

# Notes from the Editor-in-Chief

FEW PEOPLE WOULD dispute the claim that primary care is the beating heart of health-care systems the world over. One of the clearest signs of its importance is the vast catalogue, pumped out over the last 20 years, of governmental and para-governmental reports, scholarly studies and expert reviews opining on primary care's essential attributes, analyzing its current shortcomings and making recommendations for its transformation. The World Health Organization (WHO nd), for example, says that advancing primary care requires increasing "stakeholder participation" and undertaking reforms in the following four areas:

- Universal coverage
- Service delivery
- Public policy
- Leadership

These reforms are explained at length in the WHO's report *Primary Health Care – Now More than Ever* (2008), which places special emphasis on achieving "people-centred" care.

Nearer to home, the Canadian Health Services Research Foundation (CHSRF) recently published a study illustrating the economic benefits that would accrue from improving primary care (Dahrouge et al. 2012) across the country. While the focus of this report is on the financial impact of various system improvements, the authors' call for "strategic national investments" is predicated on the fact that primary care services in Canada are "of moderate technical quality" and "poorly accessible" (2012: 6). As if anticipation of several of the findings in this report,

a number of Canadian jurisdictions have already taken steps to reinvent their primary care systems. In Alberta, for instance, a "trilateral governance" model based on devolving

*CHSRF recently published a study illustrating the economic benefits from improving primary care*

local decision-making to primary care physicians seems to be paying health dividends for patients (Ludwick 2011; see also Brossart and Donnelly's report on Saskatchewan's initiative described in this issue).

## **Lead paper**

In this issue of *HealthcarePapers* we are pleased to bring you an original essay that furthers this important conversation. Working under the aegis of Ontario's Quality Improvement and Innovation Partnership (QIIP), which is now part of Health Quality Ontario, Nick Kates and his five co-authors designed a framework they believe will be useful "to guide primary care improvement." Drawing on the extensive body of Canadian and global primary care-reform research and experience, Kates et al. present a three-layer framework that lays out the main features of high-performing primary care and the "supports" required to attain it.

Kates et al.'s guiding premise is that "systems of care" must be re-organized. The framework they propose to direct that work is closely aligned with the Institute

for Healthcare Improvement's Triple Aim approach to outcomes and the Institute of Medicine's six improvement aims. Working within those theoretical parameters, when it comes to actual interventions, Kates et al.

*The hub of their framework is patient-centred, family-centred and community-centred care.*

emphasize, not unlike the WHO and CHSRF reports I touched on earlier, the centrality of “well-functioning teams that use proven quality improvement methods, effective information management systems and external resources and support to implement these changes.”

At the hub of their framework is patient-centred, family-centred and community-centred care. Kates et al. contend that the following six characteristics “contribute to the overall quality of the care being delivered” to each of those constituencies:

- A population focus
- Patient engagement
- Partnerships with other health and community services
- Team-based care
- Performance measurement and quality improvement
- Innovation

The authors anatomize each characteristic in turn, thus providing a basis on which to launch the second part of their paper: a discussion of four “forms of direct support ... required to enable practice-level transformation.” Insights into the importance of staff learning, tools and resources, support for quality improvement and innovation dissemination then pave the way for a concluding section

briefly outlining 10 system-level policies and structures that, Kates et al. argue, provide the necessary context if we are to accomplish practice-level reforms. Each of these complex facets of a “sustainable” and “supportive” system – for example, measurable goals, policy and funding support for inter-professional teams, mechanisms to support coordination and integration and adequate funding – could easily serve as the basis of at least its own article.

### **Commentaries**

Arguing from a systems theory standpoint, Philip Ellison notes that Canada's primary care sector “remains frustrating in its seeming isolation from other elements of healthcare, both horizontally and vertically.” In order to move forward, he posits, we must build “primary care infrastructures that facilitate and support system integration.” In this regard, the necessary condition for quality improvement is thorough “information system implementation,” the lack of which currently constrains family physicians.

The Health Quality Ontario framework would, Ellison argues, be useful for carrying out such work because it “stimulates systems thinking in an ecological context.” Ellison makes, however, two important adjustments. First, he urges a shift away from “such dependency-laden terminology such as *care of patients*, to relations with our practice citizens.” More than mere semantics, this change would help to foster “true partnerships between equals.” Second, I find especially intriguing his call to move from the Triple Aim's focus on “patient care” to a broader concern with “health.”

In his commentary, Stephen Duckett offers a somewhat more ground-level analysis. Agreeing with Kates et al. that “system-level enablers are the sine qua non of primary healthcare reform,” he emphasizes offering “the right (financial) incentives” to providers.

The ongoing dominance of fee-for-service remuneration is, in Duckett's view, a major stumbling block to progress. In order to strengthen the utility of their framework, Duckett counsels, Kates et al. need to include such politicized system-level enablers right in their model. Only thus will their framework have the clarity and muscle to be of real use to political and system leaders.

Concerned primarily with implementation, Danielle Martin argues that, "for a framework for change to be meaningful, it must infiltrate day-to-day work in the system." While Duckett recommends system-level enablers, Danielle Martin trains her gaze on policy tools as a way to breathe life into Kates et al.'s "ideal state" framework. According to Martin, the new elements that Kates et al. add to the longstanding discussion of primary care are the importance of team-based care and performance measurement/quality improvement. But without the wielding of "authority" (e.g., by governments and regulatory colleges) and "symbolic and hortatory tools" owned and actualized by the healthcare workforce itself, Martin sees little hope of renewing primary care along the lines Kates et al. aspire.

The next commentary presents a "complementary" framework for community-oriented primary healthcare (COPHC) services. Delineating six evidence-based requirements for COPHC, John Millar argues for their role in addressing health inequities, a major element in Kates et al.'s model. Millar diverges from the lead authors' vision of data collection, however, in his emphasis on a population approach and collaborations among public health, community services and social agencies. One of the boons of such collaborations would, Millar argues, be a more effective use of additional funds invested in primary prevention and public health.

The literal and spiritual home of Canada's medicare system, Saskatchewan holds a

special place in health-planners' and scholars' bosoms. Bonnie Brossart and Lauren Donnelly's commentary takes us inside that province's Primary Health Care Framework, which was released in early 2012 and "validates" much of Kates et al.'s approach. A belief in the fundamental importance of relationships – among health providers and health-services users, their communities and health-delivery organizations – is key to understanding Saskatchewan's approach. As well, similar to Kates et al.'s framework,

*A belief in the fundamental importance of relationships is key.*

Saskatchewan built in a focus on "continuous improvement capability" tied to clear expectations and accountabilities. As other commentators in this issue have noted, quality improvement is no easy feat, often because the main players lack the requisite skills and knowledge to manage and lead change (on family physicians' shortcomings in this regard, see Ellison). I admire the confidence and courage of Saskatchewan's health leaders, and it might just be that the broad consensus involved in establishing that province's framework will be enough to carry the day.

From the west we now travel east, to Nova Scotia. Drawing insights from ICONS, that province's approach to managing acute and chronic cardiac diseases. Joanna Nemis-White, James MacKillop and Terrence Montague concur with Kates et al. on the critical role of integrated care (i.e., community-based, multi-professional teams) in abetting population health. I was struck, however, by the authors' analysis of the "care gaps" that persisted despite the application of ICONS' principles, as well as their illumination of the "striking variance

among practitioners in the valuing of specific characteristics of successful team care.” Finally, in an intriguing thematic overlap with Millar’s commentary, the authors convincingly recount the disabling disconnect between patients’, caregivers’ and non-governmental organizations’ support for integration versus the government’s lacklustre resolve to make it happen.

Our final commentary is by Stephen Peckham, who, drawing in part on examples from the United Kingdom, argues that successfully improving primary care requires that “the direction of travel must be mapped

*Primary care is context specific.*

out.” While Peckham sees much to admire in Kates et al.’s framework, he also notes that their “useful first step” lacks “continuity of care” as a care-quality indicator, and he wonders at length about what the placement of “community” at the model’s centre means “in practice.” Overlapping with that latter point, Peckham sees a “confusion” in Kates et al. between “concept” and “practice.” Primary care is, he argues, “context specific”; therefore, he advises more attention be paid to understanding how to organize and deliver care, as well as how policy- and decision-makers ought to “structure” organizational models, payment and incentivizing systems and accountability structures – a concern voiced in several of the other commentaries as well.

“There is no disputing that the key to any high-performing healthcare system is a high-performing primary care system,” observe Brossart and Donnelly. While there are still many factors to be investigated and adjustments to the framework to be made, all our

commentators agree that Kates et al. developed a tool that will prove useful for grinding that key and then fitting it into the lock.

*Peggy Leatt*

Peggy Leatt, PhD  
Editor-in-Chief

## References

- Dahrouge, S. et al. 2012. *The Economic Impact of Improvements in Primary Healthcare Performance*. Ottawa: CHSRF. Retrieved June 24, 2012. <[http://www.chsrf.ca/Libraries/Commissioned\\_Research\\_Reports/Dahrouge-EconImpactPHC-E.sflb.ashx](http://www.chsrf.ca/Libraries/Commissioned_Research_Reports/Dahrouge-EconImpactPHC-E.sflb.ashx)>.
- Ludwick, D.A. 2011. “Primary Care Networks: Alberta’s Primary Care Experiment is a Success – Now What?” *Healthcare Quarterly* 14(4): 7-8. Retrieved June 25, 2012. <<http://www.longwoods.com/content/22669>>.
- World Health Organization. nd. Health Topics: Primary Health Care. Geneva: Author. Retrieved June 25, 2012. <[http://www.who.int/topics/primary\\_health\\_care/en/](http://www.who.int/topics/primary_health_care/en/)>.
- World Health Organization. 2008. *Primary Health Care – Now More than Ever*. Geneva: Author. Retrieved June 24, 2012. <<http://www.who.int/whr/2008/en/index.html>>.