January 30, 2015
Presentation to:
Standing Committee on Finance and Economic Affairs regarding Pre-Budget Consultations 2015

Ensuring Access to Team-based Primary Care

Objective: Maintaining health and controlling health costs

- Ontario's population is aging; people are living with more chronic conditions and complex health needs.
- Research evidence shows that a strong primary care system is associated with improved system quality, equity and reduced cost. [i,ii,iii,iv]
- Interprofessional primary care teams (e.g. nurse practitioners, registered nurses, dietitians, social workers, pharmacists, administrators, etc.) working alongside family physicians, produce better results for people living with chronic disease and complex needs.[v]
- Today in Ontario, team-based primary care is delivered by Family Health Teams (FHTs), Community Health Centres (CHCs), Nurse Practitioner-Led Clinics (NPLCs) and Aboriginal Health Access Centres (AHACs).
- This care is currently available to about one-quarter of Ontarians – over 3.5 million people. High-needs patients identified through Health Links initiatives clearly point to the need for more Ontarians to be able to access team-based care to help them stay as healthy as possible and out of hospital.

The crisis in accessing team-based primary care

- Communities are not receiving the level of primary health care service that was planned and promised to them:
  - Vacancy rates of up to 19% in some professions have shrunk overall service capacity by an estimated 6-7%.
  - When staff leave, two-thirds leave primary care entirely.
  - The main cause is non-competitive compensation and lack of pensions.
- Studies by the Hay Group found:
  - Compensation levels are significantly below market. In 2009 the gap for each profession ranged from 5 – 30% below market.
  - The compensation gap is growing. The gap expanded, on average, by 5 percentage points over 2009 – 2012, bring the total gap to 8 – 40%
  - Lack of access to pensions is a barrier to labour mobility.
- For example, in the past year CCACs have been "poaching" primary care NPs for their new positions with offers of salaries up to $25,000 per year more, plus the HOOPP pension plan.
- An NP reported she could work three shifts as a hospital RN and earn more than a full time NP lead working 60 hours in a NPLC. It's no wonder current openings in training programs are going unfilled – who would want to stop earning for two years and pay substantial tuition costs, to train for a role that pays less!
- Primary care teams are launching pads for careers since this is such a rich environment for learning and growing. However, patients lose continuity of care as well-developed, experienced staff feel compelled to move to better-paid jobs outside primary care, despite the fact these roles characteristically have less autonomy and responsibility.

All three parties recognize the need to fix this problem

- The Liberal Party's *Primary Care Guarantee* recognizes that, "To make the Guarantee a reality, Premier Kathleen Wynne's Liberals will improve the recruitment and retention of community-based primary care teams."
- Over the past few months, members from the PC and NDP parties have pressed the Minister to address the growing crisis in recruiting and retaining staff in primary care teams.

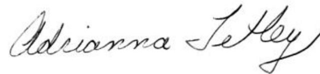
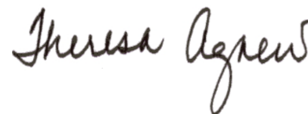
The solution

- Our three associations, AFHTO, AOHC and NPAO, call on Government to extend their commitment to increase the community care budget by 5% annually to encompass primary care. Primary care is the critical foundation for community-based care, and these funds would enable the current compensation gap to gradually close over 4 years.
- The dollar value of this proposal is an increment of $36M in the first year and $28.6M per year for the next three years.

The payoff

- This investment in AHACs, CHCs, FHTs and NPLCs will yield a high return. It will enable primary health care organizations to deliver the level of services and programs they have been mandated to provide. It will also provide a firm footing so that primary health care lives up to its potential as the foundation of a transformed health system in Ontario.
- The consequences of not making this investment are severe. Without it, Ontario faces a human resource crisis in primary care.

Respectfully submitted by:

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[i] Shi L, Starfield B, Kennedy BP, Kawachi I. Income inequality, primary care, and health indicators. J Fam Pract. 48 (1999), 275--84.

[ii] Starfield B. Family medicine should shape reform, not vice versa. Fam Pract Man. May 28, 2009; Global health, equity, and primary care. J Am Board Fam Med. 20(6) (2007), 511--13; Is US health really the best in the world? JAMA. 284(4) (2000), 483--4; Research in general practice: co-morbidity, referrals, and the roles of general practitioners and specialists. SEMERGEN. 29(Suppl 1) (2003), 7--16, Appendix D.

[iii] Starfield B, Shi L. Policy relevant determinants of health: an international perspective. Health Policy. 60 (2002), 201–18.

iv Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Quarterly. 83(3) (2005), 457--502.

[v] Sophia Gocan, RN, MScN; Mary Ann Laplante, RN, BScN; & A. Kirsten Woodend, RN, BScN, PhD. Interprofessional Collaboration in Ontario's Family Health Teams: A Review of the Literature. Journal of Research in Interprofessional Practice and Education Vol. 3.3 January, 2014.

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