



**AUSTRALIAN PRIMARY HEALTH CARE  
RESEARCH INSTITUTE**

**UNIVERSITY OF NEW SOUTH WALES**

**APHCRI STREAM 7  
TRAVELLING FELLOWSHIP REPORT**

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**January 2008**

## *ACKNOWLEDGMENT*

The research reported in this paper 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 under the Primary Health Care Research, Evaluation and Development Strategy. The information and opinions contained in it do not necessarily reflect the views or policies of the Australian Government Department of Health and Ageing.

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## 1. Introduction

The Australian Primary Health Care Research Institute (APHCRI) commissioned a series of 12 systematic reviews (known as Stream 4) in 2005/06. Following the reviews, APHCRI announced a number of Travelling Fellowships for mid-career researchers involved in the reviews. The objectives of the Fellowships were:

- to further develop the linkage and exchange model;
- share lessons learned from Australia and develop a multinational perspective and network of contacts to facilitate policy exchange and collaboration; and
- improve the capacity of Australian PHC researchers to conduct international research.

One of the Stream 4 reviews, led by the author, involved a comparison of system-wide comprehensive PHC models in Australia, Great Britain and New Zealand. It became apparent during this review that there were a number of Canadian examples of different models of PHC reform that were worth further investigation, but that at the time fell outside the definition of system wide initiatives. Furthermore, for a number of years Canada has had a strong focus on building applied health services research capacity, and has developed an international reputation in developing ideas around knowledge transfer and building linkage and exchange mechanisms between researchers and policy-makers<sup>1</sup>. For these reasons Canada was chosen to be the focus of the Fellowship. Most of the Fellowship was spent in Ontario, meeting with researchers and national and provincial public servants/policy advisers. Meetings were also held with researchers in Quebec and Alberta (see Appendix 2.). Other activities included attendance (as an observer) at a national roundtable meeting on the future of PHC research, and participation at the North American Primary Care Research Group conference, where a paper on the review was presented.

The report starts with a short section on the Canadian context followed by a summary of the major PHC reforms in Ontario, Quebec and Alberta provinces, a comparison of the Canadian and Australian linkage and exchange mechanisms and experiences with the APHCRI model and finishing with implications and learnings for Australia.

## 2. Canadian context

While Canada shares some similarities with Australia in terms of geography and demographics, a universal health insurance scheme (also known as Medicare), and concerns about cost and quality of primary health care services, there are important differences that have influenced primary healthcare reforms. Through the Canada Health Transfer, the bulk of health funding goes to the provinces, which have constitutional responsibility for planning, development and delivery of health services, subject to the principles of the Canada Health Act. This has resulted in considerable diversity between provinces

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<sup>1</sup> The work led by Johnathon Lomas at the Canadian Health Services Research Foundation and by John Lavis at McMaster University.

in how primary health care has developed. Between the late 1990's-early 2000's, there were a number of reviews of the Canadian health care system, including the Romanow Commission which identified significant challenges such as fragmented healthcare delivery, little evidence that a 'system' operated, differing physician payment methods, services and outcomes and problems with access to primary health care services, due to a mixture of workforce shortages and mal-distribution<sup>2</sup>.

In recognition of the need for health care system reform, the Health Transition Fund (1997-2001) allocated \$150 million for projects to test and evaluate innovative ways to deliver health services. This was followed by the six-year \$800 million Primary Health Care Transition fund which was the first (and seemingly last) national investment designed to strengthen the PHC sector, with most of the money going to the provinces. Since it finished, some but not all provinces retain a commitment to reforming the sector, while others are focussing more on system wide responses to specific aspects of health care (for example chronic disease management).

It was acknowledged in the 1990's that Canada lacked research capacity and that there was a need to train the next generation of researchers and to build linkage and exchange mechanisms between researchers, decision-makers and practitioners. In response:

- the Canadian Health Services Research Foundation (CHSRF) was established to fund health services research in priority theme areas<sup>3</sup>, and to develop linkage and exchange capacity;
- the Canadian Institute of Health Research<sup>4</sup> (CIHR) and CHSRF jointly funded 12 Chairs for 10 years (2000-2010) to build future capacity, with common objectives of education, linkage and exchange, mentoring, and research<sup>5</sup>, and
- five health service research training centres were funded, which were expected to include policy placements and explicit policy/research exchanges.

The national government also created a new permanent \$300 million per year program to establish a number of research professorships (Research Chairs).

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<sup>2</sup> Romanow Commission (2002) Building on Values: The Future of Health Care in Canada - Final Report.

<sup>3</sup> One of which included Primary Health Care

<sup>4</sup> The equivalent to the NH&MRC

<sup>5</sup> While none of these are designated PHC chairs, 5 are nursing and 7 are generic health services research Chairs

### 3. PHC reforms

The major focus of PHC reforms in Ontario, Quebec (the 2 largest provinces) and Alberta has been the introduction of new service delivery models that involve a mixture of three major approaches:

- networked general practices,
- alternative payment mechanisms, and
- enhancing inter-professional collaboration.

While there are important differences in how these models have been introduced, there are similar challenges in change management and developing more team-based and collaborative inter-disciplinary approaches. None of these provinces have introduced meso-level organisational structures such as divisions of general practice to support the implementation of the reforms. From a research perspective (but not necessarily a policy perspective) this has been identified as a major barrier to sharing learnings and supporting practices and clinicians to implement the new models and ways of working.

#### 3.1 Ontario

Ontario has been experimenting with a range of models since the mid 1970s, with the two earliest models being capitation funded groups of family physicians called Health Service Organisations (HSOs); and salaried and multidisciplinary community health centres (which include family physicians). More recently family physician centred models have included Family Health Networks (mixed funding) and Family Health Groups (FFS).

The newer models introduced in the late 1990s-early 2000s have built on and learnt from previous initiatives and developed in an iterative way. The Ontario Medical Association (OMA) has played an important role in bringing the membership along and their relationship with the Ministry of Health has been described as 'close', with the government ensuring there is agreement and consensus with the OMA before introducing major changes.

Alternative payment mechanisms have resulted in financial gain for GPs and the minimal reporting requirements have avoided much of the administrative burden that remains a challenge in Australia. Funding has also been made available for administrative resources and to access professional expertise in, for example, governance. Findings from a recent comparison of these 4 models found that each offers benefits and drawbacks that attract physicians and patients with specific profiles and that a number of models are required to account for socio demographic variations, and patient and provider needs. Generally salaried CHCs performed better than other models in relation to chronic disease management, prevention, health promotion and comprehensiveness; whilst capitation models (ie HSOs) performed better on access. These findings are not inconsistent with other Canadian research<sup>6</sup>.

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<sup>6</sup> Lamarche PA .et al (2003) Choices for Change: The path for Restructuring Primary Healthcare Services in Canada

Family Health Teams (FHTs), the latest model, are rostered capitation funded practices, which bring together family physicians, nurse practitioners and nurses as the core team, and often additional professionals including pharmacists, dieticians and mental health workers. Additional money is provided for physician leads and to support the employment of allied health professionals. This latter funding enhancement is one of the factors that distinguishes FHTs from earlier models which had a largely unfunded aim to encourage more interdisciplinary collaboration.

Family Health Teams will be expected to provide extended hours of practice, link with community organisations and have an emphasis on chronic disease management and preventive care<sup>7</sup>. This focus will be supported by incentives. FHTs have gone ahead rapidly with 150 being approved, (with approximately 2.5 million registered patients across 112 communities) and most are operational. While most are GP led, some are community-led and others are based on a mixed governance model. There are different models for collaborative care and inter-professional teamwork, but in most cases other professionals are integrated into the practices.

In response to the need to assist practices with change management and team development, Quality Management Collaboratives are being funded across the province to support implementation. Their initial focus will be on team development, training, and community partner linkages. A prospective 5 year evaluation of FHTs (\$500 million program), compared with other models, is being put together at present.

### **3.2 Quebec**

Quebec province has taken a quite different route. The two major models prior to the most recent reforms were salaried community health centres (known as CLSCs) and FFS family physicians. The Clair Report<sup>8</sup> critiqued this parallel system and recommended that the models be integrated. Unlike Ontario, Quebec elected for wholesale, rather than incremental reform with the implementation from 2002 onwards of Family Medicine Groups (FMGs) which are a partnership between a number of family physician practices and CLSCs. FMGs are capitation funded, generally comprise 8-10 family physicians and nurses, involve voluntary patient registration (with individual GPs), and are expected to provide extended hours access. Nurses from the local CLSCs are co-located on a permanent basis with the FMG with functional authority to the FMG, but financial responsibility remaining with the CLSC. Nurses have an enhanced role in prevention and chronic disease management. Like FHTs they have been popular, and by 2007 there were 127 established involving 1,500 GPs and 230 nurses, and over 1 million registered patients. Most are private clinics, but some are former CLSCs, and hybrid models. The government has also provided considerable new funding (from the PHCTF) to support their establishment. At the same time, CLSCs have also changed, with mergers, a loss of autonomy and government requirements that they provide a core range of services. While previously they were semi autonomous organisations and governed by lay boards, the changes have bought them under a single governance model as part of hospitals and long term care.

The FMG evaluation found early discontent among both family physicians and nurses with the new arrangements as they were introduced, but that these had largely settled down after two years. While

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<sup>7</sup> Ontario ministry of Health and Long Term Care. Introduction to Family Health Teams.

<sup>8</sup> Quebec's Health Review. The Clair Commission (2001)

some FMGs are well integrated, others remain less so, and similar to the implementation of FHTs in Ontario, there is a continuing need for support and help to develop more integrated ways of working across and within the groups.

### 3.3 *Alberta*

The PHC reform focus in Alberta has been on establishing Primary Care Networks (PCNs) across the province under the auspice of the Primary Care Initiative. The provincial government (Alberta Health and Wellness), the Alberta Medical Association and the Regional Health Authorities are all parties to this initiative. In essence PCNs are networks of family physicians and other primary care providers. They have been rolled out with some overarching principles, but the considerable diversity makes comparisons difficult, not helped by a lack of consistent/standard outcome measures. Across the province, there are 26 networks involving 1245 family physicians. The greatest take-up has been in Calgary, where 40-70% of family physicians are involved. However like the FHTs, there is no data readily reported on the involvement of other primary care providers.

## 4. Comparison of Canadian and Australian linkage and exchange mechanisms

Similarities between Canada and Australia include the emphasis on building researcher capacity to link with policy makers and a lack of concerted effort to build capacity within the policy environment to develop and sustain links with PHC researchers. In addition the ‘commissioned research’ approach is seen by researchers in both countries to work against establishing sustained relationships and linkages with policy people as does the constant change of policy personnel, which is a feature of both the systems.

John Lavis describes the knowledge translation process as being about ‘building bridges’ between the research and policy-making communities and has developed a framework that groups the processes into 4 major categories:

- *Production* of research evidence that addresses identified priority areas for research.
- *Push efforts* by the researchers/intermediary groups to bring research evidence to the attention of policy-makers to inform policy development and implementation.
- *User pull efforts* of a) researchers to make it easier for policy-makers to identify research evidence; b) policy-makers to create in-house receptor functions for research evidence.
- *Exchange efforts* involving partnerships between researchers and policy-makers committed to asking and answering policy-relevant questions together<sup>9</sup>.

The following summary compares Australian and Canadian experiences in relation to primary health care using this framework, with a particular focus on the APHCRI experience.

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<sup>9</sup> Lavis J (2006) Research, Public Policymaking and Knowledge-Translation Processes: Canadian Efforts to Build Bridges. *Journal of Continuing Education in the Health Professions*, 26(1)

## **4.1 Production**

APHCRI adds an important layer of policy informed and coordinated PHC research effort not apparent in Canada, where a recent review concluded that there were widespread deficiencies in the sustainability and co-ordination of the research and little visibility with the Canadian Institutes of Health Research (CIHR)<sup>10</sup>.

There is no specific national PHC priority setting process in Canada or dedicated funding support for PHC research or career development, a key finding of this same report. By contrast the PHC research priority setting process in Australia has resulted in a series of APHCRI commissioned systematic reviews in the identified priority areas and the broader PHCRED program has stimulated research capacity building across a number of levels and areas. Nevertheless, the PHCTF was an important stimulus to research production, including literature reviews and synthesis reports relating to specific PHCTF initiatives as well as priority theme areas.

## **4.2 Push**

In both Canada and Australia push efforts have been a focus of specific research organisations. The 1:3:25 page report format promoted by the CHSRF has been adopted for CHSRF commissioned work and by APHCRI. The resources and education provided by APHCRI to assist the systematic review research teams to comply with the format was helpful, but ultimately for many teams it proved difficult to achieve the page limit in the first round of these new types of reviews that involved a steep learning curve.

Both the CHSRF and the Australian Primary Health Care Research Information Service (PHCRIS) play an important role in research dissemination. The explicit PHC focus of PHCRIS gives it a significant advantage, whereas it is only one aspect (albeit it with dedicated resources) of the broader health services research mandate of the CHSRF. At a provincial level (e.g Ontario), push/pull efforts include the requirement by funders for research teams to produce regular and short briefing notes which were invaluable in guiding policy discussions on the development of FHTs.

In both countries, research findings are disseminated through the usual academic channels and (variable levels of) presentations to policy makers and others. However, in relation to the latter, there remains an inherent tension in the knowledge translation process for researchers who operate in an academic environment that does not necessarily reward policy dissemination processes.

## **4.3 User pull**

The CHSRF has a strong and recognised role in facilitating user pull through its series of publications (eg myth busters, evidence boosters), PHC specific research summaries and a clearinghouse function. This is also an important role of PHCRIS. The facilitation role played by APHCRI to disseminate research findings through selected journals and conferences has been notable initiatives to facilitate user pull. In both countries there has been less attention within the policy environment to create receptor functions for research evidence (see Appendix 1 for an example of this). While APHCRI is able to monitor web page activity on the APHCRI reports, the lack of data on who is accessing the reports or which reports are being accessed makes evaluation of user pull difficult.

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<sup>10</sup> Russell G et al (2007) Mapping the future of PHC research in Canada. CHSRF

#### **4.4 Exchange**

There is a well developed culture and expectation for linkage and exchange in Canada, particularly in relation to health services research. It is a contractual requirement for any CHSRF funded research and all proposals go through a merit review panel comprising researchers, policy-makers and decision-makers and explicit linkage and exchange mechanisms with decision-makers are identified.

The PHCTF also provided the opportunity to develop PHC research capacity, credibility and track record, which has helped with the exchange process. At the more local level, provinces have used a variety of ways. For example, within the Ontario Ministry of Health an academic expert reference group has been established to inform PHC policy, and both Ontario and Alberta have joint university/government appointments with specific knowledge translation functions, although the arrangements differ (see Appendix 1).

Stakeholder linkage and exchange was an explicit, and funded, APHCRI requirement. APHCRI also facilitated exchange through regular national meetings that brought together the research groups and national policy officers and negotiating a policy contact person in the Commonwealth Department of Health and Ageing for each research group. Despite these endeavours, it remained an ongoing challenge to actively engage policy makers through these processes. Perhaps it was an ambitious objective to expect such widespread policy engagement across all 12 teams. Our team had limited success in obtaining policy input early on, although the stakeholder workshop on the draft findings helped shape the final report's discussion section and policy options; but ultimately earlier and more active involvement would have been desirable and would have shaped the review differently. The lack of any policy feedback since the review has left the team unsure as to its influence or impact. By contrast, there has been considerable researcher interest internationally in progressing and extending the work.

### **5. Significance for Australia & learnings**

The diversity of funding models in Ontario has enabled greater choice and flexibility for family physicians, than is currently available in the Australian context. The comparison of different models provides additional evidence that a range of PHC models is needed to achieve PHC goals of quality, efficiency, access, and equity and to address differing patient as well as provider needs. The evidence that capitation models perform better on access is perhaps more significant for Australia than the findings for community health centres, as few centres in Australia include GPs in the staff mix. The Ontario experience suggests that Australia would benefit from implementing a broader range of funding mechanisms to meet population health goals. The choice inherent in having a number of options has clearly been of benefit for both patients and providers and an important factor in their take up by family physicians.

The model of Family Medicine Groups in Quebec may hold considerable interest for the development of more integrated primary health care services such as HealthOne Centres in NSW, which aim to integrate GPs and community health services and GP Plus Health care Centres in South Australia. Given that most documentation relating to this initiative, including research and evaluation reports is

available only in French, the initial contacts made during the Fellowship are a useful starting point for exploring international collaboration opportunities. This will be pursued by the Centre for Primary Health Care and Equity as part of undertaking the 5-year evaluation of HealthOne.

The focus and investment in interdisciplinary collaboration and the associated research agenda in a number of provinces has the potential to inform Australian developments, including the move to more multidisciplinary team development in practices and linkages with other allied health professionals in independent practice.

## Appendix 1: Case study: Bringing researchers into the policy environment

An interesting initiative to support knowledge transfer and exchange between researchers and policy development processes has been the funding by the Ministry of Health of a dedicated research/policy linkage position who is employed by McMaster University, but spends most time in the Ministry as part of the PHC management team<sup>11</sup>. The Ministry related work includes providing research/evaluation technical expertise and advice and chairing an expert reference group of PHC related academics whose role includes reviewing the research evidence in priority policy areas to inform the decision-making around PHC investment. The research aspect of the role includes conducting independent, typically policy relevant, research as an academic with McMaster University. Both the Ministry and University see the advantages of this position, including:

- *For research:* improved insight and understanding into the policy-making environment, the development of trust and support for research, of relationships with key policy stakeholders, identification of research opportunities and the generation of policy relevant research ideas and proposals, and improved access to data and informants.
- *For policy:* access to timely research/evaluation expertise and advice, research capacity building of policy officers, better understanding of the academic and research environment, more policy relevant research

There are also challenges:

- *For research:* ensuring confidentiality and avoiding conflict of interest may mean excluded from research opportunities; conflicting priorities, research may be diverted because of Ministry demands;
- *Organisational:* differing organisational structures and objectives; securing long term funding for position; ownership of research.

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<sup>11</sup> I'm indebted to Gillian Mulvale for providing access to this information from a lecture presentation at University of Toronto & subsequent discussions

## Appendix 2: People consulted

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