

MEDICAL REFORM

Newsletter of the Medical Reform Group of Ontario

Medical Reform Group of Ontario, P.O. Box 366, Station J, Toronto, Ontario M4J 4Y8 (416) 588-9167

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"MEDICINE IS POLITICS WRIT LARGE" – *Rudolf Virchow*

MRG Fall Meeting Looks at Primary Care

Neighbourhood/Community HUB Model of Primary Care

Introduction

The primary care working group has developed a model for the delivery of primary care in Ontario. We have named it the "Hub model". The model has six components that interact. They are described in point form in this article. We hope that this article and the accompanying schematic of the model will serve as an introduction. We apologize for the point form format. For additional background, see the April and September issues of Medical Reform. Primary care will be the focus of discussion at the Medical Reform Group's fall general meeting on October 13 in Toronto.

Ministry of Health (MOH)

- this is source of funding
- too remote to be subject to real democratic control
- necessary to establish wider standards and provide research administrative support

District Health Council (DHC)

- already established
- needs to be democratized – perhaps in similar manner to elected school boards i.e: elected "health representatives" to the DHC
- the democratization would put health issues further in the political arena and would allow real debate on local health priorities. Liaison officers would be responsible mainly to DHC although officially employed by the MOH - there may be less local

political interference if this were the case

- although the liaison officer has a difficult tightrope to walk
- would be given budget responsibility for all health care in the region (only physician salaries would be funded directly from MOH)

Community Office (CO)

- these are family physician's offices
- HSO's or CHC's or fee-for-service. Ultimately we hope fee-for-service would wither away
- this model allows for a variety of types of practice therefore allowing both professional satisfaction as well as room for local (private or community) initiative in office models
- physicians may be enticed into the model by a variety of factors: benefits, salaried lifestyle, administrative support (see HUB and Liaison Officer below), paid and quality CME
- some people will exercise their involvement through the community boards that exist with CHC's (one type of Community Office) but we don't want to force boards on all types of Community Office because of some of our own unhappy experiences with them
- equivalent of today's doctors' offices
- "friendliness" and non bureaucratization make it essential that they be small in size
- 3-6 GP's backed by a nurse practitioner
- social services as needed or as the office has an interest
- see HUB for specialty, midwifery, etc

Agenda

MRG General Meeting

Saturday, October 13
South Riverdale C.H.C.
126 Pape Ave., Toronto

- 9-10** Business
- 10-11** Discussion: The MRG under an NDP government
- 11** Coffee
- 11:15** Introductory Comments
The HUB Model of Primary Care
- 11:30** Explanation of HUB Model of Primary Care
- 12:00** Question & Answer about HUB Model
- 12:30** Lunch
- 1:30** Small Groups Discussion.
1. The HUB Model and the democratisation of care.
2. How does my practice fit into the HUB Model?
3. Implementation – is the HUB model just another bureau- cracy?
- 3:00** Plenary
- 4:00** Adjournment

Neighbourhood/Community (HUB)

- would have a physical office with staff located in the community
- several Community Office (number depends on local population base and demographics) come together to form one HUB
- the HUB is the coming together of the sense of neighbourhood or community
- the Community Office (which are computerised) provide the demographic data which is collected at the HUB level
- at this point the Liaison Officer collates the data which is then passed on to the DHC to aid in priority setting
- most importantly, the HUB may be a less remote access point for the community to be involved in - it is yet to be determined in what way people would exercise some control
- it is not reasonable to expect elections at the DHC level and another level of "health government" at this level
- at the very least one might expect some kind of non decision-making advisory board at the HUB level
- the HUB is also the source of much CME because here, with the help of the Liaison Officer, the care providers learn of the community needs and therefore perhaps their own need of upgrading
- as well it is the source of CME for a political reason: we are attempting to form a self-defined community (both in the patient population and in the care-giver group)
- directing CME thru the HUB not only may make it more relevant but offers a forum to further integrate the local care-givers (see also the role of the Liaison Officer)
- community outreach is probably more efficiently done here than through the Community Office (see Liaison Officer)
- the care-givers in the HUB may share several specialists thus integrating further GP's and specialists by more

precisely defining the group of GP's a specialist "belongs to" and perhaps enhancing communication in both directions

- specialist may work out of community hub office through visiting clinics
- including could be midwives as well as social service personnel this could be done on a rotating visit basis to each Community Office (space necessary could be subsidized by the MOH as another enticement for physicians to join the model) or perhaps some HUBs would receive funding to rent premises for these purposes
- the care-givers in the individual Community Office would meet as a HUB from time-to-time for CME, health promotion, and general administrative reasons
- the time lost from work would be subsidized either by not negating patients seen elsewhere during this time (HSOs or CHCs) or a direct administrative stipend
- Community Offices might organize on-call through HUBs

Liaison Officer (LO)

- this person is crucial... hired by the MOH but responsible to the DHC and working out of its offices
- all the while working closely with individual Community Offices in a way to gain their trust as a helper through the system
- the system must not become bureaucratic... the Liaison Officer is the instrument of success here
- the Liaison Officer visits the Community Offices coordinating their efforts to provide care..
- the Liaison Officer will do "rounds" with a Community Office, offering help and suggestions in patient care and community care and overseeing that standards of care are met..
- the Liaison Officer can report poor quality to the appropriate authority (the CPSO or DHC)
- the Liaison Officer will oversee the collection of demographic data and therefore ensure the Community Of-

fices are living up to their commitment to do health promotion... hopefully this will be with a carrot and not a stick approach

- the Liaison Officer will have earmarked resources at their disposal (similar to the Health Innovation Fund) which they may apply for to help an individual Community Office or HUB in their efforts to provide care e.g: money to upgrade computer systems or perhaps to hire temporary secretarial staff to do demographic research on a practice
- the Liaison Officer acts a go-between for the Community Offices within a HUB
- physician time spent with the Liaison Officer is duly compensated to relieve the burden and resultant resentment all such people engender
- the Liaison Officer will suggest community projects and through their office will provide administrative and financial support to carry them out
- the Liaison Officer's office will do the bureaucratic work of applying for grants, health promotion personnel, etc to act as a buffer between Community Offices and the rest of the bureaucracy

Public Health Departments - (PHD)

- for the first time the PHD is link to the individual Community Office via the HUB where it will send representatives (as well as to the DHC)
- the data gathered by the HUB can influence PHD decisions and vice versa.

**The MRG under
an NDP
Government?**

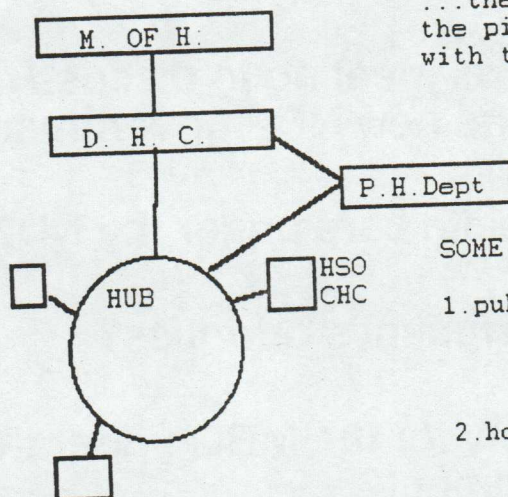
See page 4.

NOTES:

...the HUB becomes a focal point for community action around health issues and as such politicizes both community and health

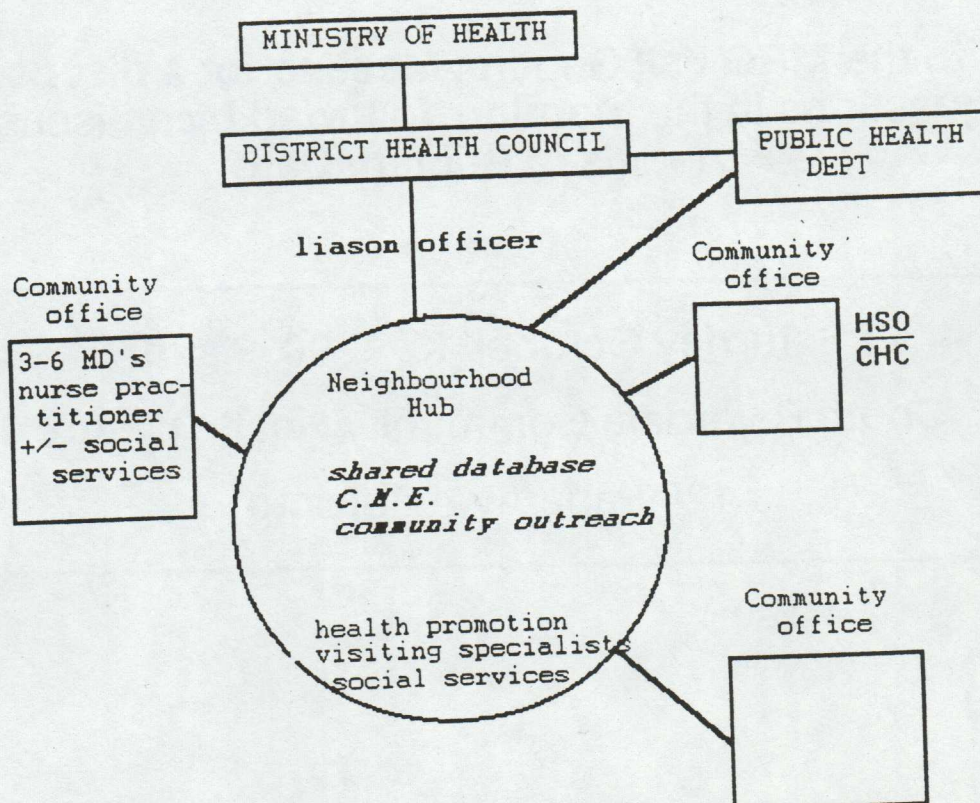
...the HUB also becomes the focal point for standards of health care thru C.M.E. and the role of the liason officer (L.O.)

...the L.O. is crucial in tying the pieces of the puzzle and works with the community, DHC, HUB, offices



SOME ISSUES OUTSTANDING:

1. public (democratic) input..how and when
 - DHC (schoolboard-like elections)
 - neighbourhood hub levels (community advisory boards)
2. how to encourage G.P.'s to join
 - benefits packages
 - C.M.E
 - administrative support (via liason officer)



The Medical Reform Group under an NDP government

**Come to the MRG's Fall General Meeting to discuss the
outlook for health care under the new NDP government...**

What are the prospects for health care under the NDP?

What are the new government's priorities?

**What are the implications if any for the MRG under the
new government?**

How can we best work for the implementation of our policies?

**Come to the MRG Fall General Meeting for a discussion of
these questions in the morning, followed by a discussion of
models of Primary Care**

**Saturday October 13, 1990, 9 a.m.
South Riverdale Community Health Centre
126 Pape Ave., Toronto**