PHC mix of models, performance and context

By

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PHC Cost-Effectiveness Research Project
Think Tank 2

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Contexts,
Mix and performance of PHC models

3 Ideas

- Contexts
- Contexts and Mix of PHC Models
- Contexts and Performance of PHC Models

1 Source

- Research project in Quebec
  - PHC in urban and rural settings : Organisation Models & Effects

Contexts

- **Definition**
  - Important, different and identifiable circumstances influencing the values, attitudes and behaviours of people
- **2 dimensions differentiating contexts**
  - Composition :
    - Characteristics of individuals
  - Circumstances
    - Characteristics of contexts
- **Quebec study : 3 characteristics of environment**
  - Size of Population size of municipalities
  - Distance from Urban centres : Montreal and Quebec
    - UrbCE, UrbPE, RurPE, RurRE
  - Availability of healthcare resources within 15 minutes distance

PHC organisation Models & Geographical areas

	Professional Contact			Professional Coordination		Community	Total
	Solo	Groups					
	Closed	Closed	Open	PHC	System	Integrated	
UrbCE	**41%**	**11%**	**30%**	6%	10%	2%	100%
UrbPE	0%	**29%**	**17%**	**42%**	0%	*11%*	100%
RurPE	**50%**	0%	*15%*	*19%*	7%	*9%*	100%
RurRE	**24%**	**25%**	0%	**14%**	**28%**	**10%**	100%
Total	38%	12%	24%	12%	10%	4%	100%

GRIS
Groupe de recherche interdisciplinaire en santé
Faculté de médecine, Université de Montréal

Université de Montréal

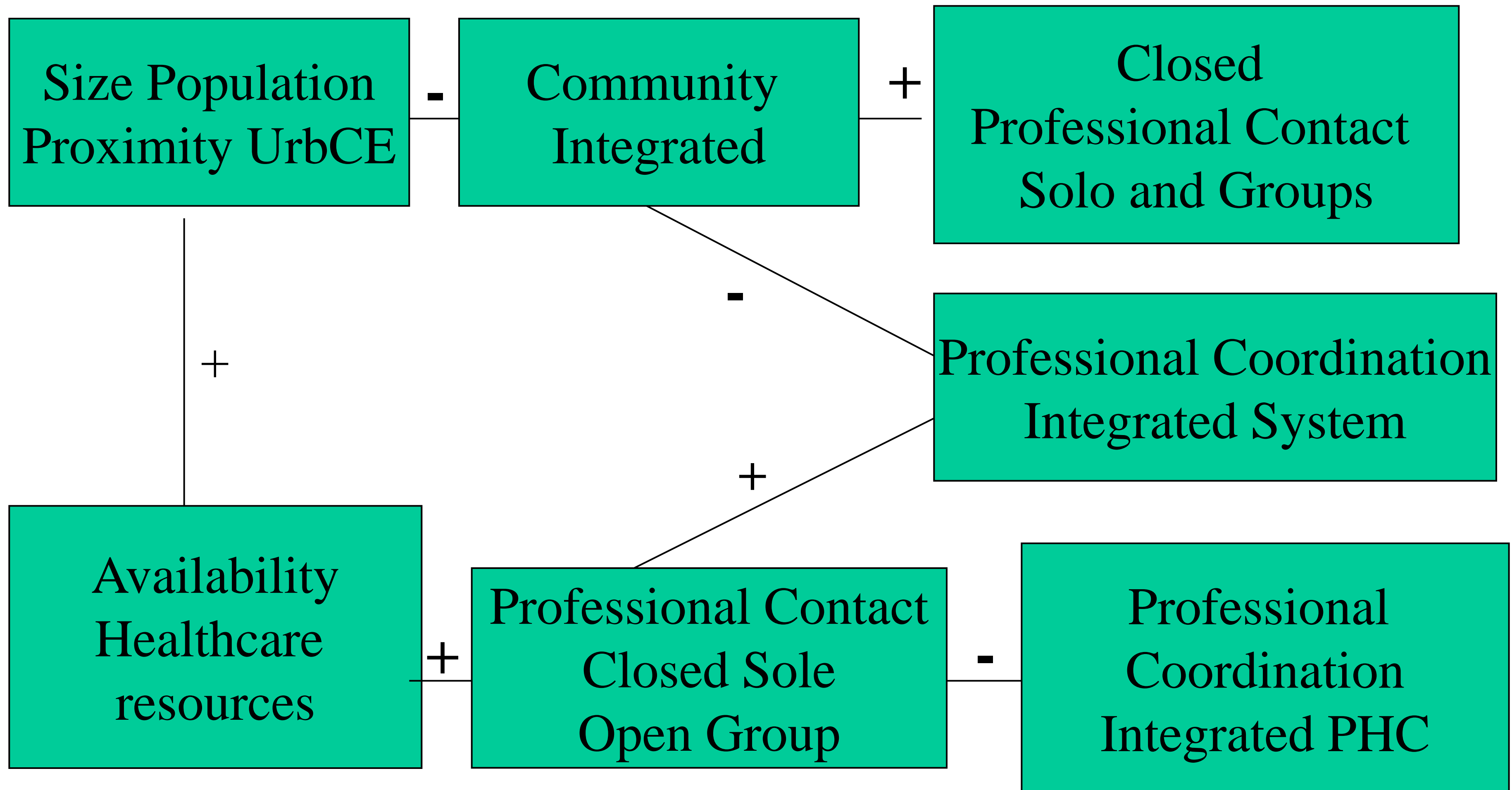
PHC organisation Models & PHC Resources

	Professional Models					Community Model	
	Contact			Coordination			
	Solo closed	Group Open	Group Open	Integrated PHC	Integrated System	Integrated	Total
Few	19%	16%	19%	26%	10%	10%	100%
Average	66%	9%	20%	3%	3%	0%	100%
Plus	26%	9%	35%	9%	18%	3%	100%
Total	38%	11%	25%	12%	10%	4%	100%

PHC organisation Models & Sub specialty Hospitals

		Professional Contact			Professional Coordination		Community Integrated	Total
		Solo	Groups					
		Closed	Closed	Open	PHC	All levels		
Nb Sub specialized Hospitals	None	15,4%	15,4%	7,7%	**30,8%**	**23,1%**	**7,7%**	100,0%
	Few	0,0%	0,0%	**25,0%**	**50,0%**	0,0%	**25,0%**	100,0%
	More	**43,4%**	**10,8%**	**26,5%**	7,2%	8,4%	3,6%	100,0%
Total		38,4%	11,1%	24,2%	11,1%	10,1%	5,1%	100,0%

Factors related to configuration of PHC models



Context and Health Care Experience

All users	Rank of presence of effect : Rank 1 > OR			
	RurRe	RurPE	UrbPE	UrbCE
ORGANISATIONAL ACCESSIBILITY	**1**	**2**	**3**	**4**
Ease of contact	1	2	3	4
Accessibility in urgent situation	1	2	3	3
CONTINUITY	**1**	**2**	**3**	**4**
Relational continuity	1	2	2	4
Management continuity	1	2	3	4
Information continuity	1	2	3	4
RESPONSIVENESS	**1**	**3**	**2**	**4**
Patient considered as a person	1	3	2	3
Time aspect	1	3	2	4
USE OF SERVICES	**1**	**2**	**3**	**3**
PHC	1	2	3	3
Specialists MS	1	3	3	1
ER	1	2	2	4
GLOBAL : RANK	**1**	**2**	**3**	**4**
Sum of ranks	4	9	11	15

PHC organisation Models & Effects

Rank of presence of effect controled for vulnérability : Rank 1 > OR	Contact Solo Closed	Coordination All levels	Community Integrated	Coordination PHC	Contact Groups Closed	Contact Groups Open
ORGANISATIONAL ACCESSIBILITY	**1**	**2**	**2**	**2**	**5**	**6**
Ease of contact	1	2	4	3	3	4
Accessibiliti in urgent situation	3	3	1	2	3	3
CONTINUITY	**1**	**3**	**3**	**5**	**2**	**6**
Relational continuity	1	5	4	2	3	6
Management continuity	1	1	1	5	1	6
Information Continuity	2	1	2	2	2	2
RESPONSIVENESS	**1**	**1**	**2**	**2**	**2**	**6**
Patient considered as a person	1	2	3	3	3	3
Time aspect	2	1	2	2	2	6
USE OF SERVICES	**3**	**1**	**3**	**2**	**3**	**3**
PHC	1	1	1	1	1	1
Specialists MS	1	1	1	1	1	1
ER	3	1	3	2	3	3
GLOBAL RANK	**1**	**2**	**3**	**4**	**5**	**6**
Sum of ranks	**6**	**7**	**10**	**11**	**12**	**21**

PHC organisation Models & Geographical areas

	Professional Contact			Professional Coordination		Community	Total
	Solo	Groups				Integrated	
	Closed	Closed	Open	PHC	All levels		
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Context : Observed – Expected ranks

	RurRE	RurPE	UrbPE	UrbCE
ORGANISATIONAL ACCESSIBILITY	**0**	**-2**	**-1**	**-2**
Ease of contact	0	-1	1	-3
Accessibiliti in urgent situation	0	-1	-2	1
CONTINUITY	**2**	**-1**	**3**	**-5**
Relational continuity	2	-1	2	-2
Management continuity	0	0	0	-2
Information Continuity	0	0	1	-1
RESPONSIVENESS	**2**	**-3**	**4**	**-4**
Patient considered as a person	2	-2	2	-2
Time aspect	0	-1	2	-2
USE OF SERVICES	**0**	**-2**	**-4**	**-3**
PHC	0	-1	-2	-2
Specialists MS	0	-2	-2	0
ER	0	1	0	-1
TOTAL DISCREPANCY	**4**	**-8**	**2**	**-14**

Sub specialty Hospitals & Observed – Expected Ranks

	Expected minus observed		
	Nb CH ultra-spécialisés		
RR Nb CH ultraspécialisés/effet sans vulnérabilité ni interaction	**Aucun**	**1-10**	**11 & +**
ORGANISATIONAL ACCESSIBILITY	**1**	**1**	**-2**
Ease of contact	1	1	-2
Accessibiliti in urgent situation	0	0	0
CONTINUITY	**3**	**6**	**-2**
Relational continuity	3	4	-1
Management continuity	0	1	-1
Information Continuity	0	1	0
RESPONSIVENESS	**1**	**2**	**-1**
Patient considered as a person	1	1	-1
Time aspect	0	1	0
UTILISATION DES SERVICES	**0**	**-1**	**-1**
Intensité utilisation 1ère ligne	0	-1	-1
Intensité utilisation spécialistes	0	0	0
Utilisation urgence	0	0	0
TOTAL DISCREPANCY	**5**	**8**	**-6**

Implications for Economic Evaluation of PHC

1. **Need capture the Mix of PHC Models which populations exposed to** : Limited number
    - Models Performance Related to Other Models co-exist
2. **Need capture main context characteristics**
    - Socio-demo--Geographic characteristics
    - Health care resources availability
    - Social cohesion
3. **Focus on fit combination PHC models to context**
    - Not on single characteristics of Models
    - Not on Models independently
    - But on mix of Models in their context