



LINKING FAMILY PHYSICIANS WITH LOCAL HEALTH INTEGRATION NETWORKS (LHINS) IN ONTARIO

FINAL REPORT

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LINKING FAMILY DOCTORS AND LHINs IN ONTARIO:

Executive Summary

Purpose

This research attempts to identify how family physicians might link with the newly formed Local Health Integration Networks (LHINs) in Ontario, by exploring the experiences and perceptions of family physicians in other national and international jurisdictions that have undergone some similar form of health system regionalization.

Methods

The research was undertaken by McMaster's Department of Family Medicine during the spring, summer and fall of 2005. The project's timeline was intentionally short (January 2005 to September 2005) in an effort to provide some input into the process of getting the LHINs up and running. The research included a literature review, teleconferences/interviews with expert family doctors from places where regionalized systems were already in place, focus groups with family physicians, a strategic planning and recommendations meeting and a final report describing the key findings and recommendations. The project was funded by the Ministry of Health and Long Term Care (MOHLTC) (Primary Health Care Team and the Health Results Team) and ongoing feedback to drafts of the final report was obtained from project participants and the MOHLTC.

Main Findings

Literature review

The literature highlighted the importance of primary care (i.e., the number of family physicians in a community) in terms of improving community health status, reducing health inequities and ultimately reducing healthcare expenditures (Starfield and Shi, 2002). As such, health policy should be directed towards strengthening the primary care orientation of health systems.

While health system regionalization has a relatively long history, both in Canada and abroad, there is little evidence regarding its effectiveness (Lewis & Kouri, 2004). Equally, while there is

little evidence to suggest that health system regionalization has been a success, there is little evidence suggest that it has failed. Regardless, ‘loose coupling’ and new power relationships can impact on the effectiveness of health system regionalization (Hinings et al., 2003).

Focus groups

During the focus groups, family physicians voiced a number of concerns surrounding the introduction of the LHINs including: the lack of communication surrounding the LHINs and their purpose; the apparent low priority of primary care in the LHINs; and, the possibility that the issues and concerns of larger urban areas will dominate at the expense of the smaller rural communities. In an effort to address these problems (and others), the family physicians in our focus groups indicated that they would like to have input into the LHIN decision-making process. The importance of developing an organizational structure for family physicians was also highlighted.

Teleconferences

During the teleconferences, our expert key informants put forward a number of suggestion and advice for family physicians in Ontario including: the importance of family physicians organizing and unifying; the importance of getting involved in the health system planning process (and being appropriately remunerated for their participation); and, the importance of establishing primary care and family medicine as a priority within each of the LHINs.

Recommendations

Based on our research we present the following recommendations:

1. Establish Family Medicine as a priority area for each of the Local Health Integration Networks (LHINs) in Ontario.
2. Establish LHIN Family Medicine Advisory Committees (LHIN FMACs) in the 14 regions, comprised of key family physician representatives from: the Hospital Chiefs of Family Medicine, urban family physicians, OMA/Section of General Family Practice, OCFP, COFP, Academic Chairs of Family Medicine, Society of Rural Physicians, PAIRO Representative, PCR Representative.

3. Include, on the LHIN FMACs, consumer and government members from: LHIN CEO's, Medical Officers of Health, consumers, local politicians, MPPs, and the MOHLTC.
4. Appoint one representative Family Physician Lead from each of the 14 LHIN FMACs to each LHIN Board.
5. Set up an organizational structure (i.e., subcommittees) for LHIN FMACs that allows family physicians to address comprehensive care in family practice within the LHINs: office practice, chronic care, mental health, prevention, home care, hospital care, palliative care, Long Term Care, obstetrics, emergency care, rural family medicine etc.
6. Establish an interdisciplinary Primary Care Committee representing nursing, nurse practitioners, dietitians, pharmacists, social workers, and other health professionals that work in family practices with a representative on the LHIN FMACs.
7. Set up LHIN FMAC administrative structures that allow the LHIN FMACs to address operational issues across the regions such as: primary care reform, physician recruitment/retention/shortages, credentialing, continuing professional development, CQI, research/evaluation and information/communications management.
8. Establish a Provincial Family Medicine Advisory Committee comprised of one representative from each of the 14 LHIN FMACs. The committee will elect a chair. The Chair of this committee will also sit on the provincial FMAC Committee.
9. Fund the LHIN FMAC organizational structure through the LHINs/MOHLTC.
10. Remunerate family physicians for any time they spend formally participating in the LHIN structure.

LINKING FAMILY DOCTORS AND LHINs IN ONTARIO: FINAL REPORT

Introduction

Ontario's healthcare system is in the process of rapid change and transformation. Local Health Integration Networks (LHINs) have been identified by the Ministry of Health and Long Term Care (MOHLTC) as a primary mechanism to make Ontario's health system more responsive to patient needs. According to the Ministry, the LHINs are intended to coordinate health service delivery by "enhancing and supporting the capacity to plan, coordinate, integrate, and fund the delivery of health services at the local level" (Ontario Ministry of Health, LHIN Bulletin No. 1, 2004, p. 1).

Recently, the Ontario College of Family Physicians (OCFP) prepared a report for the Minister of Health and Long Term Care which highlighted the importance of ensuring that family practitioners are involved in the creation of the LHINs and their subsequent governance (OCFP, 2004). Given that much of family medicine practiced today takes place outside of the hospital environment and in the community, there is the need for an organizational process in place that reflects this reality and allows family physicians working in the community to have their voices heard (OCFP, 2002). This research attempts to identify how best these linkages and integration might be achieved within the newly formed LHINs. This will lead to a better linked health system for Ontario and, ultimately, to improved care for patients.

Purpose

This research attempts to identify how family physicians might best link with the newly formed LHINs in Ontario, by exploring the experiences and perceptions of family physicians in other national and international jurisdictions that have undergone some form of health system regionalization. Investigating the relationships between family practitioners and regional health authorities in Canadian provinces such as British Columbia, Alberta and Saskatchewan (amongst others) provides valuable lessons for family practitioners in Ontario. Similarly, the United Kingdom, Australia and New Zealand have all undergone significant health system restructuring

efforts and concomitant changes in the nature of the relationship(s) between family practitioners and the health system. Ideally, this research will provide family practitioners in Ontario with an indication of the keys to a successful partnership.

Objectives

Specifically, the objectives of this research were:

- 1) To conduct a literature review of both national and international sources examining health system regionalization and linkages with family physicians.
- 2) To solicit the experiences and perceptions of family physicians/general practitioners in other jurisdictions (both nationally and internationally) who have experienced health system regionalization.
- 3) To hear from family doctors in Ontario with respect to their thoughts and concerns about the LHINs and what kind/type of organizational structure they would like to see so that they could link, connect and provide input into decisions surrounding the delivery of primary care.
- 4) To hold a strategic planning meeting with key stakeholders to begin to develop preliminary recommendations to be taken forward to the MOHLTC.
- 5) To make final recommendations to the MOHLTC informed by the findings of the research project.

Methods

The research was undertaken by McMaster University's Department of Family Medicine during the spring, summer and fall of 2005. The project's timeline was intentionally short (January 2005 to September 2005) in an effort to provide some input into the process of getting the LHINs up and running. The project was funded by the MOHLTC (Primary Health Care Team and the Health Results Team).

The research included a literature review, teleconferences/interviews with national and international expert family doctors, focus groups with family physicians, a strategic planning meeting with key stakeholders, and a final report describing the key findings and recommendations. Ongoing feedback to drafts of the final report was obtained from project participants and the MOHLTC. The final report is available on the McMaster University,

Department of Family Medicine website (www.fammedmcmaster.ca). The main findings and recommendations resulting from this project were presented as a poster at the North American Primary Care Research Group (NAPCRG) conference in Quebec City (October 2005) and a manuscript is being prepared for publication.

Literature review/environmental scan

The literature search included works published in recognized academic journals as well as “grey” literature (i.e., reports, position papers, web sites, etc.). The purpose of the literature review was to identify both Canadian, as well as international, examples of linkages between family physicians and regionalized health systems. Medline and Google Scholar were used to search for published works and grey literature. In addition, an intensive Internet search was performed in an effort to identify grey literature (e.g., reports, position papers, etc.) available from experts, governments, family physician organizations, etc. Appendix A contains the annotated bibliography compiled for the project.

Focus groups with family physicians in Hamilton, Toronto, Niagara, and Kitchener-Waterloo.

Focus group discussions (4) were held with family physicians in Hamilton, Toronto, Niagara and Kitchener-Waterloo. Participants were asked to comment on their concerns about the LHINs, areas that they hoped the LHINs would address, as well as to share their views surrounding an appropriate and effective linkage for family physicians with the LHINs. The focus groups were tape recorded, transcribed and entered into a computerized data management system (i.e., NVivo) for thematic content analysis.

Key informants from each locale were initially identified by the principal investigator. They were contacted (by e-mail and/or telephone), informed of the nature of the research project, and asked if they would be interested in participating. If they agreed to participate, the key informants were asked to identify other family physicians in the area to participate in the focus group discussion. Each of the discussions began with a brief presentation from the researchers which provided some background information about the research project, the findings to-date, and the nature of the discussion to take place. The participants received a package that included copies of the introductory presentation (in PowerPoint), a ‘backgrounder’ article on the LHINs

(Harrison & Boadway, 2005) and a map illustrating the 14 LHIN boundaries in Ontario.

Participants were also provided with an information letter describing the nature of the project and their participation in it, and asked to sign a consent form. Following the discussion, the participants were asked to complete an evaluation form. See Appendix B for the focus group questions and the letter of consent.

National and international interviews with family physician representatives

Interviews (both face-to-face and telephone) were conducted with key informants from British Columbia, Alberta, Saskatchewan, Manitoba and Quebec. In addition to the Canadian participants, we also interviewed representatives from the United Kingdom, Australia and New Zealand. A total of ten (10) interviews were completed. Key informants were identified through our literature and internet searches as being individuals that were particularly knowledgeable about the links between health system regionalization and family physicians/general practitioners in their particular location. During the interviews, information was solicited regarding respondents' experiences and perceptions of the linkages between family physicians and the health system. Participants were asked to comment on the history of health system regionalization in their particular jurisdiction, the structure of family physician/general practitioner organizations in their jurisdiction, as well as any advice/suggestions they would have for family physicians in Ontario. The aim was to gain an insiders understanding of the experiences of family physicians in other jurisdictions during the process of health system transformation in an effort to guide family physicians in Ontario. See Appendix C for the interview guide. The interviews ranged between 45 and 80 minutes in length.¹ They were tape-recorded (with consent), transcribed and entered into a computerized qualitative software data management program (i.e., NVivo) for thematic analysis.

Strategic planning meeting

A strategic planning and recommendations meeting was held on June 3, 2005 with a number of the Chiefs of Family Medicine in the Province, members of the OCFP Executive, representatives from the Family Medicine Association of Hamilton (FMAH), Family Physicians Toronto and focus group participants. The primary purpose of the meeting was to identify recommendations

¹ The transcribed interviews are not included in their entirety in this report, but have been kept on file in the Department of Family Medicine, McMaster University Research Office as per the informed consent agreement.

to be taken forward to the MOHLTC regarding the linkages between family physicians in Ontario and the LHINs. Participants listened to two presentations (one describing the establishment of LHINs in Ontario and the other which introduced the research project and some of the key findings) before breaking up into two groups to discuss organizational structures for linking family physicians with LHINs in Ontario. The participants then reconvened in one large group and shared their recommendations with the larger group. A report of the meeting was subsequently prepared and circulated amongst the participants for feedback. A final version of the strategic planning meeting report is attached (see Appendix D).

Results

Literature review

Health system ‘regionalization’ is a dynamic, fluid and highly complex process that has played out in different ways in different places throughout the world. In Canada, Ontario is the last province to move towards regionalizing its health delivery system. Many Canadian provinces have been experimenting with the ‘optimal’ number of regional health authorities for some time, most ending up with fewer than they had initially started out with. In any event, it is important to note that these changes (i.e., regionalization) are inherently situated within highly complex, ‘loosely coupled’ political and health systems (Hinings et al., 2003).

Lewis and Kouri (2004) note that while, as of yet, there is little evidence to suggest that the regionalization of health services has been effective, there is equally little evidence to suggest that it has not. On the positive side, it has been suggested that health system regionalization can lead to improved and more responsive local decision making (to better meet local needs) (Lewis & Kouri, 2004). More negatively, health system regionalization can be perceived as a way for the provinces to down-load health system responsibility to communities that are ill equipped to handle them (Casebeer, 2004). Regardless of the evidence (or lack thereof), the regionalization of health services in Canada has a relatively long history, dating back to the early 1990s in Quebec and Saskatchewan. Outside of Canada, the UK, Australia and New Zealand (and many others) also engaged in health system regionalization during the 1990s. So, nationally and internationally, the ideology of regionalization appears to be a particularly powerful and politically appealing one.

In an effort to move the debate forward, Lewis and Kouri (2004) identify three factors which, they suggest, can lead to successful regionalization. First, they suggest that, in most instances, regional health authorities are better able to function when there are fewer autonomous agencies to deal with. Second, they note that drug budgets should be incorporated into RHA structures. Third, and perhaps most importantly, they highlight the fact that “physicians must be brought fully into the RHA fold” (p. 28). They also suggest that RHAs should focus on changing the organizational culture amongst providers by focusing on quality issues and improving provider morale. Harrison and Boadway (2005) also highlight the importance of physician involvement as a key element of health system transformation noting that, “direct physician consultation is essential in order to avoid the experience in Alberta and B.C., where the health-care systems endured significant turmoil and instability for almost a decade, before relative calm was restored” (p. 19). Ontario can potentially avoid these problems if physicians are involved in the initial LHIN roll-out and their on-going operation.

While the evidence regarding health system regionalization is equivocal, there is an abundance of compelling evidence suggesting that having a strong primary care infrastructure (i.e., an adequate supply of high quality family physicians) in place can lead to improved population-level health status (Starfield and Shi, 2002) and reduced health system costs (Starfield & Shi, 2002). Interestingly, no such relationship exists when one looks at the supply of specialists (Starfield et al., 2005). Shi et al. (2005) observed that an increase of just 1 primary care physician, per 10,000 population, was linked to a 2% increase in the likelihood of reporting good or excellent health. In other words, the number of primary care physicians in a community is directly and independently linked with improved health status. The introduction of LHINs in Ontario provides an opportunity to strengthen Ontario’s family physician infrastructure (both organizational and clinical) through the inclusion of family physicians in their development and ongoing operations.

Focus groups

Focus group participants were asked to share their concerns about the LHINs, issues that they would like to see the LHINs address, any potential benefits of the LHINs and any suggestions they might have about providing input into the LHINs. The results presented here are grouped by theme and are based on all four of the focus groups.

“I don’t know what to think about them because I don’t really understand them.”

— focus group participant

“My feeling is that the unfolding of this has been very poorly communicated”

— focus group participant

“I guess that one thing I’d like to see is primary care be a priority. I have this copy of integration priorities by LHIN. In fact, only three LHINs reported primary care as a priority.”

— focus group participant

Concerns

Focus group participants expressed a number of concerns with respect to the MOHLTC’s introduction of Local Health Integration Networks in the province. Concerns included:

Awareness/knowledge of LHINs

There were, generally, low levels of knowledge and awareness amongst family physicians about the LHINs. The family physicians we spoke to felt like they have been ‘shut-out’ of the process to-date and that there had been a lack of family physician involvement/consultation.

There was also some confusion as to how family physicians would ‘fit into’ and relate to the new (LHIN) structure.

However, despite this uncertainty and confusion, there was a general feeling that they (family doctors) want/need to be involved:

“I mean, the LHINs are here, we can’t do anything about this. FHTs are here. The government is mandated to regionalize healthcare and it’s critical for us to find ways regionally to strengthen family medicine and coordinate family medicine while we’re doing the LHIN. If we don’t do that, and we don’t do it now, as the LHINs would formulate how they’re actually going to do their work and we’re going to be left out.” (focus group participant)

Priority of primary care

Respondents were very concerned about the fact that primary care did not appear to be a priority in the LHINs.

Equity

Respondents also expressed concern about the fact that the issues and priorities of larger urban areas might dominate the LHINs at the expense of smaller and more rural communities. Similarly, there were also concerns over the size of the LHINs and some

“I mean, how are you going to administer something as big as having extended it to Hamilton and what other areas... Is it possible, practical, if we could not even do it at a local level?”

— focus group participant

wondered if they will be able to address local needs given their broad (i.e., regional) make-up. There were also some concerns about how the system would be administered given that smaller and supposedly more manageable health systems have had tremendous difficulties managing themselves.

Other concerns

Participants expressed other concerns about the LHINs including the fact that the LHINs will be governed by government appointed, as opposed to elected, representatives, the nature of the relationship between the LHINs and the newly designated Family Health Teams (FHTs), the possibility of continued, or even strengthened hospital dominance and the present lack of an organizational structure for primary care organizations (as illustrated by the SARS issue).

Issues for LHINs to address

Focus group participants identified a number of family medicine issues that they would like to see addressed by the LHINs (with input from family physicians). Issues identified included:

- Improved Information Technology Systems
- Improved Continuity re: access to primary care
- Continuing Education/CME
- Physician Recruitment/Retention/Shortages
- Credentialing
- Palliative Care
- Quality of Care
- Mental Health
- Rural Family Medicine
- Obstetrics
- Low Morale amongst Family Physicians in the Province

“We’re the front line. We’re the ones who know what the needs are out there for the community. I think we should have a major voice in the first place.”

— **focus group participant**

“We need to get our act together and speak with a stronger family medicine voice in the community...”

— **focus group participant**

“I think we have to create a new structure ...whereby local practitioners have a forum in which they can voice their concerns, and which will take them forward to the Ministry and will be representative of the entire region.”

— **focus group participant**

“You’ve got unbelievable opportunities here. But you’ve got to get yourselves organized!”

— **focus group participant**

Potential Benefits

Participants also identified a number of possible benefits resulting from the LHINs such as the potential for decreased hospital dominance, improved planning for local needs, and better coordinated IT systems for family doctors.

Suggestions

The focus group participants offered a number of suggestions.

The family doctors stressed the importance of getting involved in the process and presenting a strong and unified voice on a LHIN-wide basis. The family physicians suggested that a new organizational structure was necessary to facilitate this involvement.

The opportunity to follow other models was also suggested.

For instance, one participant commented:

“The British system sounds ideal to me... The top two people running it are a physicians and a public health person. And they have access to the decision-makers, clear away to the top. And I think if they have that sort of access to the leaders in that model, then they could put all kinds of political, and I don’t care who they put on the boards, but if the top guys there are running 300,000 people and they decide the priorities in the community... It’s a beautiful system and I think that would, I think we can learn from what they’ve already done elsewhere in the world. And in the British system, I think, in that sort of situation, be ideal.”

A number of participants also highlighted the importance of not only having family physicians organized to be able to bring their concerns to the LHIN, but of also having support and family physician champions within the MOHLTC itself to ensure that their suggestions and recommendations are listened to and acted on. The possibility of setting-up ‘shadow boards’ (e.g., a physician advisory board) for each of the LHINs, (similar to what the OMA is doing), was also suggested.

“I think the key is (for family doctors) to be in a position of strength. And, the position of strength is essentially... a clear organizational structure and reporting structure and clear governance structures.”

— **Australian expert**

“They (family doctors) should have a very strong organizational voice, rather than being individual groups.”

— **New Zealand expert**

“The first piece of advice I’d have for doctors is just to suck it up and attend a few meetings. If you say, “No, I don’t have time ...” or “If you’re not going to pay me ...” they’ll just cut you out of the planning process. And all you’ll have left is the chance to complain for ever.”

— **Canadian expert**

National and international teleconferences/interviews

The primary purpose of the teleconferences and interviews was to obtain advice surrounding how family physicians might link with LHINs in Ontario. Key informants were asked for their recommendations and suggestions based on their own experiences with health system regionalization and organizational structures for family physicians. Our key informants put forward a number of suggestions and recommendations including: the importance of family doctors being organized and unified; the importance of family doctors in Ontario getting involved in the planning process; the importance of establishing primary care as a key priority on the government’s agenda and the importance of facilitating and supporting the involvement of family physicians in the regional health planning process. The key themes to emerge from all of the teleconferences and interviews are included below.

Organizational structure for family physicians

One of the key messages to emerge from the teleconferences centred on the need for family physicians to get organized. This organization, it was suggested, would enable family doctors to present a strong, unified voice to decision-makers as opposed to being perceived as a series of isolated independent practitioners:

“I have thought for a long time, that having family physicians entirely dissociated from any contact with anybody for anything, wasn’t good for anybody. And so, the idea of having everybody, say, credentials, and out of that group, having some local health areas and having a representative structure, to bring family physicians together, particularly if there’s something actually to deal with, to make decisions around changes, to provide input, both ways. I think it is important to have those kinds of structures.” (Canadian expert)

“And I guess, that proactive step right at the start, of saying, “Yes, I’ll attend and I’ll help,” defines what will constitute a primary healthcare network, and primary healthcare is really important. It gets way harder to do once those managers have made those decisions for you.”

—Canadian expert

“Well, these (the regionalization of health systems) have the potential to do tremendous good, but they also have potential to do enormous harm because you’re putting all of your eggs into one regional bag. And, unless the region is strongly supportive of family medicine, I think it can destroy family medicine in a region, or seriously damage family medicine in a region.”

—Canadian expert

Importance of family doctors getting involved

Another key message to emerge from the teleconferences highlighted the importance of family doctors actively getting involved in the primary care decision-making process and taking a proactive rather than re-active stance.

Respondents noted that if family physicians fail to get involved, they run the risk of having no say in the resulting organization and delivery of primary care services:

“It’s been quite interesting for me, working as a primary care rep with the health region, that once I started offering my services, how keen they (the government) were. I’d go to meetings and they’d listen to suggestions and everything. But they just didn’t have that. They always invited physicians, but they didn’t go because they have busy practices, so, I think it’s very key. Get involved.” (Canadian expert)

Decision-making culture/priority of primary care

While respondents generally felt that the bottom-up involvement of physicians was critical, it was also generally perceived that in order for any policy-level change to take place, those in positions of power would have to be supportive and facilitative of this. In other words, the entire culture surrounding primary healthcare decision-making would have to be supportive of family physician input. As such, a conducive and supportive ‘culture’ of decision-making within the government was identified as a key facilitating factor:

“The culture, certainly at the top now, in the Department of Health, has completely turned around to three years ago. The State Health Department, even as far back as three years ago, would create documents on primary care, create documents on health reform, and the word “G.P.” wouldn’t even be mentioned there. Now, I think there’s been a complete turn-around to the point now, in anything they develop or think, the first thing that comes into their heads is, “We should contact the physicians and see how this might impact on general practice.” And more importantly, from their point of view, they’re starting to realize

“...and get structures that recognize family medicine, and that include, when family medicine people go to the meetings, they’re paid, they’re paid too...Because if they have the time they’re recognized and legitimized; they’re part of the organization; and their contribution to healthcare in the community is fundamental to the community. And it’s structurally acknowledged.”

—Canadian expert

that general practice is what’s going to help them achieve their objectives in terms of improved population health base and reduce the costs, contain the costs.” (Australian expert)

In concert with a supportive regional decision-making culture, respondents highlighted the fact that primary care needs to be a main priority of the regions:

“Well, that’s what my message would be: to get primary care as a priority... I hope that in moving to this, you will lobby and manage to get some sort of organizational structures... I really feel very good about what we did. We have this graphic, it’s circles, and the big circle in the middle is primary care. Then it’s got two somewhat overlapping circles on top of that, that don’t obscure it, called the acute network and the community care network. But the base, this big circle out there, is the primary healthcare network. So it really is seen, visually, primary healthcare is the base.” (Canadian expert)

Family physician remuneration

Respondents repeatedly emphasized the importance of physician remuneration for attending and participating in regional-level meetings.

Patients/consumers as advocates for family medicine

It was also suggested that one potential way to raise the profile of family medicine at the regional level would be to find a way to use patients/consumers as advocates of the importance of primary care and family medicine:

“I would get the patients, first and foremost, on your groups. One of the things I haven’t mentioned so far is the power of patients in the U.K. It’s huge. And I think that’s actually, when you say to patients, “What do they want?” They want access to a family physician. I think we could mobilize support from patient groups, and we could encourage patient groups, and I would say that every regional board, actually every decisional-making group, at whatever level, needs patient representation. And we should be encouraging our patients to be more representative, because I think we can actually teach them how important primary care is, a lot more easily than we can teach politicians.” (Canadian expert)

Opportunity to try different approaches

It was also noted that this change in health system organization, as represented by the LHINs, should be thought of by both the family doctors and government representatives alike as an opportunity to experiment with different models and to recognize that the LHINs system will likely need to be tweaked and modified:

“I would say that you have the opportunity to actually test two or three different models. Because I would bet that the model the government comes down with, or you and the government develop, won’t work. It’ll work more or less, but there’ll be things about it that are difficult. And you do have an opportunity here to say, “We’re not quite sure which model to go for, so why don’t we go for different, slightly different, models, with slightly different structures, and test out ...” I don’t mean doing it in a trial or anything, but just in an action research, or however you want to phrase it. Because, you know, every time anyone wants to produce a structure, it never is actually completely right, and I just think you have an opportunity here to try a few.”
(Canadian expert)

Importance of (Re)-Establishing Links with Specialists in Hospitals

The importance of establishing improved linkages between primary and secondary care sectors, through the creation of a GP advisor/liaison role, was also highlighted as an important consideration for Ontario. For instance, following the lead of Denmark (see Olesen et al., 1998), New Zealand is now utilizing GP advisors/liaisons to better connect GPs with specialists in an effort to improve communication and coordination between them. In most instances, GPs work as part-time advisors to inform hospital departments about primary care and provide a link between the sectors. In New Zealand, in most cases, the GP Advisor position is funded through the regional health authority (i.e., District Health Board), though some are paid by Primary Health Organizations (DHBs). In the case of Denmark, there is some evidence to suggest that this system is having a positive influence in terms of improving coordination and communication between the primary and secondary care systems (Olesen et al., 1998).

Strategic planning meeting

The strategic planning meeting represented an opportunity for key informants and other experts to come together to brainstorm preliminary recommendations for this important issue. The combination of small and large group formats enabled participants to develop a broad range of recommendations which are summarized in the meeting’s final report (see Appendix D).

Discussion

While there is little scientific evidence for or against the regionalization of health systems, many governments around the world have embraced health system regionalization as the way forward in the 21st century. It is apparent, therefore, that regionalization (of one form or another) is here to stay for some time. Ontario, through the introduction of LHINs, represents the last Canadian province to adopt some form of health system regionalization (even though for the time being, the present hospital board structure will remain unchanged) (Harrison & Boadway, 2005).

Despite the fact that health system regionalization is an inherently complex and messy process, Casebeer (2004) highlights a number of potentially positive aspects of regionalization, including the fact that it can facilitate improved health system integration and coordination (particularly in instances where there has been greater physician involvement in primary care reform and through joint management arrangements). She also notes that regionalization can reduce fragmentation and help us move towards a more population-based preventative/promotion approach (Casebeer, 2004). Another determinant of ‘success’ with respect to health system regionalization centres on the extent to which governments are able to let go of their decision-making power and trust it to the RHAs. There is some evidence to suggest that regionalization is more likely to be successful if governments resist the tendency to micro-manage the process (Lewis & Kouri, 20004). On the negative side, in some instances, regionalization may serve to exacerbate turf protection and tensions and potentially mask hidden agendas (Casebeer, 2004).

Through documenting and learning from the experiences of others, this research is designed to provide the MOHLTC and the province’s family doctors with evidence about how the linkages should occur between family physicians and LHINs so as to avoid the pitfalls and problems experienced by other national and international jurisdictions that have engaged with health system regionalization. Based on the compelling evidence, regarding the importance of family medicine, and the subsequent strengthening Ontario’s primary care system, the recommendations to enhance linkages should serve to improve the health status of Ontario residents whilst simultaneously reducing healthcare costs (Starfield et al., 2005; Starfield & Shi, 2002). The development of the LHINs with recommended input from family physicians and the primary care sector could represent a positive step forward in terms of the provision and quality of health services delivered in the province.

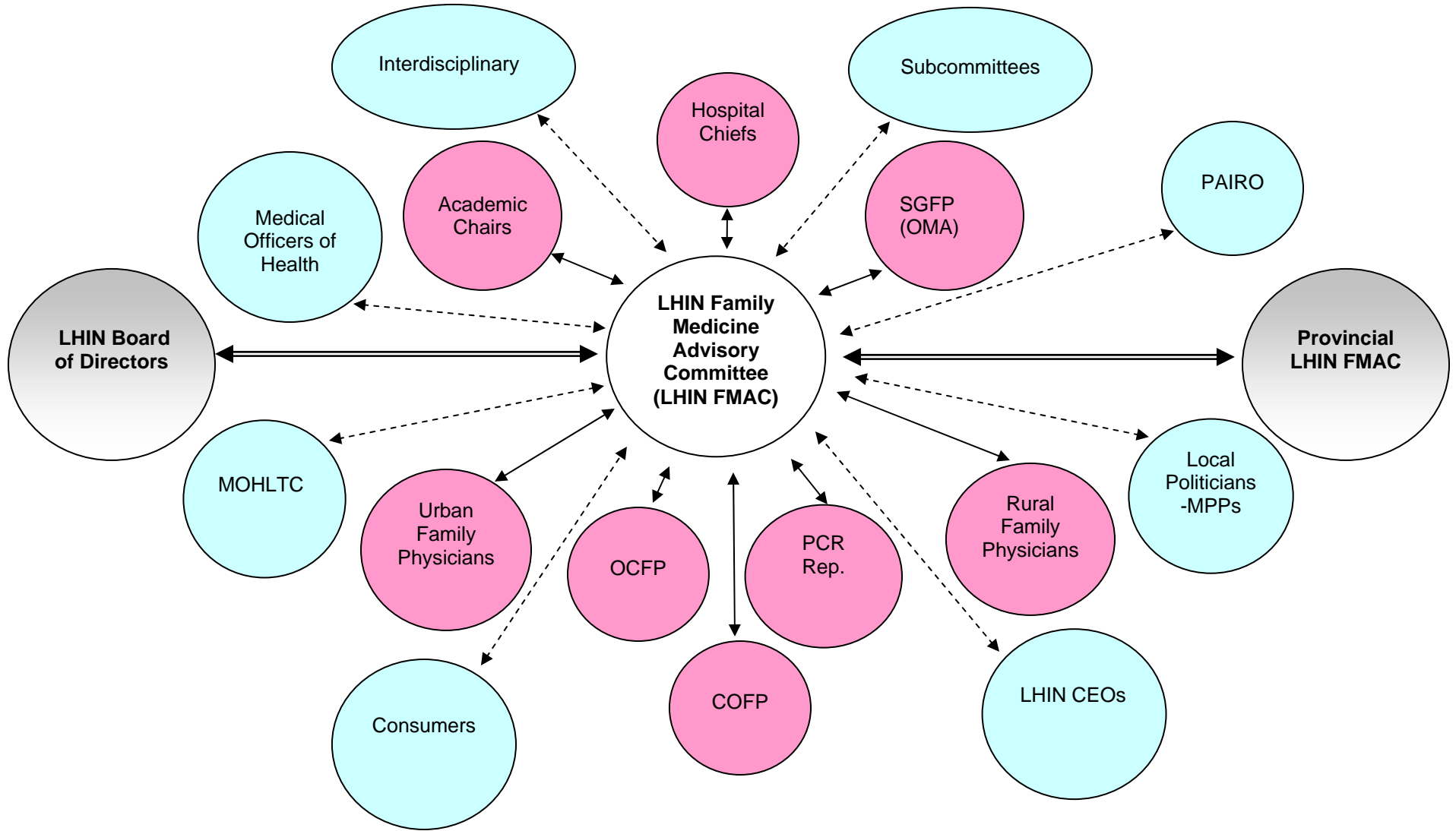
Recommendations

Based on the information gleaned from our research we present the following recommendations:

1. Establish Family Medicine as a priority area for each of the Local Health Integration Networks (LHINs) in Ontario.
2. Establish LHIN Family Medicine Advisory Committees (LHIN FMACs) in the 14 regions, comprised of key family physician representatives from: the Hospital Chiefs of Family Medicine, urban family physicians, OMA/Section of General Family Practice, OCFP, COFP, Academic Chairs of Family Medicine, Society of Rural Physicians, PAIRO Representative, PCR Representative.
3. Include, on the LHIN FMACs, consumer and government members from: LHIN CEO's, Medical Officers of Health, consumers, local politicians, MPPs, and the MOHLTC.
4. Appoint one representative Family Physician Lead from each of the 14 LHIN FMACs to each LHIN Board.
5. Set up an organizational structure (i.e., subcommittees) for LHIN FMACs that allows family physicians to address comprehensive care in family practice within the LHINs: office practice, chronic care, mental health, prevention, home care, hospital care, palliative care, Long Term Care, obstetrics, emergency care, rural family medicine etc.
6. Establish an interdisciplinary Primary Care Committee representing nursing, nurse practitioners, dietitians, pharmacists, social workers, and other health professionals that work in family practices with a representative on the LHIN FMACs.
7. Set up LHIN FMAC administrative structures that allow the LHIN FMACs to address operational issues across the regions such as: primary care reform, physician recruitment/retention/shortages, credentialing, continuing professional development, CQI, research/evaluation and information/communications management.
8. Establish a Provincial Family Medicine Advisory Committee comprised of one representative from each of the 14 LHIN FMACs. The committee will elect a chair. The Chair of this committee will also sit on the provincial FMAC Committee.
9. Fund the LHIN FMAC organizational structure through the LHINs/MOHLTC.
10. Remunerate family physicians for any time they spend formally participating in the LHIN structure.

Appendix E contains the LHIN FMAC Terms of Reference.

Chart #1: Organizational Structure for Family Medicine and the LHINs



Pink: Members - Voting Members

Blue: Members at Large - Non-Voting Members

Chart #2: LHIN FMAC - Subcommittees

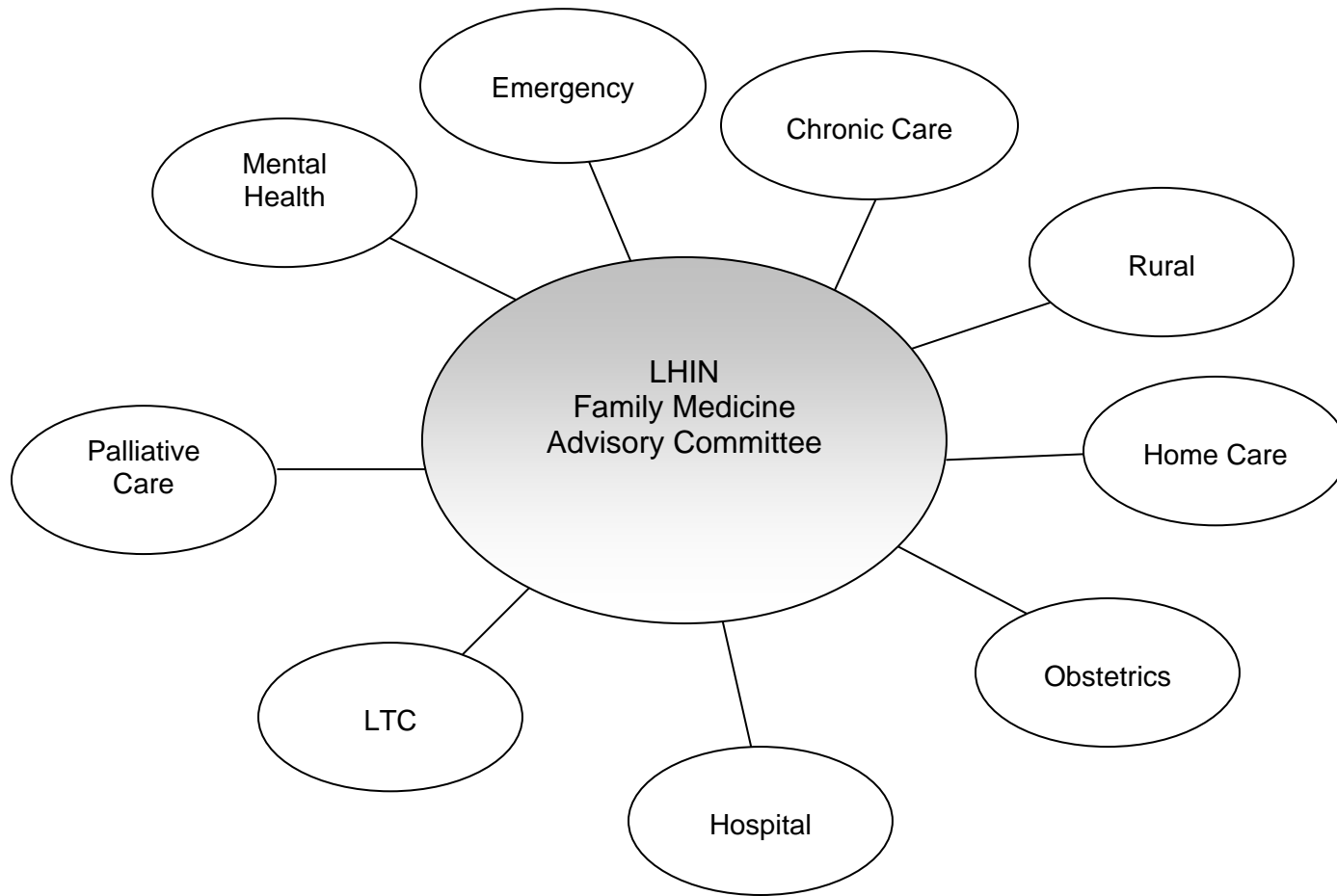


Chart #3: LHIN FMAC - Operations/ Admin

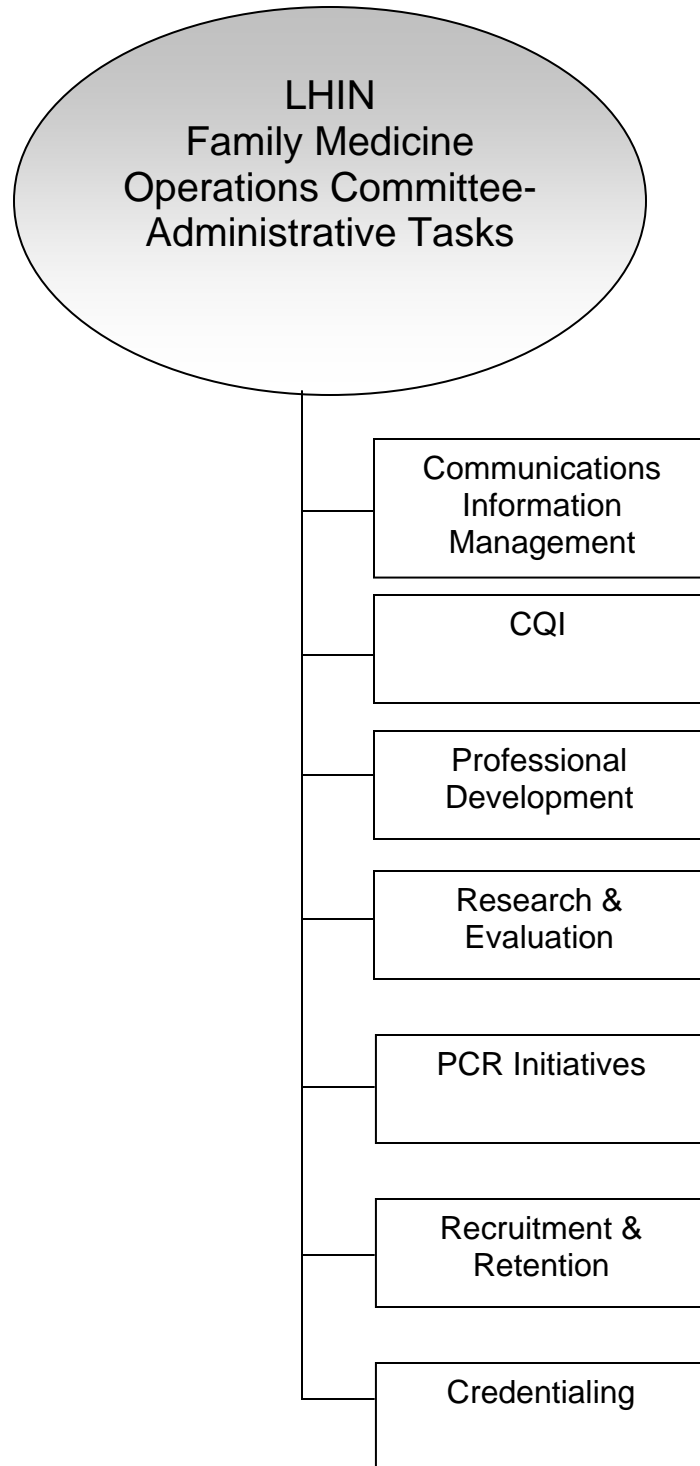
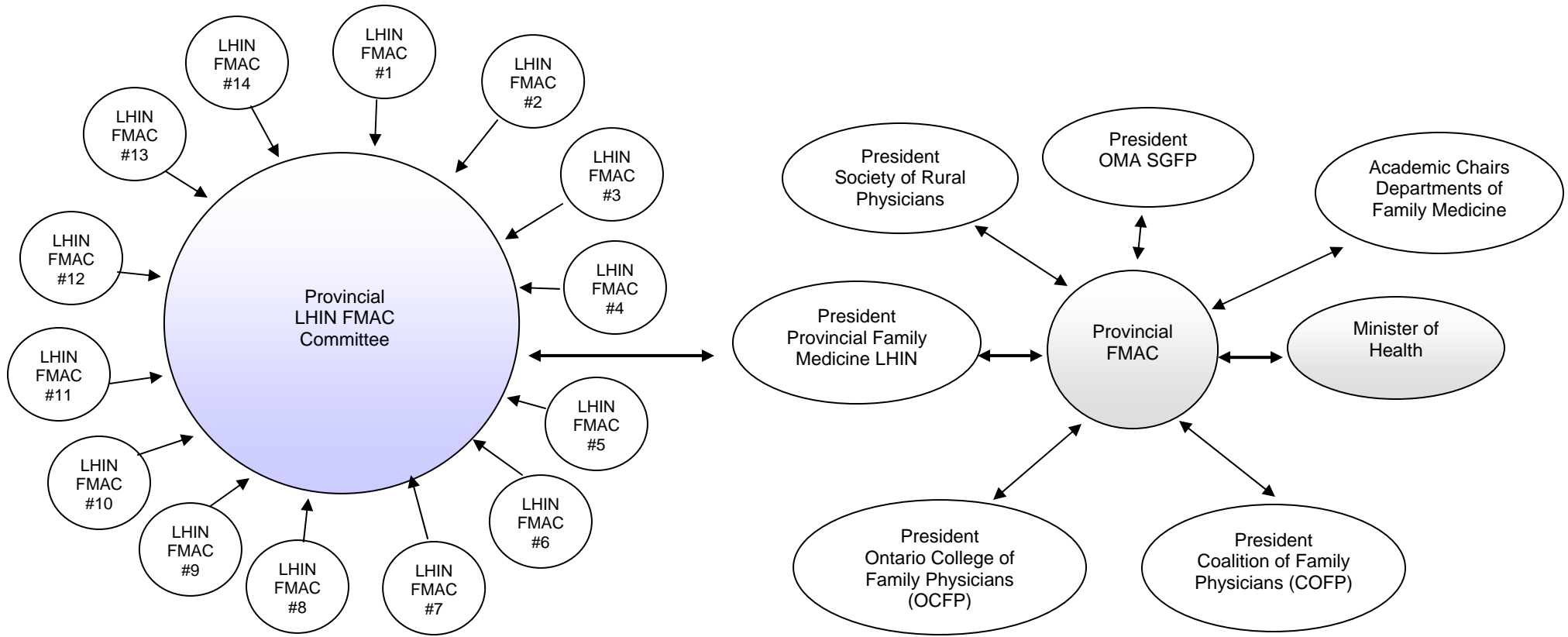


Chart #4: Provincial Family Medicine Advisory Committee



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APPENDIX A: LHIN PROJECT BIBLIOGRAPHY

Canada

Bruge, F. Foy, R and S. Gillam. (2002). Reforming primary care: ending inertia but avoiding fatigue. *Canadian Family Physician*, Apr, 48: 663-5.

In this editorial, the authors review the impact of primary care reforms, in England, on general practice. Based on their findings, the authors make a number of suggestions for Canadian reforms. Their discussion centres on four areas: remuneration, information systems, tools for evaluating reforms, and the need to develop effective coalitions.

Lessons for Ontario: Remuneration: The authors suggest that there should be a move away from the fee for service model because they feel a salary model would more easily reimburse physicians for time spent on administrative activities. They do suggest, however, that financial incentives are necessary to compensate doctors for caring for patients with complex needs and also argue for financial support for the development of primary care teams. Information Systems: The authors suggest that better information systems would provide data concerning patient and community needs and outcomes, and support the development of primary care teams. Evaluation Tools: The authors highlight the importance of defining and measuring outcomes. They note that the CMA has developed evaluation tools to measure the impact of healthcare reforms. Effective Coalitions: The authors stress that early feedback from health transition projects illustrate the need for, and importance of, collaborative planning. As such, they suggest that academics, practicing physicians and managers, and user alliances must work together in an effort to build consensus and manage change.

Casebeer, A. and T. Reay. (2004). Reinventing primary healthcare. *Canadian Family Physician*, Oct.

In this editorial, the authors present a brief discussion of the results of their research into the role that family physicians have played in primary healthcare reforms in Calgary, Alberta. Their qualitative investigation examined both changes over time as well as changes as they occurred. Casebeer and Reay found that family physicians made significant contributions to healthcare reform as a part of their daily work. The authors found that family physicians contributed in several main areas: joint leadership with other physicians, collaboration with other healthcare providers, partnerships with representatives from the third sector (social services, community and educational organizations), and the provision of primary care.

Lessons for Ontario: *Joint Leadership:* Though not officially part of the regionalized health system in Alberta, family physicians are increasingly taking on joint leadership roles alongside healthcare executives to lead and support decisions in primary healthcare in the province.

In Alberta, physician leaders receive release time from their practices and remuneration from the region for their work. These developments are regarded in the literature as breakthroughs in best practice. In Alberta, family physicians are working with other providers to develop, implement and evaluate new treatment plans and service delivery options, including evaluating the benefits

of shared care arrangements and alternative funding. Family physicians are also participating in broad and integrated health collaborations and networks across Alberta.

Harrison, A and C. Mitton. (2004). Physician involvement in setting priorities for health regions. *Healthcare Management Forum*, Winter: 21-27.

Harrison and Mitton note that the history of integrating physicians into healthcare organizations has been both important and problematic. Physicians' knowledge and expertise about patient care makes their input in setting priorities vital, however, by assuming managerial roles their time to provide care may decrease. As such, a major challenge is to utilize physicians' expertise in the clinic, while at the same time including them (and their expertise) in the organizational decision making processes. The authors describe the impact of regionalization and presents results of seven program budgeting and marginal analysis (PMBA) case studies which were conducted in Alberta.

Regionalization

In 1994, 200 hospital and health related boards were replaced by seventeen health regions in Alberta. Regionalization was intended to promote the coordination and integration of healthcare services in the province and the regions in Alberta were intended to provide a coordinated continuum of services to geographically defined populations. The authors note that integration has occurred both horizontally (i.e. through the consolidation of hospital services) and vertically (i.e. through the merger of independent boards under a single board with a one administrative structure). Regions, in Alberta, are accountable for both clinical and financial outcomes.

Regionalization has impacted physicians. In the Calgary Health Region, approximately 1,500 physicians belong to a single medical staff organization. There is also a common credentialing process for all hospitals in the region.

The authors note that most of the physicians in the province are paid under a fee for service model which is separate from the regions' budget. While some physicians receive remuneration for participation in administrative activities, increased participation by physicians is desired. It has been suggested that when physicians are involved in administration, their integration in the health system increases. This is, in turn, related to clinical integration.

The authors suggest that a program budgeting and marginal analysis (PBMA) approach can serve as a tool to integrate physicians into organizational decision making.

The stages in a PBMA priority setting process are as follows:

1. Determine the aim and scope of the priority setting exercise
2. Compile a program budget (i.e. a map of current activity and expenditure)
3. Form a stakeholder advisory panel
4. Determine locally relevant decision making criteria and consultation required e.g. decision makers, Board of Directors, Public, etc.
5. Advisory panel identifies options for areas of growth, and more efficient use of resources.
6. Advisory panel recommends funding new programs, transferring resources and trade-off decisions.

7. Evidence from a variety of sources is used too make final decisions regarding budget planning.

In order to be effective, the PBMA process must deal with several barriers. Barriers identified include the lack of trust and support of physicians, and the fact that many times political considerations take precedence over clinical evidence sometimes preventing meaningful evaluation.

The PBMA approach has been applied to a number of programs in Alberta including: the management of chronic illness, a rural surgery department, long term care programs, infant head remodeling, musculoskeletal program, surgical services and a pediatric neonatal transport program. The authors concluded that the application of the PMBA process was successful in six of the seven projects. A key element of success within the projects they examined was physician involvement.

Lessons for Ontario: While the importance of both physician and managerial representation on committees was recognized, it was noted that without direct physician involvement, recommendations were often unlikely to be implemented. Further, the involvement of physicians in priority setting is critical because physicians have a direct influence on the utilization of healthcare services. Also, physicians actively involved in decision-making tend to develop a greater appreciation for the financial constraints affecting healthcare. An advantage of the PMBA model is that it can be used when physicians work within a variety of different remuneration models. The case studies found that when physicians and managers worked together to set priorities they were able to deal with resource limitations in a creative manner.

Harrison, T. and T. Boadway. (2005). Local Health Integration Networks: form and function of government transformation initiative unclear, OMA calls for more input from frontline physicians. *Ontario Medical Review*, April: 17-19.

In this article, the authors describe the introduction of Local Health Integration Networks (LHINs) by the Ontario Ministry of Health and Long Term Care (MOHLTC). LHINs are a new governance structure responsible for overseeing the delivery of healthcare at a local level. Ontario has been divided into 14 LHINs based largely on Hospital Service Area: (HSAs) and patient hospital discharge information.

Despite the fact that the LHINs were first announced in May 2004, the authors note that there has been no formal strategic plan, policy directive or model has been developed. While limited community consultations were held in late 2004, the authors note that input from physicians has been negligible to-date. This should not be a surprise as regionalization in Ontario, and elsewhere in Canada, has largely (at least initially) failed to consider input from front line providers. Consequently integration has been slow (and painful) in many jurisdictions.

The authors note that it appears clear that funding for physician services, public health, municipally governed ambulance services and public laboratories will not be transferred to the LHINs. It is also clear, however, that, for the time being at least, hospitals boards will remain unchanged.

Experience in the United Kingdom, Australia, New Zealand and the rest of Canada has illustrated that there is a connection between successful regionalization and the involvement of the primary care sector. There has been a lack of physician input and involvement in the proposed changes in Ontario. The involvement of physicians in Ontario (were it to happen) may act to avoid some of the problems experienced in Alberta and B.C. The OMA has appointed an Integration Committee to follow the changes. This committee will lead the OMA's response as the Ministry's plans become clearer.

Hinings, C., Casebeer, A., Reay, T., Golden-Biddle, K., Pablo, A and R. Greenwood. (2003). Regionalizing healthcare in Alberta: legislated change, uncertainty and loose coupling. *British Journal of Management*, 14: S15-S30.

In this paper, the authors describe the regionalization of healthcare in Alberta and its consequences in terms of 'loose coupling'. Healthcare is provided by many different professional groups practicing in many different locations and consequently, the various actors have developed different strategies to cope with change. While the consequences of some changes can be anticipated, many others cannot. The authors suggest that loose coupling exists when each group attempts to preserve its own identity and uniqueness. In healthcare there is an inherent loose coupling between government inspired change and governance of the health system. Changes in healthcare often produce high levels of uncertainty due to the sheer scale of the changes, a lack of understanding of what the outcome should be and ongoing contextual changes. Since change occurs over many years, uncertainty may not diminish over time.

Lessons for Ontario: In 1994, the newly elected government passed legislation to regionalize healthcare in Alberta. They replaced over 200 hospital boards, public health boards and nursing home agencies with 19 Regional Health Authorities. Physicians were excluded from participating in the reconfiguration of healthcare because they were seen as being part of the problem of rising healthcare costs. While the government had hoped that reorganization would occur over three years, all of RHAs in Alberta has reorganized itself at least once in the past six years and many have reorganized two or three times. Differences in RHAs have emerged such that three types can now be identified: urban, regional and rural.

Konkin, J. Howe, D and T. Larsen Soles. (2004). SCPC policy paper on regionalization. *Canadian Journal of Rural Medicine*, Fall 9(4): 257-259.

The authors discuss the impacts of health system regionalization on rural communities and provide recommendations for the future development of regionalized healthcare. They discovered that as a result of the consolidation of healthcare resources and services in Alberta, many rural communities lost services and hospitals. Further, the authors suggest that the goal of increasing local input and citizen participation has been largely unsuccessful and that in most rural communities, community participation has actually decreased.

Lessons for Ontario: The authors make the following recommendations.

Stated measurable goals: While governments have turned to regionalization as a means of containing healthcare costs, in most cases, the authors note that this reorganization has not yet

led to any demonstrably significant savings. They also note that, in some cases, even the information needed to make such assessments is still unavailable some ten years after the introduction of regionalization. In an effort to address these problems, they note that a clear definition of the problems to be solved by regionalization and assessment methods need to be clearly stated up front.

Evidence-based decision making: The authors also suggest that any changes to existing healthcare structures must recognize, and make explicit, risks for rural residents.

Rigorous cost analysis before changes: The authors state that the financial cost in terms of accessing healthcare is generally greater for rural residents. As such, the hidden costs to patients and their families, who must take time from work to travel to regional centres, must be taken into account in any cost-benefit analysis of regionalization.

Definition of a viable region: The authors note that all types of care, from primary to tertiary, must be available to all citizens and that the range of services available and equity of service delivery are key principles that need to be considered.

Core Services: The authors state that governments need to identify core services for local, regional and provincial levels of care and that Regional centres need to provide care for all of their residents. To achieve this, meaningful input from local citizens and professionals is critical.

Education of health professionals and research: The authors also note that support is necessary for the continuing education of health professionals and to support research activities within the regionalized structure.

Lewis, S and D. Kouri. (2004). Regionalization: making sense of the Canadian experience. *HealthcarePapers: New models for the new healthcare*, 5(1): 12-33. Retrieved from www.healthcarepapers.com, May 5, 2005.

This article presents an overview of health system regionalization in Canada. The authors address four main questions including: what is regionalization in healthcare and what distinguishes it as a structure?; how was regionalization intended to contribute to the achievement of health goals in the 1980's and 1990's?; how has regionalization been implemented in Canada and how have these factors affected it's potential to achieve goals?; and what have we learned during the past decade?

Lessons for Ontario: The authors discuss the characteristics and goals of regionalization. The goals of regionalization include: aligning needs and resources, the integration of health services, increased service quality and evidence-based practice, and an increased emphasis on health promotion and prevention. It is interesting to note that of the nine Canadian provinces with regionalized health systems, seven have appointed boards and two have a combination of both appointed and elected boards. The authors suggest that regionalization requires long term stability and authority. They state that physicians must be brought fully into the regionalization process and compensated for spending time with complex cases, promoting coordinated care and ensuring that resources go where the need is greatest. Further, they suggest that drug

expenditures should be included in RHA budgets and that RHAs provide adequate funding for IT support.

Lomas, J. (1997). Devolving authority for healthcare in Canada's provinces: emerging issues and prospects. *Canadian Medical Association*, 156(6): 817-823.

Lomas identifies three primary objectives behind the establishment of regional health boards in Canada: community empowerment, service integration, and conflict containment. He notes that it is often difficult for boards to achieve these goals given that they must balance pressures from the government, providers and local citizens. Governments typically state that one of the purposes of regionalizing healthcare is to 'empower' communities and ensure that the services provided fulfill the needs of the community. However, more cynically, Lomas suggests that devolved boards may also enable governments to shift blame for unpopular decisions to the region thereby functioning as a buffer between the government and the community.

Lessons for Ontario: Lomas discovered that most of the regional authorities developed their own solution to the tensions between provincial government expectations and local community desires and needs. Lomas notes that while many of the regional health authorities tended to tolerate budget cuts, they also lobbied aggressively on behalf of their communities once the cuts had exceeded the "squeal threshold." Many times, Lomas suggests, the local boards tried to represent, if not empower their communities. Lomas argues that the future of citizen governance and empowerment is tied to the issue of elected (as opposed to appointed) boards. However, the low voter turnout (for elections to regional health boards in Saskatchewan) does not bode well for the future of citizen representation on regionalized health boards according to Lomas.

Lum, L and J. Gough. (2005). Volunteer governance of health services in Canada: redundant or relevant. *Healthcare Management Forum*, Spring, 18(1): 14-18.

In this paper, Lum and Gough discuss the nature of voluntarism, and accountability and how these can change once governments become involved in healthcare boards. The authors note that while voluntarism has long been a significant characteristic of non-profit healthcare organizations, the nature of voluntarism has been significantly affected by the regionalization of healthcare.

The authors define voluntarism as "actions undertaken freely by individuals, groups or organizations, not compelled by biological need or social convention, mandated or coerced by government directed principally at financial or economic gain". Lum and Gough offer 'responsible voluntarism' as a model to conceptualize board governance. They note that the effectiveness of voluntary boards rests largely on the assumption that citizens are more capable of caring for the public interest than government employees.

They note that there are two main arguments supporting volunteer governance: free labour and the feeling that board members have skills beyond the skills of the administrative staff. Board members may often act as links between a non-profit organization and the community at large. Trustees may function as information channels, inter-organizational intermediaries or act as sources of legitimacy. Interestingly, they note that when board membership is controlled by the

government, input from the general public or institution is irrelevant as the primary responsibility of appointed boards is to those who appointed them (i.e., the government). Under this model, the responsibility to other stakeholders is often secondary.

Lessons for Ontario: Given that the boards of directors of the LHINS will be appointed by the government, the discussion regarding board composition and autonomy is of particular relevance.

Malus, M. (2004). User's Guide to healthcare reform. *Canadian Family Physician*, vol 50.

Malus argues that family physicians are frequently wary of healthcare reform because they are concerned that they will become one in a "horde of colourless civil servants under the thumb of the government." To avoid this, Malus suggests that family physicians need to be full partners in the development of health policy.

Lessons for Ontario: To assist family physicians, Malus presents an Ethical Apgar Score for Healthcare Proposals. The test is divided into two sections: the first deals with issues affecting patient care (doctor patient relationship, access to care, right to privacy) while the second half of the test presents issues important to doctors. This section is interesting because it states that physicians should be concerned with the healthcare needs of their communities, not just their patients. Malus also calls for compensating doctors for the time they spend maintaining links with public health, regional health boards and the community.

Ontario Hospital Association (OHA). (2002). *Regional Health Authorities in Canada*. Ontario Hospital Association: Toronto. Retrieved from www.oha.com, on February 15, 2005.

This paper examines the rationale and goals of Regional Health Authorities (RHAs) across Canada, assesses the progress of RHAs in meeting these goals, and offers suggestions for further research. The main goals of regionalization are identified as: cost containment, enhanced public participation, improved planning and service integration, and greater accountability. Interestingly, the review found that RHAs in Canada have largely failed to meet these goals.

Cost Containment: The report notes that RHAs in all areas have experienced deficits. These deficits were due, in some cases, to increases in administrative costs while in others, regions continued to submit budgets that exceeded their revenues.

Enhanced Public Participation: While it has often been stated that regional decision making is more responsive to local needs, the OHA report states that the reasons for, and evidence of, this are rarely "fully elucidated or completely obvious".

Improved System Planning: Given the lack of evaluation of health system regionalization, the report notes that it is difficult to determine if system planning has improved. However, data from Alberta, British Columbia and Saskatchewan suggests a continuing need for improved planning and coordination of service delivery.

Service Integration: While some gains have been made, in some provinces, with respect to service integration, the authors note that, in general, the delivery of healthcare services continues to be largely fragmented.

Greater Accountability: While supporters of regionalization often cite greater accountability as an outcome of regionalization, the authors note that there is little evidence to support this claim. Several provinces have identified confusion over roles and responsibilities as an ongoing problem between regions and governments. Until this issue is addressed, the report notes that identifying clear lines of accountability will be very difficult. The OHA concludes by identifying the impacts of regionalization as an appropriate avenue of further study.

Lessons for Ontario: According to the OHA, given that Ontario already outperforms the regionalized provinces in the areas of hospital efficiency and accountability, Ontario should focus more on system integration. Along these lines, the OHA suggests that health networks are a more effective means of integration than regionalization.

New Zealand

Ashton, T. (2005). Recent developments in the funding and organization of the New Zealand health system. *Australia and New Zealand Health Policy*, 2(9). Retrieved May 26, 2005, from www.anzhealthpolicy.com/content/pdf/1743-8462-2-9.pdf

This paper reviews the changes to New Zealand's health system following the most recent wave of reforms. Three issues are discussed: the devolution of funds and decision making to District Health Boards (DHBs), developments in primary healthcare, and the position of the private health insurance industry. Twenty-one DHBs are responsible for a wide range of services (including primary health services as well as secondary and tertiary care). The size of DHBs ranges from 33,000 to 430,000 people. Ashton notes that the dynamics, management and issues facing these 21 organizations vary significantly. DHBs have been working alongside primary healthcare workers to establish networks of providers called Primary Health Organizations (PHOs). By April 2005, 77 PHOs had been established and now provide care for more than 90% of New Zealand's population. Ashton highlights some of the problems with the reforms including the fact that the devolution of funds to the DHBs was not always smooth as some of the contracts were incomplete or inaccurate and there were often long delays in receiving contracts in the first place. Therefore, the DHBs frequently lacked the necessary information to monitor the services provided under these contracts. In New Zealand, the MOH earmarks some funds for specific purposes in order to meet National-level policy objectives and, as such, the boundaries between the responsibilities of the MOH and DHBs are sometimes unclear. While the locus of decision making has been shifted to the regional level, the Ministry still must approve annual and strategic plans of the DHBs which results in the fact that local and national priorities may occasionally conflict.

New Zealand has also experienced problems with population funding arrangements. Problems have occurred in New Zealand due to inaccurate population forecasts; inadequate adjustments for high need people, the lack of adjustments for new immigrants who often have special health

service needs; and the ‘medical migration ‘ of people with on going special needs to larger boards with a wider range of services. The problems with this funding model can make achieving government goals to achieve equality in access difficult.

Devlin, N., Maynard, A., and Mays, N. (2001). New Zealand’s new health sector reforms: back to the future? *British Medical Journal*, 322: 1171-1174. Retrieved April 14, 2005, from www.bmj.com

The authors review New Zealand’s experience with a ‘quasi market’ model and assess the rationale for further healthcare system restructuring. They identify a number of the challenges faced by policy-makers in attempting to achieve their policy goals, consider the general lessons provided by frequent changes in healthcare policy, and offer a set of criteria useful in assessing new health systems.

Theoretical Model: The authors suggest that the changes to the New Zealand healthcare system have been largely based on a quasi market model which introduced competition to the health sector. Four minister appointed regional health authorities were initially established and hospitals became publicly owned corporations. Regardless, the authors note that the quasi market model did not result in savings nor was it more efficient, as originally espoused. They also suggest that the “demoralization and disempowerment of the healthcare workforce has been attributed to the clash managerial and clinical cultures” resulting from these reforms.

While the MOH advocates local input into decision making, the authors argue that local autonomy needs to be balanced against national objectives. The authors note that the government plans to put into place strict accountability arrangements which will enable the MOH to, partially at least, control the actions of DHBs.

Lessons for Ontario: The changes in the structure of the New Zealand healthcare system have been developed by the National government and must be largely fulfilled by DHBs. Given the nature of this relationship, the desire for local autonomy has to be balanced with the need to fulfill the goals of the Government. Although local representation on DHBs is a key element of their structure, strict accountability arrangements now provide the MOH with a potentially powerful control mechanism. One of the major arguments in this paper is that restructuring the healthcare system will not eliminate health rationing, therefore it is important not to create unrealistic expectations. The authors also point out that health system restructuring is expensive and disruptive, and takes considerable time before results can be measured. As such, they highlight the importance of program evaluation based on a series of clearly measurable objectives.

Ministry of Health. (2001). *The Primary Healthcare Strategy*. Ministry of Health. Wellington: New Zealand.

This document, “outlines a new vision for primary healthcare” for New Zealand. It also presents a useful description of the roles of the Ministry of Health (MOH), District Health Boards (DHBs) and Primary Health Organizations (DHBs). The MOH is the national body

responsible for health policy development, regulating, funding and monitoring in New Zealand. Twenty-one regional DHBs are responsible for assessing the health needs of their region and managing the delivery of health services in their region. Primary Health Organizations (PHOs) are the local (interdisciplinary) structures that deliver primary healthcare to the population. PHOs are funded by the DHBs to provide primary healthcare. All care providers in the PHOs are expected to play a role in their governance. This helps to ensure that the control of the PHO boards by one group is virtually impossible. While physicians have been encouraged to join PHOs (large through government incentives), membership is voluntary. A model describing the relationship between the MOH, DHBs and DHBs, Aboriginal Groups, independent practices and community based organizations is also developed.

Lessons for Ontario: There is an obvious parallel between the DHBs in New Zealand and the LHINs in Ontario. The model is also useful and may parallel the new structure in Ontario (with the DHBs being similar to the LHINs and PHOs being similar to Family Health Teams (FHTs)).

Ministry of Health. (2003). *Implementing the New Zealand Health Strategy*. Ministry of Health. Wellington: New Zealand.

This document reviews the impact of the New Zealand Health Strategy three years following its implementation. It assesses the results of a number of programs established by the federal government to reduce rates of smoking, obesity, cardiovascular disease, cancer, violence and suicide. The initiative also hoped to improve exercise rates, oral health, the health status of the mentally ill, and ensure access to healthcare services for children. The document also describes the roles and responsibilities of the DHBs and PHOs.

Lessons for Ontario: As of 2001, the DHB boards were comprised of a combination of appointed (4) and elected (7) members. Members are appointed to ensure the adequate representation of the Maori people and to ensure that boards have an appropriate mix of skills. The report identifies four main challenges faced by the DHBs since their inception: dealing with a lack of trained staff, difficulty meeting guidelines for first specialist assessments, the devolution of support services for disabled people, and managing deficits.

Structure and Responsibilities

Ministry of Health: The MOH is responsible for funding some primary maternity services, public health services, disability support services and some national personal health services. By the release date of this report, the MOH had not decided if they would transfer the responsibilities for these services to the DHBs. DHBs are responsible for both funding and providing healthcare. They are also responsible for delivering hospital and related services. Responsibility for mental health services, personal health services, Maori health services and disability support services for older people were devolved to the DHBs between 2001 and 2003. The amount of funding allocated to each DHB is based on the number of people living in the catchment area. The funding is to be sensitive to the size and needs of the population, and the cost of providing health and disability services to meet those needs.

PHOs are responsible for providing essential primary healthcare services to defined populations, including first level general practice services, some health promotion services, services for

groups for whom access to healthcare has been historically problematic (e.g., Aboriginal peoples), and the management of prescriptions and diagnostic testing. Private and non-governmental providers provide primary, secondary and community based care. Providers include general practitioners, midwives, independent nursing practices, private hospitals, voluntary organizations, community trusts, Maori and Pacific providers, pharmacies and laboratories. Private and non-governmental providers have service agreements or contracts with the Ministry of Health, DHBs and the ACC (Accident Compensation Corporation). PHOs are the local interdisciplinary organizations responsible for achieving the overall goals of the Primary Healthcare Strategy. Public health services are provided by a combination of publicly funded and private organizations. Twelve DHB-owned public health units provide more than half of public health services in New Zealand and the remaining services are provided by more than 200 NGO's.

Simon, J. (2001). The New Zealand Primary Healthcare Strategy and First Health/PrimeHealth. *Healthcare and Informatics Review Online*, Vol 5(2), Retrieved April 1, 2005, from hcro.enigma.co.nz/website/index.cfm.

While Simon feels that the New Zealand Primary Healthcare Strategy represents an improvement over previous policies, he highlights a number of ongoing problems with it. These problems include: little direction on how to achieve the strategy's goals, the increasing bureaucratization of primary health care, the absence of the words 'general practitioner' and 'Independent Practitioner Associations (IPA)' from the document, and confusion surrounding patient enrolment.

Lessons for Ontario: Simon's critique of New Zealand's Healthcare Strategy illustrates many of the universal issues facing family physicians during the reorganization of healthcare systems. Despite the fact that general practitioners should be the basis for any healthcare policy, the author feels that there has been a deliberate attempt by the government to marginalize and ignore general practitioners from the Health Strategy. Further, Simon notes that a lack of adequate funding for DHBs has made it virtually impossible for them to fulfill their roles; a serious problem given that the government has raised expectations of the public.

Australia

Department of Human Services. (2004). *Memorandum of Understanding Between South Australian Divisions of General Practice, Divisions of General Practice and the South Australian Department of Human Services*. Department of Human Services. Melbourne.

This document represents a formal agreement between the South Australian (SA) Divisions of General Practice, the Divisions of General Practice and the Department of Human Services. The purpose of the document is to try and improve collaboration between these departments. The document begins with a description of General Practice, the Department of Human Services, and the SA Divisions.

As in many other locales, the nature of general practice in Australia has been undergoing significant change. According to the report, some of the major factors precipitating these changes include: the changing structure of the broader healthcare system itself, a shift in medical education towards a more problem based approach, an increasingly multidisciplinary approach to healthcare, and the increasing desire amongst practitioners to have a more flexible work life.

Department of Human Services: The Department of Human Services emerged during public sector restructuring and integrates health, housing and community services. The Department aims to coordinate planning across the state and build links across government and establish partnerships with the SA community. It is responsible for developing and administering health policy in SA. It is also responsible for operating, maintaining and improving hospitals, community health, residential care facilities and a range of other health and community services.

SA Divisions of General Practice Inc.: This is the support and coordination body for the 14 Local Divisions of General Practice in SA. Its purpose is to improve healthcare outcomes by coordinating the role of the divisions in the healthcare system. It acts as a conduit for information between the Divisions and State and Federal governments and an advocate for Divisions in health policy, planning, program development, implementation and evaluation.

Lessons for Ontario: The section of the Memorandum which is of particular interest to our project is section 8, which states that the “Department of Human Services, the 14 Divisions of General Practice and the SA Divisions of General Practice will develop an agreed framework of consultation to ensure general practice input into health policy and health service development and is appropriate at the State and local levels.”

The document also provides information concerning projects which reflect the desire of the government to promote and support integrated care, such as the project designed to develop GP obstetric shared care. The purpose of this program is to educate GPs so that they have the skills necessary to provide antenatal and postnatal care. A series of other programs aim to promote improved integration between allied health practitioners and GPs include: mental health programs, elder care, aboriginal health program, and programs to manage chronic diseases like diabetes, asthma and cardiovascular disease and recruitment and retention of GPs practicing in rural areas.

Ministry of Health and Aging. (2004). *Divisions of General Practice: Future Direction. Government response to the Report of the review of the role of Divisions of General Practice. Ministry of Health and Ageing. Canberra.*

This document represents the response of the Ministry of Health and Ageing to the Philips commission review of the Divisions of General Practice. The review committee found recommended that changes needed to be made to ensure that the Divisions would be able to make significant contributions to healthcare.

Funding: In Australia, the development of Divisions of General Practice began in 1991 with a demonstration project of 10 divisions and has now grown to include some 120 local Divisions. 95% of GPs in Australia are members of a local Division. The government funds Divisions to

strengthen the role of GPs and as a means of achieving outcomes which would be difficult to achieve through individual doctors practicing in isolation. State Based Organizations (SBOs) and the Australian Division of General Practice (ADGP) support the Divisions at the State, Territory and National levels. During 2003-4, the government provided 132 million dollars, about \$9,400 per FTE GP for the Divisions. The number of patients in each Division ranges between 17,051 and 583,486 and the number of FTE GPs ranges between 8 and 455. In an effort to facilitate greater staff retention and stability, funding periods have been increased to four years. Also, agreements can now be reconsidered for renewal after the third year. This aims to ensure that the Divisions will have a year's notice of changes so they can plan more effectively. Divisions that achieve excellent appraisals are also able to apply for additional funding.

Performance Appraisal: The report notes that a single comprehensive reporting system will be introduced to replace the several different forms currently used. Further, information management and technology are considered essential and Divisions are expected to provide support to help local practices get computerized. Core funding from the government is to be used to advance the following national-level goals: increased access to care, reduction of inequality, encouraging multidisciplinary care, and improved chronic disease management. Divisions are also expected to identify and meet the local needs of their populations.

New South Wales Health. (2000). *General Practice Policy*. New South Wales: New South Wales Health.

This discussion paper brings together the major policy directions influencing general practice in Australia and outlines future directions. It also seeks to define a broad role for general practice in improving the health of the people of New South Wales (NSW) by promoting collaboration and partnerships between general practice and the NSW public health system.

The document notes that the NSW Health Department will 'maintain and enhance' formal consultation mechanisms through the General Practice Advisory Committee (GPAC) to ensure the involvement of GPs. It will also use GPAC to disseminate information to GPs on projects and initiatives promoting continuity of care. The NSW Health department will also work with the Alliance of NSW Divisions to develop and implement a strategic plan to improve GP involvement in policy development and implementation. GPs will be represented on Area Health Service Boards, NSW Health Forums and the NSW Health Research and Development Advisory Committee. It is important to note that the links between the GPAC and the Health Department are formalized.

<http://www.health.nsw.gov.au/health-public-affairs/gppol/>

Rudd, C. and D. Steed. (2000). *The structural organization of general practice*. In, *Department of Health and Aged Care, General Practice 2000*. Department of Health and Aged Care, Canberra.

This document provides information on the history of general practice organizations in Australia, and the development of new organizations during the 1990's.

Lessons for Ontario: State Based Organizations (SBOs): By 1998, eight SBOs had been established in Australia. SBOs are responsible for supporting Divisions and coordinating cross divisional activities. SBOs were developed to assist in the move to decentralize funding and overall management of the divisions. They provide support to members of Divisions by providing management support and training. SBOs represent Divisions in regional, state and national health policy and planning and work with state/territory health departments to implement health policy. They are also responsible for developing policy in relation to general practice (e.g. workforce issues), as well as establishing and maintaining a database for Divisional members.

Australian Divisions of General Practice (ADGP): The urban and rural divisions have merged to form a single, national representative body (ADGP). The mission of the ADGP is to represent and support general practitioners. The board of directors is comprised of one urban and one rural representative from each State and Territory. They work with SBOs to ensure that national policy positions and directions can be coordinated and they provide advice to the government and other agencies. The authors note that Divisions can promote change through the development of new partnerships and collaborative teams.

Sprogis, A. (2001). The Divisional alternative. *The Medical Journal of Australia*, 175: 70-72.

Family medicine in Australia is provided through a combination of not-for-profit and profit making bodies. In this paper, Sprogis discusses the advantages of practicing medicine in a Division versus a profit making corporation. According to the author, membership in a Division enables general practitioners to maintain their role as patient advocates, enhances their capacity for population-based activity, and increases the possibilities of participating in the development of public policy. Sprogis argues that GPs involved in making decisions within local Divisions are better able to represent the interests of their patients at the regional level. Further, the Divisions enable GPs to make their own clinical and business decisions.

Lessons for Ontario: Sprogis' discussion of the need to practice medicine which is sensitive to local needs is important to note. Also, GP participation in decision making is important and, in Australia, is facilitated through the local divisions of general practice.

Wade, T. (2005). Health System Integration and General Practice Teams: Motherhood statements or real drivers of change? *SADI Statewide: News of SA Divisions of General Practice Inc.* April 2005, 2(1): 1-2.

In this brief article, Dr. Wade discusses three dimensions of health system integration: 1) areas of activity, 2) degrees of closeness, and 3) methods and processes.

1. Areas of Activity: Since it is impossible to integrate everything at once, Wade suggests that priorities need to be set about which linkages are most likely to improve health outcomes and are realistically achievable. Some areas for possible consideration include policy and planning, healthcare records, clinical service delivery, transfer of care and joint purchasing. Different types of integration are needed for each of these issues.

2. Degree of closeness: In terms of describing the degree of closeness between healthcare providers, Wade draws on the work of Gawaine Powell Davies:
Cooperation refers to the fact that the different healthcare providers communicate with each other and are willing to help each other if asked.
Coordination refers to the fact that while some processes may be carried out in common, such as referral systems or shared records, the organizations maintain their individual autonomy.
Coalescence: According to Wade, full coalescence occurs when all aspects of the health service work for the same organizations (i.e. a large multidisciplinary community health centre). However, lesser degrees of coalescence are possible, such as a governance framework applicable to many organizations.
3. Methods and Processes. Linkages can take different forms from the informal to the formal. While informal linkages can be effective, they are vulnerable to changes in staff, policies or the environment. Wade reminds us that formal linkages require both time and money to maintain their relevance and ability to deliver outcomes.

United Kingdom

Chisholm, J. (1998). Primary care and the NHS White Papers *The British Medical Journal*, 316: 1687-88.

In this editorial, John Chisholm (former Chair of the General Practitioners Committee of the British Medical Association) discusses changes to the National Health Service (NHS) first detailed in the White and Green papers.

Lessons for Ontario: Of particular interest for this project, is Chisholm's discussion of the concerns brought forward by the General Practitioners regarding the implementation of healthcare reform. Their concerns centred around: maintaining their status as independent contractors, maintaining the freedom to prescribe medications, control over referring patients to specialists, adequate financial support and training for preparatory work, continued resource support once Primary Care Groups were established, protecting the budget for the infrastructure of general practice and securing the role of local medical committees as representing all NHS general practitioners. GPs were also concerned that their clinical freedom would be undermined, funding would be inadequate, they would inherit the debts of health authorities, and that they would be forced to ration access to healthcare.

Dowswell, G. Harrison, S. and J. Wright. (2002). The early days of primary care groups: general practitioners' perceptions. *Health and Social Care in the Community*, 10(1): 46-54.

Primary Care Groups (PCGs), described by Dowswell as compulsory federations of general practices, came into legal existence in Britain during the spring of 1999. This paper contains a review of general practitioners' initial perceptions of the impact of these reforms and considers the wider issue of changes in professional autonomy for GPs in Britain. A random sample of 49 GPs from two adjacent health districts in the north of England, were interviewed as part of a longitudinal qualitative study. The first round of interviews took place 7 to 9 months following

the creation of PCGs and a second round of interviews were carried out some 6 months later. The authors were interested in assessing GPs knowledge of the recently formed PCGs in terms of their plans and priorities, the impact of PCG activity to date, and the predicted future impacts of such activity.

GPs were generally unaware of their PCGs published priorities at both time periods. Although over a third of the GPs interviewed reported no current impact associated with the PCG, the majority expected PCGs to have a considerable impact in the future. In particular, control, management and accountability arrangements were all perceived as central issues in the future. Performance management arrangements related to specific clinical priorities were expected by most of the GPs interviewed. Although the new arrangements were not met with enthusiasm, the authors note that the reforms did not appear to threaten GPs sufficiently enough to provoke any form of active resistance.

Lessons for Ontario: The discussions concerning governance (e.g., the lack of time available to actively participate in governance committees, the cost of taking time away from the practice to participate in governance), dealing with a new level of bureaucracy, and the impact of government health policy on clinical freedom are important to this project. GP control over setting local priorities, the corporatization of healthcare, and the organizational structure of general practice are also relevant.

North, N., Lupton, C and P. Khan. (1999). Going with the grain? General Practitioners and the new NHS. *Health and Social Care in the Community*. 7(6): 408-416.

During the mid 1990s, in Britain, a number of policy initiatives were introduced that encouraged general practitioners (GPs) to participate in the commissioning of healthcare. This role was reinforced following the release of the White Paper: The New NHS.

Lessons for Ontario: The authors found that some GPs were concerned that collaboration with other physicians would be difficult because some doctors would be more concerned with the needs of their own patients and would be unable to concern themselves with the health needs of the greater community. The discussion of how general practitioners relate to the government and the community is also relevant.

North, N. and S. Peckham. (2001). Analyzing structural interests in primary care groups. *Social Policy and Administration* 33(4): 426-440.

North and Peckham employ Alford's theory of structural interests in healthcare to examine health system reforms in the UK and the emergence of primary care groups. They begin by identifying the key players amongst English primary care groups as they relate to Alford's theory: the professional monopolizers, the corporate rationalizers and the community. The paper outlines the nature of the involvement of the key players and then examines relationships between them. Through this, the authors raise concerns about the structure and purpose of primary care groups and the likelihood that tensions will arise between those general practitioners who adopt a corporate rationalizer role, and those who retain a professional monopolizer role. With respect to community interests and involvement, they suggest that the professional monopolizers (amongst

GPs) will likely retain a powerful voice (at the expense of the corporate rationalizers), continuing to claim that they best represent the community's interests.

Lessons for Ontario: The section concerning the relationship between family physicians and government agencies, community agencies and health/community service providers are of interest to us. The ability of Alford's theory to highlight the competition for resources, possible alliances and structural interests of the three stakeholders is useful.

Smith, P and N. York. (2004). The case of UK general practitioners. *Health Affairs*, 23(3): 112-118.

The United Kingdom has recently implemented a new contract for general practitioners. The authors discuss the possible impacts of this new contract on general practitioners and the delivery of primary care through an examination of several key previous policy initiatives.

Fund-holding Experiment: Between 1991-1998, GPs in the UK were given annual budgets to purchase routine (non-emergency) secondary care and medications for patients. By 1998, more than half of NHS patients were involved in this program. As a result, the authors note that inpatient procedures had decreased by 5% and that patients generally experienced shorter wait times for care.

Quality Improvement Scheme: The quality improvement program was tested in East Kent (1998-2000) where nearly 80% of local GPs enrolled in the program. As part of the program, GPs were required to meet a number of chronic disease management targets for 13 conditions (e.g., angina, heart disease, and diabetes). GPs were offered £3000 per annum which accounted for approximately 5% of their income. If targets were not met, the money had to be paid back.

An evaluation of the program revealed that it was a success on many fronts. While they recognize that financial incentives were necessary to encourage participation, the authors suggest that GPs were also motivated to participate through a sense of professionalism and ownership. The program was successful because physicians and managers felt that the goals of the program were important. While there was some concern about the increased numbers of referrals to specialists and diagnostic services and the possibility that other chronic conditions were neglected, on the whole, the authors note that the program was a success.

The New GP Contract: According to the authors, under the new contract, there are now fairer capitation schemes and a major increase in funding for primary care (£1.9 billion annually which is an increase of 33% over 3 years). Quality incentives are a significant part of this contract as well and GPs will continue to set their own priorities.

Lessons for Ontario: The sense of professional pride and ownership the family doctors experienced while participating in the incentive program is very significant for doctors in Ontario. Programs are successful when physicians feel engaged.

Evidence of the Effectiveness of Family Medicine

Shi,L., Macinko, J., Starfield, B., Politzer, R., Wulu, J. and J. Xu. (2005). Primary care, social inequalities, and all cause, health disease, and cancer mortality in US counties, 1990. *The American Journal of Public Health, 95(4): 674 – 680.*

The purpose of this study was to examine the association between the availability of primary care and income inequality on several categories of mortality across counties in the US. The authors highlight the fact that there is now compelling theoretical and empirical evidence of the association between a strong national primary care systems and improved health outcomes. Previous research in the US identified that states with a higher primary care physician to population ratio, experienced better health outcomes even when socio-demographic measures (i.e. elderly population, unemployment, education, income, lifestyle factors, urban residents and pollution) were controlled.

The authors analyzed cross sectional data from 1990 Census information at the county-level. They examined the impact of availability of primary care, income inequality and socio demographics. For the purpose of the study, primary care physicians were defined as the number of medical doctors per 10,000 people in active office based patient care in family medicine, internal medicine and pediatrics.

Results indicated that access to primary care was significantly associated with lower mortality rates. Counties in the lowest three quartiles of primary care had approximately 2% higher over-all mortality rates than counties with more primary care providers. Counties with low numbers of primary care physicians had an average increase 3% higher mortality rate from heart disease. A higher number of primary care physicians was also associated with lower cancer mortality. Counties in the lowest primary care percentiles had about 2% higher cancer mortality rate than those in the reference group.

Further, the authors go on to suggest that a strong primary healthcare system may reduce the impact of social inequalities by reducing the levels of disease transmission, reducing risk factors (i.e. hypertension, weight gain), improving county wide screening and early diagnosis and coordinating and continuity of care.

Lessons for Ontario: The Ministry of Health in Ontario has focused on improving access to specialists rather than reducing the number of patients who do not have a family physician. Given the results of this study and the shortage of family physicians the Ministry's focus should expand to include improving the number of family physicians. If access to primary care is improved, reduction in mortality rates could be expected.

Starfield,B., Shi, L., Grover, A., and J. Macinko. (2005). The effects of specialist supply on population's health: assessing the evidence. *Health Affairs* (Web exclusive), W5-97-W5-107.

In this article, the authors examined the relationship between the supply of specialists and death rates based on data for U.S. counties. Physicians who engaged in office based patient care in

family medicine, general practice, general internal medicine and general pediatrics were considered primary care physicians for the purposes of the study because previous data indicate that these doctors fulfill the criteria for primary care practice. All other physicians were considered to be specialists.

The authors examined the relationship between primary care physicians, specialists and health in two ways. First, they used the supply of primary care or specialists as a predictor of mortality. The second approach employed an adjustment for population characteristics associated with higher mortality. They compared county level mortality rates, per capita income, education, income and race to examine the impact of primary care provided by family physicians and care provided by specialists.

Previous results have indicated that deaths from a variety of different causes decreased when the number of primary care physicians increased. However, the authors of this study discovered that this trend did not apply for specialists. When socio-demographic characteristics were considered, the ratio of primary care physicians to population was strongly related to lower total heart disease and cancer mortality, whereas the ratio of specialist to population was actually associated with an increase in mortality.

The results of this study are consistent with research conducted in the United Kingdom. In fact, the number of specialists in a population appears to have little impact on population-level health outcomes. In countries where the number of generalists exceeded the number of specialists, health outcomes tended to be better.

Lessons for Ontario: The Ministry of Health has focused on improving access to specialists rather than reducing the number of patients who do not have a family physician. Given the results of this study and the shortage of family physicians the Ministry's focus should expand to include increasing the number of, and improving access to, family physicians.

Starfield, B., and L. Shi. (2002). Policy relevant determinants of health: an international perspective. *Health Policy* 60: 201-218.

In this paper, the authors reviewed data on the importance of policy related health determinants from 15 countries. These indicators included low birth weight; neonatal mortality; postneonatal mortality; total infant mortality; life expectancy at ages 1, 15, 40, 65, and 80 for males and females separately; and the years of potential life lost from all but external causes for males and females separately. Analysis of the data indicated that the comprehensiveness of primary care services and family centredness of primary care were the practice characteristics that differentiated the best primary care systems from the worst systems.

Lessons for Ontario: Health policies designed to ensure equitable access to primary care resources, reduction of financial barriers to primary care and family orientation of services contribute to better overall health.

APPENDIX B: FOCUS GROUP QUESTIONS & LETTER OF CONSENT

Focus Group Questions:

What do you think about the introduction of the LHINs?

Do you have any concerns? What are they?

What kind of impact will this new structure have on the work of family physicians in Ontario?

Are there specific areas/issues you hope will be addressed by the LHINs?

Would you like to have on-going links with/ a voice in the LHINs?

What kind of mechanism/organization would be helpful to ensure that the concerns of family physicians are heard by the LHINs?

What would the structure of such an organization look like?

Who would participate in this organization?

How would/should such an organization be funded?

How would they (family doctors) provide input in this structure? Would it be ongoing or intermittent?

March 7, 2005

Consent Form

Linking Family Medicine Practitioners and Local Health integration Networks

Investigators:

Principal Investigator: Dr. Cheryl Levitt
Department of Family Medicine
McMaster University
Hamilton, Ontario, Canada
(905) 525-2100 ext. 6195;

Co-Investigator Dr. Colin McMullan
Department of Family Medicine
McMaster University
Hamilton, Ontario Canada
905-525-9140 ext. 27931
Research Sponsor:

Purpose of the Study

Ontario's healthcare system is undergoing rapid change and transformation. Towards this end, Local Health Integration Networks (LHINs) have been identified by the Ministry of Health and Long Term Care as a primary mechanism to make Ontario's health system more responsive to patient needs.

It is important for family practitioners to be involved in the development of the LHINs and their subsequent governance. It is apparent that for the LHINs to be truly "patient centred", family physicians will need to have strong linkages with the LHINs. This research will attempt to identify how best these linkages and integration might be achieved by obtaining information from family physicians.

Procedures involved in the Research

You have agreed to participate in a focus group. You will be asked questions regarding the development of LHINs and related issues. We would like to hear your views on what you think an effective linkage mechanism would look like.

Potential Harms, Risks or Discomforts:

It is not likely that there will be any harm or discomfort associated with participating in the focus groups. You do not need to answer questions that make you uncomfortable or that you do not want to answer. You may leave the focus group at any time. Any information you have provided will be removed from the transcript and will not be used in any way.

Potential Benefits

If Ontario is to develop a more patient-centred and responsive health system, family practitioners will need to have a "voice" in the new Local Health Integration Network (LHIN) system. This project hopes to identify a mechanism and an organizational structure that will link family practitioners to the new system of health services delivery. The ultimate goal is to improve patient care.

Payment or Reimbursement:

Participants will not be paid or reimbursed for their time.

Confidentiality:

Anything that you say or do in the study will not be told to anyone else. Anything that we find out about you that could identify you will not be published or told to anyone else, unless we get your permission. Your privacy will be respected. We will not be asking you to provide your name or any personal information

We will ask the other members of the focus groups to keep what you say confidential, but cannot guarantee they will do so.

The information obtained by me will be kept in a locked cabinet at the research office. The tapes/transcripts will be only available to the lead investigator and people who will be analyzing the data. The information will be destroyed within six months.

Legally Required Disclosure:

Information obtained will be kept confidential to the full extent of the law and all information provided will be treated as subject to researcher-participant privilege.

Participation:

Your participation in this study is voluntary. It is your choice to be part of the study or not. If you decide to participate, you can decide to stop at any time, even after signing the consent form or part-way through the study. If you decide to stop participating, there will be no consequences to you. If you do not want to answer some of the questions you do not have to, but you can still be in the study. Should you decide to withdraw from the project, any data provided by you will be destroyed immediately and will not be used in the project in any way.

Information About the Study Results:

You will be able to view and provide feedback on any written reports that are prepared during the course of the project. You will be able to comment on the interpretations of their comments and suggestions and your suggestions and feedback will be incorporated into the final report. All participants will receive a copy of the final report.

Information about Participating as a Study Subject:

If you have questions or require more information about the study itself, please contact :

Dr. Cheryl Levitt, Principal Investigator
Department of Family Medicine
McMaster University
Hamilton, Ontario, Canada
(905) 525-2100 ext. 6195;

Dr. Colin McMullan, Co-investigator
Department of Family Medicine
McMaster University
Hamilton, Ontario Canada
905-525-9140 ext. 27931

This study has been reviewed and approved by the McMaster Research Ethics Board. If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact:

McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142
c/o Office of Research Services
E-mail: ethicsoffice@mcmaster.ca

CONSENT

I have read the information presented in the information letter about a study being conducted by Dr. Cheryl Levitt and Dr. Colin McMullan, of McMaster University. I have had the opportunity to ask questions about my involvement in this study, and to receive any additional details I wanted to know about the study. I understand that I may withdraw from the study at any time, if I choose to do so, and I agree to participate in this study. I have been given a copy of this form.

Name of Participant

In my opinion, the person who has signed above is agreeing to participate in this study voluntarily, and understands the nature of the study and the consequences of participation in it.

Signature of Researcher or Witness

[A signature of the researcher or a witness may not be appropriate in many cases. While it may be generally preferable to have the researcher, an assistant or a witness attest to the signature by the participant, it is not always appropriate, or possible, in which case, this line should not be included.]

APPENDIX C – TELECONFERENCE/INTERVIEW GUIDE

During the teleconferences, respondents will be asked to comment on:

- 1) The background, history and set-up of their respective GP organizations and how they (GP's) are currently linked with/connect to, their respective regionalized health systems;
- 2) The strengths and weaknesses of the current structure;
- 3) How they would “do things differently” if they had to do it again;
- 4) Advice for GP's in Ontario currently facing health system reorganization through the LHINs.

Questions:

Could you tell us a little bit about the historical development of the General Practitioner associations/organizations in your area?

What is its present organizational structure of these organizations? Have/How have, they changed with regionalization?

At present, do you have input/connections with the local Regional Health Authority? If so, how and in what ways are you linked/connected? Who represents GP's? How are they represented in the terms of the decision-making of the RHA? Are there structures in place to ensure that your (GP's) voices are heard? Are you satisfied that your input is heard? How has this process changed/is this process changing?

What would you consider to be the strengths of the current structure? What works about it?

What would you consider to be the weaknesses of the current structure? What doesn't work?

What changes would you like to see to improve this linkage (or lack thereof)?

Is there anything that you would do differently if you were going to do it again?

Ontario is presently undergoing a similar transformation to a type of regionalized health system (LHINs). Do you have any advice for family physicians in Ontario?

APPENDIX D - LHIN STRATEGIC PLANNING MEETING FINAL REPORT

Linking Family Physicians with Local Health Integration Networks (LHINs)

Strategic Planning
&
Recommendations Meeting Report
June 3, 2005



By: Cheryl Levitt MBBCh CCFP FCFP &
Colin McMullan PhD

Strategic Planning & Recommendations Meeting Report - June 3, 2005

Participants:

Dr. Tom Freeman – Chair, Department of Family Medicine University of Western	Dr. Art Kushner – Chief of Family Medicine Humber River Regional Hospital
Dr. Walter Rosser – Chair, Department of Family Medicine, Queen’s University	Dr. David White – Chief of Family Medicine North York General Hospital
Dr. Jill Konkin – Executive, OCFP	Jan Kasperski – Executive Director and CEO, Ontario College of Family Physicians
Associate Dean of Admissions and Student Affairs Northern Ontario School of Medicine	
Dr. David Price – Chief of Family Medicine Hamilton Health Sciences, FMAH	Dr. Cheryl Levitt
Dr. Sandy Buchman – Executive, OCFP	Dr. Colin McMullan
Dr. Ruth Morris – Past President FMAH	Lois Freeman-Collins
Dr. Peter Nord – Chief of Staff, Providence Healthcare, Toronto	Sabrina Dorris
Dr. David Dec – Regional Director ROMP, Niagara	
Dr. Val Rachlis – President, OCFP	

Regrets:

Dr. Peter Deimling – Executive, OCFP	Dr. Claudette Chase- Executive, OCFP
Dr. Brian Gamble – Executive, OCFP	Mary Fleming -MOHLTC
Dr. Yoel Abells- Family Physicians Toronto	

Project Purpose:

Local Health Integration Networks (LHINs) have been identified by the Ministry of Health and Long Term Care (MOHLTC) as a primary mechanism to make Ontario's healthcare system more responsive to patient needs. However, for the LHINs to be truly 'patient-centred', family physicians should have strong linkages with these organizational structures. Our research attempts to identify how best these linkages and integration might be achieved by exploring experiences in other national and international jurisdictions and combining these findings with the perceived needs of family practitioners in Ontario.

Meeting Purpose:

The strategic planning and recommendations meeting, a critical component of the project, provided an opportunity for participants to identify and develop recommendations to be taken forward to the MOHLTC. This will help ensure that the integral 'voice' of family physicians is taken into consideration with respect to the development and operationalization of the LHINs in Ontario.

Introductions/Opening Remarks – Val Rachlis

Following the introductions of the participants, Dr. Val Rachlis kicked-off the session with reference to the current state of regionalization in New Zealand whereby the 21 District Health Boards (DHBs) currently contract the services of General Practitioners through organizations known as Primary Health Organisations (PHOs). Despite some problems with the system, approximately 90% of the population in New Zealand receives primary healthcare from a PHO.

Local Health Integration Networks: A Means Not an End – Jan Kasperski

Jan Kasperski, Executive Director and Chief Executive Officer of the Ontario College of Family Physicians brought participants up-to-date on the current organizational structure and mandate of the LHINs in Ontario. She began with a brief discussion on the governance structure of the LHINs highlighting the fact that they will be governed by a Board of Directors and bound by performance agreements with the Ministry. Participants were informed that the first three Board members have been announced and that the board members are to review and appoint the CEOs for each LHIN.

It was noted that despite the fact that there is no real evidence that health system regionalization is leading to 'real' improvements in other jurisdictions, in theory, money can move more easily if RHAs have total control over funding allocation.

In Ontario, the question remains as to whether or not the provincial government is willing to delegate decisions for health system funding entirely to the LHINs. It was suggested that the system is likely to fail if the MOHLTC insists on micro-managing the process.

Ms. Kasperski highlighted the need for a clear role and mandate for the LHINs, noting that a number of key questions still remain unanswered at this stage such as:

- Will LHINs play a leadership role in advancing system change and integration?
- Will LHINs become autonomous community-based organizations designed to meet local needs within a wider provincial context?
- Will LHINs serve as a vehicle for greater government influence over healthcare decision-making?
- Will LHINs have the authority to realign and consolidate programs and services within their region?
- Will the MOHLTC devolve some of their responsibilities to the LHINs or will we see duplication of effort?
- Will local decision-making be replaced by regional decision-making?
- Will the weakest voices (e.g., rural communities, community-based providers) be silenced?
- Will appointed, paid Boards (with the right political stripes) silence advocacy for quality care and adequate resources?
- What do they mean when they talk about accountability, agreements and measurement?
- Will LHINs overcome regional inequities in terms of funding and access?
- How will FHTs and other primary care models function under (or outside) of the LHIN activities?
- Where does public health fit within the LHINs and the PCR movement?

Ms. Kasperski went on to briefly explore the emerging Family Health Team (FHT) models including the physician sponsorship model, the provider/community sponsorship model and the community sponsorship model along with three potential emerging roles within the LHINs: 1) Primary Healthcare Community Development Coordinator; 2) MOHLTC Site Coordinator; and 3) P.C. Physician Champions.

Ms. Kasperski noted that one of the key factors yet to be determined deals with the question of whether or not the LHINs will be given the authority to reallocate and re-distribute resources to best meet the needs of their local communities, or whether the Province will still have a say. Regardless, she concluded her presentation highlighting the fact that having a strong and united physician voice in the LHIN decision-making structure is key and that physician leaders need to make appropriate changes on the frontline and with organizations in their community.

Linking Family Physicians and Local Health Integration Networks (LHINs) – Colin McMullan

Dr. Colin McMullan (Research Associate, Department of Family Medicine, McMaster University) introduced the participants to the research project being undertaken within the Department of Family Medicine at McMaster University. He began with a brief review of the purpose and governance structure of the LHINs. Responsible for planning, coordinating, integrating, funding and evaluating the delivery of health services in Ontario, the LHINs are intended to enhance the effectiveness, efficiency and responsiveness of the health system. This aim highlights the need for timely and ongoing input from family physicians.

The research project addresses two primary research questions:

1. How might family physicians link with the LHINs to provide input into the decision-making process?
2. What could be the role of the LHINs with respect to supporting primary care?

In addition, the research is interested in identifying:

- What has happened in other jurisdictions with a history of regionalization?
- What can we learn from these experiences to inform Ontario's experience with LHINs?
- What kind of organizational structure would ensure the effective/efficient delivery of primary care services in Ontario?

These questions are being addressed through:

1. A Literature Review
2. Teleconferences (national and international)
3. Focus Groups (with family physicians in Hamilton, Toronto, Niagara and Kitchener-Waterloo)
4. A Strategic Planning and Recommendations Meeting

Dr. McMullan went on to briefly highlight some of the key preliminary findings that were beginning to emerge from the research project. These findings included:

- The fact that early involvement (by physicians) in RHA's is important (although this failed to happen in many other jurisdictions) (literature)
- There are generally low levels of awareness and knowledge amongst family physicians about the LHINs (focus groups)
- Despite a relatively low level of awareness, family physicians have told us that they want to be involved and contribute to the development of this new system (focus groups)
- Concern surrounding the fact that primary care has been identified as a key transition priority in only three of fourteen LHINs (focus groups)
- The importance of ensuring LHIN-wide representation amongst family physicians in the LHINs (focus groups)

- Concerns over issues of equity in the LHINs (i.e., will Hamilton dominate LHIN #4?) (focus groups)
- The importance of patient/consumer involvement with respect to acting as advocates on behalf of family physicians (teleconferences)
- The surfacing of urban/rural tensions in other RHAs (literature/focus groups/teleconferences)
- The potential development of “shadow boards” to monitor the activities of the LHIN boards (focus groups)
- Issues surrounding elected vs. appointed leadership on boards (literature/focus groups/teleconferences)
- The importance of being supportive and not adversarial in this transition process (focus groups)
- The importance of using this opportunity to try out different models (teleconferences)

With respect to organizational structures being adopted in other areas, it was noted that a co-leadership model has emerged in Alberta and Saskatchewan (e.g., general manager/FP leader/academic chair). In addition, family physicians have been hired by RHAs as physician consultants in Saskatchewan and GP Advisors in Australia. In other words, family physicians are paid to participate in their local RHAs by the RHAs.

The presentation concluded highlighting the fact that the LHINs are being implemented whether or not family physicians agree with them or not. As such, it would appear to be important to focus on how the LHINs can be rolled out in a manner that includes the input of family physicians. Further, it would seem that the input of family physicians in the LHINs can only serve to improve and enhance the delivery of primary healthcare in the province, a goal shared by both the provincial government and the family physicians practicing in Ontario. As such, it would appear to be in both parties interests to be involved in the operationalization and subsequent governance of the LHINs.

Linking Family Physicians with Local Health Integration Networks (LHINs): Small Group Breakout Session

Following the presentations, participants were divided into two groups and asked to identify three recommendations for each of the following two issues:

- 1) Discuss how family physicians could link with Local Health Integration Networks. In particular, address the issue of what role family physicians should take on in order to ensure the integrated and effective delivery of primary care services (e.g., quality/accountability, CME, physician recruitment/retention, etc.). In other words, how would you ensure that primary care services are provided at the highest level within the LHINs and what kind of organizational structure would that require?

- 2) How should the key special areas within family medicine (e.g., comprehensive family medicine, rural family medicine, palliative care, hospital, obstetrics, emergency, etc.) be addressed and funded? How can we ensure that these areas are addressed within the LHIN structure?

Group #1: Recommendations Issue #1

1. Establish an ‘umbrella’ family medicine organization in each of the 14 LHINs. This group would be comprised of representatives from a variety of organizations including: OMA, OCFP, chiefs/chairs of family medicine, Medical Officers of Health, MPP’s, LHIN CEOs, and local politicians (i.e., mayors).
2. One representative, of this organization (above), from each of the 14 LHINs, should sit as a voting member on the LHIN Board of Directors. If this isn’t possible or acceptable, at the very least this representative should serve in an advisory capacity.
3. These (14) representatives become a committee of the OCFP and meet as a group.

Group #1: Recommendations Issue #2

1. Establish funding through MOHLTC for the governance of this family medicine organization and all of its subgroups.
2. Funding should be flowed to this organization through a separate mechanism at arm’s length to the LHIN in an effort to maintain independence.
3. This family medicine organization should be collaborative and represent all sections of the many primary care disciplines.

Group #2: Recommendations Issue #1

1. Primary Care Coordinators should liaise with the Family Medicine Leaders in the LHINs.
2. Remind the LHINs that family medicine is more than just primary care, but often includes secondary and even tertiary care as well.
3. Use and expand on, the existing feedback structure (e.g., OMA, hospital chiefs, etc.) in the short term in an effort to foster grassroots communication.

Group #2: Recommendations Issue #2

1. If we get #1 ‘right’, this (issue #2) will flow from the structure developed in the first section.
2. It is important to fund ongoing evaluations of the infrastructure.

Other Recommendations

During the morning, participants were also asked to write down and hand-in any other recommendations or suggestions that they might have with respect to the linkage of family physicians and the LHINs. These recommendations/suggestions are summarized below:

- We need an appreciation of how all practice models, including fee-for-service are represented: how they will be affected by the distribution of LHIN services (varying types of infrastructure costs)
- Within LHIN “Shadow Boards”, structure the feedback/information dissemination tasks, key deliverables need to be identified via sub-committees or other groupings
- Sounds like mimicking New Zealand’s system may be our best bet, especially if the Ministry seems interested!
- Use present structural bodies in short term to facilitate feedback for LHINs
- Keep focus on being advocates for our patients and seek alliances with like-minded individuals in other organizations (e.g., CCAC, Health Units, hospitals, etc.)
- Emphasize that family medicine is larger than primary care; although we are the main providers of it (PC). We also provide secondary and occasionally tertiary care.
- Seek infrastructure support for family physicians.
- Need to evolve the structures from the bottom-up or grass roots: Encourage diversity not homogeneity
- Need to avoid being co-opted or absorbed by LHIN Boards
- Focus on patient care issues
- ‘Influence’ of the LHIN on primary care issues is the key
- Need bottom-up representation (not top-down)
- Start by using existing structures (e.g., chiefs of FM @ hospitals, academic chairs, PCN leaders, etc.)
- Have primary care coordinator call a meeting of chiefs
- Who pays for administrative support?
- Family docs need to act as patient advocates and focus on articulating the pressure points for their patients
- Get on with it. Don’t try to be too big and too inclusive
- Need representation of family docs w/ LHINs- advisors?
- Start to get family docs together NOW and then add all of the pieces (players) as time and \$ permit
- Where is the OMA?
- Will physicians be paid via LHINs? If not, where is the control?
- Still a centrally-funded model.
- We need to put the ‘why’ before ‘how’
- We need to determine how receptive the LHINs are to FM issues
- The funding structure of the LHINs needs to be clarified

The Rural Perspective and Closing Comments – Jill Konkin

Dr. Jill Konkin (Dean of Admissions and Student Affairs, Northern Ontario School of Medicine, previous rural physician in Jasper Alberta and OCFP Executive Member) was asked to comment briefly on the rural perspective (based on her experience as a rural physician in Jasper, Alberta) and to sum up the morning's discussion. Dr. Konkin emphasized the importance of being aware of what is happened in other Canadian provinces ("look at the local!") and to learn from these experiences. Dr. Konkin expressed concern about the fact that providers appear to have been excluded from the LHIN Boards and encouraged family physicians to advocate for a voice. In particular, she highlighted some of the 'mistakes' of the Alberta system (e.g., the loss of local services and input in many rural areas) and encouraged family physicians in Ontario to take advantage of the opportunity they have to influence the process and have their voice heard.

Dr. Konkin also raised concerns about regionalization having the opposite effect from what is intended – the isolation of individuals from their 'bosses' and the impact this can have on local services. She also raised concerns about excluding providers from boards and that it is very important to advocate for appropriate provider representation in the LHINs. Alberta took two years to include providers on their boards, and then only as non-voting members. This proved to be a big mistake.

Finally, she said that Ontario has a great opportunity to learn from what has happened elsewhere. By doing so, Ontario could miss out on the dislocation and demoralization experienced by other regionalization projects in Canada.

Next Steps

- At the end of the meeting, participants were told that the summary of the day would be developed as a draft and circulated to the participants.
- In addition, the OCFP Executive would continue to discuss how to move the project forward.
- A meeting would be arranged with Marsha Barnes, Jim MacLean and Gail Peach to discuss the findings and recommendations.
- The research project with telephone interviews would continue and the summary of the environmental scan, literature review, focus groups, teleconferences, individual interviews and the planning meeting would all influence the final report.
- The planning meeting participants would be encouraged to continue to send in thoughts about recommendations and suggestions which would be incorporated into the report.
- The final draft would be shared with the Ontario Chiefs of Family Medicine at a meeting to be held in September 2005 and their input incorporated into the final report.
- The final report will be submitted to the Ministry of Health at the end of September.

Meeting Evaluation

Following the meeting, participants were asked to evaluate the meeting based on the following scale:

- 1 = Useless
- 2 = Not very helpful
- 3 = OK
- 4 = Quite helpful
- 5 = Very helpful

Evaluation Item	No. Responses N = 9				
	1	2	3	4	5
1. The background information presented was... (mean = 4.11)	0	0	0	8	1
2. The small group breakout sessions were... (mean = 4.22)	0	0	1	5	3
3. Overall, the LHIN strategic planning meeting was... (mean = 4.11)	0	0	1	6	2

Comments:

- Meeting well planned
- Clear objectives and tasks – focused
- Workable small groups
- Comprehensive in scope
- My perception is of a satisfactory outcome with workable recommendations to take forward
- Well organized
- Important topic and a good start forward
- Follow-up might include the development of a couple of approaches and organizational structures to be e-mailed to group for further comments/suggestions
- Interesting to meet many of the players!
- The meeting was a good start to what is obviously a work in progress
- Well organized
- We were unable to focus on some of the tasks ahead of us largely because of the discussion regarding the ambiguity and uncertainty of the LHIN concept
- Involving broad groupings will be important as we go forward (e.g., OMA, hospital representatives, community representatives, palliative care reps., ER reps, etc.)

**APPENDIX E: LHIN FAMILY MEDICINE ADVISORY COMMITTEES (LHIN
FMACs) – TERMS OF REFERENCE**

LHIN FMAC Terms of Reference

The LHIN FMACs are intended to facilitate and enable family physicians to meet the highest possible standards of care in family medicine in each region and liaise with their regional LHIN and with other LHIN FMACs. This will be accomplished through the creation of an advisory committee with broad representation from key family practice organizations and community stakeholders which ensures 2-way communication between the family physicians, the family physician organizations, other primary care disciplines, consumers and community representatives, as well as between family physicians and the LHIN Boards, and between the fourteen provincial LHIN FMACs.

The family medicine special interest groups will link with the LHIN FMACs to ensure comprehensive care family medicine (e.g., office practice, chronic care, mental health, prevention, home care, hospital care, palliative care, Long Term Care, obstetrics, emergency care, rural family medicine) is addressed.

Set up of LHIN FMAC

Each region will establish its own LHIN FMAC based on local needs. Each LHIN FMAC will have a lead family physician (elected or appointed) responsible for liaising with the LHIN and the Provincial LHIN FMAC.

Organizational structure

LHIN FMAC

Each LHIN FMAC will consist of voting representatives from the following organizations, numbers and terms to be determined by each LHIN FMAC:

- Chiefs of Family Medicine
- Academic Chair
- OCFP representative
- OMA, SGFP representative
- COFP representative
- Section of Rural Family Medicine
- Urban family physicians

- Rural family physicians
- PCR representative

In addition each LHIN FMAC will have the following members at large:

- Representatives from the Interdisciplinary Committee
- Representatives from the special interest groups Subcommittees
- LHIN CEO
- MOHLTC representative
- MPP
- Mayors and city councilors
- Consumers
- Community agencies (i.e. CCAC)
- Public Health MOHs

Interdisciplinary Committee

An Interdisciplinary Committee will be established to advise the LHIN FMAC about interdisciplinary issues and will consist of members (not limited) from the following disciplines:

- Nursing
- Nurse practitioners
- Registered practical nurses
- Social workers
- Dietitians
- Psychologists
- Chiropractors
- Physiotherapists
- Occupational therapists
- Pharmacists
- Optometrists
- Chaplains

Special Interest Groups Subcommittees

Each LHIN FMAC will establish mechanisms to liaise with family practices regarding the provision of comprehensive family practice care in the following areas (not limited):

- Office practice
- Chronic care
- Mental health
- Palliative care
- Long-Term Care
- Obstetrics
- Hospital care
- Home care
- Emergency care

Administrative structure/operations

Each LHIN FMAC will be responsible for the following administrative functions/operations to ensure the best quality of care:

- Professional development
- Credentialing
- Continuing quality improvement
- Communications/information management/linkage with specialists
- CHC/HSO/FHTs/FHNs/FHGs/PCNs (PCR initiatives)
- Research and Evaluation
- Physician recruitment/retention/shortages
- Continuing professional development
- Database management