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# Overview of Primary and Community Health Service Reforms in Canada, New Zealand and the United Kingdom

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This is a summary of a report that provides an overview of recent developments in primary and community health services (P&CHS) in Canada, New Zealand and the United Kingdom (UK), predominantly England. This work was funded by NSW Health as part of a two year project on Strengthening Health Care in the community.

## Summary and implications for NSW Health

In the countries with significant primary health care (PHC) structural reform, it has been based around general practice, with multidisciplinary efforts, especially in the early stages, largely confined to practice/primary care nurses. The central and important roles of GPs in providing first contact care and access and as a gatekeeper to other health services continues to mean that they remain central to any primary health care (PHC) reform.

Evidence of the importance of multidisciplinary teamwork for the provision of comprehensive care, and good linkages between PHC and more specialised services are influencing developments in building up the supports around general practice. Thus primary care nurses who are the other core members of primary care teams have the important role of liaising and integrating with other parts of the health system.

In all countries reviewed here, the role of community health centres/ services is dependent on their context and location within the organisation and delivery of health services overall. However in the early stages of reform, community health services have had little influence over or benefited from developments. They have been in a sense a parallel structure. Only the UK has started integrating community health services, including health visitors, community nurses and allied health practitioners in a systematic fashion.

The establishment of PHC organisations has, importantly, required governance and decision making structures that extend beyond general practice to involve other primary health related professional groups and local community representation.

This has not been an easy process. Leadership development has been an important enabling mechanism for bringing about cultural change.

A focus on primary health care workforce development has also been a feature of reforms especially in relation to changing professional practice (extended practice, flexibility and adaptability in roles and activities), education and training associated with developments in evidence-based practice and clinical guidelines, as well as new post graduate courses and scholarships.

A number of key elements of primary health care reform can be identified. These include:

- Defining a core range of essential primary care (PC) services for defined populations
- Improving 24 hour access to essential primary care services
- Greater focus on planning and delivering services for geographically defined populations
- Emphasis on prevention, early intervention and management of chronic disease
- Use of multidisciplinary approaches (but multidisciplinary team development beyond GPs and primary health care nurses remains a challenge)
- Development of structures/networks that bring together GP and other PC/PHC providers for the provision of more integrated care for defined populations
- Increasing use of mixed funding models that include capitation, incentives in addition to FFS components
- Significant funding to support implementation of reforms

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## Context for Reforms

The key impetus and drivers for change in the countries reviewed included the following:

- **Recognition that PHC was not central to health systems and the full potential of PHC was not realised** The increasing prevalence of chronic disease coupled with increasing evidence of effectiveness of PHC responses/interventions for ongoing chronic disease management (CDM).
- **Inequitable access to PC services** Characterised by workforce shortages, geographical maldistribution and financial impediments.
- **Over use of emergency services**
- **Fragmentation within PHC** A diversity of PHC providers and a lack of integration of GPs and other PHC providers.
- **PHC disconnected from other parts of the health system** In general care was poorly coordinated and in some cases duplicated and hospital services inappropriately used for Ambulatory Care Sensitive Conditions (ACSCs).

## Canada

Canada has a federated system of government, PHC is largely a provincial government responsibility. There is little national consistency, with each province determining the focus of initiatives and who's involved.

Two thirds of family physicians operate in solo or informal group practices [1] and there have been relatively few practice nurses or local organisations of physicians.

There is a parallel structure of not-for-profit community health centres (with some, but not all employing family physicians). However there is no formal infrastructure to support collaboration between solo/group practices of physicians and community health centres [2].

### Primary Health Care Transition Fund

In 2001, a 5-year **Primary Health Care Transition Fund** (PHCTF) was established to support the costs of implementing large scale PHC renewal initiatives to

improve access, accountability and integration of services. The bulk of PHCTF funding goes to provinces and has resulted in considerable variation in scope/focus of initiatives.

There is considerable interest in developing family physician based primary care networks with the aim to improve access and quality of care, increase patient and provider satisfaction and cost effectiveness.

However these models are not likely to comprehensively address the health needs of particularly vulnerable and disadvantaged populations. The core roles and strengths of community health centres have been argued as the reason why they should continue to play a strategic role in PHC reforms especially for populations who experience barriers to care. [3]

Provider resistance especially amongst physicians remains an ongoing issue with the implementation of the PHCTF reforms, especially those relating to multidisciplinary teamwork (MDT). This resistance is a mixture of lack of incentives for their MDT participation, cultural/attitudinal issues over roles and responsibilities associated with teamwork, and a lack of willingness or capacity to work as part of teams. [4]

### Romanow Commission 2002

In April 2001 a major review of the national health system was undertaken which validated the central role of PHC in the health system.

The Romanow Commission noted that the PHCTF had not created the major breakthrough in PHC required to transform the health system and address the key obstacles and suggested that a better approach would be to:

- provide targeted funding tied to a common national platform of essential building blocks for primary health care;
- create an impetus and the right incentives for widespread change;
- clearly identify and remove obstacles;
- public accountability through open and transparent public reporting.

*The Primary Health Care Transition Fund had not created the major breakthrough in PHC required to transform the health system*

The essential building blocks they identified were:

- continuity and coordination of care
- a focus on early detection and intervention
- better information on needs and outcomes
- incentives for health care providers to participate in PHC approaches
- certainty and stability re PHC initiatives
- recognition of front line staff
- flexibility re organisation, delivery, scope of practice etc
- quality of care especially recognition of time for consultations to give patients the attention they need, develop relationships, reduce errors, achieve better outcomes. [5]

## New Zealand

A single level of government is responsible for overall health policy development. In 2000, District Health Boards (DHBs) were established with responsibility for improving, promoting and protecting the health of communities, promoting the integration of health services, especially primary and secondary care services, and promoting effective care or support of those in need of personal health services or disability support. DHBs provide some services, including hospitals, public health services and community health services, or contract with Primary Health Organisations (PHOs) to provide primary health care services. There is a diversity of PHO models and variability in their size.

Prior to the 2000 health reforms, the government focussed on their role as a purchaser and reduced their role in the provision of health services, while the not-for-profit sector increasingly provided services, especially for marginal and disadvantaged groups, including Maori, Pacific peoples and low income/unemployed groups.

### National PHC strategy, 2002

In March 2002, a Primary Health Care strategy was released which has two central aims:

- a) reduce health inequalities;
- b) improve overall health status of the population.

*The Primary Health Care strategy is intended to position PHC as having a central role within the health system and is driven by a national agenda*

Unlike the Canadian reforms, the Primary Health Care strategy is intended to position PHC as having a central role within the health system and is driven by a national agenda.

The central plank of the strategy is the establishment of Primary Health Organisations (PHOs) that are local provider organisations contracted by DHBs to provide PC services to enrolled patient populations (GPs and Primary Health Care Nurses at minimum) under a capitation funded arrangement. The reforms involve major structural changes including patient enrolment and capitation based funding to address locally identified priorities and health needs. The definition of PHC articulated in the strategy includes first level contact essential health care services that are universally accessible to local communities.

*Community Health Services remain a parallel structure*

While General Practice is central to the reforms, and not-for-profit PHC organisations also have an important role, at this stage community health services are not an integral part and to an extent remain a parallel PHC structure organised and delivered from DHBs.

While GPs enjoy a strong role in governance of PHOs, ensuring local community input into decision-making remains a challenge as does the involvement of other professional groups.

Independent Practitioner Associations (IPAs) which are associations of general practices, have given GPs a strong voice in the reforms. IPAs can choose to become involved in the PHO roll out by either broadening themselves into PHO style organisations, or by contracting out their local expertise in management services to the PHO for that area.

In order to gain GP support for the strategy, agreement was reached in mid 2003 on a proposed fees framework. The framework will be part of the contract between PHOs and DHBs. PHOs will consult with DHBs, advise them of the range of fees to be charged for GP services, and fees will be identified in a schedule listed in the contract between DHBs and PHOs.

*GP support gained through agreement on fees framework*

## United Kingdom

Although the UK has a long history of commitment to the National Health Service (NHS), by 1997, the health expenditure per person and as a proportion of GDP was substantially less than other comparable countries and the health system was under considerable stress. This manifested itself in PHC as problems with access to GP services, with many practices not accepting new patient enrolments and lengthy waiting lists. Since the election in 1997 of the Labour Government, there has been a significant overhaul of the NHS in which PC has been central to the reforms.

*Since 1997 there has been a massive overhaul of the NHS and PC is central to the reforms*

### Primary Care Trusts

In England the most recent changes have involved the establishment of Primary Care Groups/Trusts (PCGs/PCTs). PCGs/PCTs represent a move away from voluntary to mandatory participation for GPs. As PCGs attain Trust status they take on a much wider set of responsibilities for planning and commissioning a full continuum of services, including primary health care services and manage over 75 per cent of the NHS budget.

The change for GP contracts to be with local PCTs, rather than with the NHS, has been popular and is a mechanism that provides the potential for greater integration of GPs with other health care providers and services.

### PC Teams, include attached Community Health Services

PCTs integrate family health services and community health care within one organisational structure. Primary care teams (whether PCTs or nurse-led walk-in clinics) are the first point of contact and assume the central management role for patient care and refer to secondary and specialist care and support services. Community/district health nurses are now attached to practices and provide a range of home-care type services (e.g. leg ulcer care, injections, wound care).

Health visitors are also attached to GP practices and provide public health type functions, including immunisation, health education and health promotion.

Practice nurses employed by the practice are involved in chronic disease prevention and management with GPs. Larger practices have the capacity to employ a broader range of allied health staff.

Population/public health has not been well integrated in the PHC reforms. Challenges include developing an effective strategy for population health that creates a bridge between primary care with its individual care focus and population health.

### Representative governance

PCTs are governed by appointed boards made up of a range of health professions (including GPs and nurses) as well as local community members. There is the potential for role confusion and conflict between a lay dominated board and an executive committee dominated by clinicians (especially GPs). GPs are uneasy as are community nurses about the changes; with GPs concerned about their loss of dominance and community nurses concerned about their lack of input in decision-making. [7]

### Performance framework

A key aspect of the reforms has been the establishment of a performance framework with indicators and targets to be met as part of PCT contracts. This is driving the development of more collaborative ways of working amongst the range of primary health care providers and drawing in social services. Access targets stipulate that all patients will be able to see a PC professional within 24 hours and a GP within 48 hours.

*A performance framework sets indicators and targets to be met by Primary Care Trusts*

### Primary care workforce planning framework

In 2002, the DHS developed a **Primary Care Workforce Planning Framework** [8] as a management tool to assist PCTs to plan and develop their workforce in an integrated whole of workforce fashion rather than on a single profession basis. The development of local workforce plans is a key element of the framework and these plans are to include identifying future demands, mapping the existing PHC workforce (numbers, roles, skills, types) and developing the future workforce through an action plan. Educational issues relevant to PHC workforce planning as well as inter-professional education and training are

also outlined. These local plans will feed into workforce development planning up through regional whole of healthcare workforce planning structures (Workforce Development Confederations) to a national structure.

## What can we learn from developments elsewhere?

### Clear directions provide the greatest potential

A national vision for PHC, that positions PHC as central to the health system provides the platform for future directions. A single level of authority for policy, funding and accountability and regional level structures for service delivery maximises national consistency and local flexibility. Defining the scope of PHC and essential services enables planning and monitoring. Finally a robust performance framework provides clarity about expectations and responsibilities.

### Representative governance

Governance structures at the regional level that involve the range of health professions working in PHC and local communities signals external accountability as does the requirement to report outcomes to the range of internal and external stakeholders.

### Building capacity across the PHC system

Addressing the workforce in an integrated, rather than single profession approach strengthens capacity in an integrated way and has included focusing on ongoing skill development. This has been in the context of increasing specialised approaches to care; reviewing roles, responsibilities and changing practices of especially GPs and nurses; and early developments in new categories of staff (health assistants).

Supporting effective organisations at both practice and regional level has been important with a focus on communication, information management, care delivery systems and tools; having/access to a range of staff at service level; and structures/efforts to support horizontal and vertical integration.

Targeted funding/incentives to support new models of care, new ways of working and systems development has been fundamental.

### Achieving change

The political will to support the change agenda, deal with the contentious issues and not allow opposition from particular groups to derail reform has been a feature of both UK and NZ reform. In addition, clarity about the desired outcomes and incentives to achieve targets as well as the firmness to withdraw funding if targets are not achieved gives unambiguous messages.

## Implications for NSW

Despite the rhetoric, most reform elsewhere has centred on primary care rather than comprehensive primary health care, especially in the early stages. It seems likely that primary care reforms in Australia will continue to develop in an evolutionary way with a focus on enhancing general practice capacity through supporting multidisciplinary team developments. Judging by developments elsewhere, over time community health services will be brought into these developments to meet broader primary health care goals.

This underscores the importance of strengthening the capacity of community health services in relation to multidisciplinary teamwork, their linkages with communities and other government and non-government agencies, their population health focus, information and communication systems and evidence-based practice.

The continued development of partnerships between community health services and divisions of general practice for regional planning and delivery of primary health care services needs to be encouraged and supported as it provides the basis for future more formal regional structures. A focus in these partnerships on developing models of integrated service delivery and care for the management of the most common chronic conditions is opportune.

Leadership development is a key factor in bringing about a more integrated primary and community health services system. It is timely to systematically build a cadre of people across primary and community health services with strong leadership skills, including change management and cultural change. The twin drivers for change in NSW – achieving

greater health equity and reducing hospital costs - suggests that primary and community health services will continue to play an important role in the NSW health system. Greater clarity about the scope of primary and community health care services, core services and functions would be enhanced through the development of a primary and community health policy framework and a workforce development plan.

## Useful websites/resources

### General

The Commonwealth Fund  
<http://www.cmwf.org/>

The European Observatory  
<http://www.who.dk/observatory>  
then follow links to Research Topics/ Primary Health Care

WHO  
[http://www.who.int/health\\_topics/primary\\_health\\_care/en/](http://www.who.int/health_topics/primary_health_care/en/)

### Canada

Health Canada  
<http://www.hc-sc.gc.ca/phctf-fassp/english>

Association for Ontario Community Health Centres  
<http://www.aohc.org/fyi.asp>

British Columbia Network of Community Health Centres  
<http://www.chcnet.bc.ca/>

Canadian Health Services Research Foundation  
<http://www.chsrf.ca/>  
Follow link to primary health care

### New Zealand

Ministry of Health  
<http://www.moh.govt.nz/primaryhealthcare>

### United Kingdom

England Department of Health  
<http://www.dh.gov.uk/Home/fs/en>  
then follow links to policy & guidance/ organisation policy/ primary care

Ireland Department of Health  
<http://www.doh.ie/hstrat/primcare/contents.html>

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