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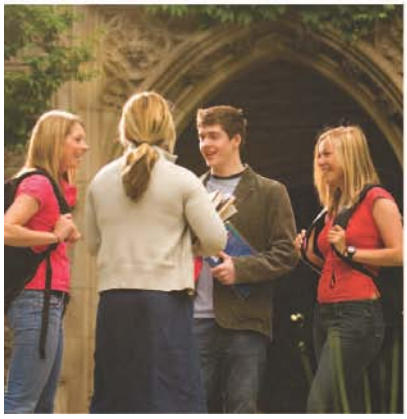
McMaster HEALTH FORUM

DIALOGUE SUMMARY

STRENGTHENING PRIMARY HEALTHCARE IN CANADA (DIALOGUE 2)



8 JANUARY 2010

EVIDENCE >> INSIGHT >> ACTION

Dialogue Summary:
Strengthening Primary Healthcare in Canada (Dialogue 2)

8 January 2010

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at the regional/provincial level and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

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Funding

The issue brief and the stakeholder dialogue it was prepared to inform were both funded by the Health Council of Canada. The views expressed in the issue brief are the views of the authors and should not be taken to represent the views of the Health Council of Canada, its Councillors or secretariat, or its principal funder (Health Canada).

John Lavis receives salary support from the Canada Research Chairs Program.

The McMaster Health Forum receives both financial and in-kind support from McMaster University.

Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the issue brief. The funder played no role in the identification, selection, assessment, synthesis, or presentation of the research evidence profiled in the issue brief.

Acknowledgments

The authors wish to thank Ileana Ciurea and the staff of the McMaster Health Forum for assistance with organizing the stakeholder dialogue. The authors also wish to thank Nancy Johnson (Lead, Publications, McMaster Health Forum) for assistance with writing/editing. We are grateful to the Health Council of Canada and its Secretariat for contributing to the intellectual development and direction of the project.

Citation

Lavis JN, Shearer JC. Dialogue Summary: Strengthening Primary Healthcare in Canada (Dialogue 2). Hamilton, Canada: McMaster Health Forum, 8 January 2010.

Dialogue

The stakeholder dialogue about strengthening primary healthcare in Canada was held on January 8, 2010 at the McMaster Health Forum in Hamilton, Ontario, Canada.

Product registration numbers

ISSN 1925-2226 (print)
ISSN 1925-2234 (online)

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SUMMARY OF THE DIALOGUE

Dialogue participants discussed both the long-standing challenges in primary healthcare and current efforts to strengthen it. Most participants had a "glass half full" perspective and identified many signs of significant progress across the country, while recognizing that much work remains to be done. A small number of participants were less positive about the progress made over the last decade and the short- to medium-term prospects for change.

Common themes emerged throughout the day's discussion. Time and again, many participants returned to key areas of focus that they believe will accelerate the strengthening of primary healthcare across Canada.

First, dialogue participants said that significant work needs to be done to "**connect the dots**" in ways that resonate with politicians, health system managers, healthcare providers, and the general public. To dialogue participants, this meant articulating and communicating the following:

- the "business case" for primary healthcare as the foundation of the health system;
- the valuable role of primary healthcare in making progress on other prioritized issues (e.g., H1N1, wait times, chronic diseases, and managing what one participant described as the "coming tsunami" of an aging population); and
- the need for improved linkages within and among diverse initiatives that contribute directly or indirectly to strengthening primary healthcare.

Second, **management structures** need to be put in place between the practice/clinic level and the provincial government level in order to steer and support the process of strengthening primary healthcare. Some participants argued that such structures currently exist only in Québec.

Third, **funding agreements** negotiated with a range of professions and organizations over the next five years need to include an explicit goal of strengthening primary healthcare. Ontario was recognized for its significant progress in this regard: the province has supported the move towards rostered patient populations through funding agreements with primary healthcare physicians. However, even in Ontario, few other funding agreements have been negotiated with a view to how all professions and organizations could support the strengthening of primary healthcare.

Fourth, all levels of the health system need to place greater attention on **performance measurement** (including the electronic health records at the primary healthcare level that make this possible) **and feedback to support quality improvement**. British Columbia was identified as having made significant strides in this regard.

Finally, participants noted that much greater attention needs to be given to **change-management processes** within primary healthcare systems.

A number of participants argued for continuing (and ideally accelerating) the momentum of incremental changes that are starting to affect the entire system, while simultaneously preparing for and taking advantage of "**windows of opportunity**" at the intergovernmental, governmental, regional, and practice/clinic levels. Possible opportunities discussed by participants include the upcoming renegotiation of the Canada Health Transfer (due to expire in 2014), government deficits (which could spur system change, not simply system cuts), elections, funding agreement renewals, plans for new policy initiatives directly or indirectly related to primary healthcare, consultations about primary healthcare (such as one taking place in Québec), the "unlocking of" and reorientation of Canada Health Infoway funds, and human resource shortages looming as a result of workforce aging.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

Dialogue participants began by acknowledging that the problem of limited or inequitable access to sustainable, high-quality, community-based primary healthcare in federal, provincial, and territorial health systems is a complex, multi-faceted problem, with some shared elements across jurisdictions and some jurisdiction-specific elements. Participants held different opinions on whether system-level changes are starting to emerge and were likely to accelerate in the foreseeable future. Most participants had a "glass half full" perspective when assessing improvements in access to high-quality primary healthcare across the country and prospects for further improvements. These participants identified many signs of significant progress (and argued that we needed to learn from these successes, as well as the failures), while recognizing that progress was uneven within and across jurisdictions and that much work remains to be done. On the other hand, some participants had a "glass half empty" perspective. As one participant put it: "We have made great progress but we want more of it." A small group of participants were more gloomy about the progress made over the last decade and the near-to-medium term prospects for change.

A few participants explicitly acknowledged the "policy legacy" that so profoundly influences the pace of change in this sector, namely the long-standing private delivery / public payment "bargain" between governments and physicians. This bargain, which dates back to the introduction of medical care insurance in 1968, means that movements away from small-scale autonomous private medical practices and fee-for-service payment of physicians must result from the independent decisions of many primary healthcare physicians (and many of the medical specialists who support them), rather than from planning and management. Other dialogue participants noted that funding agreements, the offer of having externally paid staff placed in practices/clinics, and financial support for electronic health records have been (and will continue to be) important mechanisms to support such shifts.

While dialogue participants did not disagree with the way the problem was articulated in the evidence brief

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

1) it addressed an issue currently being faced in federal, provincial, and territorial publicly funded health systems;
2) it focused on different features of the problem, including (where possible) how it affects particular groups;
3) it focused on four options (among many) for addressing the policy issue;
4) it was informed by a pre-circulated issue brief that drew on both a documentary analysis and key informant interviews, as well as two background documents (an evidence brief that mobilized both global and local research evidence about the problem, options and implementation considerations, and a dialogue summary from a stakeholder dialogue convened in May 2009);
5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible options for addressing it;
6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
7) it ensured fair representation among policymakers, stakeholders, and researchers;
8) it engaged a facilitator to assist with the deliberations;
9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and
10) it did not aim for consensus.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue and by those who review the dialogue summary and the video interviews with dialogue participants.

and issue brief, they spent the bulk of the deliberation about the problem focused on the political economy of primary healthcare. In other words, they focused on the "causes" of the problem, not the manifestations of the problem, as described in the two briefs. Comments about the **higher-order causes** of the problem tended to relate either to the incentives currently offered to those accountable for or working in health systems or to our understanding about the types of initiatives that could trigger system-level change.

Turning first to the **issue of incentives**, several participants made the following observation about the structure of political incentives related to health systems: healthcare is increasingly what provincial governments "do," representing as it does between 40 and 50 cents on every dollar spent by these governments. The resulting high level of political accountability helps to explain politicians' preoccupation with day-to-day crisis management and their historical lack of interest in separating governance from management and in delegating managerial authority to independent bodies (the "Hydro Santé model," in the words of one participant), especially when it comes to physicians. A number of participants noted the lack of rewards for physician leadership (and for leadership by other health professions as well) and more generally the lack of incentives for entrepreneurial innovation in primary healthcare, for forging connections between primary healthcare practices/clinics and other healthcare organizations, and for forging connections between the health system and other sectors (e.g., social services and recreation) that can complement the health system and possibly reduce demands placed on it. One participant noted the lack of incentives for developing a management career in primary healthcare, as opposed to the incentives available to those working in regional health authorities and hospitals.

Turning now to the **issue of system-level change**, several participants noted that we know little about the types of initiatives that could trigger such change. What can be done, they asked, to create a chain reaction that "rotates the system on its axis" (e.g., from a system built around autonomous providers to a system built around patients whose "medical home" is a primary healthcare practice or clinic)? If there is little appetite for "compelling system change," what sequence of initiatives could collectively "introduce a compulsion to change?' These initiatives could take place at the practice/clinic, sub-region, region, or province level and they could be prioritized for the short term (e.g., electronic health records at the practice/clinic level and funding agreements at the provincial level), medium term (performance measurement and feedback to support quality improvement at the practice/clinic level), and long term (e.g., management structures at the regional level that allocate resources to support and reward improved access to high-quality primary healthcare).

Moving on to **more proximal causes** (some of which intersect with manifestations of the problem as articulated in the two briefs), dialogue participants noted: 1) the lack of communication strategies to educate politicians, health system managers, healthcare providers, and the general public about the importance of primary healthcare; 2) the lack of management structures to steer and support the process of strengthening the primary healthcare system (at least outside Québec, where such structures were put in place in 2004); 3) the lack of inclusion of primary healthcare strengthening as an explicit goal of funding agreements negotiated with a range of professions and organizations; 4) the lack of attention to performance measurement (including the electronic health records at the primary healthcare level that make this possible) and feedback to support quality improvement (at least outside Ontario and British Columbia, where quality-improvement initiatives have been put in place); and 5) the lack of attention given to change-management processes within primary healthcare systems.

The first of these more proximal causes of the problem – the **lack of communication strategies** to educate politicians, health system managers, healthcare providers, and the general public about the importance of primary healthcare – manifested itself in the lack of documents that "connect the dots" for these different groups and the lack of organizations that popularize and disseminate the key messages from these documents. Several dialogue participants felt that three types of documents were missing: 1) the "business case" for primary healthcare as the foundation of the health system, which could be used across jurisdictions; 2) the role of primary healthcare in making progress on other prioritized issues (e.g., H1N1, wait times, chronic diseases, and aging), which could be used across jurisdictions and adapted for use in particular jurisdictions; and 3) the linkages within and among a diverse set of initiatives that contribute directly or

indirectly to primary healthcare strengthening, which would need to be jurisdiction-specific. One participant argued that an additional document was missing: a long-term plan (like England's ten-year National Health Service Plan). A few participants noted that provinces like British Columbia and New Brunswick had a policy framework to support the strengthening of primary healthcare and a clear statement of how primary healthcare serves as the foundation of the health system, respectively. Many participants noted the importance of execution of and follow-through on any such documents, and some lamented the lack of execution and follow-through on the 2003 Accord that arguably did provide a vision for primary healthcare but that lacked an operational plan for achieving the vision.

The second of these more proximal causes of the problem – the **lack of management structures** to steer and support the process of strengthening the primary healthcare systems – means that effectively no one is in charge of and accountable for this domain between the practice/clinic level and the provincial government level. Whereas Québec now has 95 health and social services networks, each of which has its own management structure, and these networks are in turn nested within regional management structures, other provinces do not have such arrangements. For example, Ontario does not have 14 "Councils of Family Health Teams" that engage with the province's 14 Local Health Integration Networks. This means that primary healthcare practices/clinics and other healthcare organizations operate in "silos" with "no one in charge," and new initiatives, such as those focused on diabetes, are not placed in primary healthcare practices/clinics. With or without such structures, however, the lack of communication strategies described above means that primary healthcare remains politically managed. Politicians have not been equipped with the arguments to engage those who predict "doom and gloom" if hospital budgets are reallocated to primary healthcare, to engage the hospital foundations who raise funds for new technology but not to support the operating costs for this technology, or to reassure their constituents that the health system can provide better alternatives than emergency rooms. Management structures alone will not ensure that the process of strengthening the primary healthcare system is steered and supported.

The **lack of funding agreements that include primary healthcare strengthening as an explicit goal** was noted by some dialogue participants as a third proximal cause of the problem. While provinces like Ontario were said to have made significant progress in supporting the move towards rostered patient populations through funding agreements with primary healthcare physicians, even in this province few other funding agreements have been negotiated with a view to how all professions and organizations could support the strengthening of primary healthcare. A few dialogue participants noted that, even during such a difficult economic time, there is money available: "It's just not being targeted to primary healthcare strengthening" and according to a multi-year plan to support such strengthening. Several dialogue participants noted that a major challenge is that few funding agreements ensure that any savings (e.g., in reduced emergency room visits and hospital admissions for diabetes) accrue to the primary healthcare practices/clinics that were responsible for the savings. Two dialogue participants cautioned that funding models "don't make you into a good doctor or nurse," but they said what funding models can do is to ensure that health professionals are working in a supportive environment and that those doing the right thing are rewarded (or at least not penalized) for doing so.

The **lack of attention to performance measurement and to feedback** that would support quality improvement was considered a fourth proximal cause by the dialogue participants. Those initiatives supported by the Primary Health Care Transition Fund typically measured performance locally, and not across the system. And while provinces like Ontario and British Columbia have put in place system-wide quality-improvement initiatives at the practice/clinic level, namely the Practice Support Program and Quality Improvement and Innovation Partnership, respectively, most other provinces have not. When primary healthcare indicators are being collected across provincial health systems, the indicators tend to focus on select process indicators (e.g., number of Family Health Teams, number of patients rostered), and not on access and quality indicators (e.g., wait times for primary healthcare, available physician and administrative champions, and available expertise for safety and quality improvement), and outcome indicators that politicians and the public can readily understand. Participants offered a number of different possible organizing frameworks for such indicators, including: 1) the Chronic Care Model (self-management support,

decision support, delivery system design, clinical information systems, health system supports, and community resources); 2) the Institute for Healthcare Improvement's "Triple Aim" objectives (health of the population; patient experience of care - quality, access, and reliability; and per capita cost of care); and 3) the Institute of Medicine's six aims for improvement (safety, patient-centredness, effectiveness, efficiency, timeliness, and equity).

Moreover, dialogue participants argued that all provinces have neglected the system-wide establishment of electronic health records at the primary healthcare practice/clinic level that would make performance measurement and quality improvement possible. Instead, attention has been directed to establishing electronic health records in hospital settings, in technical domains like diagnostic imaging, and in select tertiary care fields like cardiac care. Without performance measurement (and electronic health records) at the practice/clinic level, a number of dialogue participants argued that we "can't know how we're doing or whether we're getting value for money" despite making significant investments in primary healthcare.

The fifth proximal cause of the problem – the **lack of attention given to change-management processes** within primary healthcare systems – was articulated by some dialogue participants as a focus on the "what" and not on both the "what" and the "how to," and by other dialogue participants as a lack of attention to and investment in moving from local successes to system-wide successes. As one participant said: "I knew I was providing inadequate care, but I didn't know how to make change happen." This same individual observed: "But now I've seen people change their practices... [when they've been supported by resources, tools, and coaches at the practice/clinic level]." A number of participants noted that: "Canada is a nation of pilot projects." Both for local pilots and their scaling up, several participants emphasized the importance of engaging health professionals more in leading change, while recognizing that they have to balance "keeping care going" and "delivering change."

Over the course of the deliberation about the problem, dialogue participants talked about a number of interpersonal aspects of the problem: 1) primary healthcare teams cannot be created by decree (but teams can be promoted by showing health professionals how others are making teams work for them and by supporting health professionals as they transition to working in teams); 2) indicative rosters (i.e., rosters created by administrative algorithm) are a poor substitute for active engagement between patients and health professionals in the rostering process; 3) physicians left practicing in fee-for-service remuneration arrangements cannot be left behind but rather need to be engaged in making the changes for which they are ready; and 4) the culture of primary healthcare, which includes physicians who see themselves as independent entrepreneurs, expect a high level of involvement in decision-making, and expect free continuing professional development, cannot be ignored. One participant noted that the problem of improving access to high-quality primary healthcare is even more complex and multi-faceted in northern and aboriginal populations.

DELIBERATION ABOUT POLICY AND PROGRAM OPTIONS

Several participants commented on the three options that were presented in both the evidence brief and the issue brief. One dialogue participant noted that all three options are "just tweaking a legacy system, not turning [the system] on its axis." Another dialogue participant noted that some provinces, such as Ontario, are already moving on all three options at the system level. Also, given the participants' focus early in the dialogue on the problem statement itself, it is not surprising that a fair amount of the deliberation about the options focused on addressing the proximal causes of the problem.

Option 1 - Support the expansion of chronic disease management in physician-led care through a combination of electronic health records, target payments, continuing professional development, and auditing of their primary healthcare practices

A number of dialogue participants acknowledged that the vast majority of primary healthcare remains physician-led, and that making this explicit in the option statement might spur some stakeholders to come to grips with this reality (either to work with it or to try to change it over time). However, a number of other participants felt that the wording "physician-led care" was not helpful in a broad range of environments, including educational environments where team-based training is increasingly common, practice environments where collaborative care is increasingly common, and underserved communities where nurse practitioners may be leading primary healthcare teams. Participants favoured a range of alternatives to the language of "physician-led care," including "medical home," "responsible physician," "treating physician," and "Family Health Team" (although the latter is language used only in Ontario). Regardless of the language used and the health professional assigned responsibility for leading a team, most participants agreed that the functional lead of a team for a given patient at a given point in time could easily be a health professional other than the designated lead. Several participants also preferred the language of "performance measurement and quality improvement" over audit/accreditation when describing one of the option's elements.

Some dialogue participants argued this was just the status quo and not an option for addressing the problem of limited or inequitable access to sustainable, high-quality, community-based primary healthcare. Others argued that: 1) physician-led care is what many Canadians know and appear happy with, and what many Canadian physicians demand, so it should be built upon (plus a movement away from it would cost a great deal of money, in a time when "new" money is not available); 2) this option captures the direction in which some provinces, such as Québec, are now heading and the real question is how to support movements in this direction (e.g., incentives for physician leaders to be entrepreneurial, loans for physician leaders to set up ideal primary healthcare practices/clinics); 3) a number of the elements embedded within this option (e.g., electronic health records, financial incentives, effective continuing professional development, and performance measurement and feedback) are far from being realized across health systems but they remain critical to strengthening primary healthcare systems; and 4) collaborations within and among health professions take time to develop, both through the educational system and through practical experience working in team environments.

With regard to option elements, dialogue participants noted that: 1) "physician-led" does not mean fee-for-service remuneration and that many physician-led teams are paid by capitation or mixed remuneration methods; 2) electronic health records offer significant promise, including that they enable panel searches, comparative performance assessments, and prompts for screening, plus they can inform which disciplines are the right ones to bring in for a given patient population and they can enable the functioning of virtual teams; 3) for the promise of electronic health records to be realized, there must be interoperability within and across jurisdictions and their use must be supported in primary healthcare, not just in hospitals and other settings; 4) financial incentives need to be at the team level, not necessarily (just) the physician level, in order to motivate practice/clinic managers and the whole team.

Participants noted a number of limitations with this option: 1) patient rostering needs to be included in order for there to be a recognized accountability for a defined patient population; 2) self-management supports and community resources, which are covered under Option 3, also need to be included in order to empower patients and engage local communities; and 3) the creation of larger practice/clinic sizes, with visits by collaborators (e.g., pharmacists, physiotherapists, diabetes educators, and mental health workers) and by specialists who support "shared care (and, for some dialogue participants, with the co-location of specialty services like radiology) needs to be considered given many isolated small practices/clinics are not sustainable and given the importance of "keeping the patient in the practice" (and not allowing them to be swept up unnecessarily into specialty practices/clinics). As alluded to earlier, several dialogue participants noted that this option (as is the case with the others) does not address the broader "ecology" of primary healthcare, and

specifically the reality that there is no locus of management that would cause this to happen in a systematic way in most health systems. They also commented that it is not clear whether politicians would want this locus of management to be created unless they can be equipped with the arguments to engage those who will hold them politically accountable for each and every shortfall in how primary healthcare is managed.

Option 2 - Support the targeted expansion of inter-professional collaborative practice primary healthcare

Participants differed in whether their preferred way forward at this time is: 1) inter-professional collaborative practice primary healthcare in *all* primary healthcare practices/clinics; 2) the targeted expansion of this form of primary healthcare; or 3) a wait-and-see approach because this form of primary healthcare was the likely outcome of ongoing developments in health professional training programs and in physician-led practices and clinics. Those who preferred to see inter-professional collaborative practice primary healthcare in *all* primary healthcare practices/clinics as soon as possible typically did not think that it should be restricted to complex or hard-to-reach populations (as are the focus of community health centres). One dialogue participant noted that a great deal of work had already been done to support inter-professional collaborative practice primary healthcare (e.g., www.eicp.ca).

Those who preferred targeted expansion or a wait-and-see approach were concerned about five challenges associated with the widespread adoption of this option at this time: 1) convincing physicians to move away from leadership roles in most practices/clinics; 2) recruiting the nurses, pharmacists, and others needed for inter-professional collaborative practice; 3) assisting health professionals to work together effectively and efficiently; 4) making flexible arrangements for appropriate space to house such practices/clinics (although some dialogue participants felt that co-location is too frequently over-emphasized); and 5) finding the resources to pay these other team members while continuing to pay physicians for all medically necessary care (as required under the Canada Health Act). A few dialogue participants singled out payment systems as the single biggest barrier to the widespread adoption of moving rapidly to inter-professional collaborative practice primary healthcare in *all* primary healthcare practices/clinics.

One dialogue participant was concerned about balancing comprehensiveness and specialization in collaborative practice, and emphasized the importance of retaining a general orientation among the core team members even if shared care with specialists supported some degree of specialization. The same participant was concerned about teams becoming preoccupied with shared tasks and ignoring exclusive tasks, and about both liability insurance and professional regulatory colleges creating road blocks (e.g., pharmacists and nurses sometime reject "collective prescriptions"). Another dialogue participant argued that liability insurance was the source of a problem only when there is a team member without it. A third dialogue participant noted that extended health insurance plans can also be a challenge because physicians are often required to sign forms even for health professionals whose patients can access them directly without a referral from a physician.

Option 3 - Support the use of the Chronic Care Model in primary healthcare settings, which means the combination of self-management support, decision support, delivery system design, clinical information systems, health system supports, and community resources

Most dialogue participants considered this option to be a "no brainer," viewing the six features of the Chronic Care Model – self-management support, decision support, delivery system design, clinical information systems, health system supports, and community resources – as key primary healthcare system features that should be embodied in both Options 1 and 2. Dialogue participants were particularly happy to see self-management supports and community resources given attention. A number of dialogue participants argued that greater attention needs to be paid to patient empowerment and patient goal-setting in primary healthcare practices/clinics (as well as in other healthcare organizations and in population-wide initiatives).

Two participants noted the H1N1 vaccination campaign was both a success for primary healthcare in some provinces (in that more than half the population was reached by primary healthcare practices/clinics) and a failure (in that an opportunity for communication about patients' roles was lost). Echoing the comments (raised above) about the need for greater attention to be given to change-management processes within primary healthcare systems, several participants noted that, while this option is a "no brainer," the big question is how to operationalize it.

Option 4 - Promote a pan-Canadian vision for primary healthcare and a knowledge-sharing platform to support cross-jurisdiction learning arising from the execution of the vision

A number of dialogue participants said "no" to the idea of a pan-Canadian vision for primary healthcare, unless there is funding linked to the vision and the list of criteria required to access that funding is short. Some dialogue participants noted, however, that a statement of the key features of primary healthcare would be helpful, especially for those jurisdictions where little is happening. A few dialogue participants endorsed the idea of vision, and one of them argued that the vision should take the form of a new intergovernmental accord in 2010 (to follow-up on the accord made in 2003). Several dialogue participants highlighted the need to recognize both that "everyone is at different stages and needs different things," but also that despite "different lived experiences… we can coalesce around fundamentals."

Many dialogue participants enthusiastically endorsed the idea of a knowledge-sharing platform that supports cross-jurisdiction learning about strengthening primary healthcare (and, in the view of some dialogue participants, that also actively promotes cross-jurisdiction/comparative evaluation and that has a very advanced communications function). Several dialogue participants observed that such a platform would require a framework that describes key primary healthcare system elements even if a "vision" for primary healthcare in Canada is not articulated. A number of dialogue participants lamented the current lack of an established, independent knowledge-sharing platform, particularly one that can popularize both the available research evidence and practical success stories related to strengthening primary healthcare.

Dialogue participants commented how each of the four target audiences for the knowledge-sharing platform would need different types of information. Politicians, for example, may need to be educated about primary healthcare and reassured (where appropriate based on research evidence and real-world experiences) that new approaches will enhance the patient experience (e.g., faster access), improve outcomes (e.g., fewer complications of diabetes), and manage costs. This could give them the political will and the arguments to support the investment or reinvestment of the money that is already in the system in order to strengthen primary healthcare. Health system managers may need to be kept abreast of new development in the field of change management. Healthcare providers, on the other hand, may need to be reassured that there is evidence and experience to suggest that a different way of doing things is better for them and for their patients, and that they will be rewarded (or at least not penalized) for "doing the right thing." Future providers, such as health professionals in training, may need to be reassured that there is an exciting future in primary healthcare. The general public may need to be informed about how the primary healthcare system can work better for them. One dialogue participant said: "Imagine a public-service announcement that said: "It doesn't have to be like this. If you were in Holland you'd have X and Y, and at a lower taxation rate." Another dialogue participant argued for a cross-country conversation at the level of local communities. Several dialogue participants emphasized the importance of not using "negative" stories (given how many Canadians are very happy with their family physicians) and of finding language that works for citizens in any given jurisdiction (e.g., many citizens are not familiar with the jargon of "primary healthcare teams" and "primary healthcare providers").

Two dialogue participants expressed hope that the nascent Primary Health Care Working Group, with support from the Canadian Health Services Research Foundation, could support some of the work of a knowledge-sharing platform. They noted that Working Group members had expressed similar comments to

those of dialogue participants: "there's no chance to talk." However, they acknowledged that the Working Group would need more decision-maker involvement, while recognizing that the Working Group needs to continue to be able to say things that government-linked individuals and groups cannot say. A few dialogue participants noted that other, less costly knowledge-sharing mechanisms are also needed, such as a "one-stop shop" website and a regular series of webinars (and ideally make the link between research evidence and real-life examples of implementing change).

A few dialogue participants noted that now is a difficult time to make a pitch for a new initiative like the Canadian Strategy for Cancer Control and the Mental Health Commission of Canada, but they noted that there are strong nodes in different provinces and national organizations (e.g., Health Council of Canada, Canadian Health Leadership Network, and Canadian Alliance of Community Health Centres) that can, together with the Primary Health Care Working Group, build the case for such an initiative.

Several participants noted that one key priority for any knowledge-sharing platform would be to "connect the dots" about primary healthcare strengthening in ways that resonate with each of politicians, health system managers, healthcare providers, and the general public. For these participants this meant articulating and communicating to these four groups: 1) the "business case" for primary healthcare as the foundation of (and the best value for money in) the health system and how access to high-quality primary healthcare can be improved within publicly funded health systems; 2) the role of primary healthcare in making progress on other prioritized issues (e.g., H1N1, wait times, chronic diseases, and aging); and 3) the linkages within and among a diverse set of initiatives that contribute directly or indirectly to strengthening primary healthcare. The Primary Health Care Working Group plans to take on at least the first of these tasks and possibly the second.

A few participants commented that a second key priority for any knowledge-sharing platform would be to report on a regular basis the extent to which federal, provincial, and territorial health systems have: 1) put in place management structures between the practice/clinic level and the provincial government level in order to steer and support the process of strengthening the primary healthcare system; 2) negotiated funding agreements with a range of professions and organizations that include primary healthcare strengthening as an explicit goal (although one dialogue participant noted that this could create difficulties for jurisdictions whose agreements come up for renewal later than other jurisdictions); 3) established system-wide performance measurement (including the electronic health records at the primary healthcare level that make this possible) and regular feedback to support quality improvement in primary healthcare practices/clinics; and 4) used different types of change-management processes within primary healthcare systems. Participants were not aware of any groups that had taken on this task.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Many dialogue participants argued for continuing (and ideally accelerating) the momentum of incremental changes that are starting to affect the entire system, in large part by developing and communicating the business case for strengthening primary healthcare and by profiling innovations and gaps in primary healthcare systems on a comparative basis. Several participants noted that just having participated in the dialogue provided reassurance that they needed to keep doing what they are doing (e.g., working with a primary healthcare advisory committee), and they argued that others working in the system needed exposure to similar messages. One dialogue participant emphasized that "organizations and jurisdictions that can do it, should do it," because this will create the conditions for evaluating and learning from their experience and make it easier for those facing a similar challenge to decide what to do and how to do it.

Many dialogue participants also argued for simultaneously preparing for and taking advantage of "windows of opportunity" at the intergovernmental, governmental, regional, and practice/clinic levels. While some dialogue participants believe that we have 30-year policy cycles, and others felt we have ten-year policy cycles, most agreed that there was a lost opportunity the last time significant attention was targeted at primary

healthcare systems (with the Primary Health Care Transition Fund and the First Ministers' Accord in the early 2000s), and that attention had then shifted to wait times, doctor shortages, and other topics (and more recently to the e-health scandal and H1N1). They argued that effort needs to be directed to preparing for and taking advantage of a "next time."

At the intergovernmental level, participants noted the opportunity afforded by the upcoming renegotiation of the Canada Health Transfer, which is due to expire in 2014. They also noted the opportunities afforded by upcoming conferences of Ministers and Deputy Ministers and the growing recognition that some other priorities would not be achieved without a strong primary healthcare system. One challenge identified at the intergovernmental level was that questions would be raised about why the last $800 million investment over five years (through the Primary Health Care Transition Fund) did not yield more, and whether even that sizeable an investment would be "a small pry bar with which to leverage change in a $40 billion primary healthcare system." A second challenge is the very real possibility that, at least with the current federal government, there would be no new initiatives to lever change in health systems, only a renegotiation of the Canada Health Transfer. A third challenge is that very tough questions will be asked about value for money. First Ministers and Health Ministers will want to know the benefits, harms, and costs of alternative ways forward – management structures, funding agreements (which include placing externally paid staff in practices/clinics), performance measurement and feedback to support quality improvement (which includes electronic health records), change-management processes, and a knowledge-sharing and communication platform – and the likely barriers to implementation and strategies to overcome them.

At the governmental level, participants noted the opportunity (and risks) posed by government deficits (which could spur system change, not simply system cuts), elections, funding agreement renewals, plans for new policy initiatives directly or indirectly related to primary healthcare, consultations about primary healthcare such as the one taking place in Québec, the "unlocking of" Canada Health Infoway funds and the (hoped for) refocusing of these on ensuring that all primary healthcare providers are using an electronic health record, and human resource shortages looming as a result of workforce aging. Government deficits, which have been exacerbated in Québec by the "harmonization of its books" so that hospital and regional deficits now appear on the government's financial accounts statement, provide an opportunity only if politicians are provided with strong arguments based on research evidence and real-world experience that doing things differently rather than doing fewer things will help their constituents. Elections, such as the one in Nova Scotia that brought to power a majority party after a long period of minority government, provide an opportunity for a reassessment of how the jurisdiction compares (especially its strengths), what others are doing (i.e., the gaps), and what they should be considering in going forward. Preparations for funding agreement renewals provide the "space" to think about what a government wants to achieve in the new landscape created by past funding agreements, such as those in Ontario that have led to the creation of many Family Health Teams and the rostering of more than half of Ontarians, and what potential problems need to be guarded against (e.g., underutilization of services in practices/clinics paid by capitation rather than by fee-for-service).

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

A number of dialogue participants noted that the organizations in which they work or the groups with which they are affiliated have already made plans to step up their engagement in improving access to sustainable, high-quality primary healthcare in federal, provincial, and territorial health systems. Other groups identified the need for action plans to guide these health systems' efforts to strengthen primary healthcare. Some plan to work with regional health authorities to explore the possibility of introducing management structures to steer and support the process of strengthening the primary healthcare system. Others plan to reflect on and establish a new approach to funding agreements. Still others are committed to enhancing performance measurement and feedback to support quality improvement, which includes advocating for scaling up the use of electronic health records in primary healthcare practices/clinics. Few participants identified a focus on change-management processes, and only the Primary Health Care Working Group is known to be taking

small steps towards a knowledge-sharing and communication platform. For real change to come about, it seemed clear to at least some dialogue participants that a national coalition of interested organizations and groups was needed to enhance synergies and avoid duplication.