BACKGROUND.

**Access to Primary Health Care**

Primary health care is traditionally defined as the first point of contact that a person has with the health care system. Statistics Canada figures tell us that almost 5 million Canadians do not have a primary health care provider and those that do often have a hard time accessing care. The situation in British Columbia is equally serious. In B.C., an estimated 1in 10 British Columbians are without a primary health care provider (IPSOS poll sponsored by BCMA 2011). This results in increased visits to emergency departments and unnecessary hospitalizations. Both of these methods of service are more costly to the health care system than community primary health care and they do not give the client the continuous care that enhances quality of service.

The importance of primary health care and the need to improve the system in Canada is clearly expressed in the Romanow Report (20) which mentions the "almost universal agreement that primary health care offers tremendous potential benefits to Canadians and to health care systems". The report also underlines the fact that Canadians place a great deal of importance on health promotion and disease prevention both of which are an integral part of the primary health care system.

Few would disagree that the primary health care system needs to respond better and faster to the health needs of British Columbians. However, in order to increase access to primary health care without significantly increasing health care costs, a new method of delivering services in British Columbia must be implemented. The current system of primary health care offered by family physicians on a fee-for-service basis will not increase access to primary health care services and will not contain costs. One of the most effective ways of expanding access to primary health care and one that is being implemented in many jurisdictions is the use of nurse practitioners. In this model, Nurse Practitioners work autonomously to their full scope of practice in a team setting under a salary method of payment.

**Nurse Practitioners in Canada**

The generic definition of Nurse Practitioners for use in Canada is as follows: "Nurse Practitioners are registered nurses with additional educational preparation and experience who possess and demonstrate the competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within their legislated scope of practice "(10). It is generally agreed that nurse practitioners can, within their scope of practice, provide primary health care services to individuals and families throughout their lifespan. "The focus of their practice is health promotion, preventive care, diagnosis and treatment of acute common illnesses and injuries and monitoring and management of stable chronic conditions" (10).

In Canada, the first University programme to graduate Nurse Practitioners was offered in 1967 at Dalhousie University in Halifax, Nova Scotia. The graduates of this programme, called Primary Healthcare Nurse Practitioners (PHCNPs), were generally nurses working in northern nursing stations. In the early 1970's, the Canadian healthcare system was experiencing a shortage of doctors and there was a great deal of support for an expanded role for nurses with the result that PHCNPs were introduced into southern urban communities. The Nurse Practitioner initiatives ended in the mid-1980's because of a perceived oversupply of physicians as well as the lack of a satisfactory remuneration mechanism for nurse practitioners, lack of applicable legislation and opposition from the medical profession. As a result, PHCNPs disappeared in all but remote areas and a few sites in southern Canada.

From the mid-1990's to the early 2000's, federal and provincial governments commissioned several studies on the health care system. In the reports from these studies, the use of nurses and other health care professionals was identified as a way to improve patient access to primary care services and to increase the emphasis on health promotion and disease prevention. (20).

All jurisdictions in Canada now license nurse practitioners; however there are still only just over 3000 licensed nurse practitioners in all of Canada to-day. Moreover, in many areas, they have not become a fully integrated part of the primary health care system and cannot work to their full scope of practice. That is because of restrictive legislation, lack of suitable funding models and an antiquated health care system that puts the emphasis on disease treatment rather than disease prevention and health promotion. In this regard, Canada lags behind many other countries where nurse practitioners are a fully integrated part of the Primary Health Care System. Nurse practitioners are widely used in European countries and in Australia and New Zealand.

In British Columbia, the first nurse practitioners were introduced into the health care system in 2005. Currently, there are more than 3,000 nurse practitioners in Canada but that number still looks small when compared to the 68,000 licensed physicians who practise in Canada. More than half of Canada's nurse practitioners work in Ontario. British Columbia has only slightly over 200 licensed nurse practitioners while there are 33,000 registered nurses and 6,000 general practice physicians. Even with this small number, only a small percentage of Nurse Practitioners in British Columbia are working to their full scope of practice and only a few positions have been created for them since the profession was regulated 7 years ago.(1) As a result, Nurse Practitioners are leaving the province to work in other jurisdictions where they can work as full primary care providers.

**Method of Payment/Health Promotion and Team Care**

The current fee-for-service payment system penalizes doctors who spend extra time with their patients discussing their overall health or who consult with other health professionals. As Dr. Meili points out in his recent book: "(Fee-for-service) results in some perverse incentives away from the best quality of care. For example, in Saskatchewan a clinic visit is classified as a 5B. and pays the same amount whether it's a cold or a new diagnosis of cancer. (…) In essence, the system encourages speedy care to minor problems and avoidance of complexity. Shifting to salary or mixed payment schedules encourages physicians to spend more time at the front end of care, taking the time to address all the issues of a patient before they get out of hand".(16) Fee –for-service also discourages physicians from doing health promotion work or from working in interdisciplinary teams. And yet health promotion decreases the need for primary health care services. Nurse practitioners are paid through a salary system of payment and take the time to work with their clients on keeping well. They also work as part of interdisciplinary health teams, which gives the clients a holistic approach to health.

One example of a successful team approach occurred in southwestern Saskatchewan where, in 1995, three doctors were serving three small towns. When two of the doctors died, the remaining doctor was left with a caseload of 3,200 people. In 1996, that doctor left fee-for-service payment and signed a contract with the health district to provide payment for himself and his "team". As the other part of the team, he hired the first graduate of a new nurse practitioner programme offered by Saskatchewan's Institute of Applied Science and Technology. To-day, the doctor for these three small towns works with three nurse practitioners, one in each town, as well as an extended team that includes mental health, public health and home care. As a result, the doctor is able to maintain a case-load more than twice that of the national average. In addition, 80-98% of non-emergency patients (depending on the town involved) are given an appointment within forty-eight hours of calling for one. (19)

**Quality of Care/ Patient Satisfaction**

The above example shows very clearly how the employment of nurse practitioners as primary care providers can increase access to primary care. Moreover, studies done on the employment of nurse practitioners as first point of contact indicate that there is no reduction in quality of service as a result. On the contrary, it is indicated that quality of care can be enhanced because nurse practitioners, who are on a salary method of payment, can take the time to talk to the patient about all of his/her health care needs rather than only discussing a specific problem and can educate the patient about ways to stay healthy. According to the studies done, this also results in greater patient satisfaction.

The Canadian Health Research Foundation has discovered that research that compares nurse practitioners with physicians providing primary care show that health outcomes are equivalent and, in the case of chronic disease management, patient outcomes improved. The CHRF also found that patients who saw a nurse practitioner reported "higher levels of satisfaction and better quality of care" when compared to physicians.(6)

A 2009 Harris/Decima poll (12) found that 72% of the Canadians surveyed believe that the role of nurse practitioners should be expanded in Canada and 77% would be comfortable seeing a nurse practitioner in place of their family physician. Harris/Decima senior Vice-President Jeff Walker sums up the attitude of Canadians as follows: "Canadians believe that expanding the role of nurse practitioners in the health system is both a medically and an economically effective idea. While in some jurisdictions the role of the nurse practitioner has expanded, there remain far more Canadians willing to see a nurse practitioner instead of their doctor than have seen one. This appears to be one of the potential remedies to pressure on the health system that Canadians are comfortable with".

**Cost Effectiveness**

When the nurse practitioner is part of an interdisciplinary team, the patient with related health problems can be referred to another health professional such as a Social Worker or a Nutritionist which will further increase the chances of preventing illness. This approach helps keep patients out of the hospital. Having access to a primary care provider keeps patients out of the emergency department. Providing primary care in a team setting and paying primary care providers through a salary method of payment rather than fee-for-service has proven to be less costly on a per patient basis.(19)

As a result, providing primary health care using nurse practitioners as first point of contact and allowing them to work in interdisciplinary teams reduces costs to the health care system. If you reduce the amount of time people spend in the hospitals, you drive down health care costs. By educating people on how to stay healthy nurse practitioners help to keep people out of hospitals. In addition, Canadians who cannot access a primary health care provider will use hospital emergency departments. It has been estimated that the cost of treatment of non-urgent health problems is 10 times more expensive in an emergency department than in a primary health care setting. For example, seeing a family physician for a sore ear, eye or throat can cost the health care system $30, whereas having the same problem treated in an emergency department can cost $300.(24) Yet Canadians are increasingly being forced to use emergency departments for non-urgent problems because they don't have access to a primary health care provider.

**Community Health Centres**

One of the very successful models of funding that increases primary health care services, employs nurse practitioners as autonomous, fully integrated primary health care providers working to their full scope of practice, emphasizes health promotion and disease prevention and uses a salary method of funding is the Community Health Centre.

Community Health Centres (CHC's) have been in existence in Canada since the 1920's. Currently, CHC's provide health care to over 2 million Canadians, most of them living in Quebec and Ontario. Generally, they function as incorporated, non-profit organizations governed by a Board of Directors made up of Community members. The Board of Directors establishes a budget and receives funding based on this budget from the public health insurance system of the province in which they operate.

The CHC is the first point of contact into the health care system for its clients. It offers an interdisciplinary approach so that nurse practitioners, family physicians, nutritionists, nurses, health promoters and other care providers work together as a team to provide comprehensive care under one roof. The health care providers at a CHC are generally on salary. Through its interdisciplinary approach, the CHC provides primary health care and emphasizes health promotion and disease prevention. As a result, the CHC is an ideal funding model for nurse practitioners to work autonomously in a team setting to their full scope of practice.

A recent study conducted by the Institute for Clinical Evaluation Services (ICES) compares seven different primary care models in Ontario. The study found that Ontario's Community Health Centres are the most effective model for keeping people out of the emergency departments even though they serve populations with more complex health needs. The study found that visits to the emergency department by CHC clients was 21% less than expected while emergency use by clients from other models was as much as 11% higher than expected even though their clients were wealthier and healthier. "CHCs' comprehensive services and their focus addressing the social determinants of health are two potential reasons for CHCs' strong results in the study". (11) The study's authors also suggest that longer appointment time at CHC's because of the salaried method of payment could be a contributing factor to these results.

Currently, the use of CHC's in British Columbia is very limited. The establishment of CHC's would be a very effective way to increase access to primary care in the province without increasing cost to the health care system. Indeed, the money saved through reduced use of hospital beds and emergency departments would be more than enough to fund CHC's. This would also make full use of nurse practitioners in the province giving them the incentive to stay and not seek employment elsewhere.

**Conclusion**

We are asking the provincial government to improve access to primary health care in BC by increasing the role of Nurse Practitioners and ensuring that they are working to their full scope of practice. In order to do this, restrictive legislation will need to be eliminated and primary health care funding models will have to be developed which allow Nurse Practitioners to work autonomously within an interdisciplinary team.