

THE COLLEGE OF
FAMILY PHYSICIANS
OF CANADA



LE COLLÈGE DES
MÉDECINS DE FAMILLE
DU CANADA

A Submission to the House of Commons Standing Committee on Finance

Pre-Budget 2012 Consultations

August 12, 2011

EXECUTIVE SUMMARY

The College of Family Physicians of Canada (CFPC) represents over 25,000 family physician members nationally. The College is the voice of family medicine in Canada and advocates on behalf of its members to ensure high quality in the delivery of care. Education is a key element of our mandate, and the CFPC establishes standards for the training, certification and ongoing education of family physicians; it is responsible for accrediting postgraduate family medicine training in Canada's 17 medical schools.

On behalf of our family physician members and their patients the CFPC presents three recommendations to the House of Commons Standing Committee on Finance's deliberations leading to Budget 2012. Our recommendations focus on **timely access, chronic disease management, and value for money**. Federal leadership and investment in these recommendations is crucial in achieving an overall reduction in health care spending.

1. Timely Access

Access to care is one of the most important issues for Canadians. Recent studies have indicated that, compared to those in other developed nations, Canadians today are less satisfied with their access to and quality of care.¹ To improve access for patients, Canada needs well-supported team-based care, the implementation of advanced scheduling systems in family practice, and support for health information systems and technology.

Recommendation 1: That the Government of Canada provide appropriate support and funding for Patient's Medical Homes - incorporating the goals and recommendations that will define these practices:

- Health Human Resources - a personal family physician for each patient; physicians and other health care professionals including nurses on teams working with each family physician.
- Encourage advanced access booking systems, and strategies for after-hours coverage that may enable physicians and practices to consider increasing "panel size" (the number of patients that can be registered with that practice).
- Provide support and governance systems for health information systems and technology.

2. Chronic Disease Management

The cost of chronic diseases to Canadians is estimated to be \$80 billion annually due to illnesses and disabilities.² The mortality and morbidity of chronic disease places a significant burden on the Canadian economy. Patients' Medical Homes should be supported by the federal government to ensure their key role in health promotion and prevention, management and coordination of care for patients with chronic diseases.

Recommendation 2: That the Government Canada invests in ongoing research related to chronic diseases including: studies of the incidence and patterns of diseases, health system resource utilization (hospitalizations, emergency visits, etc.), the effectiveness of different medical and health care interventions and management approaches, individual and population health outcomes, and cost-effectiveness.

It has been shown that patients with their own family physician as a regular care provider have lower rates of hospitalization and better health outcomes.³ Well-supported family practices that function as a Patient's Medical Home will have the opportunity to possibly lead to lower costs and better health outcomes.

Recommendation 3: That the Federal government move to strengthen and support primary care in Canada through: 1) sufficient physician and health care provider resources, and 2) support the infrastructure and governance to promote the Patient Medical Home model nationally.

INTRODUCTION: A healthy primary care system leads to a healthy society.⁴

The sustainability of Canada's health care system depends on ensuring a strong foundation of primary care and family practice. In recent years, there has been much discussion about the sustainability of the health care system and the level of quality and service available to Canadians. Access issues, the lack of institutional and community support for patients with chronic health conditions, and changing demographics can lead to inefficiencies and be costly. To address the issues of health care at the core of health care delivery, systems for family physicians and patients must be strengthened.

International research provides evidence of the correlation of access to effective family practices with better population health outcomes.⁵ A strong and high-performing primary healthcare system with an essential role played by family physicians has the potential to deliver better health care for the population as a whole and specific groups such as those with chronic diseases.^{6,7}

To preserve a single-payer, publicly-funded Canadian health care system, the health transfers in the current federal /provincial/territorial Health Accord must be extended for at least a decade beyond 2014.

I. FEDERAL LEADERSHIP IN HEALTH CARE- SUPPORT FOR THE PATIENT'S MEDICAL HOME, A NEW MODEL FOR DELIVERY OF CARE

We invite the federal government to consider the advantages of implementing a new and effective family practice model, and to ensuring that resources are available to those who are working toward improving the delivery of care. We value and acknowledge the role of family doctors can play in improving and their practices, and recognize that federal leadership is essential to system changes.

The **Patient's Medical Home (PMH)** is a conceptual framework for primary health care and one that the CFPC sees as the way of the future. We present it to the people of Canada as a vision and a plan – a vision of the future of family practice - a plan for better patient-centred care and better health outcomes.

The Patient's Medical Home (PMH) proposes goals, each supported by a series of recommendations, including:

- A PMH will be **patient-centred**.
- A PMH will ensure that every patient has a **personal family physician**, who will be the most responsible provider (MRP) of his/her medical care.

- A PMH will offer its patients a broad scope of services carried out by **teams** or networks of providers - including each patient's personal family physician working together with medical home team nurses and other health care professionals.
- A PMH will ensure **timely access** to and coordination of both appointments in the practice and referrals for other health and medical services needed outside the practice.
- A PMH will provide its patients with a **comprehensive scope of family practice services** that meet population and public health needs, including those that address the importance of illness and injury prevention and health promotion.
- A PMH will provide **continuity of care** throughout the lives of its patients.
- A PMH will maintain **electronic medical records (EMRs)** for its patients.
- Patients' Medical Homes will serve as ideal sites for **training** medical students, family medicine residents and those in other health professions and for carrying out family practice and primary care research.
- A PMH will carry out **ongoing evaluation** of the effectiveness of its services as part of its commitment to a Continuous Quality Improvement (CQI) program.
- PMHs will be strongly supported by: (i) **governance and management structures** defined by each practice and (ii) **governments and other key stakeholders** throughout the health care system.

The PMH would build upon the successes of current practice patterns; it is flexible and allows each practice to incorporate the best of all experiences into their individual situations and jurisdictions.

To achieve their objectives, Patients' Medical Homes will need the support of governments across Canada through both leadership messaging and support. This must include the assurance of resources for core practice components such as electronic medical records and the establishment of the legal and systemic framework for implementation. All stakeholders including governments, the public, family physicians, other medical and health professions and their organizations, should support and participate in establishing and sustaining Patients' Medical Homes across Canada.

II. RECOMMENDATIONS

1. Timely Access to Primary Care

Patients' Medical Homes will offer a broad scope of services carried out by teams or networks of providers. The mix of health care professionals include each patient's personal family physician working together with nurses and other health professionals. A comprehensive set of health professional services is available to the patient.

Health Human Resources: Access to primary care/family practice teams have been shown to reduce emergency room use,⁸ improve access to care, offer more preventive services, and enhance patient satisfaction.⁹ As has been shown by Starfield and others, a relationship built and strengthened over time between patients and their personal physicians contributes significantly to better health outcomes.¹⁰ These benefits could potentially be further strengthened through team-based care where relationships are established between patients and other members of the health care team.

To realize these benefits, sufficient health human resources are needed to meet patient needs and improve national health outcomes. Health human resource strategies must not only be provincially focused – we need a pan-Canadian plan that assesses the health needs of the population in each and

every community and ensures that we have enough doctors, nurses and other health providers to meet our population's constantly changing needs.

Information Infrastructure: Timely access to care and medical information can be achieved through optimal use of communications tools including, email, telephone, and websites. As appropriate supports (including resolution of privacy liability and remuneration issues) are introduced, patient interactions with their physicians and other health professionals will be increasingly carried out through a range of communication options. Haggerty et al. found that being available to patients by telephone helped to improve accessibility and continuity.¹¹

Advanced Access: Same-day scheduling, (also known as open or advanced access scheduling) has emerged as a strategy that many practices have introduced to improve timely access to primary care. It is one of the features of the PMH and has been shown to enhance access for patients and to help physicians and teams become more organized and satisfied with their practices.

Wait Times: The Wait Time Alliance's 2011 Report Card and Ontario Auditor General's 2010 Report both found that the most significant cause of wait times are the high numbers of hospital patients waiting for alternative levels of care such as rehabilitative or long-term care. Patients would receive more appropriate and cost-effective care outside of the hospital.

The Patient's Medical Home can become the hub or centre that coordinates the medical care services received by their patients throughout the "medical community". The physicians and other health care providers in a Patient's Medical Home team can go out into the community and provide care as needed. These settings may include the family practice office/clinic, patient's residence, hospitals, long-term care and other community-based institutions.

Recommendation: That the Government of Canada provide appropriate support and funding for Patients' Medical Homes - incorporating the goals and recommendations that will define these practices:

- Health Human Resources - a personal family physician for each patient; physicians and other health care professionals including nurses on teams working with each family physician.
- Encourage advanced access booking systems, and strategies for after-hours coverage that may enable physicians and practices to consider increasing "panel size" (the number of patients that can be registered with that practice).
- Provide support and governance systems for health information systems and technology.

2. Chronic Disease Management

As reported by the World Health Organization (WHO), the leading causes of death in Canada are often related to chronic illnesses.¹² The cost of chronic diseases to Canadians is estimated to be \$80 billion annually due to illnesses and disabilities and is increasing.¹³ The mortality and morbidity of chronic disease places a significant burden to Canadian economy. The 2010 National Physician Survey (NPS), Canada's largest census survey of physicians and physicians-in-training, showed nearly three-quarters (72%) of respondents reported that the complexity of their patient caseload is placing increasing demands on their time. Two-thirds (63%) of respondents said that managing patients with chronic diseases was a factor.

There is evidence that primary care can reduce the burden of illness for those with chronic disease. In Canada, the work of Hollander et al. showed more cost-effective care and better outcomes for patients with chronic diseases who have the benefit of continuing care from a personal family physician.¹⁴ Research has shown that a population, regardless of socio-economic status, is healthier when it has access to comprehensive health care services; a more comprehensive "basket of services" can lead to better health outcomes for all, including vulnerable populations.¹⁵ Not only does a wider range of services provided by primary care practitioners result in better health outcomes, it does so at lower costs.¹⁶

Family practices in the Patient's Medical Home model can identify and provide needed services not only to individuals, but to the populations and communities they serve. Preventive care, health promotion, chronic disease management, the delivery of public health information and services are components of the PMH. Beal et al. found that, "When adults have a medical home, their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially".¹⁷

Recommendation: That the Government Canada invest in ongoing research related to chronic diseases including: studies of the incidence and patterns of diseases, health system resource utilization (hospitalizations, emergency visits, etc.), the effectiveness of different medical and health care interventions and management approaches, individual and population health outcomes, and cost-effectiveness.

3. Value for Money

Costly care, such as hospitalization, can often be prevented through better utilization of public health practices, primary care services, self-care models, disease prevention, and access to mental health services, and by optimizing our investment in research and innovation.¹⁸

Well-supported family practices that function as Patients' Medical Homes will have the opportunity to be an investment that can lead to lower costs and better health outcomes. Patients' Medical Homes can lower costs to the health care system by minimizing use of after-hours clinics and emergency rooms. Starfield et al. also found that consistency of provider /continuity of care has potential benefit for all patient populations, including those with chronic diseases.¹⁹

Recommendation: That the Federal government move to strengthen and support primary care in Canada through: 1) sufficient physician and health care provider resources, and 2) support the infrastructure and governance to promote the Patient Medical Home model nationally.

CLOSING REMARKS

The Patient's Medical Home envisions a Canadian health care system that ranks among the world's best. It is patient-centred and can lead to better health outcomes. Patients' Medical Homes can serve as central hubs allowing access to and coordination of medical services needed by patients.

Focusing on these recommendations and providing solutions will improve the health of Canadians, reduce burdens on the health care system, advance quality of care, and help to create an efficient and effective system.

Endnotes

- ¹ K. Davis, C. Schoen, and K. Stremikis, *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, 2010 Update* (The Commonwealth Fund, 2010).
- ² Public Health Agency of Canada and The Intersectoral Healthy Living Network, *The Integrated Pan-Canadian Healthy Living Strategy* (Ottawa, Ontario: Public Health Agency of Canada, 2005).
- ³ Barbara Starfield and Leiyu Shi, "The Medical Home, Access to Care, and Insurance: A Review of Evidence," *Pediatrics* 113, no. 4 (May 1, 2004): 1493-1498; M. J. Hollander et al., "Increasing Value for Money in the Canadian Healthcare System: New Findings on the Contribution of Primary Care Services," *Healthcare Quarterly* 12, no. 4 (2009): 32-44.
- ⁴ Barbara Starfield, "Reinventing Primary Care: Lessons From Canada For The United States," *Health Affairs* 29, no. 5 (May 1, 2010): 1030 -1036.
- ⁵ Starfield and Shi, "The Medical Home, Access to Care, and Insurance."
- ⁶ Alan Katz, Richard H. Glazier, and Janani Vijayaraghavan, *The Health and Economic Consequences of Achieving a High-quality Primary Healthcare System in Canada – "Applying What Works in Canada: Closing the Gap,"* Improving Primary Healthcare in Canada (Ottawa, Ontario: Canadian Health Services Research Foundation, January 2010), <http://www.chsrf.ca/Programs/PrimaryHealthcare/ImprovingPrimaryHealthcareInCanada.aspx>.
- ⁷ Hollander et al., "Increasing value for money in the Canadian healthcare system."
- ⁸ Saeeda Khan and Statistics Canada, *Primary Health Care Teams and Their Impact on Processes and Outcomes of Care*, Health Research Working Paper Series (Ottawa, Ontario: Statistics Canada, 2008).
- ⁹ J. Barrett et al., *CHSRF Synthesis: Interprofessional Collaboration and Quality Primary Healthcare* (Ottawa, Ontario: Canadian Health Services Research Foundation, 2007), http://www.chsrf.ca/Migrated/PDF/SynthesisReport_E_FINAL.pdf.
- ¹⁰ Starfield and Shi, "The Medical Home, Access to Care, and Insurance."
- ¹¹ Jeannie L. Haggerty et al., "Practice Features Associated With Patient-Reported Accessibility, Continuity, and Coordination of Primary Health Care," *Annals of Family Medicine* 6, no. 2 (March 1, 2008): 116-123.
- ¹² World Health Organization, *Preventing chronic diseases : a vital investment* (Geneva, Switzerland: World Health Organization, 2005), http://www.who.int/chp/chronic_disease_report/full_report.pdf.
- ¹³ Public Health Agency of Canada and The Intersectoral Healthy Living Network, *The Integrated Pan-Canadian Healthy Living Strategy*.
- ¹⁴ Hollander et al., "Increasing value for money in the Canadian healthcare system."
- ¹⁵ Starfield and Shi, "The Medical Home, Access to Care, and Insurance," 1497.
- ¹⁶ *Ibid.*, 1494.
- ¹⁷ A. C. Beal et al., *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey* (The Commonwealth Fund, 2007).
- ¹⁸ ACAHO, 2009 cited in The Health Action Lobby, "People, Places & Technology: Laying the Foundations for Health System Modernization" (HEAL, August 13, 2010), 7, http://www.cpa.ca/docs/file/Practice/HEAL_Prebudget2011Brief_FINALAug13.pdf.
- ¹⁹ Starfield and Shi, "The Medical Home, Access to Care, and Insurance."