Eby Briefing Note: Primary Care Delivery

SITUATION REPORT

Unprecedented deterioration in access to primary, specialty, emergency care, waiting lists, growing disability and absenteeism, late detection of major illnesses, increasing costs, negative health outcomes.

Longitudinal primary care has been supplanted by fragmented episodic care, providing limited treatment (repeat visits, referrals, substandard care). Adding costs for limited value, resources drained from effective practices. Increasing downstream burden, overwhelming already limited capacity. Stagnant fees driving transition.

Devaluation of front-line expertise, especially family doctors. Retention crisis. Inefficient, effective practices left unstaffed. Administrative growth outpacing front-lines. Conflict of interest same org funding and operations, limits transparency and accountability. Growth of privatization, skims resources, builds demand.

ROOT CAUSES

Health authority incursion into primary care operation. Replacing effective, independent practices with top-down command-and-control structures. Driven by outmoded 20th century "manufacturing" model of healthcare: divide-and-conquer (i.e. split up work, overspecialization), standardization, optimize individual components.

Healthcare in 21st century is "knowledge work," requiring solutions like integrated (not fragmented) teams, broader perspectives, system-wide views, bottom-up decision making. Needed to manage uncertainty and variability. Current manufacturing strategies destroyed this capacity.

OUTCOMES

Restore capacity to provide treatment in longitudinal primary care context, massive reduction in episodic care, especially episodic telehealth. Restore bottom-up accountability and decision-making. Needed to accommodate variability, retention, and adapt quickly.

RESOURCES

BC still has 3rd highest per capita family doctors; > 50% doing other work (much of it episodic care, e.g., Telus Health). Prefer longitudinal practice if viable. Can be redeployed quickly given effective/predictable incentives.

Reallocation of excessive UPCC costs (5-10x independent practice) and growth of health authority corporate (> 50%, ~$1B under Dix) sufficient to make up shortfall.

RECOMMENDATIONS:

1. Remove health authorities from primary care operations.
Organizational structures and capabilities poorly suited for primary care. Rapidly devolve responsibility and funding as per pre-Dix model. Gradual/phased/negotiated transition will result in slow, expensive, ineffective hybrid. Apply clear rules, transfer resources to small providers for fixed transition period. Move fast, fix fast. Formalize later. Health authorities only involvement with primary care is coordination with broader healthcare system.

2. Transition Urgent Primary Care Centres to CHC's.
Immediate governance transfer as per recommendation 1. Reallocate existing budgets to broad-based infrastructure with local decision-making, including staffing and service provision. Mandate physician involvement in governance to ensure clinical requirements and fully-integrated teams.

3. Modernize fee-for-service to support longitudinal care.
Time-based fees sufficient to cover longer appointments and non-patient-contact overhead time. Can be modelled on e.g. psychiatry fees. Enables funding wide variety of practice models and fast workaround of system blockages without central planning. Equity with contract and other models which should continue in parallel, standardized via MSC without individual health authority intervention.

4. Bottom-up primary care networks.
Current PCN's are centrally-driven and slow. Replace with locally-led collection of clinics (Alberta model). Standard, rules-based approach to rapidly distribute funding to PCN's to support hiring clinicians etc. for local needs and fully-integrated teams and longitudinal service provision. Enable grassroots sharing of best practices.

5. Orderly transition away from episodic telehealth.
Poor use of scarce funds and physician resources is enabled by temporary fee pandemic fee codes. Can decrease these while raising fees for longitudinal care. Realigning incentives will drive necessary migration.

6. Meaningful third-party metric-driven oversight.
Patients without doctors, wait-times, etc. More detailed account of expenditures. Publicly available, mandated and collected by third-party to avoid conflict of interest.

7. Consultations with wider front-line groups.
Solicit more diverse front-line involvement given wide variety of practices. Avoid relying only on one-size-fits-all thinking, academics, medical orgs, n=1 clinic models.

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