RESEARCH PAPER

Accountability and Primary Healthcare

Obligation de rendre compte et soins de santé primaires

SHAHEENA MUKHI, MHA
Graduate Student, Institute of Health Policy, Management & Evaluation
University of Toronto
Toronto, ON

JAN BARNSLEY, PHD
Associate Professor, Institute of Health Policy, Management & Evaluation
University of Toronto
Toronto, ON

RAISA B. DEBER, PHD
Professor, Institute of Health Policy, Management & Evaluation
University of Toronto
Toronto, ON

Abstract

This paper examines the accountability structures within primary healthcare (PHC) in Ontario; in particular, who is accountable for what and to whom, and the policy tools being used. Ontario has implemented a series of incremental reforms, using expenditure policy instruments, enforced through contractual agreements to provide a defined set of publicly financed services that are privately delivered, most often by family physicians. The findings indicate that reporting, funding, evaluation and governance accountability requirements vary across service provider models. Accountability to the funder and patients is most common. Agreements, incentives and compensation tools have been used but may be insufficient to ensure parties are being held responsible for their activities related to stated goals. Clear definitions of various governance structures, a cohesive approach to monitoring critical performance indicators and associated improvement strategies are important elements in operationalizing accountability and determining whether goals are being met.

Résumé

Cet article se penche sur les structures de l'obligation de rendre compte dans les services de soins de santé primaires (SSP) en Ontario, en particulier pour savoir qui est responsable de quoi auprès de qui et pour connaître les mécanismes utilisés. L'Ontario a mis en œuvre une série de réformes progressives, au moyen d'instruments de politiques des dépenses, renforcées par des ententes contractuelles qui visent à définir un ensemble de services financés par les deniers publics et offerts par le secteur privé, le plus souvent par des médecins de famille. Les résultats indiquent que les exigences de responsabilité dans la production de rapports, le financement, l'évaluation et la gouvernance varient selon les modèles de prestation de services. L'obligation de rendre compte auprès des bailleurs de fonds et des patients est plus courante. Des ententes, des mesures incitatives et des outils de compensation ont été employés, mais ils pourraient être insuffisants pour assurer que les intervenants soient tenus responsables des activités liées aux objectifs définis. Une définition claire des diverses structures de gouvernance, une démarche cohérente pour le suivi des indicateurs de rendement et des stratégies d'amélioration constituent des éléments importants pour la mise en œuvre de l'obligation de rendre compte et pour déterminer si les objectifs ont été atteints.

Primary healthcare (PHC) is, for most people, the first point of contact with the healthcare system, usually through a family physician. It is where short-term health issues are resolved, where the majority of chronic health conditions are managed, where health promotion and education efforts are undertaken and where patients in need of more specialized services are connected with care. A strong PHC system is characterized by accessible, person-focused, comprehensive care, effectively delivered and coordinated by an interdisciplinary team across the health sector continuum using efficient technology and anchored in the principles of continuity of care (Starfield 1998).

Medically required PHC services delivered by physicians fall within the requirements of the *Canada Health Act* and as such, must be fully covered by the publicly funded provincial health insurance plans. They are privately delivered, under a variety of organizational models. In recent years, most Canadian provinces have sought to reform PHC to improve access, quality, equity, system integration and accountability (Hutchison 2008; Hutchison et al. 2011). Ontario has implemented a series of incremental reforms, largely using expenditure policy instruments to encourage transformation from a solo, fee-for-service (FFS) model to models that encourage patient enrolment, with interdisciplinary teams offering a comprehensive range of PHC services. These mechanisms include the introduction of an array of alternative organizational service delivery models, with reimbursement models using blends of capitation FFS and salary and performance-based incentives, depending on the model and the jurisdiction (Hutchison 2008). One consequence has been an increase in payments for PHC, as well as

considerable pressure to demonstrate the impact of these reforms, including a critical report from the Auditor General of Ontario (Office of the Auditor General of Ontario 2011).

This paper examines the approaches being used to ensure accountability within PHC in Ontario; it focuses on who is accountable for what and to whom, the policy tools being used and perceptions of the disadvantages and opportunities, including the intended and unintended consequences.

Method

An extensive literature review was conducted (see Appendix at www.longwoods.com/content/23849). Relevant policy literature was also examined to determine approaches to accountability in PHC, including how it is defined, the types of governing mechanisms that have been used and the key enablers and barriers. Nine key informants from Ontario were interviewed via telephone, using open-ended questions to gather data about aspects of accountability such as for what, by whom, to whom and how. The key informants came from five provincial-level agencies, plus two physician-led and two community-based interdisciplinary teams. Ethics approval was obtained from the University of Toronto.

PHC in Ontario

Ontario has implemented an "alphabet soup" of PHC models since 2000 (Hutchison 2008). These include three new funding models – family health groups (FHGs), family health networks (FHNs) and family health organizations (FHOs) – and one service delivery model with interdisciplinary teams, family health teams (FHTs). FHGs are based on blended FFS, while FHNs and FHOs have slightly different service packages funded through blended capitation. An expenditure policy instrument, enforced through contractual agreements, provides a defined set of services.

In Ontario, primary care physicians in these models sign four-year physician services agreements (PSAs) whose terms reflect agreements negotiated between the Ontario Ministry of Health and Long-Term Care (MOHLTC) and the provincial Ontario Medical Association; these PSAs include financial incentives. FHTs have yearly funding agreements with MOHLTC. Another model, community health centres (CHCs), were initiated over 40 years ago. They are situated in geographic areas with identified underserviced or high-needs populations. Staff, including physicians, are salaried. CHCs sign agreements with the regional Local Health Integration Networks (LHINs), which are delegated responsibility (and funding) from MOHLTC for a series of other provider organizations, including hospitals, long-term care institutions and home care agencies. These different agreements vary in their scope of accountability requirements for (a) services, (b) performance measurement and reporting, (c) governance, (d) goals and (e) duration of term (see Appendix at www.longwoods.com/content/23849).

Findings and Discussion

Accountability mechanisms: Who is accountable for what and to whom?

SERVICE REQUIREMENTS

The PSA incorporates financial incentives, including premiums and bonuses, to encourage specific types of physician behaviours. For example, the agreement includes incentives to enrol patients with a specified primary physician. One major requirement is for access to after-hours PHC services for enrolled patients, either by phone or clinic. Enrolled patients are free to seek care elsewhere, but if they do, the primary physician will lose a portion of a bonus payment. The agreements also include incentive payments to encourage physicians to provide specified preventive care services. Reporting requirements for physicians are voluntary and are limited to performance tied to FFS and incentivized tasks. The limited scope of performance measures may offer insufficient insight on improvement in health status and PHC system performance (Starfield and Mangin 2010) and may overlook patients with multiple chronic conditions, who account for a substantial proportion of government health expenditures.

ORGANIZATION AND GOVERNANCE REQUIREMENTS

Separate from funding provided to individual physicians through the PSA, FHTs receive funding to hire interdisciplinary healthcare professionals (IHPs), other than physicians, to deliver comprehensive and coordinated care for enrolled patients as well as for non-enrolled (unattached) patients. Separate agreements oversee the provision of IHP resources and mandatory reporting requirements for specific performance metrics (such as enrolled and unattached patient counts, chronic disease prevalence, IHP resource distribution to support chronic-condition patients and IHP vacancies or turnover), budgetary assessments and governance.

FHTs are required to establish one of three governance structures: community-based, provider-based or a mix of community- and provider-based. The PHC practice key informant interviews for this study represented a provider-based governance model in an urban setting and a mixed community- and provider-based governance model in a rural setting. In these governance models, accountability for operational activities (e.g., the governance structure of the team, balanced budget, IHP resources, privacy of records management and management of emerging risks) falls to the organization's board of directors (BOD) and the funder. The IHPs, as regulated health professionals, are accountable to their self-regulatory body. However, the scope and terms of multidirectional accountability within an interdisciplinary setting are not explicitly described in the funding agreement or other official documents.

The agreement for salary-based CHCs contains mandatory requirements for indicator reporting (e.g., preventive care activities, vacancy rates of physicians and nurse practitioners, service cost per unit, number of individuals served, variance forecast to actual expenditure and units of service), as well as for such things as community engagement, BODs' responsibilities and comprehensive service coverage. In this model, physicians and IHPs are equally responsible

for delivering a broad scope of care activities, including primary care, illness prevention, health promotion, community capacity building and service integration. The community-based BODs ensure that community needs are solicited through engagement and incorporated into strategic and program operational planning.

Accountability domains

The current agreements are largely bi-directional between a single funder (i.e., MOHLTC or the LHIN) and a physician provider or provider organization. Implicit assumptions are made throughout the agreements that providers will observe their professional and legal forms of accountability and act in the best interest of patients. The most common form of accountability involves PHC providers' interaction with patients. The second common form of accountability is provider accountability to the funder. Accountability solely based on funding poses challenges for measuring PHC system performance and whether contractual obligations are being met both by physicians as well as IHPs.

Policy Instruments

To drive the policy agenda – improve access, quality, equity and system integration – the policy making and implementation processes have addressed accountability gaps by embedding performance measurement requirements in the contractual agreements, engaging policy subsystem actors and passing a regulation to facilitate the involvement of the PHC sector with other parts of the broader health system.

Expenditure policy tool: Contracts

WHAT IS BEING MEASURED? VS. WHAT SHOULD BE MEASURED?

Key informant interviews, the agreements and other literature indicate that the PHC Performance Measurement Systems (PMSs), in general, are predominantly based on volume counts of services, focused on a small set of problems in PHC and on factors that can be measured (Saltman et al. 2006; Starfield and Mangin 2010; Working Group to the Primary Healthcare Planning Group 2011). Quality outcomes measures are absent in the PMSs. The lack of focus on the measures that may be required to evaluate PHC system performance makes it difficult to discern whether the intended PHC service delivery goals and objectives are being met and to determine opportunities to make PHC a stronger system.

The following quotations from key informant interviews offer insight into the present state of the PMSs:

> Usually they tend to be fairly straightforward operational indicators, volumes, prices, cost, averages in terms of performance.

> The scope of our accountability measures … has been very narrow. It's the service, the output, it's one point in time, it's within one practice, and I think we realize that while these things are important, many of the outcomes we are really looking to improve in the health system come from integration and coordination of care across sectors, and they are much broader in scope than those measures we currently have.
>
> But what PHC models and service providers are still not accountable for is those sorts of quality measures or outcomes that you can see downstream from primary care. For example, emergency department visits, inappropriate hospitalization for chronic conditions, or readmission.
>
> Moving more into the quality judgments around outcomes, certainly in clinical areas I would say less likely because (a) they are harder to measure and (b) oftentimes the information systems to collect and report the information aren't available.

Patient surveys, 30-day readmission rates and emergency department (ED) use, chronic care outcomes and total cost of chronic care for chronically ill patients are examples of critical PMS indicators (Guterman et al. 2011); these are absent from the reporting requirement in Ontario. To fully engage PHC practices in the collection of PHC data, quality improvement initiatives, system integration and policy governance structures (with clinician representation), reliance on expenditure policy tools has been recommended (Saltman et al. 2006; Working Group to the Primary Healthcare Planning Group 2011).

UNINTENDED CONSEQUENCES

Volume-based measures provide an incomplete view of the PHC system and act as a barrier to measure and identify ways to advance towards the characteristics of a strong PHC system. There appears to be no cohesive approach to measure how the PHC system is performing relative to the goals for which it is supposed to be held accountable. Where service volume monitoring and random auditing do show non-compliance with contractual obligations, the only corrective action currently available is contract termination. The remediation process to allow both parties to consider corrective action is absent.

Compensation models have produced some change but they also have produced some perverse effects, including overutilization of services for which incentives are offered, shift of resources from one clinical area to another, concentration on improving quality for one or a small number of diseases or patient populations, and treating all patients uniformly rather than being able to respond to differences in clinical needs (Hurley et al. 2011; Kiran et al. 2012; Primary Healthcare Planning Group 2011; Starfield and Mangin 2010). Some differential effects on care quality measures have been observed across models, but these appear to be related more to organizational characteristics (e.g., presence of electronic medical records

(EMRs), human resource composition and smaller patient panel sizes) than to the impact of funding schemes (Dahrouge et al. 2012; Kiran et al. 2012). New PHC models appear to have increased patient enrolment without improving access, particularly with regard to after-hours care (Office of the Auditor General of Ontario 2011). Because patient feedback was absent in the approach to PHC accountability, the Ontario Working Group has recommended adding this dimension (CIHI 2013b).

Key informants and PHC researchers noted that agreements, various incentives and premiums, compensation models and infrastructure funding appear to be insufficient to ensure that parties are held responsible for their activities. Ongoing monitoring and measuring of the critical PMS indicators and corrective strategies were mentioned as key to achieving accountability targets.

Information and exhortation policy tool: Indirect governing

Indirect governing mechanisms are used to coordinate a dialogue among subsystem actors and solicit input on ways to advance PHC system policy goals and inform the strategic directions for accountability levers and incentives to meet patient and health system needs and to drive performance (Primary Healthcare Planning Group 2011). In 2012, Health Quality Ontario (HQO) and the Canadian Institute for Health Information (CIHI) teamed up to launch a new initiative called the Ontario Primary Care Performance Measurement Steering Committee, which developed a series of 10 measurement priority areas to guide PHC system planning and management (CIHI 2013a).

Key informant interviews drew attention to several issues concerning the PHC PMSs:

> Defining what are the relevant indicators of accountability, meaningful. They can't always be meaningful to governments and politicians. Keeping them happy is part, but that's not going to improve the healthcare system.

> Oftentimes the accountability pieces are limited by the infrastructure of an agent. If there isn't the infrastructure, then the reporting back of more complicated accountability measures is limited.

> What's such a big barrier in the sector is the lack of infrastructure. For example, the whole access to information piece. So easy for you and I to say we should incent the outcome, but the EMRs aren't that functional; we don't have data management support.

> When we do try to put [the CIHI Voluntary Reporting System] in place, the quality of data that comes out isn't great because there isn't standardization going in and the EMRs aren't designed for this kind of data. And admin data is not helpful …

There are a number of barriers to achieving accountability – for example, absence of a cohesive PMS strategy, information infrastructure and monitoring systems, and standard approaches to governance to manage information sharing, communication and relationships within organizations and across organizations. Some of these barriers contribute to the limited scope of PMSs in Ontario, which is based on factors that are easy to measure and on what data are available.

Regulation

The *Excellent Care for All Act* is an example of a policy lever used to advance the quality and system integration agenda by facilitating formal participation of PHC providers in health system planning and integration initiatives across the continuum of care. PHC participation is perceived to be of strategic importance in steering system coordination because of the evidence to date on its moderating effect on healthcare spending and its role in serving as a gatekeeper of the system. However, to date, funding and reporting requirements have not been revised and the governance structure remains self-directed, premised on trust and mutual interdependence.

Conclusion

Accountability relationships in PHC are multidirectional within and between organizations. The current state of the contracts presents a number of gaps and points to the need to define governance structures to support partnership, data management, monitoring and reporting requirements to align with the goals, roles and responsibilities of service delivery organization, providers and funders. Some jurisdictions are moving in the direction of defining governance structure to support infrastructures for IHP teams, but are far away from defining public reporting requirements involving the medical profession. It has been suggested that the multidirectional relationship in PHC needs to be reflected explicitly in the agreements, and a mechanism is needed to capture the range of relationships that exist within the PHC system in order to assess accountability by role, for what and for whom, across the circle of care providers and institutions.

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Correspondence may be directed to: Shaheena Mukhi, Institute of Health Policy, Management & Evaluation, University of Toronto, Health Sciences Building, 155 College St., Suite 425, Toronto, ON M5T 3M6; tel.: 416-886-6409; e-mail: shaheena.mukhi@utoronto.ca.

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