitates these studies is the common identifier that allows different data to be anonymously linked together to produce richer findings. Most provinces can in theory generate these databases, but unless there is the capacity to ensure data quality and extract and analyze the



information in a timely fashion, the value will be limited. The ultimate goal is "real time" customized reporting that will meet the needs of practitioners, health service organizations, and government.

Jennifer Zelmer's presentation, showcased some of the data in the Canadian Institute for Information's (CIHI) growing library of resources. The holdings range from quality indicators to comparative uptake of new technologies. CIHI has made major strides in taking data from Canadian provinces and territories and fashioning them into a standardized format that allow comparisons. In some instances it is able to compare Canadian and international experiences. Comparison can be a major driver of performance improvement and innovation. Among CIHI's recent findings are that 1 in 2 adults with health problems had to tell the same story to multiple providers, and 1 in 5 were sent for duplicate tests. These findings reaffirm the urgency of moving towards a more coordinated approach to care that will improve the patient experience and increase efficiency. Zelmer concluded with the WHO dictum that *"The road to health passes through information."*

ACCOUNTABILITY: THE NEXT FRONTIER?

Jennifer Zelmer on Information Management

Historically, the health system has been judged implicitly on what it does. The focus is shifting to what it achieves. There are higher expectations on the part of government and the public for greater accountability and for delivering on what is promised. This is particularly important in PHC, where relationships are more horizontal than hierarchical, control is more diffused, and services are more comprehensive and complementary. Fortunately, researchers and practitioners are beginning to address the accountability issues.

David McCutcheon provided an excellent overview of the dilemma of **Untangling the Web of Complex Accountability Relationships in Primary Health Care Renewal**. Using the Ontario experience as his point of departure, he noted that some aspects of accountability are reasonably straightforward, such as direct care deliverables, rosters of patients and individual practitioner hours. Others are harder to pin down, such as collaboration, consultation, integration and navigation. Patient/public accountability raises even thornier issues, such as the extent to which empowerment entails an obligation for self-care and avoidance of risky behaviours. Often contracts with provider organizations are in place before evaluation criteria have been developed. He posed the question of whether professionals can reasonably be held accountable for outcomes over which they have only partial control.

These and other conundrums are embedded in Diane Watson's and Anne-Marie Broemeling's developmental work on **A Performance Measurement and Accountability Framework for Primary Health Care**. Among other things their framework aims to incorporate the relationship among activities, outputs, and outcomes; include the perspectives of various stakeholders; identify potential levers for change; and identify pathways through which PHC and other health care influence health system performance, and individual health. They have adopted the federal Treasury Board's Results-Based Management Accountability Framework (RMAF) to guide their logic model, which takes note of the social, economic, cultural, and political environment in which programs are delivered. The framework recognizes that as one moves from immediate to intermediate to final outcomes, attribution of cause becomes more diffused as the many factors that influence health come into play. Validation of the framework was underway at the time of the conference and a final report is expected in 2004.

End of Day Discussion

OPTIMISM TINGED WITH FRUSTRATION: A FINE BALANCE

A conference is more than just the sum of the presentations. People talk, exchange ideas and analyses, and create the subtexts. These are the unrecorded "buzz" of the event. In an effort to capture the bons mots and general mood of the PHC community, we set up end-of-day discussion groups and open-access bulletin boards. These proved to be great stimuli for contributions, and from them emerge a number of important themes.

OF POLITICS, DOCTORS, DOLLARS, AND TEAMS

Bulletin board authors and end-of-day deliberators weren't shy about identifying barriers to change. Where there is health and health care, there is politics, and the conference participants were well aware of this reality. Many commented on the importance of political commitment in moving PHC forward. Some expressed resignation: *"What is the political will to facilitate a shift in professional roles so that we can maximize the skills and health services for Canadians?" "I'm concerned the political will is not there."* But others saw hope: *"I believe that in order for primary health care to move forward, it needs the support of the political arena (this conference is a good beginning)."*

Others identified structural barriers to change. As usual, fee-for-service (FFS) drew a good deal of commentary.

- "Making the 'gate keepers' of health care fee-for-service is a HUGE conflict of interest," wrote one critic.
- "Alternative funding models for physicians…must be addressed ASAP if PHC is a priority. The smaller communities want PHC but [it is] almost impossible in fee-for-service communities."
- "Once again, the FFS model has no accountability attached to it. There can be no real chronic disease management in this model."

Many commented on the prospects for developing genuine PHC teams. "*In conversation with many people…, a common opinion is that this is too medically focused – a 'primary care' conference not a 'primary health care' conference addressing [the] needs of a multi-dimensional team." "The primary health care model throughout the isolated communities is extremely supportive of health care providers working collaboratively as a team and performing within [an appropriate] scope of practice."* One observer noted, *"Individual practitioners prefer to work in teams but their professional organizations strive to preserve independent practice."* There was clearly an undertone of frustration at the slow progress and recognition that not everyone shares the same vision of the structure and function of teams. Among the 257 conference evaluation forms returned, by far the most common substantive comment was that the presentations were heavily weighted toward primary care and resolving physician issues.

This forum was Seinfeld's 2004 National Primary Health Care Conference – "It's all about nothing." There was nothing about full multidisciplinary care and continuity of care as Romanow supports. "More to do" means thinking outside the box and moving beyond "doctors and nurses only."

But there were expressions of hope and optimism as well. Many pointed to the excellent examples of PHC scattered throughout the country as evidence that we may be approaching "critical mass" for more widespread change. Some pointed to a number of programs in First Nations and other Aboriginal communities as examples of holistic PHC in the spirit of Alma Ata. There were many reminders to keep the focus on those who use services, not those who provide them, and to continue to evaluate and modify.

IM AND IT: A SURPRISING CONSENSUS

Long the poor cousins of Canadian health care, information management and information technology got ringing endorsements from the conference. Perhaps this was a response to the first-class presentations on how information improves service. Perhaps it reflected an understanding of the role of measurement and evaluation in quality improvement. For many it was the key to change—rather than debating models or approaches, better to experiment, measure, report and improve.

Refreshment Break at Conference Showcase

Among the suggestions from the end-of-day sessions and the bulletin boards:

- "Invest in technology (sharing of health files and information)"
- "National quality indicators with accountability for best practice guidelines"
- "Recommend to CIHI to explore information systems that are used in other countries (i.e., UK) that focus on outcomes"
- "Adopt provincial IT [strategies] and electronic health records"
- "A shared electronic [health] record could assist us in moving forward."

EXPLAINING WHAT WE MEAN AND WHERE WE'RE GOING

As noted by many, PHC is a difficult and complex idea. Participants suggested a number of ways to get the message out to many constituencies. For example:

- "We need to demystify... and raise awareness about PHC at a regional, provincial [and] national level that…includes 'Joe Public' and politicians!"
- "Develop and support models of Primary Health Care delivery that recognize and incorporate the broad social determinants of health, including capacity building where communities determine their health needs."
- "Government has to take the risk of creating a provincial plan flexible enough for evolution with incentives."
- "Engage Canadians in debate on what they want and what they'll pay for."
- "Invest in a change management process, including public engagement."
- "All those responsible for the education of health care providers [should] develop an interdisciplinary curriculum for all health care team members."
- "Speak to people/communities, giving concrete examples based on relevant evidence regarding the purposes, cost-effectiveness and outcomes of a broad based approach which encompasses all those things that affect the health of the community."

HARNESSING THE PASSIONS TO MOVE PHC FORWARD

Three plenary sessions in particular raised important issues for the future of PHC. Both Roy Romanow and Rex Murphy spoke of their connection to Medicare, fuelled by their personal recollection of the time when people literally feared for their lives and their financial security when serious illness struck. Their words struck a chord in the audience, which responded enthusiastically to both. Romanow explicitly linked the future and sustainability of Medicare to a PHC agenda, while Murphy's message was more personal and less systemic.

Delegates Visit Taber Integrated Primary Care Project Showcase

Terry Tafoya's riveting address highlighted the importance of connecting culture, perspective, health and health care. He also invoked the concept of primary and secondary world views, the former conditioned by the western scientific tradition, the latter by cultural heritage. The primary world view, deeply embedded in modern western medicine, is based mainly on the notion that the mind and body are amenable to scientific understanding and intervention. Science aspires to the creation of tools and treatments whose effectiveness is largely independent of the context in which people live. Hence an antibiotic can cure the infection in a child in sub-Saharan Africa just as well as in the child in a Manhattan penthouse. The secondary world view is rooted in lived experiences and perspectives. Language, religion, the relationship between individuals and communities, concepts of responsibility and desert—all influence our health and well-being, and our response to illness and treatment. A well-known Aboriginal story-teller and psychologist, he emphasized the linkage between the self, the community, diagnosis, and healing. He used case histories to illustrate that sometimes, the key to understanding a person's health problems is to delve into the belief system—dangerous but at times fruitful territory.

The primary care content of these presentations was easiest to grasp, while the PHC ideas—particularly Tafoya's—defy instant understanding. PHC is complex, cerebral, and in many ways counterintuitive. To some extent it is a challenge to the biomechanical model of illness and forces us to think beyond traditional conceptual and organizational boundaries. It raises, as many participants at the conference noted, important political and values-laden issues. It is, in short, difficult to grasp and reach consensus on, even for people who are committed to its

fulfillment. Its time horizons are long term and its outcomes hard to measure and quantify with precision. It is hard to sustain passionate commitment to something so elusive, especially among decision-makers who confront the daily pressures and anxieties so eloquently expressed by Murphy and Romanow.

How, then, can we harness the passions that built Medicare to advance the cause of PHC? The impression left by the conference is that these passions are most likely to smoulder at the grass roots, among community groups and partnerships that discover strength in collaboration and whose commitment grows as the evidence of success accumulates. Interestingly, this may account for the growing thirst for better information—faith alone in an idea may be inspiring, but faith plus evidence is more likely to produce sustained change. Furthermore, the better measures we have of health disparities in the population and the role of PHC in addressing them, the more likely that accountability rather than rhetoric will drive change towards the models that prove effective in practice.

Terry Tofoya Inspires Delegates at Opening

And yet there was an undercurrent of scepticism at the conference that these would be sufficient. In both formal and informal sessions, the phrase "political will" cropped up again and again. Major change, and particularly the adoption of an expansive vision of PHC, requires leadership, courage and long-term strategy. It is unlikely to emerge unaided from isolated successes and incremental tinkering with policies and practices. Sustainability presents yet another dilemma: strengthening the primary care component of PHC will not in the short run save money, while pursuing the larger vision of PHC suggests, if anything, a possible reallocation of resources from health care to its partnering sectors. Reconciling these realities will require careful deliberation and hard choices. It will be impossible to please everybody all of the time. Persuasion is always preferable to fiat, but should progress remain slow while pressures mount, it may no longer be viable to wait for consensus and voluntary change.

AN **'N' OF 1** FOREVER? THE PERPETUAL UNIQUENESS OF SAULT STE. MARIE

At the end of the second day of the conference, about 35 hardy souls met to dissect why the community health centre concept has been so slow to develop. It is not for want of examples—many were described, again, at the conference. It is not for want of success—positive evaluations of Saskatchewan's community clinics were published as early as the mid-1970s, with numerous others in various jurisdictions ever since.

And then there is Sault Ste. Marie, whose Group Health Centre (GHC) has been a beacon of excellence and innovation in care, community outreach, and information management for four decades. It has a clear statement of values, a commitment to excellence, innovative management, community governance and committed staff. It has electronic health records and real-time information on the health status and service outcomes for its members. Its guestbook includes Prime Ministers, Premiers and Cabinet Ministers, plus health care experts and decision-makers from around the globe.

Yet for all its achievements, it remains for the most part an N of 1. There are community health centres in towns and cities across Canada but none has matched the scale and "market share" of the GHC, which serves over half the people of Sault Ste. Marie. Theories of innovation tell us that early adopters are followed by the mainstream, with relatively few holdouts to the end. Yet in this case, those who jumped on the community-wide PHC bicycle at the beginning appear to have shaken free of the peloton, and are riding on their own.
Why this is so is an interesting and perplexing question. Some of the conference-goers' comments offer trenchant diagnoses of the state of inertia, ranging from the triumph of narrow interests over the greater good, to structural barriers to change and disciplinary and turf battles. Others are more hopeful, suggesting that we are about to reach a critical mass of non-traditional models, with change accelerated by better data.

Sault Saint Marie, Group Health Centre; a Beacon of Excellence and Innovation.

"Nationally, the time to see a physician dropped from 4.35 days to 1.35 days in the first wave of change, and from 3.36 days to 1.68 days to see a nurse practitioner. "

Contrast Canada with the rapid and seemingly successful transformation of the UK system. The main focus of change in the NHS has been on primary care, and Peter Godbehere's presentation highlighted the impact of reorganizing a rural practice with 8 GPs and 17,000 patients. Access and working conditions have improved. The organization no longer feels powerless. The division of labour is more sensible. Afternoons are quieter, and support staff can complete the administrative work without feeling harried. Nationally, the time to see a physician dropped from 4.35 days to 1.35 days in the first wave of change, and from 3.36 days to 1.68 days to see a nurse practitioner.

The UK has also adopted a comprehensive set of policies and goals that express the fuller PHC concept[18] hailed as the most progressive in Europe[19]. There are many possible explanations for why the NHS has been able to change more rapidly than Canada, including a commitment to electronic information and analysis, performance targets and accountability, and operating in a unitary rather than a federalist political system. Another factor may be the extent to which physicians are integrated into the system. In the UK, physicians, the government and the NHS have hardly agreed on everything over the years, but there is little doubt that physicians identify themselves as part of the system. In Canada, physicians have negotiated to remain largely outside the system as independent contractors paid on a fee-for-service basis. This "two solitudes" arrangement is slowly changing. But both at the Winnipeg conference and elsewhere, many have identified the integration of physicians into the system, sharing responsibility for its performance and the best use of its resources, as vital to moving forward.

PHC is an integrated concept (as is regionalization); it is difficult to imagine how it can flourish without a shared organizational identity and commitment on the part of key actors. As one table noted in an end-of-day session, fear of change is a powerful force, and we have yet to deal successfully with the fears of those physicians who believe that they place themselves at risk by moving to a PHC model. Empirically, physicians who have made the transition to a more integrated and interdisciplinary model don't go back, and all evaluations have been on the whole positive. These realities suggest that it is important to identify the barriers to change with some care, leaving no stone unturned. Is there not enough money or too much money in the current system? Do contract negotiation processes support traditional practice too lavishly and undervalue alternatives? Are the 13 health systems too fragmented to effect widespread change? Are health science education programs preparing graduates adequately for PHC practice?

PASSING THE **TORCH:** PHC CONFERENCE 2006

Moving forward implies continuous action. The overwhelming sentiment at the Winnipeg conference was that it should be a springboard for accelerated change and improved performance in PHC. We asked for suggestions on what to do next, and participants were enthusiastic about both the need for a return engagement and the importance of making the next event a true successor rather than a rerun of 2004. In a sense, this conference was a review of the PHC journey to date in Canada and a cross-section of experiences and challenges. Participants want the next version to be different:

- "Conference suggestion – fund registration for lay persons to attend and have input."
- "The next PHC conference should include our other partners: schools, social services, municipal leaders."
- "Suggestion for future conferences – Invite other health care disciplines and dialogue directly on how to establish multi-disciplinary teams. Explore overcoming barriers."
- "Celebrate successes and learn from them."
- "Include more aboriginal people, mental health issues, workers in other sectors."
- "Focus more on the 'how' and less on the 'what'."

Participants also expressed an interest in the policy dimensions of PHC, and some straightforward discussion of the level of commitment to change, where the power to change (or not) lies, the role of the federal government in promoting PHC, and whether the principal decision-makers are aligned in what they want and what they are prepared to do to get there.

Winnipeg set a high bar for the next conference—and the next. The thousand prospective participants in National Primary Health Conference II will be looking for more about momentum and less about inertia; a major increase in uptake of PHC and successful innovation; some hard-headed analysis of the policy arena; evidence of true team development; a stronger intersectoral presence; and a giant leap forward on IM/IT. No amount of imagination can provide the content for the program—it must emerge from concrete achievements. Like Winnipeg 2004, its successor can only reflect the realities of its environment. We have the baseline. The next event will showcase how far the PHC agenda has moved forward from this starting point.

"….This should be an annual event that is held in a different province each year. Great job!"

"There should be more national meetings and provincial meetings to continue the focus on PHC."

However, there is no guarantee of a successor conference in 2006. The PHCTF presented a unique opportunity to support a conference of this scale. The Fund ends in 2006 with no assurance of either a renewal or a continuing series of PHC events. If there is a groundswell of interest in a return engagement, someone must take the lead, assemble the organizing volunteers and secure the funding. There will have to be decisions about the size of the event (is it effective to be so large) and whether it should be similarly wide-ranging or more focused in content. Participants expressed a desire for more dialogue, suggesting a different way of structuring conference time.

If Conference 2004 was about reflection and aspiration, Conference 2006—if it takes place—should be about action and achievement. It will be in a sense a report card on how solidly the foundation has been built, and what kind of load it is able to bear.

APPENDIX I: CONFERENCE THEMES AND DEFINITIONS

DETERMINANTS OF HEALTH

Primary health care recognizes the impact of health determinants (i.e., income, social support networks, education, culture, early childhood development) as well as health services on the overall health and well-being of individuals, families and communities. This theme focused on the application of collaborative intersectoral approaches to address health determinants and population health promotion. Strategies to address population health promotion include strengthening communities, building healthy public policy, creating supportive environments, developing personal skills and re-orienting health services.

INFORMATION MANAGEMENT

Privacy/confidentiality, security and legal issues are key information management considerations in primary health care. Technology is one component of a seamless information system. Issues related to the development of electronic health records, common client registries and the planning and evaluation of primary health care initiatives are examples of the many information management challenges in primary health care.

COMMUNITY PERSPECTIVE/COMMUNITY CAPACITY/CITIZEN PARTICIPATION

One of the principles of primary health care is that of addressing community issues from a community perspective including citizen participation in decision making. Community development strategies, models for citizen participation (including governance models, advisory council models, population stakeholder group models and community consultation experiences) will be addressed. Cultural diversity, changing demographics and the engagement of marginalized populations are other important considerations.

ACCOUNTABILITY

This theme focused on the accountability aspects of primary health care models. Issues addressed included access and advanced access to services, quality monitoring and improvement, primary care trusts, indicator development, funding models, cost effectiveness of primary health care and evidence-based approaches to primary health care initiatives. Various remuneration mechanisms that support primary health care were also addressed.

INTEGRATION

This theme focused on the opportunities and challenges of building effective interdisciplinary and intersectoral teams and partnerships across the continuum of care, with participants drawn from the political arena, management, the community, service providers and research/academia. The continuum has been defined in many ways such as "An integrated and seamless system of settings, services, service providers and service levels." (CCHSA, 2004)[20] Issues such as access, service navigation, care coordination/case management and other organizational models, the need for cultural sensitivity, and potential implications for regulatory and academic bodies will be addressed.

FOOTNOTES

1 (http://www.cre.gov.uk/gdpract/health_care_cop_def.html)

2 Lamarche PA, Beaulieu M-D, Pineault R et al., Choices for Change: The Path for Restructuring Primary Healthcare Services in Canada. Ottawa: Canadian Health Services Research Foundation, 2004, www.chsrf.ca

3 http://www.hc-sc.gc.ca/english/media/releases/2001/2001_123ebk1.htm

4 McGlynn EA, Asch SM, Adams J, Keesey J et al. The quality of health care delivered to adults in the United States. New England Journal of Medicine 2003;348(26):2635-45.

5 Katz A, DeCoster C, Bogdanovic B, Soodeen R-A, Chateau D. Using administrative data to develop indicators of quality in family practice. Winnipeg: Manitoba Centre for Health Policy, 2004, http://www.umanitoba.ca/centres/mchp/reports/pdfs/quality_wo.pdf.

6 van der Pal-de Bruin KM, de Walle HE, de Rover CM et al. Influence of educational level on determinants of folic acid use. Paediatric Perinatal Epidemiology 2003;17:256-63.

7 Franks P, Fiscella K, Beckett L, Zwanziger J, Mooney C, Gorthy S. Effects of patient and physician practice socioeconomic status on the health care of privately insured managed care patients. Medical Care 2003;41:842-52.

8 Solberg LI, Brekke ML, Kottke TE. Are physicians less likely to recommend preventive services to low-SES patients? Preventive Medicine 1997;26:350-7.

9 Menec VH, Roos NP, Black C, Bogdanovic B. Characteristics of patients with a regular source of care. Canadian Journal of Public Health 2001;92:299-303.

10 Booth GL, Hux J. Relationship between avoidable hospitalizations for diabetes mellitus and income level. Archives of Internal Medicine 2003;163:101-6.

11 http://www.hc-sc.gc.ca/phctf-fassp/english/

12 Source: S. Stelmack, T. Stock-Bateman, Calgary Urban Project Society (CUPS) Shared Care Mental Health Program: An integrated Model of Primary Care and Mental Health Services

13 Spitzer WO, Sackett DL, Sibley JC, Roberts RS, Gent M, Kergin DJ. The Burlington randomized trial of the nurse practitioner. New England Journal of Medicine 1974;290:251-256.

14 Source: V. Krakowski, Integration of Nurse Practitioners into Interdisciplinary Primary Health Care Teams in Saskatchewan: Reflecting Upon the Process and Lessons Derived

15 Source: N. Kates, A.M. Crustolo, Integrating Specialised Services into Primary Care: Lessons Learnt Over a Ten-Year Period

16 Source: L. Halls, S. Letourneau, Health Lines as an integrated component of Primary Health Care: The British Columbia HealthGuide Program and Capital Health's (Edmonton) Health Link Program

17 Source: Commonwealth Fund 2000 International Health Policy Survey

18 United Kingdom Department of Health. Tackling Health Inequalities: A Programme for Action. London 2003, http://www.doh.gov.uk/healthinequalities/programmeforaction/execsum.htm.

19 Mackenbach JP, Bakker MJ, for the European Network on Interventions and Policies to Reduce Inequalities in Health. Lancet 2003;362:14009-14.

20 Canadian Council on Health Services Accreditation 2004

NOTES