~~Don't~~ Sweat the Small Stuff

Chapter 16 – Primary Care Part 1 – When will we get it right?

Last week's chapter attempted to show that in over 30 years the Ministry has not really learned to "manage" our $75 billion health care system. This has less to do with the ability of the staff and is more due to the conflicting directions that the Ministry operates under. With publicly funded systems, the funder (government) becomes very involved in decision making and those who must operate the system need to take these very political realities into their daily processes. I was alarmed when the LHINs were created that within months significant resources were added to address "issues management". Issues management is code for making sure that the politicians were not caught off guard or they had proof that they were taking the right actions. Staff would try to think about any question that might be posed in the legislature and prepare a response for that question. Huge resources going to provide answers to questions that never get asked! Health care is a complex business and many things do not go correctly or exactly as planned, so there is a never ending list of questions that "might" get asked!

That is difficult enough but when you have to play out the operations in front of the media who are not really interested in the health aspect but more in the desire to have a "gotcha" moment that they can use to embarrass the politicians of the day in the press you have a system that seeks to minimize possible "issues" and forgets what its true purpose is. Upon reflection this is probably the greatest threat to our public system. The Ministry is not there to manage the system but to ensure their political masters are supported in the public arena of politics. It is the government of the day, the opposition parties and the press that are the true threat to our public system because they use it as fodder for their gamesmanship in the legislature and to fuel newspaper sales. Where is the real discourse about where we should be going with our $75 billion system that we all want to work? It just does not happen!

When the LHINs were launched in 2006 Jonathon Lomas (noted health economist) from the Centre of Health Economics and a Policy Analysis (CHEPA) at McMaster University was asked to talk to the group of staff who made up the fledgling Local Health Integration Networks. He asked a very profound question - How local will Local Health Integration Networks be? He pointed out the rationale for the creation of LHINs was to integrate a fragmented system and create standardization and economies of scale. This was to be a process of centralizing decision making, standardizing approaches and creating savings through realizing the economies of scale that the system had never truly realized. The idea of making truly local decisions flies in the face of the what the system needed. The "made in Ontario" model of LHINs pitted local decision making against system needs. By the way, one service that truly standardized care, approaches and resources all across Ontario was Cancer Care Ontario. CCO has managed to create a province wide system of screening, diagnosis and care that makes it one of the best cancer **systems** in the world, and it was mostly accomplished before the onset of the LHINs.

Instead of less bureaucracy we ended up with more!

Over the past twenty years even though steps were taken to integrate a very siloed health system, as evidenced by the creation LHINs it seems some Ministry staff missed the memo. Consider when LHINs were created the Ministry funded about 2400 Transfer Payment Agencies (TPAs). TPAs are organizations that receive funds from the Ministry to deliver health care and include hospitals, Long Term Care facilities, mental health and addiction organizations, ambulance services, public health, etc. These various organizations deliver the care on behalf of the Ministry. Overseeing the work and efforts of 2400 separate agencies requires a significant bureaucracy at the Ministry. With the advent of LHINs the unofficial goal was set to reduce the number of TPAs by about 50% through integration efforts across the system. Unfortunately there were very few integrations and thanks to Primary Care Reform we have now increased the number of TPAs to over 4,000. The real beneficiary of the Ministry's integration efforts has been a growing bureaucracy to "oversee" all these TPAs. Patients do not have appeared to benefit from these efforts.

Primary Care "Reform"

Primary Care is the first level of care that a patient accesses within the health care system and by volume is the largest part of the system. In an average month for those who seek healthcare (and statistics show that more than 50% do not!), Over 50% of encounters are with primary care. In Ontario there are around 200 million OHIP encounters each year with over 100 million being primary care visits. Primary care can be a visit to a physician, a nurse practitioner or a physician's assistant.

For over 40 years the standard model was GPs who provided the majority of care and billed OHIP on a fee for services (FFS) basis. The accepted position for the past thirty years has been that FFS is a bad thing because most of the time it allows physicians to provide (and bill for) as many services as they wish. This creates tremendous cost uncertainty for the funder (government), as there were mostly no caps on funding. The perceived solution was to move physicians to Alternative Payment Plans (APPs). Most often these plans involved paying a physician a set amount annually (capitation) for each patient they had on their "roster". The physician would be paid regardless of whether the patient received any care or not. There was a clear incentive to provide less care under these models and today we are paying the price for a poorly thought out plan of Primary Care Reform, and an even more poorly execution of that plan.

Capitation or paying on a per person basis can have many benefits – most importantly it provides cost certainty to the payer – in this case the government. It also allows practitioners to spend more time with patients as it removes the need to provide a large volume of services. Many have seen the signs in a physician's office – "one issue per visit" – this is due to the fact that the physician has to see a certain number of patients each day to make the FFS model work. Capitation has become a cornerstone of Ontario APP models.

Next week – How Primary Care reform has failed in Ontario and the consequences of that failure