

General Practice Services Committee: Improving Primary Care for BC Physicians and Patients

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Abstract

In 2002, in seeking to address a decline in family practice and gaps in patient care, British Columbia created the General Practice Services Committee (GPSC), a joint committee of physicians and members of government. Unique in Canada, GPSC is responsible for new initiatives, including clinical incentive payments, maternity care bonuses, training modules to enhance clinical and administrative skills and the creation of Divisions of Family Practice to coordinate and support family doctors at the regional level. The GPSC programs, which are open to all general practitioners, now receive a growing budget from the provincial government to approximately \$200 million by 2011–2012 and are improving physician morale and remuneration, improving patient care and revitalizing primary healthcare. The GPSC activities have evolved from disease-based initiatives aimed at target populations to wider system-based coordination, and they show that a program of gradual operational solutions can achieve meaningful and lasting systemic change without the need to impose large structural reform.

Background

Primary healthcare is the foundation of the delivery of health services in Canada, traditionally through the offices of the family doctor, who is the first point of contact for patients for most health problems and who coordinates all subsequent care including referrals to specialists. Research has found that countries with strong primary healthcare sectors have better population health and a more cost-efficient healthcare system (Atun 2004; Ferrer et al. 2005; Macinko et al. 2009; Phillips and Starfield 2004; Starfield 2002; Starfield et al. 2005).

Beginning in the mid-1990s, however, family practice went into decline across the country. Many reasons existed for this decline, which was mirrored in other countries (Bodenheimer and Pham 2010; Cross 2002; Tu and O'Malley 2007). Causes in Canada included the perception that specialty medicine had more allure and better prospects, income gaps between general practitioners (GPs) and specialists, the increasing complexity of the GP workload, fewer doctors trained per capita and the imposition of other cost restraints that affected healthcare services as a whole.

Note: This article will appear in a future issue of *Healthcare Quarterly* as the first in a series detailing the experience in British Columbia to strengthen and reform its primary care system, largely through the workings of the General Practice Services Committee (GPSC). The series of articles in this issue will describe in depth various individual GPSC programs and initiatives. This article gives an overview of the genesis and history of GPSC in relation to other primary care reform initiatives in the country, and explains the rationale behind the BC approach.

Family doctors across the country reported feeling overburdened. Many started limiting their practices, giving up hospital privileges, dropping maternity care, choosing to work shorter hours, working part time or working shifts in walk-in clinics – in essence, giving up the role of a full-service family physician. Physicians who attempted to maintain full services reported feeling overworked, overwhelmed and dissatisfied. The impact on patients included longer waits for routine and urgent appointments and difficulty finding a family doctor who was taking new patients. By 2003, an estimated 4.5 million Canadians were unable to find a family doctor and many millions more had family doctors who had reduced hours and services or were so busy that it was difficult to book a timely appointment.

The general decline of family practice also began to affect medical students' career choices. While the Canadian system is built on the expectation that the balance of GPs and specialists will be split about 50/50, by 2003, the Canadian Residence Matching Service noted that nationally just 24% of graduating doctors from Canada's 17 medical schools chose family medicine, an all-time low. In British Columbia, the figure was 23% (Sullivan 2003).

Across the country, it was recognized that family medicine was in crisis and actions must be taken to revitalize and reform primary healthcare. Ontario (Rosser et al. 2010), Quebec (Pomey et al. 2009) and Alberta (Oelke et al. 2009) chose largely to embrace structural change by encouraging physicians to leave solo or small-group practices and to abandon the fee-for-service method of payment in favour of salaries, capitation or blended models in allied health teams or community health clinics. A recent article on Ontario's primary care reform noted that from 2002 to 2010, about 75% of that province's 10,000 family physicians joined medical home models, with the single most notable change being a switch from predominantly fee-for-service to predominantly capitation practices (Rosser et al. 2010). Those physicians who joined family health teams saw their income increase by 40% (Rosser et al. 2010).

While many promote team-based primary care as the model of the future (Margolis and Bodenheimer 2010), others have remarked on the challenges of its implementation (Baron 2009). These include the need for payment reform and electronic health record capability and the transformation of the clinical culture to team-based care (Hoff 2010), for which the majority of practising GPs have not been trained.

The team model is also difficult to apply in regions with sparse populations, inhospitable geography and shortages in healthcare human resources – all factors that apply in British Columbia. In this context, team models tend not to be applicable across entire provinces. In fact, Ontario is reported to be limiting team-based primary care groups, in part due to the challenges of implementation, operation and costs (Rosser et al. 2010.) A recent report noted that some of the unexpected

outcomes of the team model in Ontario have been “policies that favour the self-selection of healthier patients, disincentives in major cities, gaps for vulnerable groups and suboptimal access to care” (Glazier and Redelmeier 2010).

The province of British Columbia has chosen to revitalize its primary healthcare sector by focusing on financial incentives to promote evidence-based care by full-service family physicians (i.e., an enhanced and modified fee-for-service system) and by offering clinical, office management and structural support to family doctors to increase job satisfaction and to enable them to obtain more skills to address gaps in patient care. British Columbia appears unique in Canada in that it is opting to systemically and explicitly address an operational problem (i.e., the decline in family practice) with an operational response, by improving the existing system with gradual but transformative change from within, largely based on research evidence and what primary care doctors have said they need in order to do a better job for their patients.

Adversaries Unite: Genesis of the General Practices Services Committee

The General Practices Services Committee (GPSC) arose in the late fall of 2002, at a time when relations between doctors in British Columbia and the provincial government were at a nadir, largely stemming from many years of fiscal restraint aimed at controlling the healthcare budget.

British Columbia's system of primary healthcare resides predominantly in the offices of family doctors, the majority of whom are GPs in solo private practice or in small group practices. The vast majority of British Columbia's 4,973 practising GPs and 4,082 practising specialists (Canadian Institute of Health Information 2008b) are represented by the BC Medical Association (BCMA), a professional organization with voluntary membership, governed by an elected body of physicians. BCMA negotiates for and on behalf of physicians for their compensation, setting medical service fee schedules and negotiating the schedule of benefits paid by the Medical Services Plan, the provincial health insurance program.

The BC Ministry of Health Services governance model is similar to that of other provinces – the ministry plays a stewardship role, providing direction, support and funding; creating legislation; negotiating fees and wages; and setting province-wide goals, standards and expectations for health service delivery. Although British Columbia's government over the past 50 years has tended to swing between leftist labour-aligned to centre-right business-aligned political parties, the relationship between the BCMA and any provincial government in the past three decades has frequently been one of animosity and confrontation. This was largely because all provincial governments have been faced with curtailing the ever-escalating costs of healthcare. Health spending for 2009–2010 was \$15.5 billion and will rise

to \$17.9 billion by 2012–2013 – a 91% increase since 2001 (BC Ministry of Health Services 2009.) The BCMA, however, promotes adequate physician compensation and solutions for increasing job stress and complexity, and lobbies for what it believes to be the best in patient care. In the late 1990s and early 2000s, the irreconcilable nature of these competing needs meant the relationship between doctors and government was extremely strained.

In the years leading up to the creation of GPSC, disputes over physician compensation had led to rotating days of work stoppages, in which the vast majority of doctors in British Columbia closed their offices and did not see patients for all but emergency treatment (Reid et al. 2002). In addition, in the spring of 2002, the BC government rejected a BC Supreme Court binding arbitration award and passed a new bill to avoid honouring a negotiated agreement. As one commentator at the time noted, this resulted in “an enormous undercurrent of anger, mistrust, acrimony and revolt among BC’s physicians” (Wilson 2002:144).

With this setting as the backdrop, GPSC was formed in the fall of 2002 under a working agreement between the provincial government and BCMA. It held its first meeting in January 2003. GPSC has been mandated to “support full-service family practice and benefit patients” and constituted with eight sitting members, four appointed by BC Ministry of Health Services and four appointed jointly by BCMA and the Society of General Practitioners of British Columbia. Of these eight members, five are current or former full-service family doctors. Representatives of British Columbia’s health authorities also attend as guests. The committee meets monthly, and all decisions are made by consensus.

Early on, GPSC decided that rather than maintaining polarized positions of organizational self-interest, the committee must de-politicize the process by focusing on how to fix gaps in patient care. Focusing on what is best for patients, not best for physicians or best for government, has enabled two former antagonists to find a way to work constructively together. This departure from past entrenched positions has been a critical success factor in the workings of GPSC.

Underlying this attitude is the Institute for Healthcare Improvement’s triple aim approach (Berwick et al. 2008), which states that new designs for healthcare delivery should simultaneously accomplish three critical objectives (Berwick et al. 2008):

1. Improve the health of the population
2. Enhance the patient experience of care
3. Reduce, or at least control, the per capita cost of care

As Berwick et al. note, preconditions for the triple aim approach include the engagement of an identified population, a commitment to universality for its members and the existence

of an organization that accepts responsibility for all three aims. In British Columbia, the group being engaged is the family physician, and all licensed general practitioners are welcome to participate. The organization that accepts the responsibility for the aims is GPSC.

GPSC decided not to force doctors into team models or attempt to restructure the primary healthcare system. At the heart was the conviction that the doctor-patient dyad – the trust-based, long-term relationship forged over time – is the critical attribute of a successful primary healthcare system. GPSC therefore chose to work within this existing system to support the full-service family doctor by enhancing the fee-for-service model. Instead of forcing structural change, GP practice change has been encouraged by paying for improvements in how care is provided, in essence “targeted” financial incentives.

GPSC Programs: Incentives, Training and Coordination

The Full Service Family Practice Incentive Program was implemented by GPSC in 2003 and started with a modest budget of \$10 million annually to target improved management of care for diabetes and congestive heart disease and provide maternity care bonuses. Its budget has steadily grown as new initiatives have been added and its scope expanded. For the 2010–2011 fiscal year, \$166.5 million (or about 1% of the annual provincial health budget) is being allotted to these various initiatives. The cumulative total of this investment through to 2012 (when the agreement is scheduled to be renegotiated) will exceed \$800 million. This sum is seen as an essential investment in primary care.

Now there are more than 15 different financial incentives, including ones for the expansion of chronic disease management to include hypertension and chronic obstructive pulmonary disease; for managing patients with mental health issues, comorbidities or palliative care needs; for creating prevention plans for cardiac disease; for telephone and e-mail consultations for complex or high-needs patients; and for embarking on shared care arrangements with specialists and other healthcare providers for patients with complex health problems.

These incentive payments allow GPs on a fee-for-service model to justify spending more time with their chronic and complex care patients, and facilitate the provision of guidelines-informed care. Patients with more complex illnesses are therefore no longer dropped in favour of easier, healthier patients. Even GPs working in walk-in clinics are eligible to bill for incentive payments if they accept the responsibility of providing comprehensive, continuous care. Since the incentives reward doctors who spend more time with patients and who are the major source of patient care, the episodic style of the walk-in clinics is being modified to encourage more full-service, longitudinal care.

In addition to establishing the incentive program, in 2004–2005 GPSC held consultations called Professional Quality Improvement Days with some 1,000 GPs across the province to hear their perspectives and solutions, which helped to build trust and support. The consultations indicated that the declining interest in family practice could be changed if GPs felt valued, were paid appropriately for their work and had adequate ongoing training and support to provide high-quality care for the increasingly complex and aging patient population. Value us, pay us, train us and support us, they said.

In response, GPSC established the Practice Support Program to offer focused training sessions for physicians and their medical office assistants to help them improve practice efficiency and to support enhanced delivery of patient care. The Practice Support Program uses the Institute for Healthcare Improvement Continuous Quality Improvement model (Langley et al. 2009), in which training sessions are interspersed with action periods when new learnings are applied and adjusted to the day-to-day medical practice, a process that is often called Plan-Do-Study-Act, or the PDSA cycle. The Practice Support Program offers learning modules and supports that span three domains: clinical improvement, practice management and information technology.

Four initial Practice Support Program learning modules – Advanced Access, Chronic Disease Management, Group Medical Visits and Patient Self-Management – began in April 2007, consisting of a series of in-person, peer-group learning sessions, alternating with reimbursed in-practice action periods. A new Mental Health module, introduced in 2009, enhances GP skills for the screening, diagnosis and treatment of mental health issues, including cognitive behavioural therapy skills. Other training modules, such as Youth Mental Health, are in development.

A 2006 agreement between the provincial government and BCMA dramatically increased the GPSC budget, strengthening the group's deliberations and initiatives. The creation in 2007 of a seven-point provincial Primary Care Charter set the direction, targets and outcomes to create a strong, sustainable, accessible and effective primary healthcare system in the province (BC Ministry of Health Services 2007, May 29). The charter was developed and supported by a broad group of stakeholders, aligning government and non-government strategic plans. Its seven priority areas for improvement are the following: access to primary care, access to primary maternity care, chronic disease prevention and management, mental health care, coordination and management of co-morbidities, care for the frail elderly and end-of-life care. Most of the GPSC programs now fall into the charter priority areas.

As well, a program to recruit new GPs to group practices in areas in need has been instituted. Called Family Practitioners for BC, this program provides up to \$100,000 in financial incen-

Key Highlights of GPSC Programs

All financial incentives and training programs are informed by clinical evidence and address identified gaps in care.

Initiatives are focused on what is best for patients, not physicians or government.

All initiatives are voluntary and open to all general practitioners (GPs).

The financial incentives in essence reward continuity of care for sicker patients, promoting a shift from episodic care to full-service longitudinal care, even in walk-in clinics.

The Practice Support Program offers training to doctors and their medical office assistants in both clinical and administrative improvements, with compensation for participation.

The programs follow the continuous improvement cycle, with the ability to adapt to changing physician and patient needs as they arise.

The creation of Divisions of Family Practice at the local level provides a collective voice and network for isolated GPs, increasing their influence on health-care delivery and policy in their community and their ability to work together to address gaps in patient care.

GPSC and the Divisions of Family Practice bring health authorities (and their acute care structure) to the primary healthcare table, fostering this important working relationship and linking networks.

tives and debt reduction for a three-year commitment to a region. Ninety new GPs have been recruited with this program.

In 2009, in order to support and connect the many family doctors who work in relative isolation from other doctors and the healthcare system as a whole, GPSC pioneered the creation of Divisions of Family Practice. A new concept, unique to British Columbia, Divisions of Family Practice organizes groups of GPs at the local level to address common healthcare goals and link solo or small-group practice physicians into a supportive network. The initiative is designed to improve patient care, to provide professional satisfaction and support for physicians and to increase family physicians' influence on healthcare delivery and policy in their community through negotiations and collaborations with health authorities. Now some 30 regions of the province are in various stages of establishing Divisions of Family Practice, whose administrative structure will be funded by GPSC on a yearly per-physician basis. More recently,

Divisions of Family Practice has been invited to explore more formalized “patient attachment” processes, again through incentives, with monies flowing first to Divisions of Family Practice, which could then return a portion to its members for their list of attached patients.

GPSC welcomes recommendations from the GPs, and financial incentives, fee structures and programs have been revised and new ones added over the years based on feedback. This flexible and evolving nature, closely tuned into the working lives of family doctors, helps build trust and support for the program and enables the committee to address issues as they arise.

Conclusion

The GPSC experience has taught British Columbia that financial incentives are necessary but not sufficient in isolation to bring about meaningful change. Rather, a combination of four factors must exist: (1) relationships and trust, (2) targeted financial incentives that aim to spur necessary system change and evidence-based clinical care, (3) training and supports and (4) measurement and feedback loops. These factors do not have to be equal but must all be present.

Perhaps the most significant indicator of success of the BC approach is GP interest in and uptake of far more transformative ventures such as Divisions of Family Practice. None of this would be occurring without the trust engendered through the collaborative deliberations of GPSC.

A 2010 survey of the BCMA membership found that 95% of GPs now support the GPSC approach, up from 90% in 2008 (Ipsos Reid 2010). Through conversations with doctors around the province, it is evident that the previous disillusionment and burnout are being replaced with optimism and enthusiasm. The uptake of incentives has increased each year of the GPSC operations so that now more than 90% of all BC GPs are billing for one or more of the incentives.

Physicians who participate fully in the program have seen an average 11.8% increase in their earnings, or about \$27,000 per physician. As well, according to the Canadian Residency Matching Service, in 2010, 30.4% of University of British Columbia students chose family practices, up 7.4% over 2003.

Moreover, outcomes for BC patients have also improved. British Columbia currently has the lowest hospitalization rates related to seven ambulatory sensitive conditions in Canada (Canadian Institute for Health Information 2008a).

The changes to healthcare in British Columbia are also proving to be cost-effective. A study tracked patient usage data in 2007–2008 and found that the more patients with higher care needs were attached to a primary care practice, the lower the costs were for the overall healthcare system (Hollander et al. 2009). A more recent study found that those GPs in the province who were higher billers for incentives increased their number and percentage of patients in which the family doctor

was the majority source of all care (Hollander and Tessaro 2009). In short, incentives increase patient attachment, and attachment in turn creates cost-efficient care.

British Columbia's experience shows that by modifying and enhancing the fee-for-service system and by working with GPs in solo and small-group practices to support them in providing quality patient care and increasing job satisfaction, it is possible to change an entire province's healthcare system for the better.

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Primary Healthcare Renewal in British Columbia: How the BC General Practice Services Committee Is Breathing New Life into Family Practice

