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CONFERENCE ABSTRACT

Analyzing The Pace and Direction of Primary Health Care Reform in Ontario, Canada: Transformative Change or Tranformation Lite?

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Background: Almost four decades after the ground-breaking Declaration of Alma-Ata identified primary health care (PHC) as "essential health care," there is growing consensus across the industrialized world that improvements in "first contact" care are crucial not only to enhance population health but to sustain increasingly stretched health care systems. According to the World Health Organization (WHO, 2008), PHC that includes, but goes beyond a "narrow offer of specialized curative care" to embrace health promotion and the determinants of health, promises "better health, less disease, greater equity, and vast improvements in the performance of health systems."

Nevertheless, in many jurisdictions, including Ontario, Canada's richest and most populous province, progress toward primary health care (PHC) has been uneven. Since the 1980s, Ontario has implemented successive waves of primary care reform, producing a plethora of reform models, each with widely varying organizational characteristics, focus and "spread." For example, Community Health Centres (CHCs), first advocated in the 1970s, feature salaried physicians, interdisciplinary teams, community boards, and a focus on health promotion and population health; however, they are limited by policy fiat to serving underserviced and marginalized populations such as the poor, recent immigrants, and persons with special needs. This compares to the considerably more numerous Family Health Groups (FHGs) which require no more than three physician owners (not necessarily co-located), paid via "enhanced" fee-for-service or mixed fee-for-service/capitation, with financial incentives for specified disease prevention and management procedures (e.g., cancer screening or diabetes management).

Given multiple waves of reform, and widely varying reform models, how can observers judge the extent to which change has occurred within a jurisdiction like Ontario, or compare the pace and direction of change across jurisdictions?

Conceptual Approach: In this paper, funded through a CIHR grant looking at integrating care for older people with complex health needs (iCOACH), we draw on the comparative policy literature to develop a conceptual approach which recognizes the multidimensional nature of primary health care and PHC reform models, and which weights these models to account for

their relative impact and "spread" within and across jurisdictions. This literature clarifies that reform is not a unitary construct, but rather, a multidimensional project spanning widely varying normative goals (e.g., curing individual illness, creating more equitable societies); target populations (e.g., individual patients, broad populations); operational elements (e.g., funding mechanisms, interdisciplinary teams); and service "baskets" (e.g., illness care, health promotion). It also clarifies that change may occur (or not) at different paces, and to different degrees along each of these different dimensions, noting that changes which alter historical "bargains" between public governments and the organized medical profession (especially those diminishing professional control over the content and conditions of medical work) will be hardest to achieve.

We then apply this framework to the case of Ontario, assessing the extent to which PHC reform models represent substantive change along each of these four dimensions from historically dominant fee-for-service, solo doctor practice, providing individual services to individual patients, to more elaborated and expansive models of PHC including a focus on population health.

Findings: Using provincial data from 2012, we observe that about a quarter (25.8%) of Ontario's patient population continued to be served by primary care physicians working in traditional fee-for-service solo practice. In comparison, more than half (53.0%) were rostered in forms of group practice including Family Health Groups (FHGs), Family Health Networks (FHNs) and Family Health Organizations (FHOs); however these are essentially business arrangements between small numbers of family doctors paid through fee-for-service with additional payments to provide specific services such as cancer screening and diabetes management to their rostered patients. Family Health Teams (FHTs), mostly physician-owned and operated small businesses accessing additional funding for interdisciplinary providers (e.g., nurses, dieticians, physical therapists, social workers), covered an additional 15.7% of patients (noting that in 2014 the province terminated any further expansion of FHTs). Considerably less widespread were Community Health Centres (CHCs) and Aboriginal Health Access Centres (AHACs); while representing the most radical shift toward PHC (including community governance, interdisciplinary teams of salaried providers, and a focus on underserviced populations, health promotion and population health) CHCs and AHACs together covered less than 2% of Ontario residents.

Conclusions: Although Ontario, like other jurisdictions nationally and internationally has engaged in successive waves of reform stretching over decades, to date, this reform has produced little movement toward more expansive models of PHC of the type envisaged by the WHO and others. Where change has occurred, it has not fundamentally altered the hard-fought historical "bargain" underlying Canadian Medicare which saw public governments fund medical care, but left the organization and delivery of such care mostly under professional control. In Ontario, the vast majority of primary care practices continue to be small businesses owned and operated by physicians, funded mostly through fee-for-service, with few interdisciplinary teams, and only a limited focus on disease prevention and population health. We conclude that although portrayed by policy-makers and the profession as "transformative change," substantive change toward PHC has, as theory predicts, been mostly at the margins.

Keywords: primary health care reform; health promotion; broader determinants of health; primary health care models