Manitoba Approaches to Primary Care (MAPC)
Physician Integrated Network (PIN)
Outline

MAPC Vision

Quality primary care is available to all Manitobans.

PIN Initiative Vision

Quality primary care is available to all Manitobans; through networked Primary Care Physicians in collaboration with other providers.

Initiative Objectives

1. To improve access to primary care.
2. To improve Primary Care Providers' access to and use of information.
3. To improve the working environment for all primary care providers.
4. To demonstrate high quality primary care with a specific focus on Chronic Disease management.

The Core Elements of the Physician Integrated Network (PIN) Initiative

To fully achieve the articulated objectives will require a collection of interlinked, yet flexible, elements. This then becomes the heart of the PIN Initiative, where all four elements can be implemented in a phased manner.

1) Structure & Practice:
   a) Grouping together of Primary Care physicians (Physician Group).
   b) Importance of local autonomy and management.
   c) Partnership with Regional Health Authorities.
   d) Increased collaboration with providers in service provision.
   e) Development of a learning environment that facilitates training, continuing medical education, teaching & research opportunities.

2) Information Management:
   a) Utilization of Electronic Medical Record to populate an Outcome Data Repository with the ability to track objectives and measure outcomes.
   b) Linkages to provincial information systems including DPIN, Immunization Records with future connectivity to such areas as lab information systems, radiology information systems, public health information systems, provider and client registry.

3) Funding & Remuneration:
   a) Predictable, stable, and direct funding to autonomous Physician Group.
   b) Ability to access services (e.g. hiring, contract, sub-contract) of providers as determined by the Physician Group using information such as Practice Population Profiles.
   c) Funding linked to measurable objectives and participation in evaluation.
   d) Developmental approach to blended funding options.

4) Monitoring & Evaluation:
   a) Framework is to be designed in partnership with the Manitoba Centre for Health Policy & the University of Manitoba.
   b) Measuring of:
      i. Quality of Care
      ii. Preventive practices
      iii. Chronic Disease Management practices
      iv. Utilization of other primary care providers
      v. Patient and Provider Satisfaction (to address patient access and provider lifestyle issues)
   c) Qualitative and quantitative evaluation approaches will be used.

Physician Integrated Network (PIN)
Initiative Rationale

Introduction
The definition of Primary Care:

> "*First-contact assessment of a patient and the provision of continuing care for a wide range of health concerns. The scope of primary medical care includes the diagnosis, treatment and management of health problems; prevention and health promotion; and ongoing support, with family and community intervention where needed."*
>
> -Canadian Medical Association (CMA 1994)

> *"Primary Care includes assessment, diagnosis and treatment of common illnesses generally provided by family physicians and nurses. Primary Care is one of the core services provided by the primary health care system."*
>
> -Manitoba Primary Health Care Policy Framework 2002

Manitoba has a long history of innovative approaches to the delivery of primary care to its residents. For example, Community Health Centres within Manitoba have been a model of collaborative, community-based service delivery for many decades. In addition, non-physician primary care providers have also been key in northern and isolated communities and, more recently, the Primary Health Care Transition Fund has supported the exploration of many different primary care delivery options. Hence, all of these are Manitoba Approaches to Primary Care (**MAPC**).

The Physician Integrated Network (**PIN**) is an approach, currently in development, which focuses on the engagement of autonomous, independently owned fee-for-service physician groups. Interdisciplinary Collaboration will be a key feature as this approach evolves. This Initiative Summary sets out the rationale for change and the vision and objectives that will guide the implementation.

Rationale for change

- **Need to re-orientate the health delivery system to enable the provision of quality Primary Care and gain maximum benefit from the contribution of Family Physicians.**

  Primary care plays a vital role in health care delivery. In fact it is "important at multiple points in the health care system. It is related to planning and meeting the needs of populations and individuals', and ensuring availability and accessibility…"[1]

  The cornerstone of primary care is the role of the family physician. In June 2005, the Manitoba Medical Association (MMA) stated, "Every Manitoban should have an ongoing relationship with a primary care physician."[2] In addition, "the MMA acknowledges the adjunctive role that may be played by other providers in a complex multidisciplinary health care system…however, such providers cannot replace the continuity and coordination of care from a physician-patient relationship."[3]

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[1] Stewart, J. (2000). Primary care reform in Canada: An overview. *Canada West Foundation.* Calgary: AB.
[2] Manitoba Medical Association. (2005, June). MMA policy statement on primary care. *Rounds.* Manitoba Medical Association. P. 1.
[3] Manitoba Medical Association. (2005, June). MMA policy statement on primary care. *Rounds.* Manitoba Medical Association. P. 1.

On September 12, 1978, the World Health Organization's (WHO) Alma-Ata declaration initiated "a new health care paradigm emphasizing the importance of primary health care as the main focus of a country's health care system." [4]

Recently, the WHO has also provided concrete evidence on the advantages of primary health care. "Since the PCH [Primary Health Care] approach was enshrined, the worldwide mortality rate has decreased from 90 per 1000 births in 1975 to 59 in 1995 - a decrease of 34% - while immunization coverage for children under one year of age has risen from 20% to 80% between 1980 and 1990…Prevention of disease and promotion of health is in theory a win-win situation. It is cheaper to prevent disease than treat it; it is also better for the person to remain healthy than to get sick and then recover."[5]

As discussed earlier, the need to shift health care funding towards a more preventive strategy is noted as the "Evidence of the ***health-promoting*** [emphasis added] of primary care has been accumulating ever since researchers have been able to distinguish primary care from other aspects of the health services delivery system…The evidence also shows that primary care is associated with a more equitable distribution of health in populations, a finding that holds in both cross-national and within-national studies". [6]

Barbara Starfield argues that "primary care is an approach that forms the basis for and determines the work of all other levels of the health systems. Primary care addresses the most common problems in the community by providing preventive, curative, and rehabilitative services to maximize health and well being."[7]

Due to the dynamic nature of primary care "family physicians…must excel at being expert generalists who can provide comprehensive care that meets the needs of varied populations in urban, rural and remote regions of Manitoba and Canada."[8]

Thus, one of the objectives of PIN is to reorient services to improve access to needed health care. This includes focusing on Primary Care to "ensure that successful models of innovation in primary care delivery are sustained and expanded upon."[9]

- **Need to demonstrate high quality primary care.**

Quality care is a critical facet of our health care system. There is little empirical evidence regarding the quality of primary care.

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[4] Rich, P. (2004). From Alma-Ata to the Health Council: Sharpening the focus on primary care. *Primary Care Reform:, Reshaping health care in Canada. P.8.* Retrieved from: http://www.cma.ca/index.cfm/ci_id/44700/la_id/1.htm.
[5] Gillies, A. (2003). *What Makes a Good Healthcare System? Comparisons, Values, Drivers.* Radcliffe Medical Press: Abingdon, UK.
[6] Reynolds, L, J. (2006). *Position Paper on Primary Care*. Winnipeg, Manitoba: University of Manitoba, Department of Family Medicine, p.2.
[7] Starfield, Barabara. (1998). *Primary Care: Balancing Health Needs, Services and Technology*. Oxford: Oxford University Press. Pg 9.
[8] CNA. (2005). Primary Health Care: A Summary of the Issues. *CNA Backgrounder*. Retrieved from http://www.cna-nurses.ca/CNA/documents/pdf/publications/BG7_Primary_Health_Care_e.pdf
[9] Health Council of Canada Annual Report. (2005). *Clearing the Road to Quality*. (Executive Summary, Health Care Renewal in Canada). pg.6

"…if you can't measure it, you can't manage it."[10]

Some academic work[11] in this area suggests that the quality of care provided is not as high as providers anticipated[12] even though Canada's existing primary care delivery system is among the best in the world, and all stakeholders agree that our system is suffering from notable deficiencies in both access and integration"[13]

In a report on principles and framework development of interdisciplinary collaboration, the Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) group state: "Health professionals from all disciplines involved in primary health care aspire to deliver the best care and services possible. Health care professionals use the results of research as a basis for setting quality standards and making decisions about the treatment of health problems. Services are continuously evaluated to measure health outcomes, ensure accountability, track performance and assure quality."[14]

Thus, one of the PIN objectives is to tackle these issues of value and develop a plan to demonstrate the quality of care to all Manitobans.

- **Need to address the challenge of Family Physician isolation**

Support inter-professional, collaborative care.

Each health care professional has their own area of expertise and unique set of skills and knowledge. However, one must recognize that no one practice can accommodate all client needs and that the collaboration and combination of multiple disciplines can improve quality of care, increase the range of available services, decrease physician wait times, and lead to a comprehensive care plan for all.[15] This is important to family physicians' as when they collaborate with other health providers it allows them to use distinctive medical skills for more complex cases requiring *medical* diagnosis and interventions.[16]

The Canadian Medical Association's report on Primary Care reform stated that "…those who succeed at integrating non-physician professionals into their practice have found that their job satisfaction increased over time, since they can concentrate on providing services that are uniquely within their expertise, which translates into more time spent with patients. In addition, waiting times tend to decrease, since physicians can see patients more promptly"[17]

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[10] Halparin, E. (2004) Imagine: How a dyed-in-the-wool, previously opted-out, no benefits, fee-for-service physician came to understand the value of primary care reform. *Primary Care Reform: Reshaping health care in Canada*, p. 20. Retrieved from: http://www.cma.ca/index.cfm/ci_id/44700/la_id/1.htm.

[11] Katz, A., De Coster, C., Bogdanovic, B., Soodeen, R. A., Chateau, D. (2004). *Using Administrative Data to Develop Indicators of Quality in Family Practice*. Manitoba Centre for Health Policy. Retrieved from: http://www.umanitoba.ca/centres/mchp/reports/pdfs/quality_wo.pdf

[12] Hogg, W., Baskerville, N., Lemelin, J. (2005). Cost savings associated with improving appropriate and reducing inappropriate preventative care: cost-consequences analysis. *BMC Health Services Research*, 5 (20).

[13] CMA. (2005). Primary care reform. *Practice Solutions.* CMA Holdings and Physician Consulting Group Inc.: Ottawa, ON.

[14] Enhancing Interdisciplinary Collaboration in Primary Health Care [EICP]. (2006). *The Principles and Framework for Interdisciplinary Collaboration in Primary Health Care* .

[15] Ontario Government. (2005). Guide to collaborative team practice. *Family Health Team: Advancing Primary Health Care.*

[16] Leatt, P., Pink, G. H., Guerriere, M. (2000). Towards a Canadian model of integrated healthcare. *Integrated Healthcare. 1(2).*

[17] CMA. (2005). Primary care reform. *Practice Solutions.* CMA Holdings and Physician Consulting Group Inc.: Ottawa, ON.

The Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative notes, "The range and complexity of factors that influence health and well-being, as well as disease and illness, require health professionals from diverse health professions to work together in a comprehensive manner."[18] This collaborative care can range from a simplistic discussion with another health care provider to more complex, arranged, and scheduled encounters with team members to provide the patient the most comprehensive care possible.[19]

The aging population will demand more services in which integrated care will help manage the load for physicians while providing the quality care clients deserve. Having a choice in types of primary care providers (e.g. nurses, mental health providers, dieticians, General Practitioner, etc) will allow the clients' more control of their health decisions and feel more empowered.[20] These claims are supported by the Canadian Nurses Association on issues involving primary care:

"PC [Primary Care] teams, which include family physicians, nurses, and other health professionals working side-by-side as partners, produce better health outcomes, improved access to services, more efficient use of resources, and greater satisfaction for both patients and providers. Nurse practitioners, for example, who integrate elements into their practices such as health promotion, diagnosing and treating health problems, and prescribing drugs, can be effective providers of primary care for many clients. All health providers, including nurses, need to be educated within a framework that supports interdisciplinary work, and interdisciplinary practice needs to be supported in health care settings, whether in the community or in an institution."[21]

Currently, there is a "silo" mentality and hierarchal boundaries in the health care system, which does not support an integrated approach to health delivery. According to Dr. Mohamed Ravalia, "our present system does not constructively engage health professionals from a variety of backgrounds and skill sets to work together."[22]

One way to increase the success of multidisciplinary teams is to provide physicians and other health care professionals support via continuing education programs. An article in the *Journal of Interprofessional Care* found that, "Among the benefits claimed for multiprofessional education by its supporters…is that it promotes more effective working relationships, which in turn result in better, more 'holistic' or more 'seamless' patient care"[23]

This same concept can be applied to future generations of health care professionals to help mobilize a team approach once they become registered in

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18 Enhancing Interdisciplinary Collaboration in Primary Health Care [EICP]. (2006). *The Principles and Framework for Interdisciplinary Collaboration in Primary Health Care* .

19 Enhancing Interdisciplinary Collaboration in Primary Health Care [EICP]. (2006). *The Principles and Framework for Interdisciplinary Collaboration in Primary Health Care* .

20 Calnan, M., Hutten, J., Tiljak, H. (2006). The challenge of coordination: The role of primary care professionals in promoting integration across the interface. In R.B Saltman, A. Rico, W. Boerma (Eds.),*Primary Care in the Driver's Seat? Organizational Reform In European Primary Care*. European Observatory on Health Systems and Policies Series. Bell & Bain Ltd.: Glasgow: UK.

21 CNA. (2005). Primary Health Care: A Summary of the Issues. *CNA Backgrounder*. Retrieved from http://www.cna-nurses.ca/CNA/documents/pdf/publications/BG7_Primary_Health_Care_e.pdf

22 Ravalia, M. (2004.), "Whither primary health care?" Page 13, *Primary Care Reform: Reshaping health care in Canada. Retrieved from*: http://www.cma.ca/index.cfm/ci_id/44700/la_id/1.htm.

23 Owens, C., Goble, R., Gray, D. P. (1999). Involvement in multiprofessional continuing education: A local survey of 24 health professionals. *Journal of Interprofessional Care. 14 (3)*

their respective profession. Currently the ways in which our students are being taught within their isolated environments do not promote a team environment:

"Each profession has their own philosophical and educational backgrounds which works against collaborative care once graduates enter their respective fields. Disjointed educational faculties do not grow and learn to work collaboratively, which results in the lack of "know how" in creating and engaging in collaborative teams…Most universities are structured such that the different health science disciplines have their own faculties or schools. Each discipline has its own curriculum with its own unique sequencing and timing of content and clinical experiences, and each uses a somewhat different approach to supervising students' clinical experiences"[24]

- **Need to address physician work life.**

Physician health is a variable that has great influence on their abilities to provide quality patient care.[25] The Canadian Physician Health Network believes that "the health care doctors provide is only as good as their health"[26] Therefore, physician health and well being needs to be in harmony and physicians need to be able to strike a balance between their professional and personal lives.[6]

Increased levels of role strain related to stress, burnout and time constraints have resulted in physician health being compromised[27] as evidenced in the following statements:

"…doctors overwhelmingly listed on call work as a very stressful part of medical practice and hundreds included comments on stress, burnout and a desire to balance their life more."[8]

"Nearly two-thirds of Canada's physicians (64%) have a workload they consider too heavy and more than half (58%) say their family and personal life has suffered because they chose medicine as a profession, according to CMA's 2001 Physician Resource Questionnaire."[7]

'The Physicians at Risk Program', devised by the Manitoba Medical Association,[28] is a peer-run program that addresses the unique characteristics physicians have in being patients themselves. "Unfortunately, there has been a traditional stigma around seeking help;"[29] therefore, other changes to primary care also need to be examined to help improve physician work life.

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[24] Pringle, D., Levitt, C., Horsburgh, M., Wilson, R., Whittaker, M. K. (2000). Interdisciplinary collaboration and primary care reform. *Canadian Family Physician. 46*

[25] Sibbald, B. (2003). Being a physician can be harmful to your health. In *CMA Guide to Physician Health and Well-Being: Facts, advice and resources for Canadian doctors.*

[26] Wansbrough, G. (2003). Awareness of physician wellness issues growing. In *CMA Guide to Physician Health and Well-Being: Facts, advice and resources for Canadian doctors.*

[27] Sibbald, B. (2003). Burnout - "an erosion of the soul'. In *CMA Guide to Physician Health and Well-Being: Facts, advice and resources for Canadian doctors.*

[28] Kaufmann, M. (2003). Canadian physician health programs: An overview. In *CMA Guide to Physician Health and Well-Being: Facts, advice and resources for Canadian doctors.* P. 16

[29] Stewart, J. (2000). Primary care reform in Canada: An overview. *Canada West Foundation.* Calgary: AB.

- **Increasing demand for, and challenge of, chronic disease management.**

As a consequence of a shift from more acute, communicable diseases to chronic, life-long diseases such as diabetes, our health care system needs to reorient its services to address this issue. Due to the chronicity of these diseases they "constitute the major demand on the health care system: the total cost of illness, disability and death in Canada due to chronic disease is over $80 billion annually. The chronic diseases considered here are estimated to have the following costs:

- Cardiovascular diseases cost $28 billion per year.
- Diabetes and its complications cost $14 billion per year.
- Cancers cost $13 billion per year.
- Respiratory illnesses cost $8 billion per year.

Given these costs, advancing integrated work on chronic diseases will support efforts to address the sustainability of the Canadian health care system and to mitigate the overall burden of those diseases on all jurisdictions."[30]

Further to this, the increase in the aging population lends further strain on, and amplification of, chronic disease incidence and prevalence rates which "may lead to a higher demand for health services in general and for more complex, multidisciplinary care in particular."[31] Additionally, "…the increasing needs of the population for prevention of disease and assistance with the management of chronic disease require more powerful primary care."[32] In fact, the Canadian Health Council of Canada's recommendation to improve population health includes management of chronic diseases "ensuring that strategies are integrated with the work of primary health care teams".[33]

Therefore, "An increased emphasis on disease prevention and health promotion will show its worth by producing healthier patients." [34]

- **Current and anticipated health care provider shortage.**

In 1996, Canada's population was 28.8 million and today has grown to 32.5 million. In other words, in a mere 10 years our nation has grown by 3.7 million people.[35] However, the number of health care workers has not increased to the same degree, causing an increased ratio of individuals to health care providers.

To elaborate on this, an article in the Canadian Medical Association Journal stated, "Since 1976, Canada's population has grown by 30%. In the same period, the number of applicants to Canadian medical schools has grown

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[30] The Chronic Disease Prevention Alliance of Canada (CDPAC). (n.d.). *The Case For Change*. Retrieved from: http://www.chronicdiseaseprevention.ca/content/case_for_change/case_for_change.asp

[31] Calnan, M., Hutton, J., Tiljak, H. (2006). The challenge of coordination: The role of primary care professionals in promoting integration across the interface. In R.B. Saltman, A. Rico, W. Boerma (Eds.), *Primary Care in the Driver's Seat? Organizational Reform in European Primary Care*. Retrieved from: http://whqlibdoc.who.int/euro/2006/0335213650_eng.pdf

[32] Decter, M. (2003). Reflections on primary care in Canada In R. Wilson, S. Shortt & J. Dorland.(Eds.), *Implementing Primary Care Reform: Barriers and facilitators.* McGill-Gueen's Univeristy Press: Kingston: ON.

[33] Health Council of Canada Annual Report. (2005). *Clearing the Road to Quality.* (Executive Summary, Health Care Renewal in Canada). pg.6.

[34] Shortt, S. (2004). Primary care reform: Change in search of evidence?. *Primary Care Reform: Reshaping health care in Canada.*, Retrived from: http://www.cma.ca/index.cfm/ci_id/44700/la_id/1.htm.

[35] Statistics Canada. (2006). *Latest Indicators.* Retrieved from: http://www.statcan.ca/start.html

by 0%, having hovered around the 7500 mark for 24 years…. According to some estimates, there is already a shortfall of about 1000 new physicians every year."[36]

While the general population in Manitoba has remained relatively stable, many physicians are now deciding to reduce their workload and opting to have a more balanced life.[37] Additionally, over 22 percent of Manitoba fee-for-service physicians are over the age of 55 and eligible for retirement.[38] Such changes in physician workload leads to, "uncertainty ahead as to the effective supply of full time equivalent physicians that will be available to provide services."[39]

Furthermore, "In 2001 less than 28% of medical students made family medicine their first choice for a career, continuing a steady decline from 40% in the early 1990s."[40] Additionally, "In the early 1990s, almost 80% of physicians started practice as FPs or GPs. By 2000, this percentage had plummeted to 45%."[41]

Physicians are not alone in this predicament. "Nurses are the largest group of health-care providers, but their services are nevertheless in short supply…If we maintain current delivery models and levels of demand, then the shortages of nurses, physicians and other professionals being experienced in 2006 are unresolvable."[42]

- **Lack of access to primary care; including Family Physicians.**

The College of Family Physicians of Canada's Principles for Primary Care Renewal includes the principle: "Every person in Canada should have the opportunity to have his or her own family physician".[43] However, "Having a family doctor has been accepted as a core value in Canada, a value now threatened. The traditional 50:50 ratio between specialists and family physicians in Canada is beginning to erode"[44]

To put it into another perspective, a staggering "one in six Canadians lacks access to a family physician"[45], which translates into over 5.4 million people across this nation.

This is unacceptable given the Canadian ideal that "the right service is provided at the right time, in the right place and by the right care provider…Geographic

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[36] Sibbald, B. (2000). Population rises dramatically but the number of med-school applicants remains stagnant. *Canadian medical Association Journal. 162(2).*

[37] Watson, Diane, Bogdan Bogdanovic, Petra Heppner, Alan Katz, Robert Reid, and Noralou Roos. (2003). *Supply, Availability, and Use of Family Physicians in Winnipeg.* Manitoba Centre for Health Policy. Winnipeg: University of Manitoba. Retrieved from http://www.umanitoba.ca/centres/mchp/reports/pdfs/famphys.pdf.

[38] Canadian Institute for Health Research. 2006). The evolving role of Canada's fee-for-service physicians: 1994 to 2003. *Canadian Institute for Health Information.* Ottawa, ON.

[39] Buske, L. (2005, May) Understanding the Physician Labour Market: Results of the 2004 National Physician Survey. *CERF Conference on Health Human Resources.* Hamilton: ON.

[40] Roser, W. W. (2002). The decline of family medicine as a career choice. *Canadian Medical Association Journal. 166(11).*

[41] Wharry, S. & Sibbald, B. (2002). What physician shortage? *Canadian Medical Association Journal. 167(1)*

[42] Canadian Nurses Association. (2006). *Tward 2020 visions for nursing.* Ottawa: ON

[43] Enhancing Interdisciplinary Collaboration in Primary Health Care [EICP]. (2006). *The Principles and Framework for Interdisciplinary Collaboration in Primary Health Care* .

[44] Health Council of Canada Annual Report. (2005). *Clearing the Road to Quality.* (Executive Summary, Health Care Renewal in Canada). pg.6

[45] Ravalia, M. (2004). Whither primary health care?. *Primary Care Reform: Reshaping health care in Canada, p.8.*Retrieved from: http://www.cma.ca/index.cfm/ci_id/44700/la_id/1.htm.

barriers are minimized. Service delivery is respectful of age, gender, culture, language, religion and lifestyle of patients/clients."[46]

In Canada, rural areas are underrepresented by physicians due to "…geographical variations in the density of GPs may lead to inequity of access to primary care."[47]

In May of this year, the WHO launched 'The Global Health Workforce Alliance' to address the inadequacy of access to health care. Dr. Timothy Evans (WHO Assistant Director) believes that "coordinated action to address this crisis at the global level, in regions and within countries must begin ***now***" [emphasis added].[48]

- **Desire to establish predictable and stable funding which supports Chronic Disease Management and the delivery of quality care.**

Exploring alternative funding mechanisms for primary care, such as blended funding, could help to increase efficiency and provide the optimum use of available financial resources to deliver universal, high-quality services[49].

The majority of the current funding models place a heavy burden on provincial budgets and do not offer the needed control or accountability on rising health care costs:

"There is an urgent need to rationalize the number, distribution and mix of physicians, but lack of control and accountability in an open-ended system makes planning difficult."[50]

So as costs increase for primary care, governments are required to examine alternative funding models that will control rising physician costs.

"Rapidly eroding fiscal environments for provincial (and federal) governments have forced provinces to get 'serious' about controlling a significant, previously uncontrolled budget line: physician expenditures"[51].

While physicians recognize the need for change in primary care delivery, the current funding system does not support providing increased preventative services or other important health care reforms.

For example, one barrier towards collaborative practice environment is that "the current way physicians are paid works against collaborative interdisciplinary practice in primary care…This remains the challenge."[52]

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[46] Enhancing Interdisciplinary Collaboration in Primary Health Care [EICP]. (2006). *The Principles and Framework for Interdisciplinary Collaboration in Primary Health Care* .

[47] Chaix, B., Veugelers, P. J., Boëlle, P. Y., Chauvin, P. (2005). Access to general practitioner services : The disabled elderly lag behind in underserved areas. *European Journal of Public Health. 15(3).*

[48] World Health Organization. (2006, May*). New global alliance seeks to address worldwide shortage of doctors, nurses and other health care workers.* Geneva Press Release

[49] Madore, O. (1993, October). *The health care system in Canada: Effectiveness and efficiency.* Economics Division, Government of Canada. Retrieved from: http://dsp-psd.pwgsc.gc.ca/Collection-R/LoPBdP/BP/bp350-e.htm

[50] Ostbye, T. & Hunskarr, S. (1997). A new primary care rostering and capitation system in Norway: Lessons for Canada. *Canadian Medical Association Journal. 157(1).*, p.45

[51] Barer, M. L. & Sanmartin, C. (1996). Re-minding our Ps and Qs : Medical cost controls in Canada. *Health Affairs. 15(2).* p.217

[52] Pringle, D., Levitt, C., Horsburg, M. E., Wilson, R., Whittaker, M. (2000). Interdisciplinary collaboration and primary care reform. *Canadian Family Physician. 46.*

According to Dr. Albert Schumacher, past president of the Canadian Medical Association, many physicians would like to change their method of payment "to enhance the care they deliver and their own lifestyles".[53]

Physicians want greater flexibility in their medical practice, where reimbursement is no longer tied to performing services under the fee-for-service system. Physicians under an alternative funding model would be able to spend more time with patients, and participate in educative conferences or research to enhance their service delivery:

"Under fee-for-service, if the physicians spends half an hour on the phone with a patient, it's not covered. Time spent with patient's family members is not covered. Alternative funding allows them to provide services in the best way they can without worrying about 'Am I getting paid?'"[54]

According to the 2004 National Physician Survey over half of all family physicians "said they would prefer to be remunerated by a blended payment model while only a quarter identified fee -for-service as their preferred means of remuneration."[55]

Interest in alternative funding is growing. Between 1995-1996 and 2001-2002 the share of spending on physician services that flowed through alternative plans increased in all provinces.[56] Increasingly, physicians are choosing alternative funding models to run their practice, which provides them with stable and predictable funding.

"Since FFS payments encourage higher levels of health services utilization, it is claimed that too many resources are directed to the health care sector, when physicians are paid by FFS…and thus resources are not used in a socially optimal way within the health care sector. Thus, alternative payment mechanisms for physicians…promise greater control over the levels of expenditures; more efficient uses of health care facilities, and physician selection of treatment methods which best serve patients, independent of physicians' incomes."[57]

Both physicians and the government require stable and predictable funding to enable long-term planning and ensure the effective delivery of quality primary care. Goals for primary care renewal not only include quality care, increased accountability, greater access, but also the need for more predictable costs[58].

Examining alternative remuneration models which will support quality primary care is a vital part of renewing the primary care system in our province.

[53] Schumacher, A. (n.d.). Family physicians must remain focal point of primary care. *Reshaping Health care in Canada.* pg 4 Retreived from: http://www.cma.ca/Multimedia/CMA/Content_Images/Inside_cma/WhatWePublish/LeadershipSeries/English/pcr_editorial.pdf
[54] Citrome, M. (2005). Nova Scotia's alternative funding experiment. *National Review of Medicine. 2(17)*
[55] Canadian Institute of Health Information (2005) Alternative Payments and the National Physicians Database, The Status of Alternative Payment Programs for Physicians in Canada, 2002-2003 Information for 2003-2004. Ottawa, Ontario.
[56] Canadian Institute for Health Information (2005) *Canada's healthcCare providers 2005 chartbook*. Canadian Government. Ottawa, ON: Retreived from:
http://secure.cihi.ca/cihiweb/products/HCP_Chartbook05_e.pdf#search='Alternative%20Payment%20Manitoba%20Physicians%20Preferences'
[57] Nova Scotia Department of Health. (2005, November). Literature Review of *Family physician remuneration models and primary health care renewal.* North South Group Inc. Halifax: NS., p.51.
[58] Mowat, D. L. (1997). Primary care reform: Is it time for population-based funding? *Canadian Medical Association Journal*, *157 (1),* page. 44

- **Need for integrated information management to support Primary Care.**

In order to provide safe, quality care, health care professionals and governments recognize the need to develop information management systems that support care delivery .

Integrated information and communication systems will provide the tools and supports necessary for making critical decisions in primary care delivery. For example, the availability of patient health information at the point of delivery can "prevent many errors and adverse events."[59]

A report from the Canada West Foundation on *Primary Care Reform In Canada: An Overview* recognizes the variety of benefits information technology can provide to primary care delivery:

"The implementation of information technology systems to generate data enables a higher degree of coordination and planning of primary care…The expectation is that the development and introduction of enhanced patient management tools, such as guidelines, clinical decision support software, electronic patient records, and historical health information data linkages will improve patient care and create efficiencies for the primary care practice and eventually the health care system."[60]

The Health Council of Canada also reports that the use of information technology may "reduce the demand on physicians' time, encourage shared care and collaborative practice, improve patient care and result in more knowledgeable patients."[61]

In addition to these benefits, the collection and maintenance of electronic medical records will "link individual practices to the outside medical world, reducing duplication and allowing information to travel rapidly with the patient."[62]

The Manitoba Medical Association held focus groups on clinics that have already incorporated the use of information technology into their practice. The groups noted that they have seen improvement in the quality of physician's work and lifestyle, the entering of more and better information on patients, and information has been retrieved faster and easier with the use of information technology.[63]

Information and communication systems are a critical part of developing a quality primary care system. "It is now equally apparent that we can't build a quality or safe healthcare system without modernizing our use of information technology."[64]

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[59] Health Council of Canada. (2005, January). Primary *Health Care: A Background paper to accompany Health Care Renewal In Canada: Accelerating Change*. Canadian Governmnet. Toronto: ON., p 10
[60] Stewart, J. (2000). Primary care reform in Canada: An overview. *Canada West Foundation.* Calgary: AB
[61] Stewart, J. (2000). Primary care reform in Canada: An overview. *Canada West Foundation.* Calgary: AB
[62] Shortt, S. (2004). Change in Search of Evidence? Primary Care Reform, Reshaping health care in Canada. P.15, Retrieved from: www.cma.ca/index.cfm/ci_ic?44700/la_id/1.htm.
[63] G. Braha & Associations Ltd. (2005). *A Definition and Cost-Estimate for the ICT Component of the Proposed New Approach to the Delivery of Primary Care (NAPC*). Manitoba Health. Pg. 61.
[64] Decter, M. (2006). Quality, not access, the key issue. The Okanogan Weekender, March 19, 2006, p. A9.