Ontario Health Coalition
Summary of "Patient Care Groups: A new model of population based primary health care for Ontario" *Primary Health Care Expert Advisory Committee*

February 2016

The full report is available at
http://health.gov.on.ca/en/common/ministry/publications/reports/primary_care/primary_care_price_report.pdf

The report proposes a system of Primary Care Groups contracted under the Local Health Integration Networks (LHINs). The Primary Care Groups would then contract primary health care providers to provide care.

General Notes:

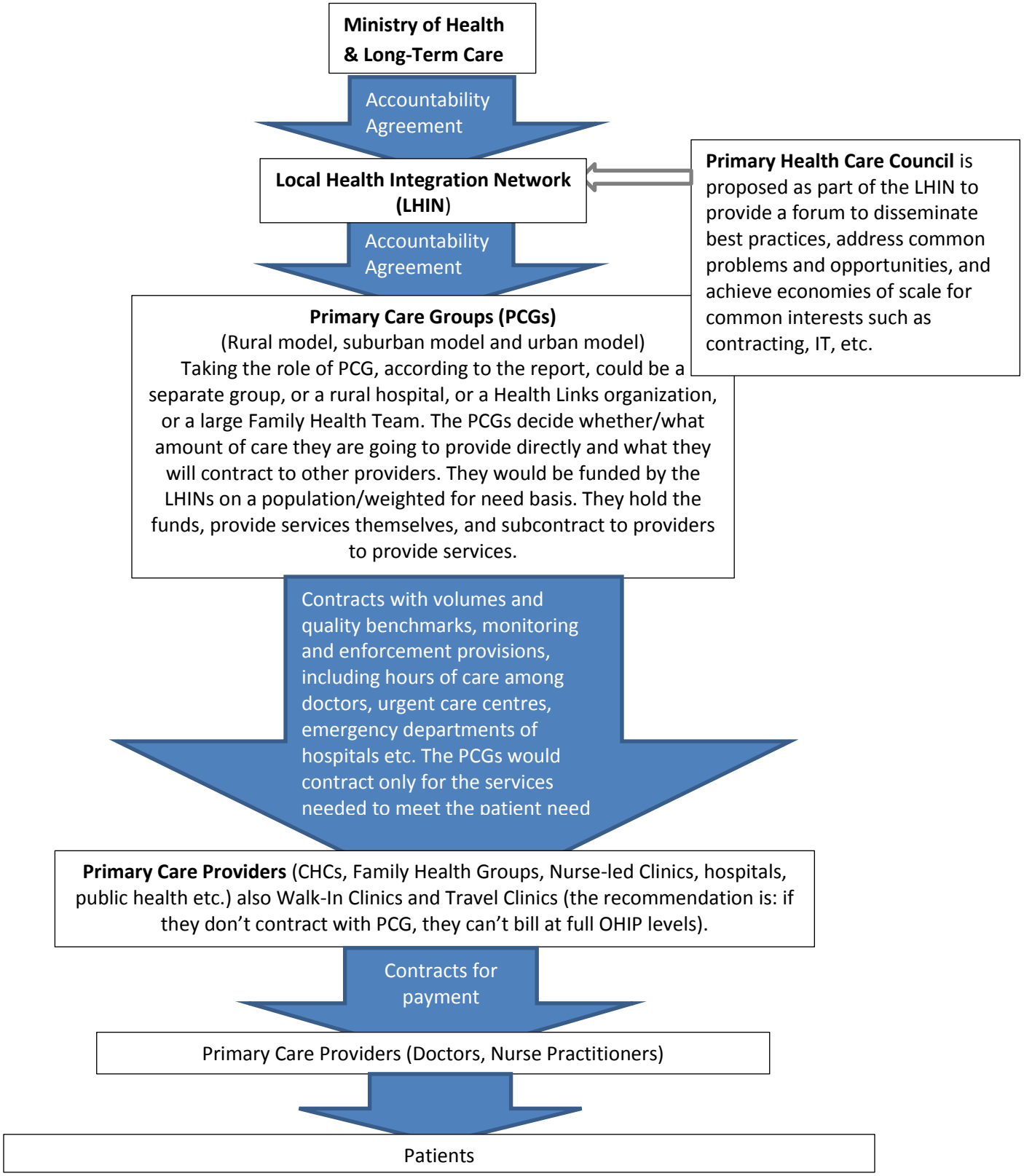
The report is based on principles that are generally progressive. It calls for greater equity, access, and population-based health planning. The goal of the proposal is to ensure that all Ontarians have access to primary care. The report refers to nurse practitioners and family doctors equally. It also embraces team-based approaches, though it does not propose to expand, in any concrete way, a team-based approach to primary care that incorporates the full team of health professionals to their full scopes.

However, the report and recommendations totally fail to mention ownership structure (public, non-profit, for-profit) for primary care. Giant multinational health corporation Centric Health has moved into Canada and has aggressive plans to expand into primary and integrated care. Group practices that are incorporated under for-profit structures could actually become the Primary Care Group and take charge of providing care directly and contracting other providers for care. Also not mentioned at all in the report are out-of-hospital premises (a form of private clinics) and other private clinics such as "boutique" physician clinics that sell two-tier executive health care and have been expanding the types of care they provide into diagnostics and day surgeries. The emergence of chain-owned for-profit companies, two-tier private clinics, and multinational for-profit expansion into primary care must be stopped and reversed. This report does not help, and it could, depending on the ideology of the government of the day, facilitate very quick system-wide for-profit privatization of primary care. There are no safeguards here, no attempt to roll back privatization and no recognition of these issues.

There are multiple tiers of overlapping oversight and administration in this model. Part of the LHIN role is redundant. Part of the Primary Care Group (PCG) role is redundant. Part of the provider groups' roles are redundant. The role of Health Links would seem to be entirely redundant, but the paper presumes that Health Links would continue. In particular, it seems that there is a lack of distinction between some of the role of the PCGs and the role of the LHINs. In some parts, the proposal seems to indicate that the PCGs would do the same things that Health Links and the LHINs are doing. See:

> "Each PCG ensures coordinated care for patients through collaborative relationships with the local hospital, long term care facility, CCAC, and other community-based providers, achieving horizontal (coordination between primary health care practice settings) and vertical (coordination between primary health care and other parts of the system) integration" and "Each PCG coordinates with other services beyond the traditional health sector to create communities and environments that promote the health of its patient population."
> Pp. 5.

The primary care structure(s) as recommended in this report:



There are a few references in the report that are just bad politics. In addition to ignoring ownership (for-profit versus public or non-profit), the report cites Don Drummond and falsely claims that health care spending takes nearly 50% of every public dollar (health care has dropped to 42%). The report claims that the proposal works within existing financial constraints but there is no actual costing.

Under this plan, patients would be rostered to a primary care provider by geography. Those who need specialized primary care (eg. falls prevention clinic), those who have existing primary care relationships outside their areas (including commuters) and others, who, for whatever reason, are getting primary care outside their geographic region, would be covered through fund transfer mechanisms between PCGs. It is not clear how complex this system of billing back or transferring funds for patients would become. It is not clear how patient choice in provider is to be protected.

The report proposes that the Primary Care Groups (PCGs) would contract for a volume of primary care to meet population need. If there are too many providers in one area, not all would get contracts. How the PCGs would choose which providers get contracts and which do not is not explained. Those primary care providers that do not get contracts in one area would, according to this report, move to underserved areas.

A simple market mechanism like this will not create equity in access to primary care in Ontario. It is hard to imagine that physicians will actually do this. Without real improvements in the way in which medical schools recruit. the use of full team-based models of care, a system linking small and rural hospitals with medical schools in their regions so that interns and residents go to those communities, a network of Community Health Centres with broader mandates to cover all of Ontario, and other changes like these, it is hard to imagine existing doctors moving from overserved places in downtown Toronto to small, rural and more remote areas where there are few or no primary care providers. (for more suggestions, see full list of recommendations in our report on small and rural hospitals at: http://www.ontariohealthcoalition.ca/index.php/toward-equality-and-access-realigning-ontarios-approach-to-small-and-rural-hospitals-to-serve-public-values-2/). Even if doctors did not stop this plan, those that did not get contracts are at least as likely to move away from Ontario as they are to move to remote communities. Furthermore, without prohibitions on private clinics, some urban d are more likely to just try to develop more of a market for private executive health care (two-tier care for the wealthy) in urban centres.

In particular, models should be considered which could expand public non-profit governance of primary care and that operate in the public interest, such as a full network of community health centres, or publicly-governed team-based models of care that could be set up in those places that have no- or very little- access to primary care (aside from the nearest hospital's emergency department) or team-based models working in local hospitals under public governance.

The report also does not speak to the issues regarding nursing stations.

The report recommends that Public Health and municipal services would get hard-to-serve people (like those without health cards or housing) enrolled with the Primary Care Group and the PCG would assign them to providers. In our experience it is groups like Street Health, shelters, and other models of Community Health Centres that actually know the most about this. It is not clear whether they have been consulted about this.

Patient electronic medical records would be accessible to any point of care within the primary care group and possibly to all providers within the LHIN. It is not clear whether patients will have any control over who gets to see their patient records, including for-profit companies with U.S. affiliations or ownership. To date, the expansion of electronic records has occurred with no public consultation at all about patient privacy issues. The U.S. Patriot Act gives U.S. intelligence agencies power to compel companies to share their records with intelligence forces if they have branch plants (or any operations) in the U.S. Privacy issues are also of concern in that information that may bias care would be accessible to a much wider array of providers. There is no public discussion in Ontario about patients' privacy when it comes to the idea of expanding access to patient health records across many providers. The public has not been consulted about protections in an electronic health records regime that enables wider access to an array of patient records.