Cracks in the Foundation:
The Precarious State of Canada's Primary Care Infrastructure

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Primary care is widely acknowledged by politicians, pundits, policy makers and healthcare providers to be the foundation of Canada's healthcare system. A recent Commonwealth Fund survey of primary care physicians in seven countries – Australia, Canada, Germany, New Zealand, the Netherlands, the United Kingdom and the United States – has vividly illustrated the sorry state of that foundation's underpinnings (Shoen et al. 2006). The survey examined information technology, clinical information systems, care coordination, use of teams, participation in quality initiatives and financial incentives.

Canadian primary care physicians' use of clinical information and office systems to support the provision of high-quality care lags well behind those of other countries. Only 8% of Canadian respondents have systems in place to perform seven or more of the 14 clinical information functions that were assessed – compared to 72–87% of physicians in Australia, New Zealand and the UK. Canadian physicians ranked lowest on 12 of the 14 functions. Only 23% use electronic medical records (vs. 79% or more of primary care physicians in Australia, the Netherlands, New Zealand and the UK). Only 8% provide patients with "easy access" to their medical records; 27% have electronic access to patients' test results; and 15% have electronic access to patients' hospital records. Ten per cent or fewer Canadian respondents have computerized systems that generate drug alerts, prompts to provide patients with test results or patient reminder notices for preventive or follow-up care. Roughly one-half find it very difficult or impossible to produce lists of patients by diagnosis or health risk, lists of patients who are due for tests or preventive care or lists of patients' current medications. Even among Canadian practices with electronic medical records (EMRs), their clinical information systems have less functionality than those of practices with EMRs in New Zealand, Australia and the UK.

The picture that emerges from the survey is almost equally grim with respect to mechanisms for coordinating care, caring for people with chronic health problems and delivering team-based care. Canadian primary care physicians were the least likely to routinely provide written instructions to people with chronic diseases about how to manage their care at home (14%) and their practices were the least likely to routinely use non-physician clinicians to help manage patients with chronic diseases (25%) or to provide primary care services to patients (22%).

Compared to physicians in other countries – and to any reasonable performance target – Canadian primary care physicians' engagement in quality management falls short. In the last two years, fewer Canadian physicians participated in collaborative quality improvement efforts (48%) or training in quality improvement methods (44%) than physicians in the six other countries. They were also least likely to have data available on patients' clinical outcomes (24%) and patients' experiences with care (11%). Forty-five per cent of Canadian respondents had conducted a clinical audit of patient care in the past two years – compared to 76%, 82% and 96% of Australian, New Zealand and UK respondents, respectively. Only 27% of Canadian primary care physicians reported that their practice sets specific formal targets for clinical performance.

How did all this come about – or rather not come about? Relative to other countries and to levels that would have been desirable, Canada's investment in primary care infrastructure, including information management systems, quality management programs and interdisciplinary staffing, has been woefully inadequate. Although none of these supports guarantees the provision of appropriate, high-quality, patient-centred care, they can provide a powerful boost in that direction, especially in the areas of disease and injury prevention, early detection and chronic disease management.

Despite fairly general awareness among policy makers, health system managers and care providers of this reality, why has investment in primary care infrastructure been so paltry? While many other jurisdictions such as Australia, New Zealand, the UK and the Netherlands were making major investments in primary care infrastructure, provincial and territorial governments in Canada have largely left investment in infrastructure to the discretion of primary care physicians. Until recently and with few exceptions, primary care physicians in Canada have received payment for the provision of patient care (usually in the form of fees-for-service) with no funding specifically designated for staffing, clinical information systems or quality improvement activities. As a result, investments in infrastructure represent income forgone from the physician's perspective. In the absence of competition (most primary care physicians have more than enough work), there is little incentive for physicians to make these investments. Arguably, the provincial/territorial medical associations could have bargained for enhanced funding for primary care infrastructure in their negotiations with provincial and territorial governments. However, this has happened to only a modest extent, perhaps reflecting traditional specialist dominance in Canadian medical associations and primary care physicians' focus on closing the income gap between themselves and their specialist colleagues.

Not surprisingly, public pressure on government to respond to the infrastructure needs of primary care has been absent. Primitive clinical and quality management systems are hardly the stuff of newspaper and television headlines. When governments are strapped for cash (even if the revenue shortfall is self-inflicted as a result of tax cuts), only the squeakiest of wheels (read

hospital and pharmaceuticals sectors) are greased. Governments and regional health authorities are undoubtedly deterred from responding to the need by the sheer magnitude of the investments required, particularly in information technology. However, it should be clear by now that information systems of the required complexity and interconnectivity will not emerge in an environment characterized by a host of IT firms developing systems (albeit often in conformity with provincially-defined minimum standards) tailored to the purchasing decisions of myriad physicians with little to spend, acting individually or in small groups.

Sophisticated information management systems that include decision support and support for patient self-management will not come cheaply. Group Health Cooperative in Seattle, Washington, a user-governed, not-for-profit HMO with over 500,000 members, recently invested US$78 per plan member in the development and implementation of a core clinical information system "to promote patient-centered and planned care for healthier lifestyles, disease prevention, early detection of disease and optimal chronic disease management" (Reid 2006). Not allowing for economies (or diseconomies) of scale, this corresponds to an investment of roughly $1.2 billion Canadian in Ontario or $3 billion for all of Canada.

Perhaps the results of the Commonwealth survey, if they become widely known, will inspire (embarrass?) healthcare funders to address the sad reality that Canada's primary care sector lacks the basic infrastructure needed to support the provision of appropriate and effective services. Unless they rise to the need, Canadian primary care will fail to achieve its potential for major health gains through improved preventive care and chronic disease management. Encouragingly, many provincial/territorial ministries of health and regional authorities, animated by funding from the now expired federal Primary Healthcare Transition Fund, have taken some initial steps forward. For example, Ontario has funded and provided developmental assistance to 150 interdisciplinary Family Health Teams and has announced a quality management initiative to support the teams' health promotion, disease prevention, chronic disease management, team building and quality improvement activities. Such efforts, while praiseworthy, are merely a beginning.

References

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