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Review Article

Primary Health Care in Canada: Strengths, Challenges and Learned Lessons

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Abstract

Background: Canada has vast geographical areas, diverse populations, and different local systems providing primary care. These factors have contributed to some of the challenges that are faced by the Primary Health Care system.

Objective: This paper explores the current state of the PHC system in Canada, highlighting some of the strengths of the system and learned lessons. This review critically analyzes the key challenges that PHC face, including access to care, particularly focusing on access to vulnerable populations, as well as program coordination to address issues of these populations.

Results: In Canada, Primary Health care plays an important role as gate keepers. It provides comprehensive care with a wide range of services. Access to care has proven to one of the key challenges. Some populations have inequitable access to health care compared to other groups, and this can result in poorer health outcomes. Lack of coordination across different providers with different organizations managing different layers of care is another key challenge to primary care system.

Conclusion: Health care in Canada- provides coverage that is deep in its value but may be narrow in its scope. Although numerous reforms have taken place to improve access and to provide more comprehensive care, considerable work remains to provide equitable access to vulnerable populations and coordinated care.

Keywords: *Primary Health; Canada Strengths; Challenges and Learned Lessons*

Introduction

Canada has a vast geographical area (9.98 million square kilometers), with a relatively small and dispersed population (more that 37 million), with 18% living in rural area [1-3]. Canada has 10 provinces and 3 territories whose governments are responsible directly for their residents' education, health, road regulations, and regulation of some natural resources, while the federal government deals with laws that affect the country as whole, as well as provide some funding to province and territory [4]. Therefore, Canada is a highly decentralized nation, with a lot of the responsibility for the province and territory to deal with legal decisions, as well as justification of the delivery of many services, including health care [5].

Canada is also considered one of the most ethnically diverse nations, with particular patterns of migration that shape the Canadian demography [5,6]. Within Canadian contexts, certain populations have been classified as vulnerable, based experience of adverse social

determinants of health (SDOH) and poor health outcomes, including low income, homelessness, disabled status, racial/ethnic minorities, immigrants, rural communities, and Indigenous populations [7]. Although Canada is a relatively wealthy nation, 10.6% of the population live in poverty [8]. This hardship seems to affect many vulnerable populations, particularly ethnic minorities and indigenous populations [8,9]. Indigenous people account for 24 - 38% of shelter use, and one in five racialized families live in poverty, compared to one in twenty non-racialized families [10,11].

All of above factors have contributed to some of the challenges that are faced by The Primary Health Care (PHC)system [8,9,12]. This paper explores the current state of the PHC system in Canada, highlighting some of the strengths of the system and learned lessons. This review critically analyzes the key challenges that PHC face, including access to care, particularly focusing on access to vulnerable populations. Finally, this paper examines how social determinants of health, compounded by the narrow scope of covered health services provided by publicly funded Universal Health Care (UHC), have contributed to inequity and poor health outcomes within specific vulnerable populations.

Health Care system in Canada

In order to understand how the PHC systems function, it is important to shed some light on the Canadian UHC. In Canada, the Health care system is funded through universal health insurance, commonly known as Medicare, that consists of 13 province and territory tax funded public health insurance plans [11-14]. Saskatchewan was the first government to introduce a single-payer universal health care program in 1947 [15]. This was adapted by all the other provinces and territories in 1961 [13,15]. Canada's federal legislature through the Canada Health Act publicly funded these health insurance programs, was in 1984 [15]. Under this act, the federal government is committed to provide cash contributions to these plans, if five conditions are adhered to by the provinces/territories, including public administration, comprehensiveness, universality, potability, and accessibility [15,16]. Therefore, the value of this coverage is significant, as it addresses point entry services (hospitals and physicians), for almost all eligible residents.

In general, the public funding accounts for 70% of total health care cost coverage, but federal funds cover only necessary medical hospital and physician's services [17]. The remaining 30% of total healthcare services are funded privately either through private insurance or out-of-pocket payments by patients [16,17]. Provinces also have some plans to cover some of the uninsured services, however, such plans often limited to specific populations [18,19]. For example, In Ontario, only 28% of residents have coverage from public drug programs, and this includes 79% of seniors [20].

Unlike other publicly funded health care systems like the UK National Health Service, the Canadian health care system is largely delivered privately by non-profit hospitals and clinics. Physicians participate as independent self-employed professionals [21,22]. Similarly, primary care is delivered privately by primary care providers, primarily family physicians, and to a lesser extent nurse practitioner [23]. Historically, primary care was delivered by solo practices owned by primary care providers [24]. However, reforms put in place by the federal and provincial ministries included focused funding for primary care in early 2000. Many of these reforms targeted improving 24/7 access, improving enrollment models, as well as creating inter-professional base teams through different models and practices [24,25]. In 2017, as per the Canadian Medical Association Workforce Survey, there were 15% solo practices, 39% group practices, 25% interpersonal practices, and 19% hospital-based practices [26]. These practices also operate under different remuneration models, including 40% Fee for Service (FFS), 39% blended models (Capitation and FFS), 1% salary, 11% other [25,26]. Reforms were engaged based on the growing body of evidence that highly functioning PHC programs were associated with reduced health care costs, improved health outcomes and improved health system efficiency and equity [26].

Discussion

There are several strengths that PHC play within the Canadian health systems. First, PHC is the first point of contact for all Canadians with the Canadian healthcare system [27]. In Canada, primary care providers play an important role as gate keepers as Provinces

and Territories require patients to have a referral from PCPs to be evaluated by a specialist [27,28]. Evidence showed that requiring the primary care provider as a first contact to allow accessibility to specialist services was related to reduced costs as well as reducing inpatient care services [29]. Second, in Canada, primary care providers practice patient concerted approach [30,31]. A recent study reported primary care providers in Canada scored above average in most patient centered indicators, including; sharing information with patients in decision making, and providing them with information [32]. Evidence supports that patient centered approaches are associated with improved treatment compliance, improved patient satisfaction, and better health outcomes [33].

Further, PHC in Canada provides comprehensive care with a wide range of services, including treatment, diagnosis, prevention, and mental health, as well as referral to other providers for more specialized care [34]. To further provide access to comprehensive care to meet the needs of an aging, diverse and complex population, Canadian PCH has made progress in adopting more inter-professional collaboration-based team since early 2000 [25,34]. This collaborative model in which family physicians are the core of such teams, with support from other health care professionals, such as pharmacists, social workers, physiotherapist, dietitians, provide more comprehensive services to patients [36]. An extensive review by Canadian Family Physicians Canada (CFPC) on the benefits of a high functioning interprofessional based teams as a part of patient care, showed that this model allowed for better access to care, enhanced coordination between healthcare providers, allowed for better patient and provider satisfaction, as well as reducing cost and increasing preventative care [36]. However, in Canada, such teams are not universally accessible and not directly targeting vulnerable populations or patients with complex conditions [25,36,37].

In Ontario, for example only 25% to 30% of patients can access team-based primary care. However, studies have shown that patients with complex conditions and disadvantaged populations, are not currently enrolled in this interdisciplinary model [36,37]. In fact, the fee-for-service/solo practices models, have the sickest and most vulnerable patients [37]. Part of this problem revolves around how the payment model of multidisciplinary teams adjusts capitation for only age and sex rather than socioeconomic disparities and patient's complexity [37,38]. Therefore, physicians has been found to enroll healthier and younger patients rather than vulnerable patients with complex medical or social issues [38]. Adjustment to such models should account for patient complexity to ensure equity and avoiding selection bias [36,37,38].

Apart from collaborations within inter-professional team models, collaboration within primary care (PC) and between public health (PH) and other sectors are also important in efforts to improve population health. In Canada, although some evidence proven collaboration between PC and PH specifically with respect to communicable diseases, parent–child programs and youth health promotion have proven successful [39]. However, for the most part, PH seems to function independently, and for most issues, there are no clear collaborations between PC and PH, and the Canadian government has no recognized funds to support such collaborations [39,40]. As both sectors address overlapping elements, including prevention, health promotion, population health, addressing SDOH, achieving a stronger collaboration between the PC and the PH will hopefully provide better care, reducing duplication of services, improve population health, as well as taking actions toward improving SDOH among disadvantaged populations [40,41]. A US study showed that better collaboration between PH and PC enhanced the implementation of complementary approaches [42].

One of the important strengths of PHC in Canada focuses on the fact that family medicine (FM) is well integrated within the PHC. According to the Canadian Medical Association (CMA), family medicine is a distinct specialty in that FM focuses on care of the individual and families across the entire spectrum, regardless of age, sex and medical condition [43]. FM is a well-recognized specialty that Canadians value in their supportive role in caring for people across the lifespan [44]. In fact, Canada was a leader in the development of family medicine as a distinct discipline in the 1980s [45].

A lesson learned from the Canadian experience revolves around targeting efforts to increase the number of family physicians in the workforce and supporting them as they provide care [35,37,45]. In the 1980s, family doctors struggled to keep up with their solo practice

demands with increasing costs and falling incomes [37,44,45]. This has led to a decrease in the proportion of Ontario medical graduates choosing family medicine as a career (FM graduates fell 24% in 1998) [37,45]. As a response to this loss of FM providers, federal and provincial governments through different strategies tried to make FM practice more attractive, including increasing FM physician's incomes through various payment models, funding for the inter-professional teams, increasing medical school's capacity, and enhancing support for family medicine residency programs across Canada [25,37,45]. A US study showed that an increase of one FM practitioner per 10,000 population associated with decreasing mortality by 6% [45].

There are some important challenges that face the PHC in Canada. Access has proven to one of the key challenges facing PHC, when compared to other developed countries with respect to timely access of services, after hours care, and inequitable access for vulnerable populations [25,37,46]. For this paper, the analysis only focuses in challenges to access care among certain populations as worse the gap of inequity.

Some populations have inequitable access to health care compared to other groups, and this reduced access can result in poorer health outcomes [37,46,47]. In Ontario, the poorest people have barriers to access and less than half have regular family doctors [11,38,47]. According to Health Quality Ontario, poorer persons in Ontario often have more multiple chronic diseases (23.2%), as well as higher ER visits compared to the richest individuals [48]. Further, Immigrant people have twice as many difficulties in accessing health care services as compared to their Canadian-born counterparts [48,49]. Although factors outside the health system that are related to social determinants may contribute to their limited access. However, other factors within the health system has also contributed to their inequitable access (i.e. current payment models) [49]. Research has shown that a community-based approach is required to help address the SDOH among disadvantaged populations [50]. A successful example in Ontario involved community health centers (CHC), which used a team based multidisciplinary approach that served disadvantaged populations [49,50]. This model shows superior outcomes compared to other models, in addition to ensuring equitable access [25,37,50]. These types of clinics could help to improve health equity within the Ontario's health system; however, these services are still very limited [50].

Additionally, integrating community health workers (CHWs) within the PHC has been shown Ito be effective in other countries like Brazil [51]. Evidence showed that CWHs can help connect those poorer individuals to the healthcare system, help improve health equity, reduce oppressive practices, and can work to create collaboration with health care services and increase community involvement [51,52]. If CHWs become an integral part of the current PC based teams, they can help to extend accessibly of key services to many vulnerable and underserved population [52].

Indigenous population, who account for 4% of the Canadian population, is one of the disadvantaged groups in Canada [2,12]. Evidence shows that Indigenous people also have limited access to health care compared to other Canadians [53,54]. Data showed repeatedly that aboriginal individuals also have poorer health outcomes and higher mortality rates comparing to other non- aboriginal counterparts [54]. For example, rates of diabetes are 3 - 5 times higher among aborigines compared to the national average [55].

There are many factors that have contributed to inequitable access to healthcare for aboriginal people. For one, geographical location in mostly rural areas is also associated with inadequate access to services, including primary care, However, there are more social and political factors that can also contribute to such disparities [54,55]. For instance, previous negative experiences with healthcare services among Indigenous peoples been found as a barrier to accessing healthcare [55]. Further, power dynamics imbalance has resulted in distrust of healthcare that act as a barrier to access services among Indigenous people [53,54]. Although the federal government has directed funds to improve access to health care for Aboriginal people, strategies should also consider all of the above factors. For example, training more culturally competent PCPs to address the needs of Aboriginal people [54].

As mentioned above, rural communities account for 18% of the Canadian population. However, there is shortage of primary care physicians for these people, as only 14% of MDs work in rural communities (50 - 53% of these are family care physicians). Studies showed

that Canadians who live in rural areas have poorer health outcomes and less range of health care options [3,55]. As a response, a successful program developed by the Canadian government was designed to increase funding to support FM training in rural areas and remote communities [55,56]. The program also allowed for the expansion of FM training sites to include rural areas (increased from 25 in 1998 to 86 in 2008). For example, building the Northern Ontario School of Medicine (NOSM) played a role in placing 70% of NOSM graduates in practice in rural communities [56]. However, more work needs to be done to reduce barriers in access to Canadians living in rural and remote communities, including expanding telemedicine. Evidence shows that the use of telemedicine can facilitate to overcome some of the geographical and social barriers [58].

Another, main challenge for Canadian PHC involves coordination across different providers, allowing organizations to link whole person care [37,59]. In Canada PHC has been very fragmented, with different organizations managing different layers of care, even within primary care services [59]. According to the Commonwealth Fund survey, only 25% of Canadian family physicians exchange clinical summaries of their patients and 33% share medication lists with other physicians who are caring for that patient, below the averages 63% and 62% respectively in other developed nations [60]. Part of the challenge focuses on the fact that most of the health care services delivered in Canada are provided in private offices, hospitals and organizations that operate independently. In fact, there are several innovative programs that target coordination issues between different health care providers [61].

Most recently, a very promising initiative in Ontario, called the Ontario Health Teams, aimed to integrate services provided by different health care providers, hospitals, and agencies [60,62]. This hopefully will allow for coordinated services, particularly for those in need (i.e. vulnerable populations). Other strategies include using technological communication and centralized Electronic Medical Records (EMR), may facilitate some of these efforts to share information.

Conclusion

In conclusion, health care in Canada- provides coverage that is deep in its value but may be narrow in its scope. Along with other factors, including vast geographical areas, diverse populations, and different local systems providing care, inequitable access to care remains a problem in Canada, with health care disparities often found in specific populations.

Although numerous reforms have taken place to improve access and to provide more comprehensive care, considerable work remains to provide equitable access to vulnerable populations. For example, In Ontario, reforms of current models are essential to target needs of vulnerable populations by identifying these groups and ensuring access to multidisciplinary teams. Other possible approaches include community-based approaches including expanding CHC that serve vulnerable populations and integration of CHWs within PHC. Further, expanding the use of Telemedical can play a role to overcome access barriers for rural communities.

Despite these limitations, Canada has addressed many issues to strengthen PHC. Also, PHC has been one of the top priorities of their universal healthcare system. The integration of family medicine within PHC, expansion of FM in Canadian medical programs, and the ongoing efforts to increase and improve the primary care work force, each of these initiatives have helped to improve primary care in Canada, but further efforts are needed to improve care for vulnerable populations and achieve healthcare equity. The focus should primarily target connecting marginalized populations to health care services.

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