



The importance of Community Health Centres in BC's primary care reforms

What the research tells us

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Community Health Centres (CHCs) have been an effective but under-valued model for delivering primary health care¹ for decades in Canada and the US. One of the unique features of the model is its strong focus on the social determinants of health and preventing acute illness among groups who are more likely to experience poor health and suffer from chronic conditions, including low-income people, ethno-cultural communities, Indigenous peoples, and frail seniors.

1 *Primary health care* refers to a system-wide approach to designing health services based on primary care as the first point of contact in a system with a focus on addressing the social determinants of health and reducing avoidable disparities in health outcomes between different groups in society. A large body of evidence demonstrates that primary care is the foundation of an effective, efficient and high-performing health care system. *Primary care* refers to the clinical level of primary health care, which should serve as the first point of contact with the health care system and where the majority of health problems are identified, treated and where other health and social care services can be mobilized and coordinated to prevent illness and support wellness.

So what are Community Health Centres? CHCs are non-profit primary care organizations that provide integrated health care and social services, with a focus on addressing the social determinants of health. Five commonly accepted characteristics include:

1. CHCs provide team-based interprofessional primary care that includes a range of health care and social service providers, including social workers, family physicians, nurse practitioners, nurses, dietitians, occupational therapists, clinical pharmacists, physiotherapists, respiratory therapists, cross-cultural health brokers, First Nations elders, mental health counsellors, and outreach workers, among others.
2. CHCs integrate medical care, mental health and substance use services, health promotion and chronic disease management programs. Many CHCs also provide vision and dental care.
3. CHCs are community-governed and responsive to the patients/members they serve. This means that they are legally established as non-profit societies or co-operatives and provide open membership to their patients (who are members of the organization). It also means that patient-members can participate on the board of directors and in other parts of the governance of the organization.
4. CHCs actively address the social determinants of health such as poverty, access to housing, education, language barriers and other factors that have a direct impact on health. CHCs take an upstream approach intended to prevent illness and promote wellness.
5. CHCs demonstrate commitment to health equity and social justice, and recognize that disparities in health status among the population are socially, economically, and institutionally structured—and that these disparities are avoidable and unfair. CHCs work to eliminate these health inequities through a community development approach and advocating for public policies that address the upstream determinants of health, including fair taxation, living wages, decent working conditions, safe and affordable housing and quality public services.

On February 1, 2019, the BC Health Coalition, Canadian Centre for Policy Alternatives, and Health Sciences Association of BC convened an invitational roundtable followed by a public talk in response to growing interest in the CHC model from communities across the province. That interest has also been taken up by government; in 2017, the NDP made an election campaign commitment to support the development of new (and existing) CHCs—a commitment that was re-affirmed in the new government's May 2018 primary care directions.

Over 70 people from a broad range of community non-profit and health sector organizations participated in the roundtable including health professionals, immigrant and newcomer-serving organizations, the Ministry of Health, Divisions of Family Practice and Health Authority representatives, the First Nations Health Authority, seniors' organizations, the BC Rural Health Network, and leaders from the CHC sector in BC. Participants heard how CHCs in Ontario, Saskatchewan, and Oregon provide responsive, team-based primary care that is community-led and that has proven very effective in addressing the unmet needs of vulnerable populations as well as the broader neighbourhoods and communities where they are situated (audio available below).

As BC moves to support a role for CHCs within a larger agenda for reforming primary care, what can we learn from other jurisdictions where CHCs are integrated into the broader primary care system? How can we support CHCs in BC to be leaders in improving the quality of care for the entire health system?

Lessons from Community Health Centres in the United States and Canada

The jurisdictions in North America that have been successful in developing the CHC model have demonstrated improvements in health outcomes, access to care and cost-savings for higher-needs populations.

In BC, we're lagging behind those other jurisdictions, which include the United States and Ontario.

LEARNING FROM THE UNITED STATES

In the United States, CHCs emerged in the 1960s based on the work of community health and civil rights activists, who fought to improve the lives of Americans living in poverty and in need of health care. The first two CHCs were established in 1965 with the creation of the federal Community Health Centres program. This program was mandated in the Economic Opportunity Act of 1964 as part of "America's War on Poverty."² Not surprisingly, the federal CHC program has a strong focus on addressing the root causes of ill health—the social determinants of health. The program also requires that at least 51 per cent of CHC board members must be patients of the clinic.³

Today in the United States, there are approximately 1,370 CHCs across the country, delivering care to almost 28 million people.⁴ This large, non-profit and community-governed sector plays a vital role as the social safety net for the broader primary care system. In the US, CHCs serve predominately publicly insured (i.e. Medicaid or low-income) or uninsured patients.⁵ More specifically, US CHCs serve the following patients:

- » 82 per cent of patients are uninsured or publicly insured⁶ and, therefore, CHCs provide care to a large share of the publicly funded health system in the US;
- » 1.36 million patients are homeless;⁷
- » 91 per cent of patients are in, or near, poverty;⁸
- » 63 per cent of patients are members of racial/ethnic minority groups;⁹
- » US CHC patients suffer from chronic conditions at higher rates than the general population, and yet CHCs achieve higher rates of hypertension and diabetes control than the national average;¹⁰ and,
- » US CHCs provide more preventive services than other primary care providers.¹¹

2 RCHN Community Health Foundation (n.d.), "Community Health Centers: Chronicling Their History and Broader Meaning," [CHC Chronicles](#).

3 Brad Wright (2013), [Who governs federally qualified health centers?](#) *Journal of Health Politics, Policy, and Law* 38(1), p. 27.

4 National Association of Community Health Centers (2019), *Community Health Center Chartbook*, Washington, DC: NACHC, pp. 2, 23.

5 National Association of Community Health Centers (2019), *Community Health Center Chartbook*, p. 2. Medicaid is the public insurance plan for low-income Americans.

6 National Association of Community Health Centers (2019), *Community Health Center Chartbook*, p. 14.

7 National Association of Community Health Centers (2019), *Community Health Center Chartbook*, p. 11.

8 National Association of Community Health Centers (2019), *Community Health Center Chartbook*, p. 13.

9 National Association of Community Health Centers (2019), *Community Health Center Chartbook*, p. 19.

10 National Association of Community Health Centers (2019), *Community Health Center Chartbook*, pp. 20, 36.

11 National Association of Community Health Centers (2019), *Community Health Center Chartbook*, p. 40.

Despite providing care to a disproportionate number of higher-needs population groups, a 2009 literature review of five peer-reviewed studies concluded that US CHCs were associated with lower health care costs.¹² Some of these cost studies found that CHC patients had lower rates of emergency department visits and hospitalization than non-CHC patients.

LEARNING FROM ONTARIO

In Canada, CHCs grew out of local community organizing, especially in low-income areas where community members identified the need for better access to comprehensive primary care services. At the time there was concern about containing public health care costs, as the dominant fee-for-service physician compensation model was placing pressure on provincial health budgets—a challenge that remains today.¹³

The first Canadian CHC was established in Winnipeg in 1926. Today there are approximately 300 CHCs represented by the Canadian Association of Community Health Centres. A quarter of these are located in Ontario where CHCs have a long history of growth and sustained support by government including core funding of just over \$400 million in 2016/17 and \$96 million in additional funding from other sources (e.g. foundations, other provincial ministries and other levels of government).¹⁴ Ontario CHCs serve about 500,000 patients each year—about four per cent of the Ontario population.¹⁵ Compared with the Ontario population, CHC served populations “that were from lower income neighbourhoods, had higher proportions of newcomers and those on social assistance, had more severe mental health illness and chronic health conditions, and had higher morbidity and comorbidity.”¹⁶

CHCs in Ontario are globally funded (one funding envelope to cover all operating and staffing costs) by the Ontario Ministry of Health through their respective Local Health Integration Network (LHIN) (similar to BC's regional health authorities) and accountable to their LHIN.¹⁷ The global funding model is critical to their success because it gives them considerable flexibility to hire staff and develop services appropriate to the specific needs of their patient population and to also shift funding priorities in response to changes in community needs and demographics.¹⁸ It also opens up opportunities for them to develop innovative funding partnerships to support new community initiatives, sector-wide improvement strategies and needed infrastructure.

Global funding models, where physicians are paid a salary (with benefits and pension) in the same way as other staff, is very different from the situation that exists in most family doctors' offices. When physicians

12 Sonya Streeter et al. (2009), *The Effect of Community Health Centers on Healthcare Spending and Utilization*, Avalere Health (literature review prepared for the National Association of Community Health Centers), p. 3.

13 Patricia A. Collins, Sarah J. Resendes, and James R. Dunn (2014), *The untold story: examining Ontario's Community Health Centres' initiatives to address the upstream determinants of health*, *Healthcare Policy* 10(1), pp. 14-29; Andrew Longhurst (2019, January 15), *How (and how much) doctors are paid: why it matters*, *Policy Note*, Canadian Centre for Policy Alternatives—BC Office.

14 Office of the Auditor General of Ontario (2017), *Community Health Centres (3.03)*, *2017 Annual Report*, pp. 180, 189.

15 Office of the Auditor General of Ontario (2017), *Community Health Centres (3.03)*, p. 185.

16 Richard H. Glazier, Brandon M. Zagorski, and Jennifer Rayner (2012), *Comparison of Primary Care Models in Ontario by Demographics, Case Mix and Emergency Room Use, 2008-09 to 2009-10*, Toronto: Institute for Clinical Evaluative Sciences, p. iii.

17 Office of the Auditor General of Ontario (2017), *Community Health Centres (3.03)*, p.189. All other primary care models are funded directly by the Ontario Ministry of Health/Ontario Health Insurance Plan. It is also worth noting that each CHC has an accountability agreement with their LHIN. Other primary care models do not have accountability agreements because non-CHC physicians are remunerated by the Ontario Ministry of Health/Ontario Health Insurance Plan (OHIP).

18 The only budget line that the clinic cannot change is the number of practitioners (i.e. physicians and/or physicians and nurse practitioners). But in most CHCs, these practitioners represented a minority of their total budget allocation.

are compensated on a fee-for-service basis, the payment goes to the physician, rather than to a team or organization, and the compensation is tied to the volume of procedures performed. This creates disincentives to working with other providers and developing collaborative strategies for improving quality and cost-effectiveness of care—concerns raised by BC's Auditor General, the Alberta Medical Association, and Conference Board of Canada, among others.¹⁹

Evidence of the value of Ontario's CHC model is provided in research studies from 2009 and 2012 comparing Ontario's 75 CHCs with the other primary care models in Ontario. This research shows that CHCs are more effective in managing chronic conditions,²⁰ reducing emergency visits,²¹ and improving access to care for people with serious mental health issues.²² As the 2012 study from the Institute for Clinical Evaluative Sciences (ICES) concludes, CHCs “stood out in their care for disadvantaged and sick populations and had substantially lower emergency department visit rates than expected.”²³ This suggests that CHCs may be a more cost-effective model for providing primary care, particularly for high needs, vulnerable populations who are high users of health services.²⁴ To date, however, there is no conclusive evidence on their cost-effectiveness due to the lack of available data in Canada to enable effective cost comparisons across primary care models.

The 2017 Ontario Auditor General report on CHCs made a similar point around the lack of data to ascertain cost-effectiveness. At the same time, the Auditor's report acknowledges the positive contribution CHCs make in “reducing the strain on the health care system and other provincial programs” because of the vulnerable populations they serve.²⁵ The Auditor General also outlined a number of areas where the CHC sector could improve its performance, including reducing variation in panel size (i.e. the number of patients per physician) and services. But the Auditor General directed their strongest critique to the Ontario Ministry of Health and LHINs for their failure to establish accountability mechanisms and provide appropriate oversight of the sector.

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- 19 Auditor General of BC (2014), *Oversight of Physician Services*, pp. 27-28; Conference Board of Canada (2012), *Improving Primary Health Care Through Collaboration: Briefing 2—Barriers to Successful Interprofessional Teams*; Daniel Muzyka (2012), *The Inconvenient Truth about Canadian Health Care*, Conference Board of Canada; Alberta Medical Association report quoted in Marcy Cohen (2014), *How Can We Create a Cost-Effective System of Primary and Community Care Built Around Interdisciplinary Teams?* Submission to the Select Standing Committee on Health, Vancouver: Canadian Centre for Policy Alternatives—BC Office, p. 12. See also: Andrew Longhurst (2018), *How (and how much) doctors are paid in BC: why it matters*, *Policy Note*, Canadian Centre for Policy Alternatives—BC Office.
- 20 Grant M. Russell et al. (2009), *Managing chronic disease in Ontario primary care: the impact of organizational factors*, *Annals of Family Medicine* 7(4), pp. 308-318.
- 21 Richard H. Glazier, Brandon M. Zagorski, and Jennifer Rayner (2012), *Comparison of Primary Care Models in Ontario by Demographics, Case Mix and Emergency Room Use, 2008-09 to 2009-10*, Toronto: Institute for Clinical Evaluative Sciences, p. 26. The study concluded that “CHCs stood out in their care of disadvantaged and sicker populations and had substantially lower ED visit rates than expected” (p. iv).
- 22 Glazier et al. (2012), *Comparison of Primary Care Models in Ontario by Demographics, Case Mix and Emergency Room Use, 2008-09 to 2009-10*, p. 9. This information is from a power point slides prepared by Adrianna Tetley (Executive Director, Alliance for Healthier Communities) showing that the portion of CHC patients with a serious mental illness is more than twice that of other primary care models in Ontario.
- 23 Glazier et al. (2012), *Comparison of Primary Care Models in Ontario by Demographics, Case Mix and Emergency Room Use, 2008-09 to 2009-10*, p. iv. The 2017 Ontario Auditor General's report references articles from 2015 suggesting that CHCs had higher rates of hospital readmissions and emergency visits, but unlike the Glazier et al. 2012 study, the Conference Board research does take into account patient complexity (see Office of the Auditor General of Ontario, 2017, p. 194).
- 24 A large body of evidence shows that people with lower incomes have worse health outcomes, higher rates of chronic conditions and lower life expectancies. Chronic conditions account for nearly 67 per cent of health care costs in Canada (Provincial Health Services Authority (2011), *Towards Reducing Health Inequities: A Health System Approach to Chronic Disease Prevention. A Discussion Paper*).
- 25 Office of the Auditor General of Ontario (2017), *Community Health Centres (3.03)*, p. 185.

A 2016 Ontario Auditor General's report, investigating the effectiveness of the different physician compensation models available in Ontario, raised similar concerns about the lack of oversight by the Ontario Ministry of Health. That report raised concerns about both the inability to control costs under the fee-for-service payment model as well as the inability of other primary care models (referred to patient enrollment models) to demonstrate improvements in patient access to care despite increased public spending associated with them.²⁶ The report also identified very large variations in compensation levels among different physician specialties.²⁷

The responses from the Ontario Association of CHCs (now called Alliance for Healthier Communities) and the Ontario Medical Association have been very different from one another. The Ontario Medical Association has been in binding arbitration with the Ontario Ministry of Health since 2018 (a settlement was reached in February, 2019), which largely centred on the Ontario government's concerns about value-for-money among both the patient enrollment models and traditional fee-for-service physician remuneration.

On the other hand, the Alliance for Healthier Communities (formerly the Association of Ontario CHCs) has embraced the Auditor General's report²⁸ and has been working with the Ministry of Health, the LHINs, the Canadian Institute of Health Information, and Health Quality Ontario to increase their capacity to share information, adopt standardized quality improvement indicators and develop a funding methodology that includes both clinical complexity and social/economic vulnerability.²⁹

For example, the Quality Improvement Plan for 2018/19 developed between the Alliance for Healthier Communities and Health Quality Ontario uses multiple measures and sources of information including administrative measures, chronic condition quality measures, screening measures, health equity information, community initiatives (i.e. best practices), socio-demographics, service utilization and a comprehensive costing of all services provided.³⁰

As early as 2012, well before the Auditor General's 2017 report, the Ontario CHC sector began prioritizing the use of data and research to identify where improvements could be made to enhance both the quality and cost-effectiveness of the care they provide. One particularly telling example was the capacity of Ontario CHCs to pool resources (with global funding) and purchase a single Electronic Health Record (EHR) system for the entire CHC sector in Ontario.³¹ The shared EHR has allowed CHCs to share key data, and use it to inform quality improvement initiatives.

The focus on improvement began with a research partnership between the Alliance for Healthier

26 In other primary care models, often referred to as patient enrollment models (i.e. capitation) physicians are paid for the number of patients enrolled with their practices and for a predetermined basket of services. In the Ontario patient enrollment model there is no adjustment for the differences in the complexity of health needs among different patient populations, and as a consequence, there is nothing to guard against practices favouring a patient population with lower complexity.

27 Office of the Auditor General of Ontario (2016), *Physician Billing, 2016 Annual Report*.

28 Alliance for Healthier Communities (2017, December 20), [Auditor General's Report on Community Health Centre: Response from Alliance for Healthier Communities](#).

29 Personal communication with Jennifer Rayner, Director of Research & Evaluation, Alliance for Healthy Communities, February 12, 2019. Ontario's Family Health Teams (one of the province's primary care models) are the only other model that is required to develop and submit quality improvement plans to Health Quality Ontario (the provincial agency that supports health care quality improvement).

30 Health Quality Ontario (2018, January), [Indicator Technical Specifications 2018/19 Quality Improvement Plans](#).

31 This work was coordinated through the Alliance for Healthier Communities (previously the Ontario Association of Community Health Centres).

Communities and Ontario's Institute for Clinical Evaluative Studies (ICES). ICES researchers worked with the Alliance to give them access to a validated measurement tool for determining the appropriate size of their physicians' panels based on the complexity of their patients. With that data in hand, each CHC could see the variation in their panel size and began to address disparities in access to care.

At the February 1st BC CHC roundtable, Simone Thibault (Centretown CHC, Ottawa) noted that the use of data—combined with the enabling support provided by various provincial agencies—has been critical to improving quality and access:

We do have clients, community members, and staff who participate in our quality improvement plan... We are now looking at [separating our client data by population group]. It's one thing to say great, we're doing well on cancer screening when it comes to this particular population... We're starting to look at [analyzing the data by population group] because that's where we're going to be seeing the real truth. We may be doing well overall, but maybe we're not doing so well with these [at-risk] populations and it's important for equity to pay attention to that. ... And because we have a common electronic health record across the province, we are able to compare how we're doing with other CHCs.

This recent history shows how Ontario CHCs are on the forefront of primary care models in their commitment to using data and research to inform their quality improvement efforts.

Why has the CHC model struggled to take hold in British Columbia and where do we go from here?

Like elsewhere in the 1970s, a handful of CHCs were established in BC as part of the broader CHC movement in Canada and the US. Early support for the development of CHCs can be traced to the BC NDP government in the early 1970s. And although the Social Credit government ended support for CHCs in the mid-1970s, a few CHCs continued to operate.³²

In 1991, BC's Royal Commission on Health Care and Costs—known as the Seaton Commission—identified CHCs an important model for delivering team-based primary health care with a focus on addressing the social determinants of health. While acknowledging that there had been historical opposition from physicians, the Commission recommended that the government support the development of CHCs in BC.³³ The reasons that the CHC sector struggled to develop in BC is complex. However, opposition from the BC Medical Association (now called Doctors of BC) to non fee-for-service forms of physician compensation was a significant factor.³⁴ It was one of the main reasons why the NDP government of the 1990s backed away from scaling up the CHC model despite the Seaton Commission's recommendation and BC Ministry of Health policy supporting CHCs.³⁵

32 Anne Crichton, Ann Robertson, Christine Gordon, and Wendy Farrant (1997), Medical Practice Organizations: Alternative Medical Care Delivery Models, in *Health Care: A Community Concern?* Chapter 11, pp. 105-106.

33 BC Royal Commission on Health Care and Costs (1991), *Closer to Home*, Vol. 1, Victoria: Government of BC, p. 16.

34 See, for example, the BC Medical Association's (now called Doctors of BC) opposition to alternatives to fee-for-service compensation including the population-based capitation model: BC Medical Association (1995), *Capitation: A Wolf in Sheep's Clothing?* Vancouver: BCMA.

35 Marcy Cohen (2005), *Democratizing Public Services: Lessons from Other Jurisdictions and Implications for Health Care Reform in BC*, Vancouver: Canadian Centre for Policy Alternatives—BC Office.

From 2001–2017, CHCs garnered little attention and support from the provincial government and health authorities. Some very well-established and well-recognized CHCs were closed (e.g. Victoria's James Bay CHC and Pine Street Clinic). And yet, interest in the CHC model has continued to grow with many local communities managing to cobble together enough funding to deliver on at least some of the key attributes of the Community Health Centre model. In 2016, these organizations joined together to form the BC Association of Community Health Centres. The Association asked for a commitment from the BC NDP during the 2017 provincial election to expand CHCs and received a commitment by the BC NDP to establish twenty new CHCs by 2020.

The first opening for CHCs in more than 20 years came in May 2018, when BC's government announced its primary care policy directions would focus on several models, including Urgent Primary Care Centres, Primary Care Networks (PCNs), and Community Health Centres. To date, Urgent Primary Care Centres and Primary Care Networks are the furthest ahead in terms of implementation, in part because these new models have secured Ministry of Health funding and an implementation plan.

Last year, a number of stakeholders—including the BC Health Coalition, BC Association of Community Health Centres, Rural Health Network, immigrant and newcomer-serving organizations, and health care practitioners—were consulted by the Ministry of Health on a provincial CHC policy framework. The intent of that framework is to support the existing CHC sector as well as the development of new CHCs in communities that could benefit from this model and where there is significant community interest. Community stakeholders are looking forward to working with government on a provincial CHC implementation strategy.

As CHC leaders from Oregon, Saskatchewan and Ontario have noted, the CHC model also could go a long way in addressing the workforce challenges of recruiting and retaining family physicians and other health care professionals. In BC, where patients struggle to find a family physician, the CHC model can attract new family medicine graduates who prefer alternatives to fee-for-service payment, such as a salary that provides a predictable income as well as a pension and other benefits. There are many family physician voices looking for team-based care models and alternatives to fee-for-service remuneration, making CHCs an attractive workplace setting for the new generation of graduating family physicians.³⁶ For other providers, it is an opportunity to work to full scope of practice (i.e. fully use your skills/expertise) with a team of providers who are committed to teamwork and quality improvement.³⁷

The CHC model is well-positioned to address the primary health care challenges we face in both rural and urban British Columbia, while also helping to reduce health care costs through quality improvement and addressing the social determinants of health.

We have the evidence that Community Health Centres could play a very positive role in BC's primary care transformation efforts.

Let's take these lessons seriously and get started.

36 Vanessa Brcic, Margaret J. McGregor, and Janusz Kaczorowski (2012), Practice and payment preferences of newly practicing family physicians in British Columbia, *Can Fam Physician* 58(5), pp. e275-e281.

37 Andrew Longhurst (2018), *Achieving High-Performing Primary and Community Care: The Critical Role of Health Science Professions: Full Report and Recommendations from the Primary and Community Care Conference*, Health Sciences Association of BC.

Further learning

Listen to audio from the February 1, 2019 roundtable, *The Promise of Team-Based Primary Health Care: The Importance of Community Health Centres in BC's Primary Care Reforms*, convened by the BC Health Coalition, Canadian Centre for Policy Alternatives' BC Office, and the Health Sciences Association of BC.

LEARNING FROM OTHER JURISDICTIONS

In the first panel discussion, Simone Thibault (Executive Director, Centretown CHC in Ottawa), Lisa Clatney (Executive Director, Saskatoon Community Clinic), and Gil Muñoz (Chief Executive Officer, Virginia Garcia Memorial Health Center, Hillsboro, Oregon) reflected on the important role CHCs have played in their respective jurisdictions. The panel was moderated by Marcy Cohen (Canadian Centre for Policy Alternatives' BC Office). Listen at: https://soundcloud.com/policyalternatives/chcs-in-bc_panel-1

THE SITUATION IN BC

In the second panel discussion, leaders and practitioners from BC's CHCs discussed the benefits of the services they provide—and why a bigger role for CHCs in BC holds great potential for patients, providers, diverse communities and for the overall health system:

- » Moderator: Zarghoona Wakil, MOSAIC/Umbrella Multicultural Health Co-op
- » Esther Hsieh, Executive Director at Umbrella Multicultural Health Co-op, New Westminster
- » Edward Staples, Chair of the BC Rural Health Network
- » Grey Showler, President of the BC Association of Community Health Centres and Director of Health and Support Services at Victoria Cool Aid Society

Listen at: https://soundcloud.com/policyalternatives/chcs-in-bc_panel-2

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