IMPACT - An Australian and Canadian collaboration to improve access to primary health care for vulnerable populations

Professor Grant Russell, Monash University, Australia
Professor Jeannie Haggerty, McGill University, Canada

Scarborough House Theatrette
July 22, 2014
WHY ACCESS TO PRIMARY HEALTH CARE FOR VULNERABLE POPULATIONS?
Fundamental components of primary care

- First contact accessibility
- Continuity/personal care
- Comprehensiveness
- Coordination
Primary care and the vulnerable

- Consistent link between primary care development and better health for the disadvantaged and reduced health care inequality

  - Shi and Starfield 2003
Access is a balance and an interaction...

- **Demand**
  - Perceived need
  - Ability to pay
  - Ability to reach

- **Supply**
  - location,
  - accommodation
  - cost and appropriateness of services.
Patient-centred access to health care: conceptualising access at the interface of health systems and populations

Jean-Frederic Levesque¹, Mark F Harris² and Grant Russell³
The vulnerable and access

• Vulnerable groups are
  o more likely to report financial barriers to care;
  o less likely to receive access to appropriate prevention and chronic disease care.

• Same findings for
  o refugees;
  o Aboriginal populations;
  o for complex patients, and
  o the homeless.
The problem with access

• It is a major driver of inequity of health care delivery.
• Poor primary care access increases the burden on emergency departments and hospitals.
• Interventions to improve access may increase inequity.
TWO HEALTH CARE SYSTEMS
... with similar challenges
<table>
<thead>
<tr>
<th>Health insurance</th>
<th>Universal insurance for medical and hospital care</th>
<th>Universal insurance but physicians able to bill</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHC Physician remuneration</td>
<td>Mostly fee for services, but increasing capitation and mixed payment</td>
<td>Fee for service GPs, some blended payments for CDM, immunisation, access etc.</td>
</tr>
<tr>
<td>Rostering</td>
<td>Increasing use</td>
<td>None</td>
</tr>
<tr>
<td>Practice trends</td>
<td>Solo moving to group models</td>
<td>Increasing practice size, corporatization</td>
</tr>
<tr>
<td>Reform agenda</td>
<td>New primary care delivery models</td>
<td>• Incremental</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Primary care meso organisations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Practice accreditation</td>
</tr>
<tr>
<td>Access challenges</td>
<td>Undersupply of family physicians</td>
<td>Financial barriers and copayments Rurality</td>
</tr>
</tbody>
</table>
# EXHIBIT ES-1. OVERALL RANKING

<table>
<thead>
<tr>
<th>COUNTRY RANKINGS</th>
<th>AUS</th>
<th>CAN</th>
<th>FRA</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>NOR</th>
<th>SWE</th>
<th>SWIZ</th>
<th>UK</th>
<th>US</th>
</tr>
</thead>
</table>

## OVERALL RANKING (2013)

<table>
<thead>
<tr>
<th>Category</th>
<th>AUS</th>
<th>CAN</th>
<th>FRA</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>NOR</th>
<th>SWE</th>
<th>SWIZ</th>
<th>UK</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Care</td>
<td>4</td>
<td>10</td>
<td>9</td>
<td>5</td>
<td>5</td>
<td>7</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Effective Care</td>
<td>2</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>5</td>
<td>4</td>
<td>11</td>
<td>10</td>
<td>3</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Safe Care</td>
<td>4</td>
<td>7</td>
<td>9</td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>11</td>
<td>10</td>
<td>8</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Coordinated Care</td>
<td>3</td>
<td>10</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>9</td>
<td>11</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Patient-Centered Care</td>
<td>4</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td>11</td>
<td>3</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Access</td>
<td>5</td>
<td>8</td>
<td>10</td>
<td>7</td>
<td>3</td>
<td>6</td>
<td>11</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Cost-Related Problem</td>
<td>6</td>
<td>11</td>
<td>10</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>1</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Timeliness of Care</td>
<td>4</td>
<td>10</td>
<td>8</td>
<td>9</td>
<td>7</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Efficiency</td>
<td>5</td>
<td>9</td>
<td>7</td>
<td>4</td>
<td>8</td>
<td>10</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Healthy Lives</td>
<td>4</td>
<td>8</td>
<td>1</td>
<td>7</td>
<td>5</td>
<td>9</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>10</td>
<td>11</td>
</tr>
</tbody>
</table>

## Health Expenditures/Capita, 2011**

- **$3,800**
- **$4,522**
- **$4,118**
- **$4,495**
- **$5,099**
- **$3,182**
- **$5,669**
- **$3,925**
- **$5,643**
- **$3,405**
- **$8,508**

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Access to Doctor or Nurse When Sick or Needed Care

Percent of adults age 18 and older

Source: 2013 International Health Policy Survey in Eleven Countries
Data collection: Social Science Research Solutions
Access to After-Hours Care

Percent of adults age 18 and older

Source: 2013 International Health Policy Survey in Eleven Countries
Data collection: Social Science Research Solutions
Access

Cost-Related Access Problem 2013

Percent of adults age 18 and older

Notes: *Did not fill/skipped prescription, did not visit doctor with medical problem, and/or did not get recommended care.

Source: 2013 International Health Policy Survey in Eleven Countries

Data collection: Social Science Research Solutions
Cost-Related Access Problems Among the Chronically Ill, by Income Level

Base: Adults with any chronic condition; Units: Percent of adults with any chronic condition who experienced access problem due to cost in past two years

Sources: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults; C. Schoen et al., "In Chronic Condition: Experiences of Patients with Complex Health Care Needs, in Eight Countries, 2008." Health Affairs Web Exclusive, Nov 13, 2008

Data collection: Harris Interactive, Inc.
Indicators of worse timeliness, percentage with long wait times, 2010

Source: Fraser Institute - Lessons from Abroad - A Series on Health Care Reform
Access in each system – and the gaps

• Australia has better first-contact timeliness than Canada
• Canada has fewer cost-related barriers to care than Australia
• Both countries have room for improvement compared to other OECD countries
IMPACT – Innovative Models Promoting Access-to-Care Transformation

BOTH NATIONS COLLABORATING TO HELP SOLVE THE PROBLEM
A Call for proposals – 5 years, $5 million

CBPHC Innovation Teams

CIHR and partners will provide funding for teams undertaking programmatic, cross-jurisdictional and interdisciplinary research to develop, implement, evaluate, and compare innovative models for chronic disease prevention and management in CBPHC and/or improving access to appropriate CBPHC for vulnerable populations.
An international research team

- **More than 40 investigators** (Canada, Australia, UK, Switzerland, USA)
  - Varied and complementary skills;
  - A pool of expertise to answer various needs;
  - Research interests focused on quality of primary care services.

- **Principal investigator’s affiliation:**
  - 3 Canadian universities (McGill, Ottawa, Alberta);
  - 5 Australian universities (Monash, New South Wales, La Trobe, Melbourne, Adelaide).
IMPACT - NEW APPROACH TO ACCESS
IMPACT – our aim

To design and evaluate evidence informed robust systems-level PHC innovations to improve access to appropriate health care for members of vulnerable populations.
Aims in plain language...

- To discover what communities, clinicians and policy makers see as regional access priorities for vulnerable populations;

- to identify the most promising access innovations in primary health care – (and their elements);

- to use this information to work with communities to design “ideal” program innovations;

- to study the implementation of these innovations.
The platform – Local Innovation Partnerships (LIPs)

6 Regions

Canada
- Alberta
- Ontario
- Quebec

Australia
- New South Wales
- South Australia
- Victoria

In each region
- Forge relationships with researchers, policy/decision-makers, health professionals and consumers;
- Be part of a wider knowledge network.
Coordinated LIP activities

- Understand the demographic, economic and geographic characteristics of each LIP.
  - Document access-related needs for the region’s vulnerable populations.

- Document access-related organisational innovations within the regions.
  - Hold **Deliberative forums** in the first year of activity to help each LIP decide on **regional access priorities**.
All 6 LIPs will

Compile a community profile and document

- Access-related needs
- Access-related innovations
1) Scoping best practice

Find world’s best practice in improving PHC access for vulnerable populations

Two research teams will scope innovations...
1) Scoping best practice

Find world's best practice in improving PHC access for vulnerable populations

LIPs will use scoping data to prioritise access related needs
Then another two teams will discover what works best and where…

1) Scoping best practice

Find world's best practice in improving PHC access for vulnerable

2) Synthesis of effectiveness and implementation

A realist review of interventions to address the priority areas of need
Combined with further understanding of context

1) Scoping best practice
Find worlds best practice in improving PHC access for vulnerable

3) Mixed method analyses of surveys
See how countries, provinces and regions are performing with PHC access

2) Synthesis of effectiveness and implementation
A realist review of interventions to address the priority areas of need
LIPs will make final decisions on innovations

1) Scoping best practice
Find world's best practice in improving PHC access for vulnerable

2) Synthesis of effectiveness and implementation
A realist review of interventions to address the priority areas of need

3) Mixed method analyses of surveys
See how countries, provinces and regions are performing with PHC access

New South Wales
South Australia
Victoria

Alberta
Ontario
Quebec
Finally, innovations will be tested across the LIPs.

4) Evaluating access innovations

The most appropriate innovations will be systematically trialled and evaluated in the LIPs.

Assess benefits of innovations
Outputs

• A deeper understanding of what really works.
• Up to 8 rigorous, locally relevant interventions ready for scale-up
• Capacity development
• Links between research / policy / clinical practice and the community.
Progress

• Funding October 2013
• Governance, planning, structures, processes
• Relationships
• Ethics
• Project 1
  o Systematic review
  o Environmental scan of innovations
• Getting the LIPs working
• A new Access Model
Vulnerable populations have limited capacity to advocate for themselves in a complex and resource-constrained environment; innovations to improve access typically benefit most non-vulnerable

Ensuring equitable access implies modifying the organisational interface

A learning community of researchers, decision makers and consumers in various jurisdictions broadens the conversation and deepens the exploration of organizational innovations to enhance access for vulnerable populations
Anticipated impacts

- New policy and program options for improving access to care by vulnerable population groups

- Expand knowledge on how innovations work in different contexts and both their direct and indirect impacts (including unanticipated impacts)

- Generate sustainable, local, national and international communities of practice able to produce innovative solutions to hitherto intractable access barriers to appropriate PHC for vulnerable populations
Key opportunities

• A diverse definition of vulnerability, but common approaches to organisational innovations

• Attention to context in the implementation of innovations

• Modus operandi of meaningful partnerships between researchers, decision-makers, care providers and community representatives

• Deliberative processes with local community and decision makers that inform the research process within a common goal of organizational innovations to improve PHC access for vulnerable populations
Our Partners

MONASH University

LA TROBE University

Touch our Future

McGill University

UNSW

Soins Continus Bruyère

BRUYÈRE CONTINUING CARE

INSTITUT DE RECHERCHE BRUYÈRE RESEARCH INSTITUTE

Affilé à l'Université d'Ottawa

Affiliated with the University of Ottawa

Alberta Centre for Child, Family & Community Research

Bureau of Health Information

The University of Adelaide

Funding Agencies

CIHR IRSC

Canadian Institutes of Health Research

Instituts de recherche en santé du Canada

Australian National University

Fonds de recherche Santé Québec

National Health and Medical Research Council
This research is a project of the Australian Primary Health Care Research Institute, which is supported by a grant from the Australian Government Department of Health and Ageing. The information and opinions contained in it do not necessarily reflect the views or policy of the Australian Primary Health Care Research Institute or the Australian Government Department of Health and Ageing.