National Pensioners Federation | Fédération Nationale des Retraités

Responsive Primary Health Care

"The nucleus of the health care system is the patient and public surrounded by responsive primary health care."

~ Dr. Tom Noseworthy. "Characteristics of High Performing Health Systems"
A Cy Frank Lecture. September 15, 2017

This paper explores the nature and delivery of primary health care in Canada; it focuses on the delivery of primary care for older adults. It has been prepared by the NPF Health Committee for the attention of Federal, Provincial and Territorial politicians, policy developers, our members and the general public.

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Contents

"There is almost universal agreement that primary health care offers tremendous potential benefits to Canadians and to the health care system . . . no other initiative holds as much potential for improving health and sustaining our health care system."

~Romanow Commission 2002

Executive Summary

Experts hold that the attributes of an effective, robust primary care system include ready and timely access to the primary care provider and to specialists, continuity of care, and comprehensive and whole-person centred care that is evidence-based, integrated and coordinated.

A review of the research indicates that a high percentage of older Canadians do have access to a regular family physician or place of care, but thousands do not. Many resort to walk-in clinics as their source of care, and they use emergency rooms when no other choice is available to them. The ideal of primary care – multi-disciplinary, team-based delivery, with the general practitioner or family physician at the core – is not a reality for millions of Canadians. Human and physical resources must be increased and reorganized so that the ideal of care is achieved for all: in one's "medical home" – where care is person-centred, informed, comprehensive, coordinated, continuing and insofar as possible, community-based.

Another challenge of our current health care system is timeliness of care. While it is true that our system generally provides immediate, first-rate care in critical medical situations such as cancer, heart attack and stroke, the less urgent problems such as knee and hip replacements or cataract surgery may mean long waits -- months or even years.

The research recommends that the timeliness, quality and efficiency of primary care delivery could be improved if teams were established to provide community-centred care. The teams might take various configurations depending on the needs of communities and their populations, but essentially they would be composed of different health care professionals such as physicians, geriatricians, nurses, pharmacists, dieticians, psychologists, physiotherapists and others, all working together to provide a wide range of benefits to providers, patients and the health care system. Teams have the potential to have a positive impact on system costs, coordination, equity and the delivery of person-centred care.

The primary care required by older Canadian adults is similar to that needed by other Canadians. Ideally, however, it goes beyond to emphasize strong coordination across the spectrum of care: the care that is required focuses on evidence-based service delivery, ensures smooth and seamless transitions between health care services, and integrates the range of comprehensive services required by senior citizens. Today many patients and their families are confused and frustrated as they attempt to navigate the complexities of our care system. For the sake of patients, health care costs and efficiency of delivery, it is imperative that the current silos of primary care, home care and home support, residential care facilities, geriatric units, and palliative and hospice services be coordinated and integrated; and that a person's electronic health record form the basis of information in knowledge-based care.

Many older Canadians have one or more chronic conditions. The management of chronic illnesses is a major function and responsibility of primary care. It is during the primary care provider-patient contact ideally that chronic condition management plans are discussed, agreed upon, and implementation planned. Studies indicate that extensive consultation between primary care providers and their patients and families results in better health outcomes.

With age, older Canadians often have multiple health conditions that require prescription medication. It is incumbent upon care providers to ascertain whether older Canadians are accessing and using their prescribed medications; primary care providers should review and oversee prescription drug use in order to prevent the possibilities of harmful interaction. If health risks and costly services are to be avoided, conscientious monitoring for possible adverse drug interactions must be a fundamental aspect of the primary care of older adults.

Another indicator of the quality of the primary care delivery is the extent to which populations are immunized. Immunization is particularly important for older adults whose immune systems change and weaken with age and who can avoid communicable diseases or lessen their effects by availing themselves of protective vaccinations. Presently, only about two-thirds of older Canadian adults are immunized for influenza; the cost of some vaccines may be a factor.

Public Health Safety of Canada reports that many older adults are not computer literate: health information presented by electronic means is not accessible to them. Many Canadians are not health literate. For the sake of the health of citizens and more healthy lifestyles, it is incumbent upon governments and education systems to raise the levels of health literacy and general literacy (including computer literacy) among all Canadians.

Countries with strong health care systems and good primary care place a premium on illness prevention and wellness. They encourage their citizens to adopt healthy lifestyles, and they focus on the social determinants of health. Such countries have health outcomes superior to ours. More work must be done to attain and maintain the personal health of Canadians and to ensure health, nutrition, housing and income security.

Canada needs a medical workforce in sufficient numbers and with the knowledge and skills required to care for older adults. Senior adults are a diverse group representing a wide range of populations, and all have the right to equitable quality care. Innovative models of compensation and incentives are needed to attract providers to all geographic areas and to geriatric specializations. Medical curricula must feature a compulsory geriatric component for all medical personnel working with older adults.

Electronic records and systems, eHealth, E-prescribing, telemedicine, telemonitoring and other systems present immense potential to enhance the health care system. Electronic programs can strengthen primary care, facilitating the flow of information; and in some areas, make possible the delivery of some aspects of primary care. In spite of recent national and regional efforts to enhance the use of technology in health care delivery, more is needed.

Strengthening primary health care is a priority. The challenge is finding the right combination

to improve delivery, to implement best practices across the land, and move to a high-performing health care system for older adults and for all Canadians.

1.0 Introduction

Primary care stands at the centre of the Canadian medical care system. It is generally the first point of contact a patient has with the health care system.[1] During this contact, care is provided by a general practitioner, a family physician, a nurse practitioner, or a team of providers. The focus of primary care is on diagnosing and treating illness and injury. But primary care also includes managing chronic conditions, promoting health through education and guidance, and coordinating services for patients who require the care of medical specialists, dieticians, nurses, occupational and physiotherapists, pharmacists, social workers or other medical service providers. The delivery of quality primary care is foundational to an effective and efficient health care system. Good primary care is accessible, comprehensive and person-centred.[2]

Primary care contacts represent about 80% of our health care interactions. That proportion of contacts in itself indicates the essential need for primary care to be the best that can be delivered. When the delivery of primary care is at its finest, when it is prompt, preventive and effective, it optimizes patient satisfaction and positively improves and sustains the entire health care system.[3] It can delay or prevent the onset of illnesses, minimize repeated tests and the use of unnecessary medications, and reduce or eliminate costly emergency room visits, hospitalizations and re-admissions. It increases opportunities for us as Canadians to live healthy, productive lives even into our later years; and it embraces our core societal values of equity, fairness and compassion.

Surveys have shown that as Canadians we are proud of our country's health care system. We regard our single-payer Medicare structure, with universal coverage for primary care and hospital care, to be fundamental to the delivery of optimal care, and we are proud that it eliminates financial barriers for all Canadians as they seek to access health care. We report that when we do see our primary care giver, results are positive for many aspects of our care.[4] In fact, for urgent medical problems such as heart attacks and cancer, our care is world-class.[5] However, we are aware, often regrettably from first hand experience, that the Canadian health care system has gaps and inconsistencies and is not the best that it can be.[6] Some of the problems lie in the shortcomings of primary care. The shortcomings affect us older adults in particular, for, with age, we may develop multiple chronic conditions and become frail. For us, the need for timely, accessible quality primary care is amplified. Primary care providers are the navigators of the health care system and gatekeepers to other needed medical services. We rely on their compassion, their knowledge of the system and understanding of our medical needs; we count on them to manage our health and to advocate on our behalf. They are essential to our wellbeing.

2.0 Responsive primary care, with an emphasis on delivery for seniors

2.1 Access to care: "Is there a doctor in the house?"

Every citizen should have access to primary care in a relationship that is founded on trust.[7] The benefits to the patient and to the system of a close primary health care relationship are

obvious: more accurate diagnoses; fewer referrals, prescriptions, diagnostic tests, emergency room visits, and hospitalizations, and, because of better coordination, less redundancy. With trust comes better compliance to medical advice and a reduction of health disparities associated with socio-economic status.

In Canada, the number of family physicians is not sufficient to meet our population's needs: in 2014, there were 2.5 practising physicians for every thousand Canadians.[8] Five million Canadians are not attached to a primary care giver.[9] Twenty-five thousand people in Nova Scotia in 2017 and 220,000 people in BC in 2015 did not have a personal front line care provider. Indigenous populations (First Nations, Inuit, Métis) and patients who require specialized ethno-cultural health service very often have difficulty accessing appropriate care, or primary care in any sense.[10] Inability to access primary health care for patients is time consuming, confusing, frustrating and dangerous; for the health system it is inefficient and costly as clients are forced to turn to other more costly health care services.[11]

2.2 Emergency room care

The emergency room (ER) serves as a sensitive indicator for how well care systems are responding to patients' primary care needs. A recent survey found that ER use-rates during the past two years were significantly higher in Canada (and the United States) than in three other peer countries. North American adults were more likely to have gone to the ER for care that could have been provided, if available, by a primary care source. In 2013–2014, more than 1.4 million visits to Canadian emergency rooms were potentially avoidable or for non-urgent care conditions that could have been treated at a doctor's office or clinic.[12] Once in emergency, patients report long waits for treatment, with two hours or more cited to be common.[13]

2.3 Team-based care

In 2003 the First Ministers' Accord designated $36 billion to health reform and then in 2004, increased that amount by $41 billion. One of the set priorities was to improve access to care. The goal was to reform primary care delivery by encouraging the creation of multi-disciplinary teams, thus shifting from the traditional single primary care provider who focuses on the diagnosis and treatment of illness and injury to teams of providers.[14] [15] It was envisioned that the teams would be organized so that physicians and other multi-specialty professionals and paraprofessionals would work together to provide services. Recommendations are that primary care physicians should be at the centre of the teams.[16] Physicians would lead in a patient-centred delivery of care, taking charge of the patient's health, coordinating care, consulting with specialists, making referrals to other team members, and establishing a relationship of trust. Teams would provide informed, effective health care service along a continuum of care that would include personal knowledge of the patient's history, effective input by clinicians and specialists, and the use of information technology.

Varying configurations have been proposed for team-based medical service structures: Bodenheimer and Smith (2013) who suggest that primary care capacity can be greatly increased without adding many more primary care physicians, recommend empowering licensed personnel, including registered nurses and pharmacists, to provide more primary care.[17] The greater use of nurse practitioners for primary and specialty team-delivered care has been recommended,[18] as well as stable "teamlets" consisting perhaps of a medical assistant

and a clinician who could form the core of a larger team.[19] Teams could be located on site or off site; the teams of specialists and paraprofessionals could be shared, although they would all be accountable to one another for the patient's care.

The Government of Canada, seeking to improve access to primary care by introducing new approaches to care, established the $800M Primary Health Care Transition Fund (PHCTF) in 2000. The fund was to support transitional costs associated with the efforts of the provinces and territories to deliver team-based delivery over a six-year period (2000 -2006). Health Canada in 2006 recommended "faster implementation of interprofessional primary health care teams".[20] That advice was reiterated in 2013.[21] Primary health care reform, however, is not happening as rapidly and broadly as hoped. The PHCTF resources have been used mainly for small initiatives, and Canada continues to rate among the lowest when compared to peer countries in providing access to quality primary care.

In summary, it has been determined that inter-professional team-delivered health care would enhance the lives of all Canadians, but particularly, the lives of citizens living in rural and remote areas, and those who have chronic conditions. Yet, in 2012, relatively few primary health care services were being delivered in a team-based setting. [22]

2.4 The walk-in clinic as opposed to a medical home

The expected role of walk-in clinics is to see patients when they exhibit less complex problems or when their primary care provider is not immediately available. A walk-in clinic can see as many as 50 or more patients in a day [23]. In BC, "fee-for-service" means that family doctors may choose to limit the time with patients based on the regulated fee for the service provided. Clearly, the kind of care sought by older patients who often need more time to discuss their complex conditions is not probable in time-restricted situations. Nevertheless, more and more Canadians, among them older Canadians who cannot find a doctor, must use the walk-in clinic, which is less likely to offer the kind of primary care that meets their needs. The medical home is much different from the walk-in clinic model. A person's medical home is one that emphasizes quality outcomes, fostering a relationship that is long term, personable, supportive and reliable. The medical home is conceived as the centre for timely, evidence-informed provision of care, and coordination of the comprehensive menu of health and medical services as needed and as close to the patient as possible. The idea of one's personal medical home was introduced in 2002 and has evolved into a model featuring inter-professional teams as the basis of care. In 2009 the College of Family Physicians embraced the idea. Practices based on the tenets similar to those of the patient's medical home already exist in several Canadian provinces, [24] [25] but the ideal, it is held, would be team-based primary care for all, in the form of a medical home -- a connecting and service point for the entire journey of each Canadian through the health care system.

Recommendations

1. Governments and relevant educational bodies should work to increase the number of family physicians so that there is a higher ratio of family doctors to population and family doctors to specialists. Every Canadian who desires one should have access to a trusted primary care giver.
2. Team-based primary care delivery, with the physician at the core, should be the norm for primary care so that every Canadian citizen has a "medical home".

3.0 Timeliness of Care: "Still Waiting"

An essential aspect of quality primary care is timeliness of care, and it is one of the greatest challenges and weaknesses of our health care system. Over the years the federal government has allocated sizeable financial resources ($1 billion in 2007 alone) to shorten wait times, usually targeting specific areas. Some improvements have been realized in the areas of cancer, heart, joint replacement, diagnostic imaging, and sight restoration (Canadian Institute for Health Information 2016).[26] Citizens continue, however, to experience unacceptable waits in areas beyond the original wait time priorities of the health accords, these unacceptable wait times existing specifically in and between primary care and specialist care.

Appointments to see the general practitioner

Timely access to primary care services would minimize the use of expensive, unneeded services and tests, and provide continuity that would result in better patient health and satisfaction. (Health Canada 2015).

As Canadians we are less successful than citizens in other developed nations when trying to access timely care [27]. In fact, among peer countries, we have one of the lowest rates of access to timely primary care, with some of the longest wait times for doctors and specialists and the longest emergency department visits.[28] Whereas an average of 57% of patients studied internationally could get same or next-day appointments to see their primary provider, Canadians were less likely to be as successful, ranging from 49% in Saskatchewan to 30% in PEI, with the whole of Canada averaging 43%.[29]

Wait times for specialists and for diagnostic tests and treatments similarly are reported to be significantly longer in all Canadian provinces than the international average; in fact, among eleven countries, wait times for specialist care is longest in Canada, and they are not improving.

After-hours care is likewise more difficult to access in Canada than in other peer countries. Compared with the Netherlands where 94% of primary care givers make arrangements for patients to see a doctor or nurse after hours, in Canada only 48% of practices make similar arrangements.[30] Only about one in three Canadians are able to access care in the evenings, on weekends or holidays, without going to emergency departments. Albertans were near the international level of 43% who could get 24/7 medical care, but other provinces reported lower averages, with only 16% of the citizens of Newfoundland and Labrador reporting after-hours access to care. Many Canadians (37% urban and 56% rural) reported having to use emergency departments more often than citizens in other countries because they could not get an appointment with a regular doctor.[31] In 2013, the Health Council of Canada reported that after-hours primary health care remains unavailable to most Canadians.

In "A Vision for Canada: Family Practice – the Patient's Medical Home" (2011), the College of Family Physicians of Canada recommends that primary care should be accessible "24 hours a day, 7 days a week, 365 days a year"[32]. No single primary care provider can offer such access to timely primary care. Often, strategies designed to improve timely access to primary care in Canada have focused on adding resources to the system -- increasing the supply of family physicians or adding financial resources, or requiring family physicians to devote after-hour

care a few times a week. However, it has been argued that alternative measures can be adopted to provide more timely delivery of primary care if the available resources were reorganized. More timely care could be provided if family physicians would work with other health care professionals to facilitate patient flow, for example, in an appropriate mix and number of personnel that would provide after-hour care depending on the needs of patients, the community, and the population. It has been suggested that strategies could also include scheduling approaches that would enable patients to get an appointment on the day they needed care: centralizing intake models, using non-doctor providers, adopting the "bank-line" intake method and instituting a single common queue, and "open access scheduling" -- keeping a majority of usually short appointment slots unscheduled, filling them only on the same day as patients call in for appointments.[33] Other suggested interventions include "dedicated telephone calls for follow-up consultation, the presence of nurse practitioners on staff, and nurse and general practitioner triage" and also email consultations, which have been found effective also at reducing wait times.[34]

For more timely health care delivery, Health Canada suggests that timely care delivery could be improved in all Canadian communities with the "creation or enhancement of telephone advice lines to provide 24-hour first-contact services".[35] Such a helpline has been established in British Columbia: people anywhere in the province at any time of the day or night can call BC NurseLine to receive the advice of a registered nurse, and from 5 p.m. to 9 a.m. they can reach and speak to a pharmacist.[36]

It has been said that in Canada pilot projects have "successfully reduced waiting times in public hospitals and clinics [and] need to be enacted on a more widespread basis".[37] It's time to move beyond isolated pilot projects, to identify and fund effective solutions that improve access to timely care for all Canadians and to spread those solutions throughout the land.

Recommendations

3. Canada should follow in the steps of high performing health care systems that offer primary care by multi-disciplinary teams in community-based, team-based structures, allowing for members of a team to be available after hours.
4. Timely access to primary care could be facilitated by increasing human resources, by making full use of professional and paraprofessional health care personnel, by implementing effective scheduling formats, establishing readily accessible health helplines and websites, and by spreading innovative practices which have proven successful in providing more timely care.

4.0 Primary Care and the Older Adult

4.1 Access and Timeliness

Statistics Canada has predicted that the population of older adults (age 75 or more) in the next 20 years will double to number 5.7 million.[38] In 2009-2010 there were approximately one million seniors considered "frail" and living in their communities; another 1.4 million were "pre-frail", and the number increases. For vulnerable frail patients, those who have multiple serious health issues, a minor problem can lead to a major change in health status. Immediately accessible care for them is imperative.

The Commonwealth Fund 2014 International Health Policy Survey of Older Adults (age 55+) shows, however, that 53% of the older Canadian adults who were surveyed waited two or more days to see a doctor or nurse the last time they needed medical attention.[39] About the same number, 51% of older Canadians, reported difficulty getting medical help after hours or on weekends without going to an emergency room (ER), making them the second most likely among similar countries to visit an ER for a condition that could have been treated by their doctor.[40]

Compared with citizens in those same peer countries, Canadian seniors have the longest waits to see their primary care providers and the longest waits to see specialists. Many are not getting consistent management of their complex medical conditions within the dimension of primary care.[41]

It has been recommended often that physician and team-based care for older adults would allow for community services to be accessed, for the gaps between hospital and continuing care sectors to be bridged, for older patients to be placed appropriately, and costly hospital and residential care avoided or delayed.

Recommendations

5. Older adults with complex and often interrelated health and social needs should be provided with interprofessional collaborative team-based care, close to home and community, with supports for prevention and management of chronic disease.
6. Care systems should enable house calls to be made to meet the needs of frail or homebound older adults who need more than in-office primary care.

4.2. Continuity, Comprehensiveness and Integration: "Falling between the Cracks"

For older adults who often have more than one chronic condition, continuity of care is imperative. The reality is, however, that follow-up care is not smoothly integrated. A study of doctor practices reveals that only 23% of primary care givers were notified when patients had been seen in the emergency department or when discharged from hospital[42] and 40% of older survey respondents reported that problems exist in transitions, in coordination with community services and hospital discharge planning.[43]

In a recent Commonwealth Fund survey, 25% of older respondents reported that after a referred visit to a specialist, their regular doctor did not seem up to date about the results. Often the test results or medical records were not available at the time of a scheduled appointment, sometimes lab and diagnostic results were not clearly explained, and in some cases, the test results were not received at all. Patients might have then been subjected to duplicate tests or procedures. In fact, according to a recent report, "up to 30% of medical tests, treatments, and procedures performed in Canada may be unnecessary."[44]

Recommendation

7. Hospitals, emergency departments, and health service agencies that admit or diagnose older adults should be mandated to notify the person's primary care provider or team within a reasonably short time regarding the reason for admission.

Care can sometimes involve accessing medical and social services across many programs that

are not integrated. Patients and their caregiver families or friends are often left to navigate our system's many uncoordinated silos on their own, and "too often fall between the cracks."[45] Poor integration of health care services often means repeated visits to primary care physicians. When the patients are older persons who might exhibit multiple chronic diseases, dementias, and palliative-care needs, fragmented care systems may result in poor health outcomes and with substantially higher costs associated with avoidable emergency room visits and hospital admissions.[46] Large numbers of older patients, ranging from 10% to as much as 46% among provinces, report lapses in continuity of care.[47] These patients feel frustrated and overwhelmed, their health is at risk, and the system must pay for inefficiencies when their tests and procedures must be repeated.

Research analyst Kimberley Fowler (2016), reviewing academic studies related to seniors care in Canada, observes, "There is often a disconnect between hospital, physicians, and public health-care workers [and] when you factor in the "fringe" areas of our health-care system (which include home care, home support, residential care, geriatric units and hospice care) it becomes difficult, if not impossible to achieve a true continuity of care [for older adults]."[48]

Clearly, there is an urgent need to break down the silos that impede coordinated patient-centred care, which is so essential to the well being of older adults. Research indicates that comprehensive and coordinated quality primary health care for older Canadians has these characteristics: the integration of services, a sound knowledge of patients and community, the use of clinical pathways and guidelines to ensure quality care, evidence-based collaborative team-based care (including all members of the care team whether co-located or not), and sophisticated electronic medical records that include clinical decision support, prompts, reminders and registries.

4.3 Integrating the system for older adults

Chappell and Hollander (2016), renowned professional and academic Canadian gerontologists and policy researchers, recommend that to address the care needs of persons with chronic conditions, a great many of whom are seniors, the health system must be re-organized. Increasing numbers of persons have diabetes, dementia, heart problems, chronic lung disease and other chronic conditions. Chappell and Hollander hold that major efforts should be focussed on giving those persons the best possible support and care in their homes. Canadians universally support this view. Few, if any, choose institutionalized care over remaining in their homes. A modest amount of tertiary care in the form of preventative and supportive care in the homes of persons with chronic conditions would very likely reduce physician visits and prevent chronic care patients from becoming worse. Chappell and Hollander recommend that the specified and needed preventative and home care should not be added to what is already characteristic of the health care system. Instead primary care, home care, home support, residential care facilities and geriatric units should be brought together and integrated as a fundamental part of the health care system. They envision the integration to be a major fourth component of health care. It would be a continuum of care which enhances the quality of life of older adults with chronic conditions and which delays more expensive care. It would become a key component of our health system – standing alongside hospital care, physician care and public health:[49] a seniors' health care strategy.

Recommendations

8. An integrated care system for caring for older Canadians should be implemented, bringing together primary care, home care, home support, residential care, geriatric units, palliative and hospice care to form a separate component of health care that ensures comprehensive, continuous care across the spectrum.
9. Communication between primary care providers, and home care and community support programs should be such that enable older adults to maintain their independence for as long as possible.
10. Needed services such as housekeeping, meal provision, transportation, and social supports should be smoothly coordinated with health care services to support older adults wishing to live at home.

4.4 Chronic disease prevention and management

Although Canadians increasingly are affected by one or more conditions such as diabetes, dementia, heart failure, and chronic lung disease, not all older persons have chronic diseases and indeed are vibrant and productive, no more costly to the health care system than younger people. In fact, a 2011 study on seniors' use of primary care resources found that those aged 85 and older with no chronic conditions had fewer than half the number of health-care visits as did those aged 65-74 who had three or more chronic conditions (Canadian Institute for Health Information [CIHI], 2011).[50]

However, approximately 75-80% of older Canadian do in fact report having one or more chronic conditions. They comprise 12% of the population and account for almost a quarter of physician consultations and half of the hospital days.[51] They use emergency rooms more and spend more time in hospitals than patients with other kinds of health needs.[52] Health Canada in 2012 reported that chronic diseases are estimated to account for 40-70% of health care system costs.

A recent survey (2011) by Schoen and others found that when compared with other member countries in the Organization for Economic Co-operation and Development (OECD), Canada performs poorly in the coordination of care for patients with complex needs.[53] When surveyed, one-third or more of those with a chronic condition diagnosis said "no" when asked if their doctor had given them a plan to manage their care at home.[54]

Primary care is the best place for early detection of chronic disease, for subsequent interventions and management of symptoms, and for reducing the likelihood of further complications.

High quality chronic disease prevention and management is essential for patients and the system. Effectiveness of care for those with chronic conditions means using inter-professional teams to integrate primary care and specialist care. It means using the best evidence-based practices, sharing longitudinal clinical records among providers, involving patients in their own care, and providing care in the least intensive setting -- in the patient's medical home.

In the course of primary care contact, providers can deliver self-management support as a routine part of care so that as much as possible patients with chronic conditions, mainly seniors, can manage their conditions in the most patient-friendly, cost effective way. The support of home care and check-in phone calls by team personnel or visits by the primary care provider

can help people manage chronic conditions. The Health Council of Canada in 2006, in support of the best possible chronic disease management, urged that we should "speed up implementation of primary care renewal, [and that] we need interprofessional teams in place—and quickly."

Recommendations

11. Persons with chronic illnesses should have optimal opportunity within primary care contacts to be guided and empowered to help manage the chronic conditions they present.
12. Standard, accessible and comprehensible self-management guides dealing with chronic diseases should be developed and distributed to Canadians.

4.5 Medication accessibility, appropriateness, and management: "Pop the right pill"

A fundamental role of the primary health care provider is to prescribe needed medicine and to act as steward of a patient's medicines. The provider must determine whether the patient is actually using needed medicines, must periodically reconcile medicines to avoid harmful interactions, and communicate the right information about the patient's medicines to other components of the health care system.

The accessibility and use of appropriate medications is fundamental to the health of older patients who often take multiple drugs and who need them to manage acute or chronic diseases. Yet 7% of older Canadians, a significantly higher proportion than the average in peer countries, report that they were prevented from filling a prescription or they skipped a medical dose because of the cost. [55]

Sixty-five per cent of older Canadians take medications belonging to five or more medication "classes", and adults over age 85 take medications belonging to ten or more medication classes. The risk for harmful drug interactions is high. Inappropriate prescription medication use is a known correlate of avoidable hospitalization and hospital readmissions due to adverse drug events.[56]

Although explaining medication side effects, reviewing medication intake and interactions, and helping patients manage medications is a fundamental responsibility of primary care, patients who take prescription drugs regularly have reported frequent failures by physicians to explain medications and review their use. This is serious and dangerous, not only to the patient but also to the entire system, which must bear the resulting costs of adverse drug reactions.

One of the barriers to more accurate prescribing of drugs as a dimension of primary care has been cited as lack of time to discuss medication use with patients. Obviously there is the need for an inter-professional approach of care,, which in every province, involves personnel such as pharmacists and the support of integrated health records.

Comparisons with other peer countries have indicated that a national drug strategy would not only save Canadians money but also mitigate the chance for older citizens, the most numerous consumers of pharmaceuticals, to be prescribed medications or medication combinations that we know can be potentially harmful to their health; and it would help avoid costly consequences attributable to the prescribing and use of such inappropriate combinations. Canadians support the establishment of a national pharmaceuticals strategy: The CMA

National Report Card in 2016 reports that when asked in an IPSOS survey to rank the initiatives that would truly transform the Canadian healthcare system, Canadians cited prescription drugs along with a strategy for seniors health. Academic support for a national drug plan is likewise strong.[57]

Recommendations

13. National medical curriculum guidelines should be reviewed to emphasize comprehensive training in medically appropriate and inappropriate prescribing and de-prescribing for older adults.
14. Team-based collaborative care should involve pharmacists; and electronic medical records for all patients should become the norm across Canada.

4.6 Precision medicine

Precision medicine, including pharmacogenomics,[1] is an emerging approach for disease treatment and prevention. It takes into account how the environment, lifestyle and genes differ for each person. It can pinpoint the right treatment at the right time for an individual with reduced side effects and maximum efficiency. Right now Canada has pockets of strength in precision medicine, in Newfoundland for example; and the Canadian Institute of Health Research is leading the development of a new strategy. However, what is lacking is a national approach for implementing sub fields of precision medicine (pharmacogenomics and cancer diagnosis and treatment) into patient care. The Advisory Panel on Healthcare Innovations (2015) suggest that "the incorporation of this new paradigm [the fields of precision medicine] into Canadian healthcare must be swift, strategic, and, where appropriate, sceptical, so that we can maximize its benefits in a cost-effective manner."

Recommendation

15. The area of precision medicine should be researched and evaluated as an approach that might possibly be supported by organizations of older adults.

4.7 Immunization

Vaccines are widely recognized as safe, long-lasting and effective ways for people to stay healthy by preventing illnesses or rendering them less severe. As such, vaccines are an integral prevention component of primary health care in Canada; the rates of immunization are a measure of the effectiveness of care delivery. Vaccinations become more important for us as we get older, as our immune systems weaken with age, putting us at greater risk for certain diseases. Among vaccines recommended are those to prevent influenza, shingles and pneumonia in older adults because these diseases may have complications that lead to severe illness, hospitalization and even death.

Vaccination rates in our country, however, are below targeted levels: The Canadian Institute for Health Information (CIHI) in 2016 reported that between 2011 and 2014, only 63% of seniors over 65 reported having received the influenza vaccination in the last 12 months and that this rate stays fairly constant – 37% of older people typically are not immunized.

[1] *Pharmacogenomics* refers to how all of the genes (the genome) can influence responses to drugs. *Pharmacogenetics* refers to how variation in one single gene influences the response to a single drug.

Financial and information barriers often are reasons for the underutilization of vaccines. Some vaccines are costly, and in some cases the costs must be borne by the individual. The shingles shot is an example of a vaccine that must be purchased by Canadians for about $150 to $200 -- except in the case of Ontario where it is free. In another example, the common flu vaccine is generally free to older adults, but a new "Fluzone High-Dose", which has been FDA approved and which is highly effective for people who are 65 or more years of age, is now available. However, it comes at a cost beginning at $65 and varying.

Obviously, for the benefit of Canadians and the health system, we want all older adults to have easy access to the benefits of vaccines. Removing the costs of vaccines for older adults would serve to increase utilization and reduce future, more costly health services. Efforts must be made also to provide people with specific information that creates awareness of the importance of adult vaccination. And vaccination history should become an integral component of an individual's electronic medical record.

Recommendations

16. Awareness should be enhanced among older adults of the availability of the vaccines for pneumonia, shingles and Fluzone High-Dose.
17. Cost should not be a barrier to accessing vaccines, including those for shingles and Fluzone High-Dose.

4. Patient engagement and empowerment: "Nothing about me without me"

The power of choice and the decisions by people for their own health care should not be underestimated when it comes to achieving their optimal health and the overall success of health care delivery. If individuals can access their medical records, if they can share in decision making about their health and treatment, they can play a significant role in their own health care. However, only about half of Canadians who have a regular doctor or place of care report being engaged in their primary care.[58]

A basic ethical principle of health care is informed consent: an individual is entitled to know the risks and benefits of a given treatment or care option, and to decide whether to pursue it, free from any form of coercion. Choice is paramount. To facilitate such decision-making, opportunities must be in place within primary care for patient-practitioner interaction to ensure appropriate treatment consideration. Older Canadians, in particular, should be able to engage in deciding on their care.

Recommendation

18. Opportunities to discuss evidence-based care options and allow for patient decisions should be an essential feature of primary health care delivery.

5.0 Health literacy and our complicated system

The Public Health Agency of Canada says that 88% of older citizens are not health literate, that they are unable to access, understand and evaluate the vast range of everyday health-promoting information available through the media or in communities. Accordingly, they may pay little mind to information about the factors affecting their overall health -- tobacco use, alcohol consumption, nutrition and physical activity.

They may be unable also to access information and resources that promote healthy ageing, through on-line methods. Websites such as McMaster University's Optimal Aging Portal are empowering health information on-line resources that aim to provide user-friendly evidence-based appraisals regarding health claims that are made about specific products and activities. However, only 60% of Canadians age 65-74 have ever used the Internet and this number drops significantly to 29% for those over 75.[59]

Closely related to health literary is the ability to navigate the healthcare system. In Canada the system is fragmented and confusing to navigate. Accessing services or information through the maze of departments that deal with them is challenging -- so much so that patients and their families are resorting to hiring "patient advocates" or "consultants" to help them navigate the "labyrinthine" system.[60]

An obvious need exists to improve the health literacy skills of Canadians, which would result in better population health as a whole. The independent ability to use and assess print and on-line resources would help Canadians appreciate and understand the things they can do to stay healthy and independent for as long as possible.

Recommendations

19. Health and social services information needed by older Canadians should be available to all.
20. Navigation of the health care system should be simplified so that older persons can easily access health and social resources available to them; and helplines and health resource websites should become a part of an integrated system of care for Canadian seniors.
21. Health literacy should pervade Canadian curricula through school-based health promotion programmes such as "Better Beginnings, Better Futures", which is a school program that promotes health and well being in primary children and families in Ontario.

6.0. Overall lack of emphasis on prevention

The relative lack of emphasis on health promotion and disease prevention within primary care delivery has been linked to poor population health and high rates of preventable illness. According to a recent five-country survey, primary care practitioners in Canada fail routinely to make sure patients are up-to-date on recommended preventive care.[61] If patients are counseled to adopt advice about proper nutrition, regular physical exercise, interventions such as vaccinations, avoidance of smoking and excessive use of alcohol, they will be less likely to develop chronic diseases; and their overall life expectancy will be extended. It has been suggested that adopting the habits of a healthy life style could reduce the risk of contracting Alzheimer's disease in later life.[62]

In 2014 Stats Canada reported that more than one-fifth of all adults over eighteen were classified as obese – 5.3 million adults.[63] And among children the rate is greater, more than 25%.[64] Obesity contributes to high health care costs, and it is one of the most significant contributing factors to many chronic conditions, including heart disease, high blood pressure, arthritis, cancer and type 2 diabetes. Yet, given the emerging epidemics of obesity and diabetes, more than half of the adult Canadians who were surveyed along with peers in four other similar countries, reported that their doctor had not recently provided advice or counseling on weight

control.

Primary care must emphasize health promotion, illness prevention, and health literacy if health outcomes are to improve and the burden on the system is to be reduced in terms of time, money and emergency care. A recent report by the Organization for Economic Co-operation and Development (OECD) calculates that Canada spends just eight per cent of total health care expenditures on public health and illness prevention. [65]

Ideally, we wish for our health span to correspond with our lifespan. We want to be encouraged, persuaded, empowered to adopt life habits that result in better health. We want to practise dietary discipline, stop smoking, exercise regularly, drink responsibly and engage in useful purposeful lives. We need our primary care providers to spend more time counselling us to adopt healthful lifestyles and monitoring us in our endeavours. We know that such attention can delay preventable illness and can result in happy healthy longevity.
Canadian school systems, too, have a responsibility. As many lifestyle habits are formed in childhood, instilling health-promoting behaviours during a child's formative and impressionable years has the potential to build healthy lifelong habits of consuming good nutritional foods and adopting habits of physical exercise.

Recommendations

21. An emphasis on health promotion and illness prevention in a primary care setting should be mandated, thus ensuring that health promotion counselling becomes an integral feature of primary care delivery.
22. Guidelines promoting wellness and preventing illness should be developed and distributed in ways that make them accessible to all Canadians, especially older Canadians.
23. Individual Canadians should be urged to adopt a healthy lifestyle by making changes related to diet, exercise, cigarette and alcohol consumption, and social involvement. It is estimated that as many as four out of five Canadians adults can make improvements to their lifestyle habits. Preserving Medicare is a responsibility of all of us.

7.0 The social determinants of health: " . . . but some are more equal than others"

One of the greatest health problems in Canada is inequality. Across our country inequities are based on many determinants – educational opportunities; housing; income security; the safety of communities and living and working environments; gender; race and ethnicity; cultural diversities; and social status. Disparities exist between rural and urban communities and between provinces and territories; among First Nations, Inuit and Métis populations as compared with other Canadians.[66] Studies have shown that a positive correlation exists between inequality and mortality, suggesting that unequal societies are less healthy overall.

The defining factor is income. The harmful effects of living in persistent poverty accumulate over the life course and have a detrimental effect on the health of citizens, whether they are children or older adults. Poverty rates are especially high among single senior women who live alone, among Indigenous seniors, immigrant seniors, seniors with disabilities, and gay and lesbian seniors.[67] According to a report by the *National Seniors Strategy for Canada*, published in 2016, there are over 600,000 seniors living in "low income" according to the after-tax low-income measure. Dr. Danielle Martin in *Better Now: Six Big Ways to Improve Health Care for all Canadians* (2016) says that poverty "has the greatest impact on health of

any [social] determinant" and that "the biggest disease that needs to be cured in Canada is the disease of poverty."

The Health Council of Canada in 2006 declared that the health system is powerless to overcome the health effects of poverty. If a minimum income level were guaranteed for all Canadians, says Dr. Martin (2016), "we'd liberate millions of dollars currently used on provincial social assistance programs. And recipients would not be treated as dim creatures, incapable of making decisions; they would be treated as human beings trusted to make life choices." Marginalization would be reduced, the generational poverty syndrome less likely to be perpetuated, and higher self-esteem, a better life, and better health outcomes would result.

Our vast geographical expanses, uneven access to economic opportunities, to education, jobs, and other social determinants of health, the failure to address adequately language barriers and cultural differences – and plain selected blindness and injustice – are responsible for some of these disparities in access to health care. While we pride ourselves on our Canadian values of fairness, equity and compassion, the truth is that we fail to address adequately the special needs of special populations.

Access to linguistically appropriate care is a right of Canadians. Improved health infrastructure, ready access to health human resources, and co-governance of health services are rights of Indigenous people. Health care services should align with the needs of the population. A national strategy must address the inequities.

Recommendation

24. With the advice and participation of Indigenous peoples, organizational structures, policies and processes should be developed so that equitable, responsive and respectful primary care services are provided effectively to Indigenous populations.

The achievement of equity in health and health services is an imperative. We need strong policies to ensure all Canadians true universal, equitable health care; high quality public education; appropriate housing; and equality reflected in community environments and opportunities. In the Nordic countries there is a particular emphasis on the socio-economic determinants of health, on tackling inequality, spending more on education and social welfare, and less on health. The resulting health outcomes are impressive. For Canada, the health determinants should be considered in all major government initiatives: federal and provincial policies overall should be guided by the overarching motif of "How does this affect the health of our people?"

To level the playing field we must at the very least deliver good primary health care to all Canadians. Its key features make it potentially a more equitable level of care than others with the prospect of narrowing disparities in health between more and less socially deprived population groups.

Recommendations

25. Governments should ensure that all Canadians are aware of supportive financial programs available to them, thus reducing poverty among older Canadians.

26. We should advocate boldly for equality among people in our country, and address poverty by having governments institute a basic minimum income level for all.

27. The primary care health needs of all older Canadians of diverse groups should be addressed equally, those diverse groups to include ethnocultural differences, gender, sexual preference, the homebound, and those with special needs.

8.0 Primary Health Care Providers: Who's going to look after us?

Canada has a shortage of physicians, family doctors and geriatricians, to meet the needs of older citizens. Today, fewer medical students are interested in the traditional family physician model of independent entrepreneurship, with the high overhead, long hours and added responsibilities that go with it. They choose instead the career of specialist wherein they can have a procedure-focused practice, see immediate results of their work, and, in the existing medical hierarchy, enjoy higher prestige among their colleagues. The preponderant choice for specialty as a career has resulted in an increasing number of under-employed and unemployed medical specialists.[68] This unfavourable family physician-specialist ratio is troublesome particularly when studies and surveys show that a higher ratio of family doctors practitioners to population and a higher ratio of family doctors to specialists would result in improved population health outcomes, reduced health disparities, and reduced system costs.[69]

As the population of older adult Canadians increases, the services of geriatricians become critical to the well being of the country's older patients and to the system. Geriatricians specialize in the care of frail patients of all cultures and ethnicities, and because they can prevent illness in an older person and restore an older ill and disabled person to independence for as long as possible, they are vital to our corps of care providers. The Canadian Medical Association states that the $2.3 billion a year spent in keeping elderly people in hospital could be used more effectively in the health care system.[70]

The problem is that relatively few medical students choose geriatrics from among medical concentrations available to them: Since 2007 the number of geriatricians has remained relatively steady at about 250 for our entire population of 34 million.[71] But who among med students wants to choose geriatrics? A geriatrician usually must spend more time in patient contact, thus becoming among the lowest paid specialists. The geriatrician's training is longer than that of most other professionals, and the specialty is not as "prestigious".

Recommendations

28. A pan-Canadian health workforce strategy should be established to lead collaboration between provincial/territorial health and education systems in order to align the health care work force with population needs and to ensure optimal utilization of the country's health personnel.

29. The pan-Canadian health workforce strategy should consider ways in which medical graduates could be incentivized to work in all communities --urban, rural and remote, as well as Indigenous communities and diverse linguistic and cultural populations.

30. The pan-Canadian health workforce strategy should facilitate certification and invigorate the processes around retention of international doctors and other medical personnel who have chosen Canada as their new home.

31. As the focus on geriatrics in medical school curricula has been described as "alarmingly anemic", governments and medical schools should ensure that geriatrics becomes a compulsory graduation component for all Canadian physicians and nurses.

9.0 Of course pay makes a difference!

Since the Medical Care Act of 1966, provincial ministries of health have tended to reimburse physicians on a fee-for-service basis, which is negotiated periodically between provinces and physicians. In 2015 about 70% of Canadian physicians still worked on a fee-for-service basis.[72]

One drawback of the fee-for-service pay model affects primary care and the system as a whole. Because there are few restrictions on the number of services that physicians can bill, the result can be uncontrolled increases in the volume of services. Canada's spending on physician services, on fact, is well above the OECD average, fourth out of twenty-seven countries with comparable data.[73] The spending is not reflected in our country's health outcomes rating.

Personal patient stories frequently reveal the "one-visit-one-problem" encounters and the apparent goal by some providers to limit physician-patient contact to ten-minute sessions. Naturally, the kind of primary care that can be delivered under such conditions significantly impacts senior patients who often require more extended, fruitful discussions about their care. Fee-for-service compensation, which rewards volume, means that a physician may not have enough time -- nor be compensated fairly -- to make an accurate diagnosis, to set a plan for health promoting activities, or, in complex cases, to make a plan to manage chronic conditions. It can also weaken physician-patient relationships and no doubt reduce the attractiveness of general practice for those who engage in it. In fact, many physicians have reported that they are uncomfortable with the fee-for-service treadmill and look toward different payment models. "[Remuneration should reward] quality and effectiveness of service rather than the amount of service provided."[74]

Recommendations

32. Physician pay models reflecting value and outcomes in the health care system should be adopted. Primary care doctors are central to the health care system; compensation should reflect that value.

33. Physician compensation models should be implemented to encourage medical students to choose family practice and geriatrics as specialties.

10.0 Technology: "Screen time"

The use of technology by primary care providers has enormous potential for timely, efficient health care delivery. E-mail, electronic medical records and videoconferencing can make it easier and quicker for healthcare providers to communicate with patients, collaborate with specialists, get the patient information they need, and reduce duplication.

In fact, since 2000 Canada has invested more than $2 billion in Canada Health Infoway to help provinces and territories implement digital technologies. The goal has been to reduce wait

times, encourage patient participation in health care, help patients manage their chronic conditions efficiently, and improve health care access in rural and remote communities. Fewer adverse drug inter-actions and better prescribing practices were, and are, anticipated as well.

It was expected that all physicians would switch to electronic medical records (EMRs).
But a report on the use of EMRs released in January 2016 found that compared to the 88% uptake by primary care providers in other countries, Canada lagged behind with 73% of Canadian physicians trading "paper for pixels in their practices", still playing catch-up. (Canadian Institute for Health Information 2016)

With Twitter reportedly being accessed monthly by more than 200 million users world wide, and Facebook by more than one billion users,[2] there is tremendous realizable potential for health services and information to be delivered and enhanced through the Internet and related technologies. With our vast geographic expanse, our relatively thin population density, and our OECD rating of first among the ten most-educated countries[75], we should be leading the world in the communication of digitally generated health-related data, in the use of mobile health and in virtual care.

The Public Health Agency of Canada in 2014 reported that indeed innovations in technologies were occurring. Alberta, Saskatchewan and Nova Scotia were reported to be pursuing provincial rollouts of personal health records and/or portals of information. BC was providing patients with electronic access to lab results. Ontario was adopting personal health records: Sunnybrook Hospital's *My Chart*. McMaster University's *Optimal Aging Portal* was introduced. Newfoundland has enthusiastically embraced the *One Patient, One Record* initiative whereby health care professionals will have access to critical patient information in a matter of seconds; and the province has partnered with Canadian Institutes of Health Research and private industry to reduce health care costs and improve patient outcomes through precision medicine approaches, harnessing big data analytics, top genetic and genomic research expertise. (Martin, 2016)

Evidence throughout the country points also to improvement in virtual care services in order to monitor individuals with chronic diseases and those recently discharged from hospitals, also to address the needs of remote patients through long-distance consultation and instruction.

The Advisory Panel on Healthcare Innovations, commissioned in 2014 by Health Minister Rona Ambrose, however, advised in their 2015 report, *Unleashing Innovation*, that much more must be done to fully realize the potential of digital information to enhance health care service. There is a need to harness and utilize meaningfully the vast amounts of digital health information stemming from research, which is growing exponentially, and also the data that are systemic and patient oriented. The Panel acknowledged that patients eagerly seek the co-ownership of their medical records, and strongly recommended such access by patients and also across jurisdictions to facilitate safe and seamless health care delivery and "to access the exciting innovations of precision medicine."

The 2017 Federal Budget recognizes the need for primary care delivery initiatives that involve the expansion of e-prescribing, the use of electronic records, and better electronic health

[2] (Twitter Inc. 2013. *Prospectus*)

records systems to link all providers and medical institutions. But can "an investment of $300 million over five years, starting in 2017–18, for Canada Health Infoway" really lead us to the fore in the use of health care information technology? To the place where technologies that support information sharing among all providers can enhance efficiency and transitions? We are looking forward to the time when patients' electronic records and good communication among providers can ensure that we older Canadians need not repeat our health histories nor undergo the same tests.

Recommendations

33. Governments and health agencies should focus on implementing electronic and digital resources and channels to enhance service and to enable integrated and coordinated health care support for older adults.
34. eHealth[3], Telemedicine[4] and telemonitoring, which connect patients with primary care providers and providers with specialists should be emphasized as health provision initiatives to facilitate communication and meet the health care needs of populations in all areas of Canada.

11.0 Implementing best primary care innovations and practices: Doing what's good

Innovations have the potential to improve primary care aspects: access, quality of care, self-management of chronic conditions, mental health, seniors' care, pay reform and governance models, and delivery to rural and remote communities and to diverse populations.

Primary health care renewal and innovation has accelerated since 2000 because of funding and delivery at the systems level. In response to the $800 million Health Canada Primary Care Transition Fund of 2000, and the additional funding and reiterated targets inherent in the 2004 Health Accord, provinces and territories between 2000 and 2006 initiated projects aimed at improving access to primary care and to components of primary care. Health Canada in 2005 identified strategies that were being undertaken: the enhancement of multi-disciplinary teams; the implementation of electronic health records and telehealth systems; the development and expansion of a range of primary care organizations and models including physician health networks, family health groups, and community health centres; new chronic disease management strategies; exploration of new funding and remuneration methods including alternate physician pay (contracts, rosters, salaries); and models to improve access and timeliness of care – self-care handbooks, call support systems, advice lines, to name a few.

In reporting out in 2011, Brian Hutchinson described a primary care delivery innovation in Saskatchewan: The "Health Bus", fully equipped with an exam room, staffed by nurse practitioners and paramedics, takes itself to socially isolated areas in an urban centre. It provides basic primary care – blood pressure checks, health checks, referrals, chronic care self-management counselling, and other basic care services. Available except for times of minus forty-degree weather, at the time of reporting, it had had five thousand visits seeking care.[76]

[3] (eHealth: health care practice supported by electronic processes and communication)

[4] (Telemedicine: remote diagnosis and treatment of patients by means of telecommunications technology)

Here's the point: Monique Bégin famously said of innovation in health care delivery, Canada is "a land of pilot projects " -- to which *Globe and Mail* journalist Andre Picard added, while in conversation with Anna Maria Tremonti on CBC's "The Current" in April, 2017: "[Health care delivery is characterized by] islands of excellence in a sea of mediocrity . . . we've solved every single problem in our health care system at least ten times on a small scale." We know what works; now we must implement.

Yes, entirely new models have been implemented by provinces and territories to improve primary care delivery -- to name some, Primary Care Networks in Alberta; Family Medicine Groups (Groupes de médecine de famille), Network Clinics, and Health and Social Service Centres in Quebec; Family Health Teams and Community Health Services in Ontario[77] and Dr. Samir Sinha's Acute Care for Elders (ACE) strategy at Mount Sinai Hospital.[78] But, as of 2011 only Alberta, Quebec, and Ontario had made substantial progress toward the First Minister's goal of giving 50% of Canadians access to multi-disciplinary teams by 2011. A philosophical change to primary care delivery is gathering momentum in several provinces, but reforms have yet to touch all Canadians. As a country, we lag behind our international peers in health outcomes. Our efforts to spread our successes within and across our regions are tepid at best.

What are the barriers to spreading and scaling up innovations that would improve primary care for all citizens? Obviously, the answer is complex. First and foremost are the values and interests of stakeholders – primary care providers and their roles, training, and supply; non-physician personnel and their roles within the team practice paradigm; the public and the expectations of patients. As well, there is the challenge of remuneration for care providers who must consent to pay models beyond the fee-for-service tradition. Then there are legal considerations, jurisdictional and governance differences, and the need for coordinated systems that can offer the full spectrum of specialized care for seniors.

Innovation in health care is strongly linked to the provision and fair distribution of funding and resources – value for service where it is needed. Federal, provincial and territorial governments are the principal funders of health care and as such they are the potent policy levers of health care reform. Strong and principled leadership is required for system transformation: for innovative and community-appropriate models; for infrastructure, including suitable community premises and appropriate staffing; as well as for information management systems and tools to enhance coordination of care.

Governments, policy makers, health authorities and primary care providers must work together. They must implement models that present primary care deliverers such advantages as enhanced income, quality of working life and professional satisfaction, in that way persuading physicians to embrace non-traditional (fee-for-service) modes of remuneration. They must encourage them as stakeholders to assume a leadership role in primary care reform. Without the presence of physicians at the policy table, the kind of transformative change we Canadians desire in primary care will less likely be realized in time to preserve the components of our health care system that we cherish and to effect the timely improvements that we envision.

12.0 Conclusion: Whither?

This report has made references to recent studies suggesting that Canadian primary health care ranks poorly in the international arena of peer countries. As primary care goes, so goes the entire health system and its outcomes at the local, regional, provincial and territorial, and national levels.

Andre Picard, who has studied Canadian health care delivery for decades and has written extensively and critically on the topic for us, notes, " What distinguishes the countries that have markedly better results than Canada – like the Netherlands and the Nordic countries – is the cohesiveness of the system, and the emphasis on primary care."

The College of Family Physicians (2011) described and recommended the ideal in primary care delivery: "A personal family physician for each patient, team-based care, timely access to appointments in the practice and for referrals, comprehensive continuous care, electronic records, system supports, ongoing evaluation, and quality improvement programs."

We older Canadian adults concur. We regard ourselves as " 'healthcare citizens' who pay for the system and expect it to serve the broad values set out in the Canada Health Act – universality, accessibility … comprehensiveness", [79] [80] portability and public administration. We desire care that accords us dignity, respect and compassion, and insofar as possible, independence. We require responsive primary care that is person-centred, community-based, comprehensive and coordinated, and continuous across the spectrum of health care. We believe that such effective primary care is achievable for our demographic of older adults as well as for our fellow Canadians.

We believe that governments must lead. The federal government must lead to enhance pan-Canadian collaboration; it must make major investments to support provinces and territories in the implementation of fundamental changes to their respective primary care systems. Provincial and territorial governments must make judicious and enlightened use of health care funds and welcome innovations that are not only appropriate for our diverse populations but that also lead to world-class primary care outcomes. It has been wisely observed that "all change is perceived as loss by someone." It may well be that physicians, who have long held the controlling role and responsibility for primary health care delivery, may feel that they have the most to lose should the recommended changes required for excellent delivery of primary care come to fruition. We will not move forward without the cooperation and leadership of our physicians. It is imperative that they have a place at the table when innovative transformation of primary health care delivery and funding is discussed.[81]

And finally, we 'healthcare citizens' are not off the hook. We, too, have a grave and absolute responsibility. Chris Power, CEO of the Canadian Patient Safety Institute, in a panel presentation with Dr. Danielle Martin and others (Jan 18, 2017) had this to say: "In the end, it won't be those who work in the health care system that drive transformation . . . There is too much vested interest in the status quo. And though there are innovative leaders within health care, with big ideas, they often lack the support to implement them. 'Patients and the public are what's going to transform and change the health care system, end of story. You see any big social movement, you see any major transformation that has happened in this world in our history, it's because the public stood up and said: no longer.' "[82]

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