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

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July 22, 2014

WHY ACCESS TO PRIMARY HEALTH CARE FOR VULNERABLE POPULATIONS?

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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.

Supply and demand: a conceptual model of access

Levesque *et al. International Journal for Equity in Health* 2013, **12**:18
http://www.equityhealthj.com/content/12/1/18

INTERNATIONAL JOURNAL FOR EQUITY IN HEALTH

RESEARCH Open Access

Patient-centred access to health care: conceptualising access at the interface of health systems and populations

Jean-Frederic Levesque[1*], Mark F Harris[2] and Grant Russell[3]

The vulnerable and access

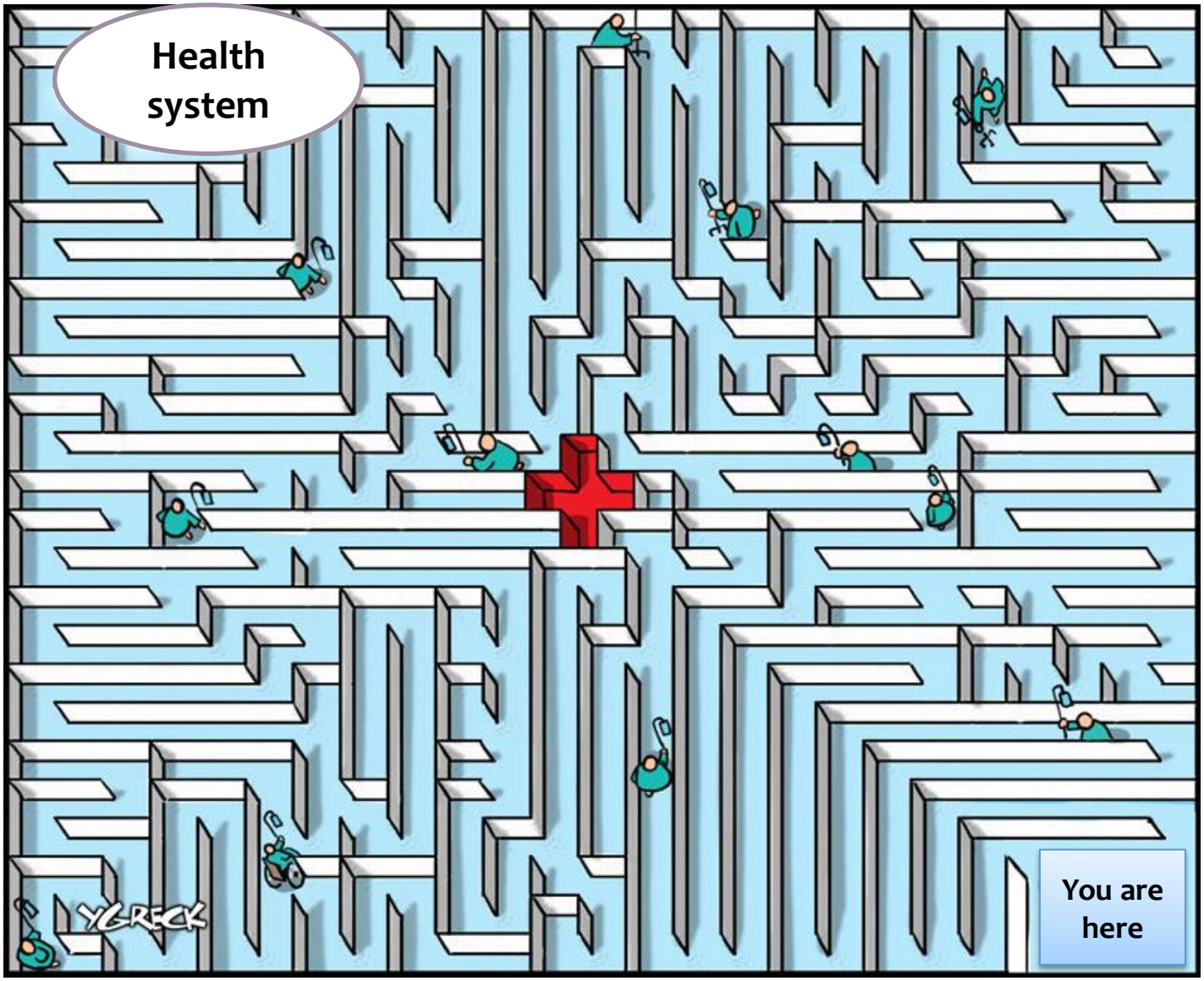
- Vulnerable groups are
  - more likely to report financial barriers to care;
  - less likely to receive access to appropriate prevention and chronic disease care.

- Same findings for
  - refugees;
  - Aboriginal populations;
  - for complex patients, and ;
  - 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

	Canada 	Australia 
Health insurance	Universal insurance for medical and hospital care	Universal insurance but physicians able to bill
PHC Physician remuneration	Mostly fee for services, but increasing capitation and mixed payment	Fee for service GPs, some blended payments for CDM, immunisation, access etc.
Rostering	Increasing use	None
Practice trends	Solo moving to group models	Increasing practice size, corporatization
Reform agenda	New primary care delivery models	• Incremental • Primary care meso organisations • Practice accreditation
Access challenges	Undersupply of family physicians	Financial barriers and copayments Rurality

EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS

Top 2*
Middle
Bottom 2*

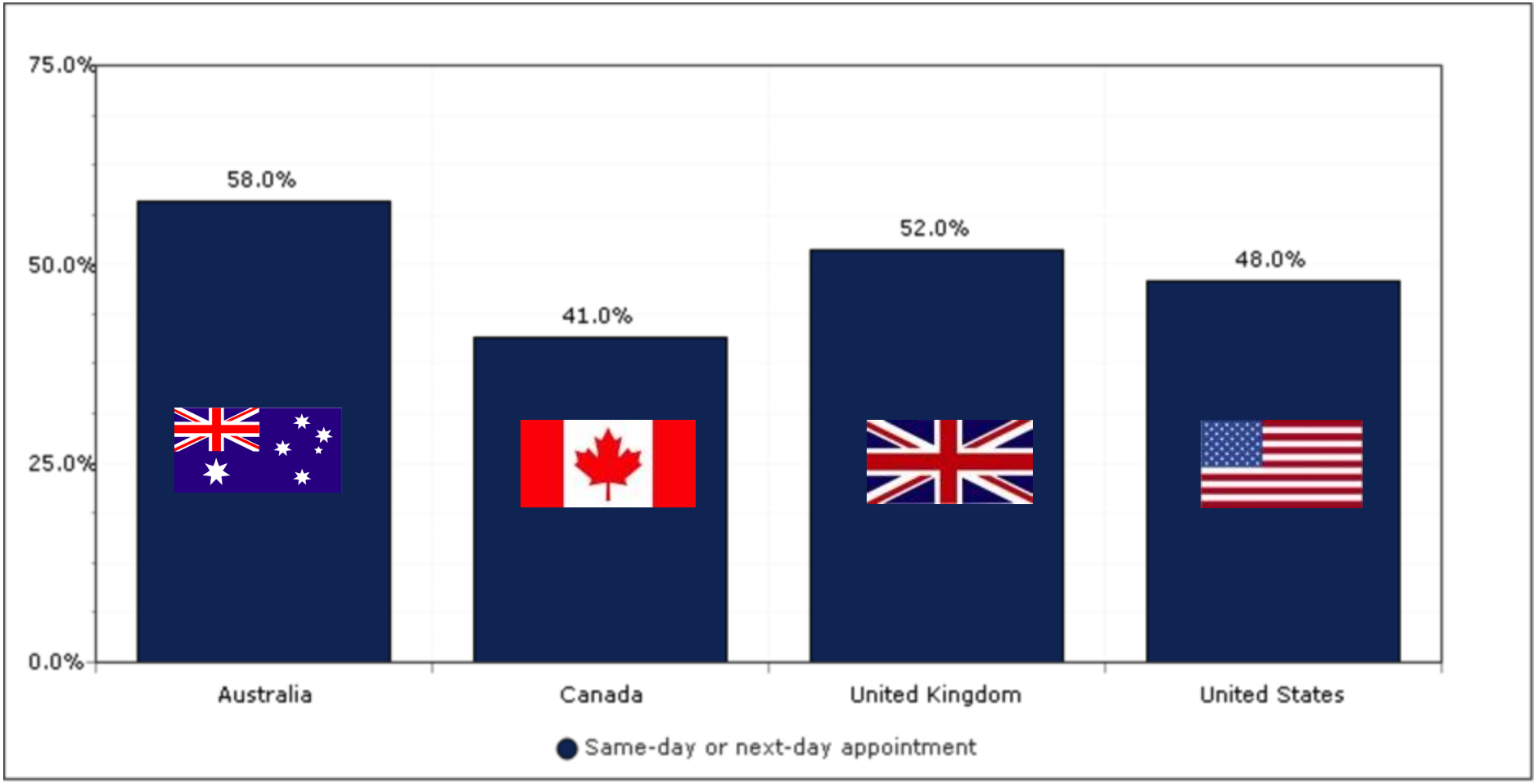
	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
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.

Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

Access to Doctor or Nurse When Sick or Needed Care

Percent of adults age 18 and older

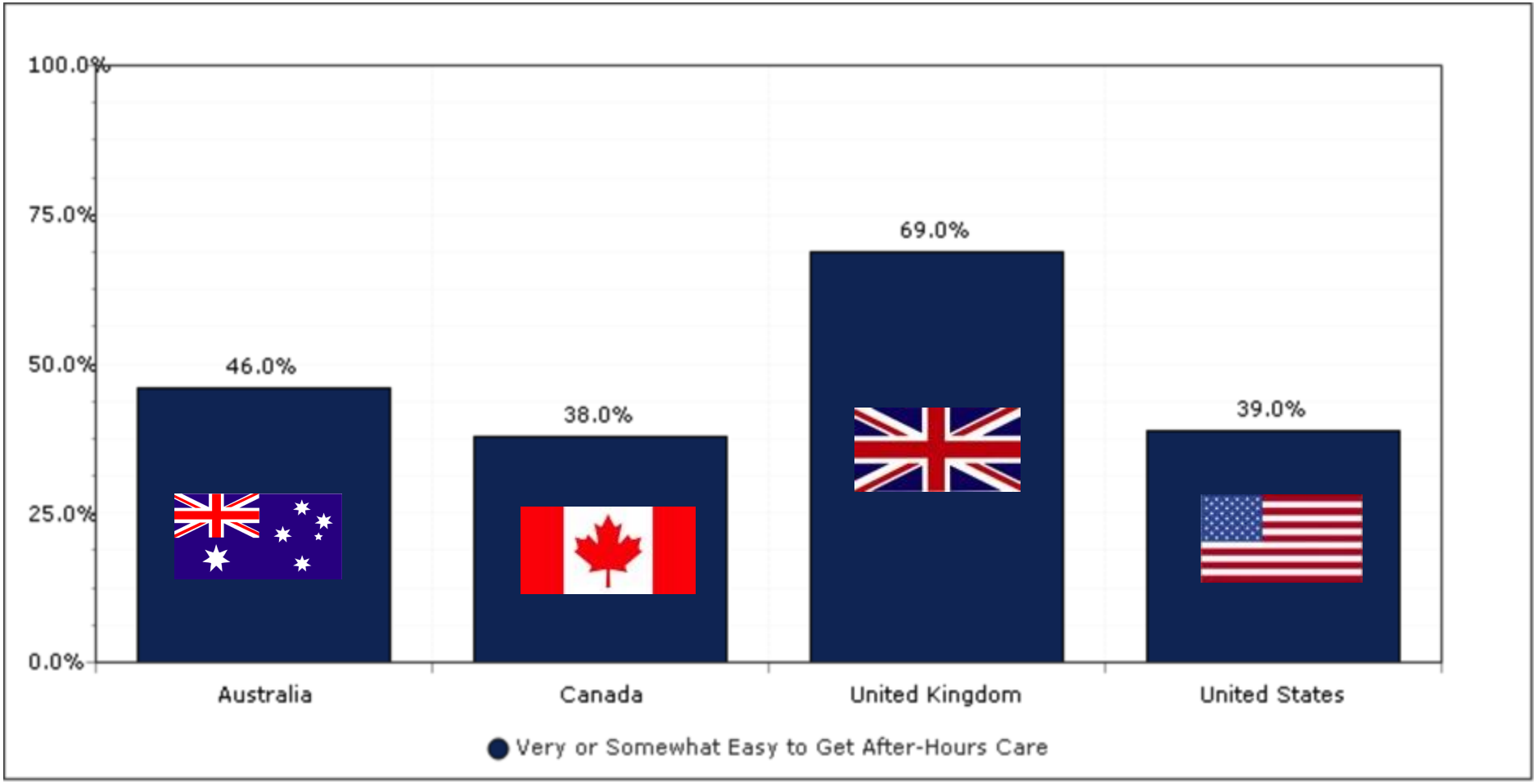


Source: 2013 International Health Policy Survey in Eleven Countries

Data collection: Social Science Research Solutions

Access to After-Hours Care

Percent of adults age 18 and older

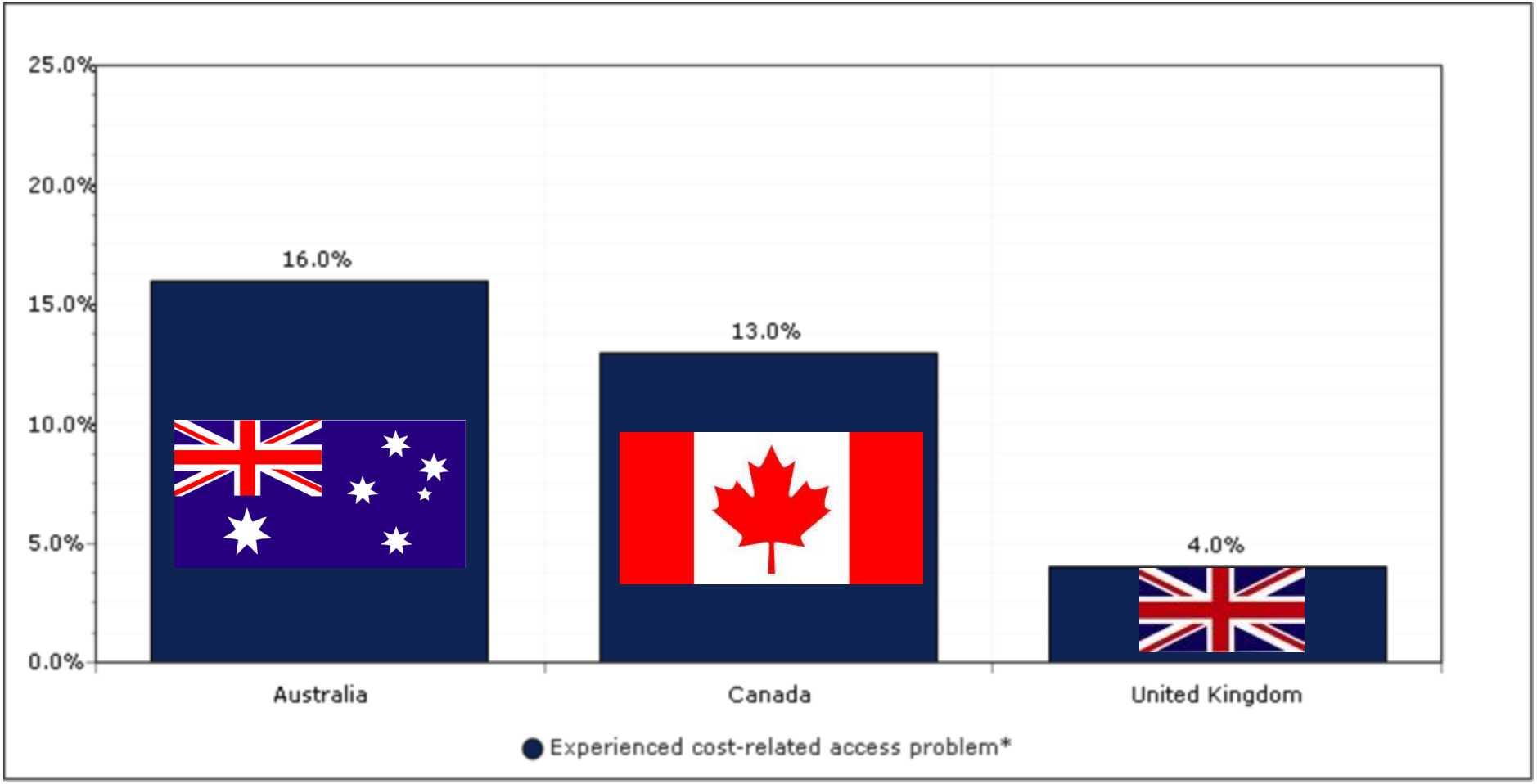


Source: 2013 International Health Policy Survey in Eleven Countries

Data collection: Social Science Research Solutions

Cost-Related Access Problem 2013

Percent of adults age 18 and older



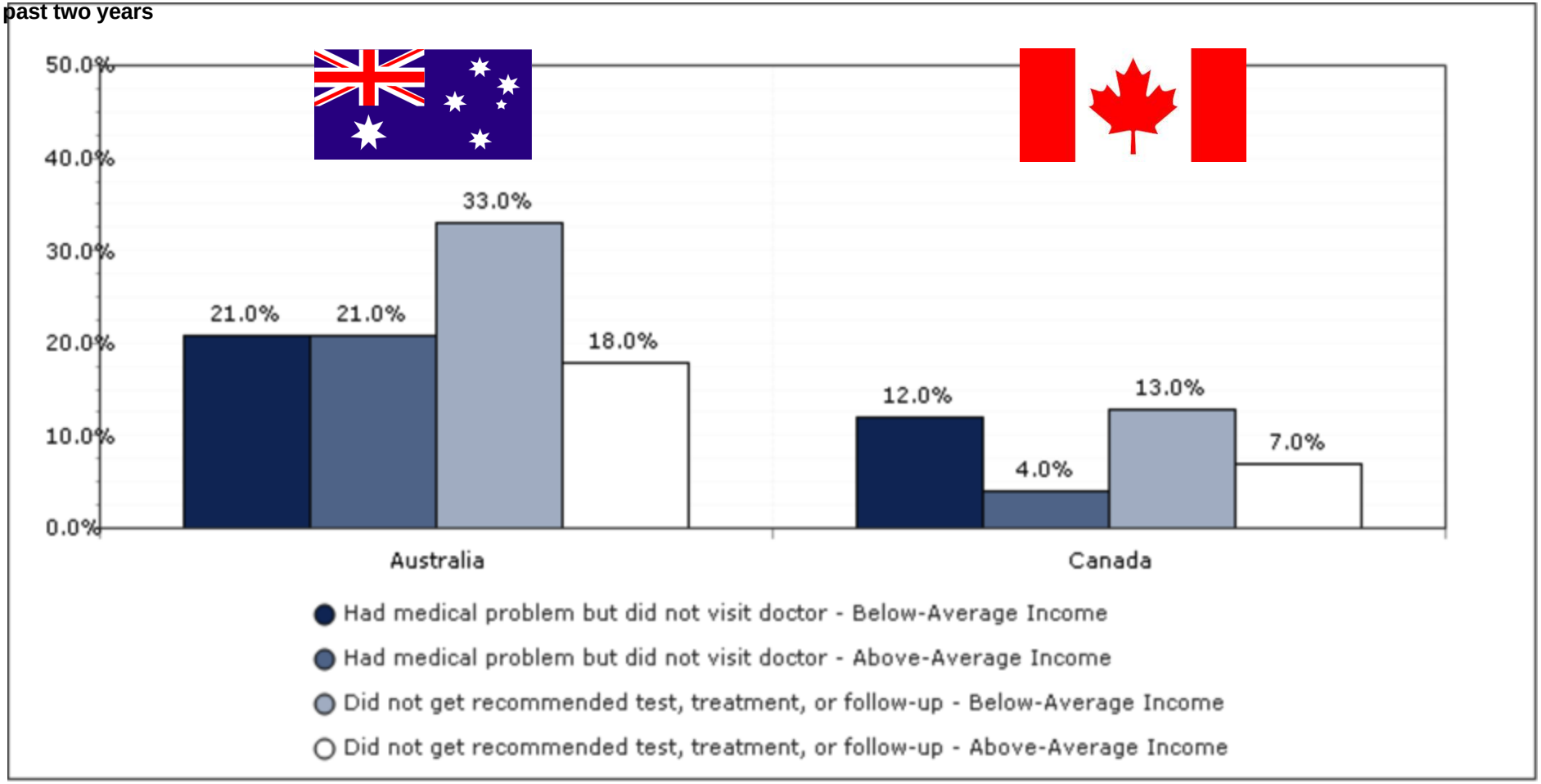
Notes: *Did not fill/skipped prescription, did not visit doctor with medical problem, and/or did not get recommended care.

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

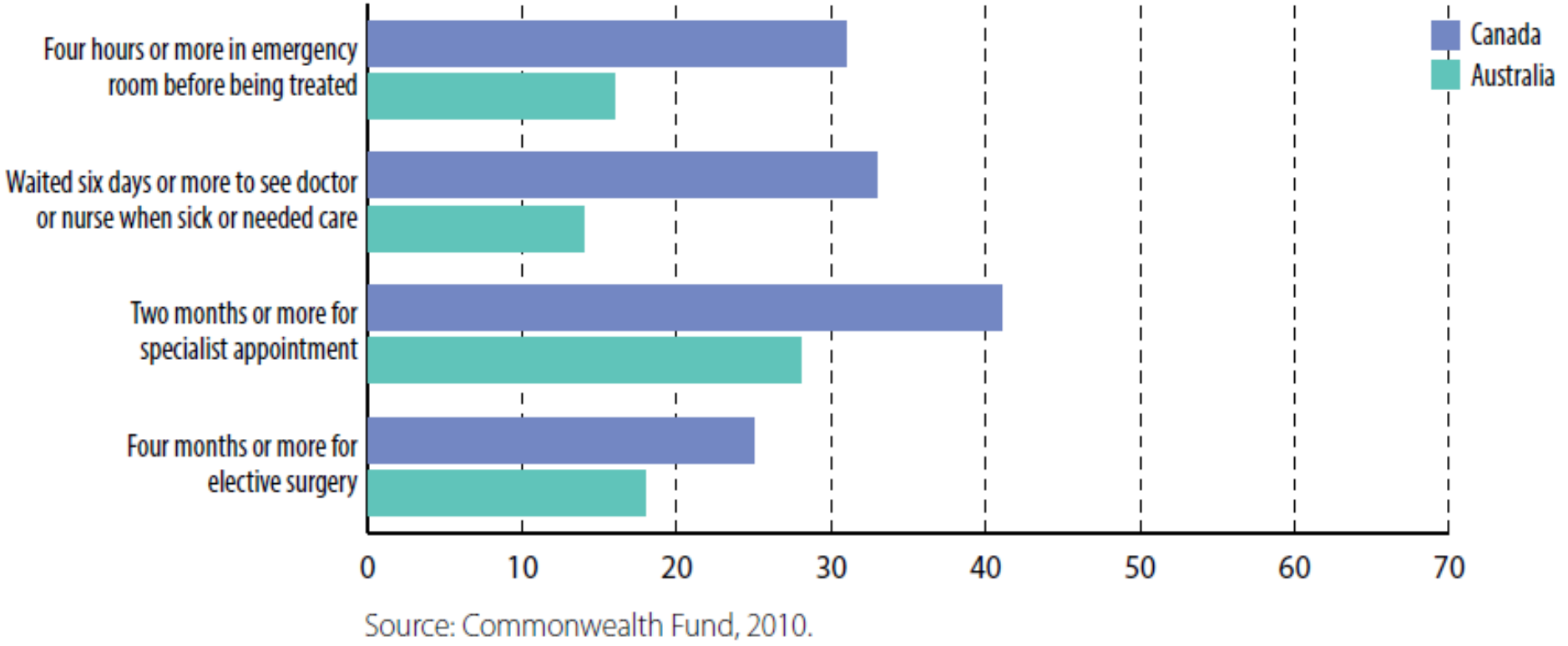
Base: Adults with any chronic condition; Units: Percent of adults with any chronic condition who experienced access problem due to cost in past two years



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: Commonwealth Fund, 2010.

Source: Fraser Institute - Lessons from Abroad - A Series on Health Care Reform
http://www.fraserinstitute.org/uploadedFiles/fraser-ca/Content/research-news/research/publications/health-care-lessons-from-australia.pdf

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

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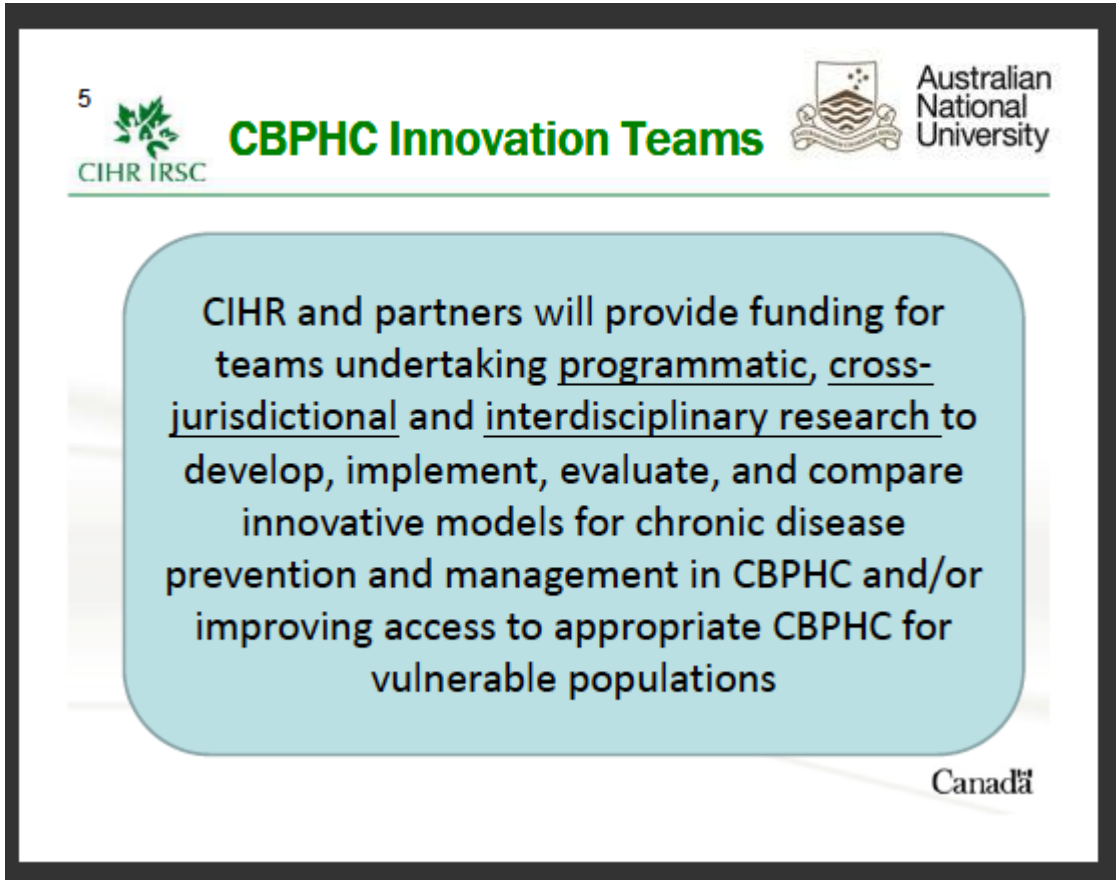
A Call for proposals – 5 years, $5 million



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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).

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IMPACT - NEW APPROACH TO ACCESS

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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**

New South Wales
South Australia
Victoria

Alberta
Ontario
Quebec

Two research teams will scope innovations…

1) Scoping best practice

Find worlds best practice in improving PHC access for vulnerable populations

New South Wales
South Australia
Victoria

Alberta
Ontario
Quebec

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LIPs will use scoping data to prioritise access related needs

1) Scoping best practice

Find worlds best practice in improving PHC access for vulnerable populations

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Alberta
Ontario
Quebec

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Then another two teams will discover what works best and where…

1) Scoping best practice

Find worlds best practice in improving PHC access for vulnerable

New South Wales
South Australia
Victoria

Alberta
Ontario
Quebec

2) Synthesis of effectiveness and implementation

A realist review of interventions to address the priority areas of need

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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

New South Wales
South Australia
Victoria

Alberta
Ontario
Quebec

2) Synthesis of effectiveness and implementation

A realist review of interventions to address the priority areas of need

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LIPs will make final decisions on innovations

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

New South Wales
South Australia
Victoria

Alberta
Ontario
Quebec

2) Synthesis of effectiveness and implementation

A realist review of interventions to address the priority areas of need

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Finally, innovations will be tested across the LIPs

New South Wales
South Australia
Victoria

Alberta
Ontario
Quebec

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
  - Systematic review
  - Environmental scan of innovations
- Getting the LIPs working
- A new Access Model

Why this research matters?

- 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

McGill

LA TROBE UNIVERSITY

Touch our future

ALBERTA CENTRE FOR CHILD, FAMILY & COMMUNITY RESEARCH

UNSW THE UNIVERSITY OF NEW SOUTH WALES

Soins continus Bruyère Continuing Care

Institut de recherche Bruyère Research Institute

Affilié à l'Université d'Ottawa
Affiliated with the University of Ottawa

THE UNIVERSITY of ADELAIDE

Bureau of Health Information

Funding Agencies

CIHR IRSC

Canadian Institutes of Health Research | Instituts de recherche en santé du Canada

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Fonds de recherche Santé Québec

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.

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