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Reviving Full-Service Family Practice in British Columbia

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Abstract: In 2003, British Columbia created a joint committee of doctors and government representatives to reverse the deterioration in full-service family practice, particularly evidenced in poor morale among family physicians. The committee introduced an array of innovative programs into the province's fee-for-service system of solo and small-group practices, focusing on operational rather than structural changes. Incentive payments for managing chronically ill patients were followed by maternity care bonuses, training to enhance clinical skills and to support practice redesign, recruitment incentives for new family doctors, and other patient care initiatives. The programs, which are open to all general practitioners, have reduced health care spending on high-needs patients, research shows. Moreover, British Columbia now has the lowest hospitalization rate in Canada for seven medical conditions. The experience demonstrates that coordinated, operational reform of full-service family practice can improve care and reduce costs without radical restructuring of the primary care system.

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OVERVIEW

In Canada, primary care is the foundation of health care delivery, mostly through the offices of family doctors. These physicians typically are the first point of contact for people with health problems, and they coordinate all subsequent care, including referrals to specialists.

Beginning in the mid-1990s, full-service family practice went into decline across Canada, for a variety of reasons. Among the consequences were poor physician morale and a lack of interest among medical residents in entering family practice. Individual provinces and territories, which have a great deal of latitude to develop their own health care solutions, are countering the decline in a variety of ways. British Columbia is revitalizing its primary care sector through operational rather than structural reform—incentives and bonuses for full-service family doctors, training programs to enhance clinical skills and promote practice redesign, recruitment incentives, and other efforts.

This issue brief explains the origin of dissatisfaction with family practice in Canada and the reforms British Columbia has made to improve physician morale and engagement, and improve patient care at lower cost, without radically restructuring the provincial health care system.

BACKGROUND

National Health Care

Canadians receive health care coverage for medically necessary hospital and physician services through Medicare, a publicly funded, universal health insurance system. Although the 10 provinces and three territorial governments have a great deal of leeway to organize, manage, and deliver health care services in their jurisdictions as they see fit, they must uphold five principles in the Canada Health Act of 1984 (see box) and abide by inter-governmental funding agreements. Medicare is largely financed through general taxation, revenues from which the federal government distributes to the provinces and territories. Responsibility for financing health care is therefore split between the two levels of government. The provinces and territories' share of revenues to finance the system is raised through corporate and individual taxation into general revenue. Not all provinces levy health care premiums, but some, like British Columbia, do have Medicare premiums paid for by the individual, adjusted for income (about \$60 a month for anyone earning annually \$30,000 or more),¹ or paid through employer contributions.

Roughly two-thirds of Canadians have private insurance, usually as extended benefits from employers, for services such as dental care, prescription drugs, and home care. Private coverage for services that Medicare covers is prohibited.

Most doctors are self-employed in private practices. They work on a fee-for-service basis, although in some provinces an increasing number receive alternative forms of payment more aligned with integrated models of care. Hospital-based doctors also generally work on a fee-for-service basis. Religious orders, universities, governments, municipalities, or regional health authorities own the hospitals, nearly all of which are nonprofit.

A 2009 study by The Commonwealth Fund found that only about 37 percent of Canada's primary care doctors had adopted electronic health records,² one of the lowest rates among countries in the Organization for Economic Cooperation and Development. Canada lags well behind the Netherlands (99%), New Zealand (97%), the United Kingdom (96%), and Australia (95%) in this regard. In addition to broadening the adoption of health information technology, Canadian health policy has recently focused on reducing how long patients must wait to receive services and on strengthening and reforming primary care.

Such care is the foundation of health care delivery in Canada. The traditional backbone of that delivery is full-service family physicians, patients' first point of contact for most health problems. These physicians also coordinate all subsequent care, including referrals to specialists. Historically, the ratio of general practitioners

Five Principles of the Canada Health Act

Health care in Canada is:

1. **Universal** All citizens are covered.
2. **Comprehensive** All medically necessary services are covered.
3. **Portable** Coverage applies when Canadians travel across or relocate within the country.
4. **Accessible** Services are available to all and there is no extra billing by providers.
5. **Publicly Administered** A nonprofit, public authority administers health insurance plans.

The federal government can withhold billions of dollars in transfer payments to provinces if they do not uphold these principles.

Full-Service Family Physicians

Full-service family physicians are general practitioners who provide primary care throughout patients' life span. They coordinate care and maintain longitudinal, comprehensive patient records. Their services include:

- health risk assessments, check-ups, and immunizations;
- referrals to specialists and follow-up care based on their advice;
- diagnosis, treatment, and management of acute ailments;
- chronic disease management;
- primary reproductive care;
- prenatal, obstetrical, postnatal, and newborn care or arrangement for such care by another provider;
- primary palliative care;
- care and support of the frail elderly;
- clinical support for hospitals, home care, and rehabilitation and long-term care facilities; and
- patient education and preventive care.

(GPs) to specialists in Canada has been about 50/50. Research shows that countries with a strong primary health care sector have better population health and a more cost-efficient health care system.³

Beginning in the mid-1990s, full-service family practice went into decline nationwide. There were many reasons for this decline, which other countries have also experienced.⁴ In Canada, the reasons included higher compensation for specialists versus GPs, medical graduates' perception that specialty medicine had more allure and better prospects, an increasingly complex GP workload, fiscal restraint that resulted in fewer doctors being trained per capita, and cost restraints that affected health care services in general. Family doctors across the country who had tried to maintain full services reported that they felt overworked, overwhelmed, and dissatisfied. Many began to limit their practices by giving up hospital privileges, dropping maternity care, or working shorter hours, part time, or on shifts in walk-in clinics.

As a result, wait times for routine and urgent appointments grew longer, and many family physicians stopped accepting new patients. By 2003,⁵ an estimated 4.5 million Canadians could not find a family doctor, a number that has remained constant through to 2010.⁶ For many millions more, their family physicians worked fewer hours and curtailed the services they provided or were so busy that booking a timely appointment proved

difficult. To keep all of their appointments and simplify billing, some physicians permitted only one health issue to be discussed per visit.

Also in 2003, the Canadian Residency Matching Service noted that just 24 percent of graduating doctors from Canada's 17 medical schools chose family medicine, an all-time low. In British Columbia, the figure was 23 percent—a huge disparity, given the historical 50/50 split between GPs and specialists.⁷

Clearly, family medicine was in crisis and primary care needed to be revitalized and reformed. Ontario,⁸ Quebec,⁹ and Alberta¹⁰ largely embraced structural change: They encouraged physicians to leave private solo or small-group practices, relinquishing fee-for-service payments, and to work instead for a salary, under capitation, or based on a blended payment model with allied health teams or in community health clinics.

Ontario, whose 12 million residents make it the most populous province, opted to reform primary care by changing how services are delivered. For example, it established allied health teams with alternative physician payment models, called Family Health Teams (FHTs) or “medical home” models.¹¹ Between 2002 and 2010, about 75 percent of Ontario's 10,000 family doctors joined these teams, the single most notable change being a switch from predominantly fee-for-service to

capitation.¹² Significantly, physicians who joined such an FHT saw their income increase by 40 percent.¹³

While some observers promote team-based primary care as the model of the future,¹⁴ others note the implementation hurdles this model poses,¹⁵ including the need for payment reform, electronic health record capability, and transformation of the clinical culture to team-based care,¹⁶ for which most practicing GPs have not been trained. Furthermore, the model is difficult to apply in sparsely populated regions with an inhospitable geography and shortages of health care human resources—conditions that often exist in Canada, where team models tend not to be scalable across entire provinces. Indeed, Ontario limits the number of team-based primary care groups that can be established as a way to control the costs and challenging logistics of implementation and operation.¹⁷ Unexpected outcomes of the team model in Ontario include “policies that favour the self-selection of healthier patients, disincentives in major cities, gaps for vulnerable groups and suboptimal access to care.”¹⁸

Health Care in British Columbia

British Columbia (B.C.), Canada’s far western and third-most populous province, is a vast mountainous region; seven states the size of New York would fit within its 367,000 square miles. About 3.2 million of the 4.5 million residents are concentrated in B.C.’s southwest corner around the city of Vancouver and on southern Vancouver Island. The other 1.3 million live in smaller cities, towns, and villages dispersed throughout the province.¹⁹

As in all of the provinces, B.C.’s health budget has grown exponentially. Overall health care spending for 2009–2010 was \$15.5 billion²⁰ and will rise to more than \$16.5 billion in 2010–2011 and to \$17.9 billion by 2012–2013—a 91 percent increase since 2001.²¹ Five regional health authorities are responsible for service planning and delivery of predominantly acute, long-term, and community care. A sixth provincial health authority ensures that all residents have access to a coordinated network of high-quality, specialized services, such as cancer care, pediatric care, and transplants. The provincial Ministry of Health, in its stewardship role, provides direction, support, and funding; creates legislation;

negotiates fees and wages; and sets province-wide goals, standards, and expectations for service delivery.

Most family doctors are GPs in solo or small-group practices. The British Columbia Medical Association (BCMA) represents the vast majority of 4,973 practicing GPs and 4,082 practicing specialists,²² whose membership in the association is voluntary.²³ The BCMA negotiates on behalf of physicians for fees and benefits paid by the Medical Services Plan, the provincial health insurance program.

British Columbia’s governance over the last 50 years has swung between leftist, labor-aligned political parties and parties on the center-right aligned with business. In both instances during the last three decades, animosity and confrontation have often characterized the provincial government/BCMA relationship. This is largely because all provincial governments in Canada have had to curtail ever-escalating health care costs while the BCMA promotes adequate physician compensation, solutions to increasing job stress and complexity, and the best patient care. The irreconcilable nature of these competing needs pushed the relationship between doctors and government to an all-time nadir in the late 1990s and early 2000s.

REFORM IN BRITISH COLUMBIA

In response to the national decline in family practice, and unlike other provinces, B.C. chose to address this operational problem with an operational solution rather than a riskier, structural solution. It would improve the existing system through gradual but transformative change from within, largely based on what primary care doctors said they needed in order to better serve their patients. Tactics included practice incentives for full-service family doctors; training programs to enhance their clinical skills and job satisfaction, and to promote practice redesign; and recruitment incentives. The goal was to reward these physicians and help them provide continuous, comprehensive care, particularly to patients who are chronically ill or have other complex health conditions.

At the heart of such reform was a conviction that the doctor–patient dyad—a long-term relationship built on trust and forged over time—is the critical attribute of

successful primary care. Although much of B.C. faces a shortage of health care human resources, there is a robust base of generalist doctors who are working throughout the province under increasingly stressful circumstances. Therefore, B.C. decided to bolster the fee-for-service model by paying for improvements in how care is delivered. Incentive payments, for example, would encourage GPs to spend more time with chronically ill patients and with those who have complex health conditions, and to consult clinical guidelines.

British Columbia's approach aligns with the "triple aim" objectives of the U.S.-based Institute for Healthcare Improvement (IHI).²⁴ These critical, simultaneous objectives for the redesign of care delivery are to improve population health, enhance the care experience,²⁵ and reduce or at least control per capita health care costs. IHI notes that preconditions for success are engagement of an identified population (which in B.C. is primarily the family doctors who deliver services to patients services), a commitment to universality for its members (meaning all can take part), and an organization that accepts

responsibility for all three aims. In B.C., the organization responsible for leading primary care reform and meeting the triple aim objectives is the General Practice Services Committee (GSPC).

The escalating crisis in family medicine and the threat it posed to a well-functioning health care system spurred creation of the GPSC in fall 2002 under an agreement between the Ministry of Health and the British Columbia Medical Association. Its mandate was to find solutions to support and maintain full-service family practice in B.C. The committee consists of four members appointed by the Ministry of Health and four appointed jointly by the BCMA and the Society of General Practitioners of British Columbia. Of the eight members, five are current or former full-service family doctors. Representatives of B.C.'s health authorities also attend the monthly meetings as guests. All decisions are made by consensus. A unifying goal from the start was the focus on how to fix gaps in patient care, versus maintaining polarized positions of organizational self-interest. As author and committee cochair Dr. William Cavers

Key Features of Primary Care Reform in British Columbia

- **Operational, Not Structural** This enables gradual but systemic change from within.
- **Incentives and Training Programs** All of these are informed by clinical evidence and address known gaps in patient care.
- **A Focus on Patients** The formerly antagonistic relationship between doctors and the provincial government has been depoliticized. It focuses instead on what is best for patients.
- **Scalable** All of the initiatives are scalable across the province. In addition, all practicing family physicians are eligible to participate.
- **Rewards** Incentives encourage doctors to provide complex, continuous care. This promotes a shift from episodic care to more full-service, longitudinal care—even in walk-in clinics.
- **Practice Support Training** Doctors and office assistants learn how to make clinical and administrative improvements. They receive compensation to attend training.
- **Organic, Continuous Improvement** This approach, unlike "pilot" stages, enables adaptation to changing physician and patient needs as they arise.
- **Divisions of Family Practice** Created at the local and regional levels, the divisions provide a collective voice and network for isolated family doctors. This increases their influence on health care delivery and policy in their community, and makes them better able to work together to address gaps in patient care.
- **Collaboration** The way they are structured, the Divisions of Family Practice and the General Practice Services Committee bring acute care-oriented health authorities to the primary care table, which fosters an important working relationship and links professional networks.

noted in a media interview, “Focusing on what was best for patients, not best for doctors or best for government, made it all come together for us.”²⁶ The departure from entrenched political positions of the past would prove to be a critical factor in the GPSC’s success.

In 2003, the committee began looking for new ways to manage chronic conditions. More than 1.3 million people in B.C. have at least one such condition and 90,000-plus have four or more. The chronically ill make up 34 percent of the province’s population, but they account for about 80 percent of the combined budgets for the Medical Services Plan, PharmaCare (the provincial drug insurance program), and acute-care spending.²⁷ Also that year, the Full Service Family Practice Incentive Program began. With a modest budget of \$10 million, its first target was better diabetes care, followed by incentives for management of congestive heart disease, hypertension, and patients needing complex care. Such patients have at least two of eight medical conditions, including renal failure; neurodegenerative diseases such as multiple sclerosis, Alzheimer’s, and Parkinson’s; and liver failure.

The incentive program pays doctors to identify eligible patients and provide evidence-based care

according to B.C.’s official clinical practice guidelines.²⁸ The charts of diabetic patients, for example, must show that in the previous year they received referrals for HbA1c blood glucose tests each quarter, an annual eye exam, renal screens, lipid monitoring, and regular foot exams. The practice guidelines do not require use of electronic health records (EHRs), but simply require chart documentation that can be audited. However, many doctors have found that EHRs help them identify patients, create registries, and initiate recalls to patients for care.

The GPSC’s efforts gained impetus with the creation in 2007 of a “Primary Health Care Charter” that set the direction, targets, and outcomes for establishing a strong, sustainable, accessible, and effective primary care system in B.C. The charter, developed by a broad group of stakeholders, aligned governmental and nongovernmental strategic plans. It cites seven priorities:

1. Improved access to primary care.
2. Greater access to primary maternity care.
3. Increased chronic disease prevention.
4. Enhanced chronic disease management.

Spurring Electronic Health Record Adoption

Although EHRs are not necessary for participation in the General Practice Services Committee’s incentive program for family physicians, there is wide recognition that health information technology can facilitate patient care and chronic disease management and also increase office efficiencies after the shift to digital records.

In 2006, the British Columbia Medical Association and the Ministry of Health created a parallel organization to the GPSC to provide transitional support for greater adoption of EHRs by all physicians in B.C., both GPs and specialists. This organization—the Physician Information Technology Office (PITO, at www.pito.bc.ca)—is funding information technology planning and implementation with \$107 million through 2012. It preselected five compatible EHR vendors/application service providers whose products offer core functions as well as the ability to integrate with laboratory, radiology, and pharmacy information.

PITO reimburses physicians up to 70 percent of eligible costs for converting to EHRs. Under the program, about 1,500 doctors had an approved product installed and implemented in their office as of December 2010; an additional 1,400 were registered to get a system and in earlier stages of implementation. More than 90 percent of general practice clinics with six or more doctors and 50 percent of GP medical practices with two to five doctors in B.C. now have EHRs.*

Now, PITO is also providing more technical support and troubleshooting services to doctors who already have or are converting to EHRs, as this has emerged as an ongoing need.

*J. Smith, “Physician Information Technology Office Annual Statistics 2010” (PITO unpublished data).

5. Improved coordination and management of comorbidities.
6. Improved care for the frail elderly.
7. Enhanced end-of-life care.²⁹

The GPSC now has more than 15 initiatives (either new Medical Service Plan billing fees, such as codes for e-mail billing or telephone consultation, or incentives for office redesign, such as the ability to bill for group visits) to help family doctors improve the care of patients, most of whom fit within the charter's seven priorities and for whom there are clinical practice guidelines. Participation is "voluntary but irresistible," as the committee often notes. Doctors can bill for just one of the 15 new initiatives, a few of them, or all of them. Those who do bill may be subject to random chart audits by the Medical Services Plan.

The committee welcomes recommendations from the GP community on ways to improve the programs, and all 15 initiatives have evolved so that patients are better served and family doctors receive better support. This flexible, evolving system, which is closely attuned to the working lives of family doctors, helps build trust and support for GPSC programs and enables the committee to address issues as they arise.

The GPSC's activities and initiatives have been expanding since 2003. The financial initiatives, practice support, efforts to attract family doctors to B.C., and organizing physicians at the local level for collaboration and other purposes are discussed in greater detail below.³⁰

Financial Initiatives

Major components of this program include:

- Annual incentive payments to manage each patient who has a confirmed diagnosis of diabetes, congestive heart failure, hypertension, or chronic obstructive pulmonary disease.
- Bonuses for each baby delivery, incentive payments to establish a coordinated group network (i.e., a team of doctors sharing call rotations) for maternity care, and a training program to update

the maternity-care skills of GPs and residents who want to provide obstetric services.

- Incentives to develop clinical-action and discharge plans with patients—those who have complex medical needs, such as the frail elderly; patients of any age with multiple needs; the mentally ill; and patients who need palliative or end-of-life care—and with their families and others on the health care team.
- Incentives to develop and monitor care plans for high-risk patients—those who have two or more chronic illnesses, such as diabetes, renal failure, vascular disease, or chronic respiratory, cardiac, liver, or neurological disease. One incentive fee pays for four annual telephone or e-mail consultations between doctor and patient.
- Incentives to administer personalized health risk assessments of patients in targeted populations, such as smokers, those who should be immunized, and those who should undergo recommended screening (up to 100 patients per year).
- Incentives to create care plans and provide cognitive behavioral therapy and ongoing management services (including e-mail and telephone consultations) to mental health patients who have been diagnosed with Axis I conditions.³¹
- Forthcoming incentives to promote shared care with specialists and multidisciplinary care with allied health professionals.

Practice Support

In 2004 and 2005, the GPSC hosted "Professional Quality Improvement Days," consulting with about 1,000 GPs across the province to solicit their perspectives on the demise of family practice and ideas about solutions. These grassroots efforts built trust and clearly indicated that GPs needed help in reforming and revitalizing primary care. Consultations also revealed that declining interest in family practice could be checked if GPs felt valued, were appropriately compensated for their work, and received adequate, ongoing training and support to

Practice Support for Mental Health Care

A 2008 survey of family physicians in B.C. found that their greatest need for further training and support was in mental health care.

Subsequently, additional funding from the General Practice Services Committee enabled the Practice Support Program to create a comprehensive learning module for family doctors and their office assistants using a cognitive behavioral skills manual developed by a shared-care team in Victoria. Office assistants learn skills that help them interact with mental health patients, book appointments, and use new, mental health-related fee codes for billing.

GP champions in each region undergo training based on this module, then teach their colleagues. In addition, practice support coordinators hired from each of B.C.'s five health authorities facilitate the recruitment and training of family physicians.

By August 31, 2010, after gradual rollout of the mental health training, 981 of 3,700 family physicians in the province had participated. Three paid learning sessions are interspersed with reimbursed “action periods” during which trainees practice their new skills in the workplace. In the learning session after each action period, they share their experiences, concerns, and problems; receive training on new components in the module; and decide what modifications, if any, they might make in practice.

Results so far have been very good, and there is now a waiting list for enrollees. Among the physicians who have participated, 96 percent said they learned something new that they were incorporating into their practice, and 90 percent said the training had improved the care they provide.

Source: R. Weinerman, H. Campbell, M. Miller et al., “Improving Mental Healthcare by Primary Care Physicians in British Columbia,” *Healthcare Quarterly*, 2011 14(1):36–38.

provide high-quality care for an increasingly complex and aging patient population.

In response, the GPSC established the Practice Support Program, which spans three dimensions: clinical improvement, practice management, and information technology. Training sessions help physicians upgrade their clinical skills, and teach them and their office assistants how to improve practice efficiency. Clinical learning modules include mental health care, chronic disease management, and patient self-management. Two other modules, for end-of-life and youth mental health care, are forthcoming. In practice efficiency training, participants learn about “advanced access” scheduling to reduce how long patients must wait for appointments and how to arrange group visits, which enable doctors to see more patients. Recently, feedback from doctors has indicated they need help with integrating information technology and EHR systems into their offices; consequently, the GPSC is planning with PITO to increase this dimension in the Practice Support Program.

Regional support teams and peer champions help GPs self-assess their practices and determine ways to become more efficient, improve patient care and access to care, achieve better health outcomes, and increase providers’ satisfaction in the full-service family practice setting. Importantly, all trainees receive compensation—\$2,900 for doctors and \$20 per hour for office staff—along with continuing medical education credits.

Key attributes of the Practice Support Program include these:

- All learning modules adhere to the continuous quality improvement model from the Institute for Healthcare Improvement.³² Between training sessions, which typically take half a day, there are reimbursed “action periods”—about six to eight weeks during which trainees apply their new skills in the workplace.
- The program is administered provincially and executed regionally. Each of the five provincial health authorities has a support team to assist,

mentor, and coach GPs and their office staff, lead the training sessions, and help troubleshoot during action periods.

- On each team are GP champions, office assistant champions, a variety of other clinical peer leaders, quality-improvement and change-management coordinators, and data support resources.
- More than half of all GPs in B.C. have completed one or more of the learning modules.
- Support for the program is very strong

About 1 percent of the province's health budget, or approximately \$149 million, funds the Practice Support Program each year. Total cumulative spending on this essential, cost-effective investment in primary care will exceed \$800 million by 2012.³³

Family Physicians for British Columbia

In this initiative, financial rewards seek to attract and retain new family doctors in areas where they are needed, in exchange for a three-year commitment. GPs who have completed their residency within the previous 10 years are eligible for as much as \$100,000 to establish or join a group practice and up to \$40,000 for related expenses, for up to \$40,000 in student debt repayment, or for a new practice supplement of \$2,000 per week for 26 weeks. Obtaining hospital privileges earns them a \$1,500 bonus.

Divisions of Family Practice

Many practicing family physicians are relatively isolated from other doctors and the larger health care system. Divisions of Family Practice, a new concept that's unique to B.C., organizes physicians locally to address common health care goals and tie solo and small-group practitioners into a network. The divisions seek to improve patient care, provide professional satisfaction and support, and increase family physicians' influence on health care delivery and policy in their communities through negotiation and collaboration with the health authorities. About 30 regions encompassing 80 percent of the province's GPs are in various stages of establishing divisions.

The General Practice Services Committee pays their administrative expenses on a yearly, per-physician basis.

The divisions are incorporated as nonprofit societies, which gives them legal authority to sign contracts and/or hold funds for programs in their communities. Each has its own internal board structure and is represented on a collaborative services committee—the coordinating entity for a division, its related health authority, the GPSC, and the Ministry of Health. Committee members discuss gaps in local health care and develop programs. Decisions are made by consensus.

According to estimates, nearly 200,000 B.C. residents do not have a family doctor. Some divisions are developing corrective measures, such as incentives for their members to accept these “unattached” patients. In addition, multiple divisions in a region could decide as a group to hire nurse practitioners or other allied health professionals to help meet patients' needs or, if suitable in their area, to create shared-care models.

RESULTS

In just eight years, the General Practice Services Committee has very successfully reversed the demoralization of family physicians in British Columbia. Rather than animosity and acrimony between the provincial government and doctors, there is cooperative engagement for the first time in three decades. Physicians who are participating in the GPSC's efforts to enhance full-service family practice express renewed energy for their profession. Consultations between GPSC members and doctors around the province, as well as the 2010 B.C. Medical Association survey of its members, reveal that optimism and enthusiasm are replacing disillusionment and burn-out.³⁴ The BCMA survey also found that 95 percent of GPs now support the GPSC approach, up from 90 percent in 2008.

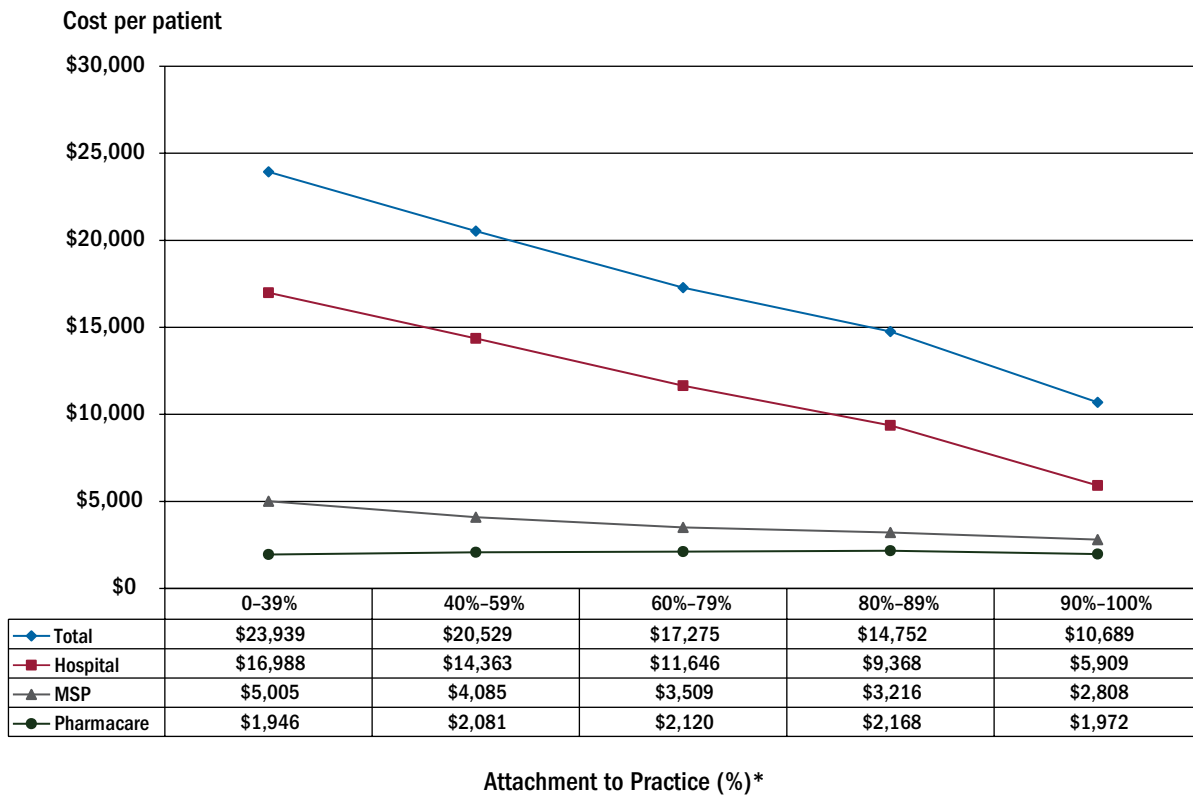
Patient care and cost-effectiveness also seem to have improved, according to Hollander Analytical Services, a consulting firm hired by the GPSC to evaluate the incentive and practice support initiatives. A key question for the researchers was whether the investment in primary care is a good use of provincial tax funds.

Hollander and colleagues tracked utilization data for 2007 and 2008. They found that health system costs were lower for patients with greater health care needs, including those who had diabetes or congestive heart failure,³⁵ if they were more attached to a primary care practice—that is, they had a regular practice where they went to for care.³⁶ For example, the average annual hospital costs for high-needs, unattached diabetes patients were nearly \$17,000 compared with an average of just \$5,900 for similar, attached patients (Exhibit 1). The highest-needs, unattached patients who had congestive heart failure cost the health system more than \$28,000 compared with about \$12,000 for the attached patients (Exhibit 2). These differences, the researchers concluded, can be attributed largely to the fact that patients without strong attachments to a family doctor are hospitalized longer, which greatly adds to the cost of their care.

Hollander and Tessaro found that GPs in the province who billed more for incentives increased the number and percentage of patients for whom a family doctor was the major source of all care.³⁷ Such attachment, in turn, leads to better care management and coordination, and to more cost-effective care.

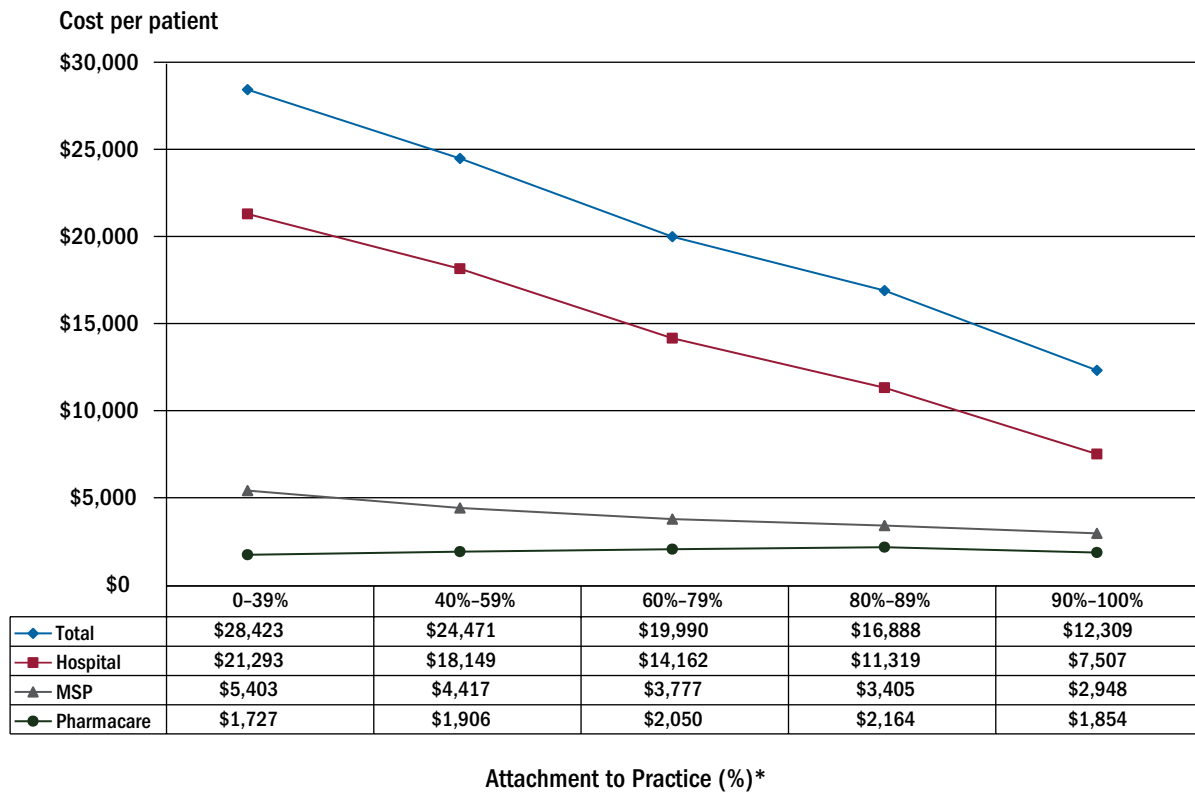
In the first few years, about 45 percent of eligible doctors billed for the diabetes incentive and just 25 percent for the congestive heart failure incentive. Since then, however, the number of such billings has grown annually. More than 90 percent of all GPs in B.C. are now billing for one or more incentives (Exhibit 3). And, unlike previously, family physicians do not drop patients who have complex health care needs in favor of those who are healthier and easier to treat. Even GPs in walk-in clinics can bill for incentives if they commit to providing continuous care. Because the incentives reward complexity

Exhibit 1. Average Annual Cost per Diabetes Patient in Resource Utilization Band 5 as a Function of Attachment to Practice, FY 2007–2008



* "Attachment to practice (%)" is the percentage of all services provided by a single family practice in the year. If a family practice provides six of 10 services, the percentage of attachment is 60%.
 Adapted from: M. J. Hollander, H. Kadlec, R. Hamdi et al., "Increasing Value for Money in the Canadian Healthcare System: New Findings on the Contribution of Primary Care Services," *Healthcare Quarterly*, 2009 12(4):32–44. Reprinted with permission of *Healthcare Quarterly*.

Exhibit 2. Average Annual Cost per Congestive Heart Failure Patient in Resource Utilization Band 5 as a Function of Attachment to Practice, FY 2007-2008



* "Attachment to practice (%)" is the percentage of all services provided by a single family practice in the year. If a family practice provides six of 10 services, the percentage of attachment is 60%.
 Adapted from: M. J. Hollander, H. Kadlec, R. Hamdi et al., "Increasing Value for Money in the Canadian Healthcare System: New Findings on the Contribution of Primary Care Services," *Healthcare Quarterly*, 2009 12(4):32-44. Reprinted with permission of *Healthcare Quarterly*.

Exhibit 3. Percentage of Full-Service General Practitioners Using Incentives

Year	Any incentive	Diabetes	Heart disease	Hypertension	Chronic disease
2003-2004	45.6%	45.3%	25.1%	0.0%	45.6%
2004-2005	63.3%	58.6%	29.0%	0.0%	58.8%
2005-2006	80.1%	76.0%	38.0%	0.0%	76.2%
2006-2007	87.5%	82.0%	47.4%	65.3%	83.8%
2007-2008	92.2%	85.9%	57.9%	78.8%	87.5%
2008-2009	92.9%	86.5%	57.9%	80.3%	87.9%

Source: Report on Uptake, Report to the GPSC. Marcus Hollander, Hollander Analytical Services. Unpublished manuscript.

and continuity, they prompt walk-in clinics to offer more full-service, longitudinal care and less episodic care.

Health outcomes also have improved. Among the Canadian provinces, B.C. currently has the lowest hospitalization rates related to seven, ambulatory care-sensitive conditions (conditions that can be effectively treated in a nonhospital setting).³⁸

According to the yearly Ipsos Reid survey of members of the British Columbia Medical Association, 95 percent said they support the GPSC's approach, up from 90 percent in 2008.³⁹

The annual earnings of doctors who bill for all of the incentives can increase by about \$27,000, or approximately 12 percent.⁴⁰

A more detailed analysis of the impact of primary care reform in B.C. generated the following statistics for FY 2008–2009, based on the experience of 3,525 GPs:

- 3,027 (86 percent) billed for the diabetes chronic disease management incentive for 154,596 patients, 2,822 (79 percent) billed for the hypertension incentive for 245,087 patients, and 1,973 (57 percent) billed for the congestive heart failure incentive for 19,440 patients. About \$34 million is spent annually on better chronic disease care.
- Doctors are developing and monitoring care plans for about 110,000 complex-care patients (those with two or more chronic diseases) and 2,250 of the GPs (64 percent) billed for this incentive. About 780 (22 percent) used the e-mail/telephone fee to consult with such patients.
- 2,566 (72 percent) worked with 47,900 patients to develop a personal action plan to reduce cardiovascular risk factors.
- GPs who completed the advanced access module in practice support training reduced the average wait time for regular appointments from 5.8 days to 2.5 days and urgent appointments from 1.3 days to 0.04 days.
- 89 percent of GPs who completed the chronic disease management module said it enabled them to deliver better patient care.

- 93 percent who completed the patient self-management module said they are comfortable helping patients embrace self-managed care.
- 91 percent who completed the group-medical-visits module felt that group visits increase patient satisfaction.
- Under the Family Physicians for B.C. program, 72 new GPs have been recruited, filling 75 percent of 92 positions.⁴¹

Furthermore, as of March, 31, 2009, about 1,200 GPs in the province (34 percent of the total) and their office assistants had completed Practice Support Program training.⁴²

DISCUSSION

Lessons Learned

British Columbia found that bringing about meaningful reform required a combination of four conditions, all of which must be present:

1. Targeted incentives.
2. Relationships and trust.
3. Training and support.
4. Measurement and feedback loops.

Unquestionably, past animosity and rancor set the stage for more conciliation, and years of “talk” about primary care redesign undoubtedly led to a climate of “readiness” for change.

Only in the last several years has true change begun to occur. Perhaps the most significant indicators of success are GPs' interest in the B.C. approach and the adoption of highly transformative ventures, such as the local family-practice divisions and efforts to improve patient attachment. None of this would be occurring without the trust that the GPSC's collaborative deliberations have engendered and illustrated.

In many ways representing the culmination of the GPSC work, the creation of the Divisions of Family Practice has brought about true system change,

particularly through the incorporation of effective GP voices that can engage health authorities. One might speculate that the Practice Support Program and new fees helped give GPs some relief from their daily grind—as well as reassurance that the GPSC was working hard to improve the situation—so that the doctors were then willing to take a chance on the Divisions of Family Practice initiative. Although Division uptake has been nothing short of phenomenal, there was much bad history between government and the doctors that needed to be undone in order for this collaborative work to proceed. In addition, by ensuring all negotiations were framed in terms of “what makes most sense from the patient perspective,” the GPSC was able to circumvent vested interests within the health care system and bring in new initiatives.

Challenges

Since all GPSC programs are strictly voluntary, not all doctors have joined. Indeed, some highly stressed, over-worked family doctors view the ever-expanding number of incentives and support programs as simply more demands on their time.

The GPSC is aware that its fee schedule for incentives is becoming more complex. The preexisting Medical Services Plan schedule of billing codes was already a massive document, containing hundreds of fee-for-service codes that doctors had to submit to the government to receive payment for patient services. Adding more fee codes to the existing billing schedule has caused some doctors to feel overwhelmed by the seeming complexity of documenting their care and submitting bills to the government for payment. Among the committee’s strategies to address this complexity are clear and frequent online and written communication between it and family doctors, as well as seminars on billing. The committee actively solicits feedback from physicians, which helps shape necessary fee revisions. Physician champions, who have taken the training sessions or are billing for incentives, help spread the word about how they bill for the fees, how the initiatives have improved the care they provide, and how their job satisfaction, and compensation for more-complex care, has increased.

So far, the family practice divisions have very effectively engaged and empowered local doctors to work together to resolve local issues. However, given that the divisions are still relatively new and control their own agendas, one concern is how their successes and failures might ultimately impact the GPSC’s effectiveness and mandate to reform health care. If they go in unexpected directions or the dynamics between them and the GPSC or the health authorities change, it could strengthen primary care or create strife and disagreement. A constraint for the committee is the limited manpower it can devote to encouraging and enhancing effective collaboration among and across divisions.

There are also challenges beyond the GPSC’s control that could greatly impact its programs. These include provincial elections, the economic climate, potential changes to the Canada Health Act, alternative models of primary care, and values and perspectives in medicine.

Provincial elections. The committee’s continuing operation depends on regular renewal of a negotiated agreement between the provincial government and the British Columbia Medical Association. Given that a provincial election may take place as early as fall 2011 and that the current agreement expires in spring 2012, any change in government philosophy could affect its substantial progress on primary care reform. The GPSC is working to ensure that its initiatives are cost-effective and best for patient health. Perhaps the proven benefits will transcend political ideologies. B.C. has a history, however, of having health care programs upended by changes in the provincial governing parties.

The economic climate. Although the annual cost of all the GPSC programs is just 1 percent of annual health care spending in B.C. when the agreement is renegotiated, the economic climate at that time will greatly impact its scope. The cost-effectiveness of programs will receive considerable scrutiny.

Potential changes in the Canada Health Act. The act is facing a number of legal challenges, particularly one in B.C. that argues that prohibiting patients from paying privately for medically necessary services runs counter to the national Charter of Rights and Freedoms. Furthermore, conservatives gained majority control of

the federal government in a recent election after years of minority rule. Prime Minister Stephen Harper has confirmed his commitment to the Canada Health Act, but some observers and opposition parties worry that the conservative majority may alter the act to allow more private health care. If courts deem the act unconstitutional or if the current government amends or abolishes it, the health care landscape in Canada will fundamentally change. Although predicting the full impact of any change is difficult, the GPSC's programs for family doctors would nevertheless encounter new pressures and challenges, and might ultimately give way to private solutions.

Alternative models of primary care. British Columbia kept the traditional family doctor–patient dyad as the nucleus for primary care reform because this seemed to be the most workable solution for its needs. However, other approaches in Canada and around the world, such as family health teams, medical homes, and the nurse practitioner model, are gaining popularity. If there is a consensus that another approach to primary care is more cost-effective and delivers superior care, and if family doctors are not central figures in that model, the GPSC's programs will lose their effectiveness or even disappear. Its model increasingly incorporates team and shared care, but family doctors are still at the core. Public demand for a different model also could have an impact.

Values and perspectives in medicine. Numerous forces in the medical culture may pose a threat to the GPSC and primary care reform in B.C. If young medical students reject family medicine as a career choice despite the committee's efforts, the imbalance between family doctors and specialists will become severe. Many residency and specialty training programs in Canada are not aligned with new models of primary care and may not provide a realistic and encouraging view of full-service family practice. In addition, the current dynamics between generalist family doctors and specialists, particularly in larger urban environments, can create referral forces or anomalous practices that are immune to change by GPSC programs. For example, in Vancouver, specialists outnumber GPs. This means patients may be going to specialists for routine primary care that could be handled

by a GP, such as getting a Pap smear from a gynecologist or treatment for mild asthma from a respirologist. This creates certain patient expectations and entrenched referral patterns that, while arguably not cost-effective, can be difficult to change through GPSC programs.

NEXT STEPS

British Columbia has made tremendous progress on primary care reform, but it is not resting on its laurels. Among numerous projects under way or soon to be completed at the GPSC are these:

- publication of an extensive evaluation of the committee's initiatives;
- new incentive payments for end-of-life planning and acute-care discharge planning conferences to improve transitional care;
- expanded bonus incentives to encourage development of care plans for people who have chronic obstructive pulmonary disorder;
- a shared-cared initiative to encourage greater coordination and cooperation between GPs and specialists;
- integration of other health disciplines into family practice; and
- creation of family practice divisions in every region of B.C., the objective being to bring 90 percent of all GPs into this extensive network.

One of the first challenges new divisions must tackle is finding ways to attach people in their area to local family doctors. If every doctor in all of B.C.'s divisions agreed to accept four or five new patients, the problem would be solved. The goal is universal attachment by 2015.

By 2020, if the GPSC's ambitious vision becomes reality, across the province there will be broad, rational deployment of full-service family physicians participating in a network of coordinated divisions. Working with this generalist base will be broadly and rationally deployed specialists. A fully functional health information system linking and supporting these players would foster not

only coordinated patient care, but also joint evaluation of and research on the impact of the GPSC's programs and other important primary care issues.

The committee envisions vibrant, effective Divisions of Family Practice firmly connected with and accountable to their communities. Ultimately, all family doctors will join a division and collaborate effectively with the health authorities on innovative solutions to regional health problems. With each success, trust will build and generate momentum and enthusiasm for addressing more-complex issues, enabling the public to reap ever-greater value and responsiveness from the local health care system. Divisions might even operate emergency departments or entire hospitals.

On a larger scale, the GPSC foresees a patient-centered system informed by population health. Among its attributes would be patient empowerment, strong patient input, strong doctor-patient relationships, self-management support for patients, and integration with public health. Allied health teams would develop and deliver services as close to the "clinical rock face" as possible. Every citizen in B.C. who wants a primary care provider could have one.

Bringing more health disciplines into primary care is certain to draw greater focus and more funding over the next decade. In addition to specialists, the expanding health care team will likely include pharmacists, nurse practitioners, and other professionals, such as psychologists, physio- and occupational therapists, and social workers. Access to these wide-ranging services, wrapped around the family physician office, will move the system more toward prevention and health promotion. That, in turn, will free up hospital and residential care beds, help patients self-manage their health and live out in their community, and redirect clinical attention to the most needy and vulnerable in B.C.

These changes will shift the power balance from acute care to community-based primary care. In the past, acute care has tended to predominate and be isolated from primary care. In the future, it will instead respond to primary care needs.

As reform in British Columbia moves forward, it is hoped that these efforts will eclipse politics and election cycles, and focus on the most important objective: meeting patients' needs.

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