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The Canadian Primary Health Care Systems from a Brazilian perspective: discussing Starfield's Attributes

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Abstract *This paper reviews the Starfield pillars and the Canadian health system. An objective and subjective evaluation are applied to the system through the lenses of access, longitudinality, integrality, and coordination of care. System vulnerabilities, actions, and proposals that are underway to improve these aspects, both nationally and in the province of Ontario, are discussed. Worth highlighting is the opportunity to establish a national free drug system, and the several challenges to advance the agenda of reforms.*

Key words *Primary health care, Health system, Canada*

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It may seem pretentious for a Brazilian to speak out about the Canadian health system, given that a recent publication evaluating virtually every country in the world placed the Canadian system in a respectable 17th place, while Brazil was bitter at 95th place[1]. On the other hand, we are a curious people, and we want to know a little about what happens in countries at another stage of development (which will be reflected in their health system) and, who knows, to envision solutions or issues that help us to narrow the gap separating us from the so-called developed countries.

The rules that we will try to use somehow are the attributes or pillars of Primary Health Care (PHC) created by the brilliant Prof. Barbara Starfield (1932-2011). They remain essential concepts to try to dissect health care aspects, and they are, using the translations used in our Family Medicine Treaty (FMT)[2], first contact/access ('first contact care/gatekeeper'), longitudinality ('longitudinality and managed care', also referred to as 'continuity of care'), comprehensive care/integrality (originally 'comprehensiveness and benefit packages', and more recently 'comprehensive care') and coordination ('coordination and the process of referral', then 'coordination of care', in its shortened version). Its definitions and details can be found in the author's seminal book[3], and interesting examples of its translations for the Brazilian reality, mainly in the context of the Family Health Strategy (ESF), are seen in the corresponding chapter of the FMT[2]. Although 'initiated' have no trouble recognizing what the author is talking about, I will attempt to simplify them here.

The first one is probably the one that covers the broadest range of PHC aspects, and involves all issues concerning access, whether they are geographic, professional availability, socio-cultural characteristics that influence this access, or the technologies that mediate it (expanding the definition for our current reality). But it goes further. It highlights the importance of the professional, preferably a generalist, who will make the patient's entry into the system.

The second refers to the importance of the patient being followed by the same health professional or the same team/location.

The third pillar explores the holistic (or not) aspect of care. Patients' needs are potentially broad, and providing comprehensive care (and to afford them in the system) is always a significant challenge.

The fourth refers to the capacity of the system and the professionals involved in effectively communicating and maintaining rationality in patient care. Its maintenance would avoid interruptions in care or duplicated interventions, both with potential harm to the patient. The probable "sacred chalice" of the concept would be the single medical record (assuming it would be read by the professionals involved in patient care).

The evaluation of these attributes in a given system is the subject of an extensive bibliography including instruments created in collaboration with the author, such as the 'Primary Care Assessment Tool (PCAT)', described in our FMT[2], and widely used in Brazil. However, we chose to use other objective indicators, relating them to the attributes, as well as the opinions of experts and, eventually, the author himself, to bring the most up-to-date outline of the Canadian system. Of course, the latter will include its dose of subjectivity.

Since the Canadian system will be the subject of this essay, we will also review it. An excellent description was published in The Lancet[4] in 2017 and will be the source of our summary below. The so-called Medicare (not to be confused with the American Medicare, which is limited to coverage of the population over 65 and part of the younger population with disabilities) is the set of provincial systems that originated in the province of Saskatchewan in 1947 and was replicated in other provinces in the following decades. The 'patchwork quilt' was harmonized with federal law in 1984 ('Canadian Health Act'). Some authors define it as 'single-payer health insurance' ('single-payer') rather than a real system[5], not to mention that provincial autonomy produces multiple 'systems'.

The history of the creation of the Canadian system allows us to understand the current limits since the characteristics behind the original proposal in the 1940s (curative, hospital-based, doctor-focused) are entirely different from the primary needs of health care of this century (prevention, outpatient care and the need for multidisciplinary intervention).

In its current operation, the Canadian system can be seen as acting in three tiers. The first, virtually all covered by the public system, includes comprehensive care in hospitals, medical visits, and diagnostic tests. The second tier, with only partial and more exceptional coverage, involves prescription drugs (in Ontario, for example, for people over 65 and young people under 25, the latter only if they do not have private coverage, people who are dependent on the welfare system) or people with "catastrophic health expens-

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es" – more than 4% of their income), home care, nursing homes for older adults ('long-term care', a fundamental aspect of care in a country where living with children at the end of life is very unusual), and mental health. The third tier, virtually all paid for with own money ('out-of-pocket') or private insurance, involves oral health, eye health, complementary medicine, including outpatient physiotherapy.

Family doctors (FD) are the system's backbone and roughly correspond to half of the country's medical professionals (122 family doctors/100,000 inhabitants vs. 119 specialists/100,000 inhabitants)[5]. The same report shows that the increased number of doctors since 2014 was twice the population growth, which tends to favor access. They mostly receive payments per consultation/procedure ('fee for service') compared to alternative payments (defined as salaries, capitation, hourly payments or sessions, and contracts): 72.6% vs. 27.4% in 2018 (the difference started to increase again slightly over the past five years, showing a stabilization on the process of increasing alternative payments that had been going on since the 1990s)[6].

FDs generally work without the support of a multidisciplinary team. From 2005 to 2012, 184 Family Health Teams ('FHT') were established in Ontario to mitigate this reality, mainly in university environments and at-risk population locations, including the north of the province, rural communities, and serving vulnerable populations in large urban centers[7]. However, the establishment of new teams has not been authorized since 2015. The current government is proposing a substantial system reform, always in line with multi-professional work, with the creation of Ontario Health Teams (OHT)[8]. We will return to this later.

Resuming the evaluation of the system, we will use data from the last round of health policy research conducted by the Commonwealth Fund in 2016[9], with publications comparing data from eleven high-income countries: USA, United Kingdom, Canada, Germany, Australia, Japan, Sweden, France, Holland, Switzerland, and Denmark[10,11], to relate them to the attributes of the renowned author.

As for access, 43% of Canadians (8th place in the group) manage to make an appointment for the same day or the next day with their FDs, with the average in the group being 57%; 39% (worst performance among these countries) wait at least two months to see a specialist (group average is 13%); 34% of Canadians consider that after-hours service – evenings, weekends and holidays – are easy or relatively easy to access – without resorting to an emergency department – ED (second to last), with group average being 43%; in mental health, 59% get professional help when they need it, above the average of 54%; however, 41% of Canadians have been in an ED in the past 2 years (last place), the average being 27%; and when they do so, 29% wait four hours or more to receive care, which is the worst performance within a group that averages 11%; similar situation on waiting four months or more for an elective surgery: again, last place, with 18% of people, for an average of 9% among the countries included in the Commonwealth Fund study. Taken together, these indicators show an apparent problem of access, although some of them refer to secondary or tertiary care. However, some of these indicators can be questioned (for example, consultation on the same day, or the next) since access to this appointment does not necessarily imply adequate care with improved quality of life for those seeking care[5]. Furthermore, while studying only people who had an FD in the province of Ontario, a broader assessment of access showed that this population mostly has positive impressions of that access[12].

But, in line with access to health in general, the primary barrier in Canada remains the lack of a national 'Pharmacare' plan, that is, a system of free medicines for the population. Canada is the only country in the world with a universal health system without this coverage.[13] The importance of incorporating free medicines into the system is widely supported by experts[4,5,11,13-16], with demonstration of economic advantages. The Liberal Party of Canada is currently holding a minority government since last October's elections. Its electoral platform included a proposal and a budget designed to support provinces to expand access to drugs. The New Democratic Party (NDP), third place in votes and bound to support the government on the issue, has an even more robust proposal. Moreover, among the main parties, only the Progressive Conservative Party (PCP) does not support the creation of 'Pharmacare'. Instead, it proposes an increased access to medicines for rare pathologies[17]. However, given the need to negotiate with the thirteen provinces and territories, some of which are governed by the defeated conservative party, an arduous process is expected ahead[18]. And the issue is not limited to the current political moment. Multiple other aspects must be negotiated, such as the fact that if the federal government estab-

lishes a fund for the procurement of medicines (benefiting from economies of scale), the provinces that currently buy their medicines would have to transfer/return money to the central government[5]. And Quebec is a specific case. The province now has a system where citizens who do not have private insurance covering medicines are obliged to pay for a similar government system (guaranteeing their drug coverage), with recognized advantages and disadvantages[19]. Its model could be followed in the rest of the country, or eventually, Quebec would be able to remain apart, given some characteristics of autonomy of this province (for example, its blood bank system is now independent)[20]. The province would have to make significant adjustments if the previous alternatives do not materialize.

But, let us return to the evaluation of the attributes. Concerning longitudinality (and also the quality of care), 85% of Canadians have a "usual doctor", which is the average of the countries in the group. They have a high number of appointments/year (7.6 vs. 5.8 average), a better perception of their doctor than the average (doctor holds essential information, spends enough time in the appointment and explains what is happening in an accessible way), and their medications are reviewed more frequently (77% vs. 68%). It, therefore, appears as one of the highlights of the Canadian system, a position shared by other authors[21].

Regarding the scope of care, we have less objective data. The low prevalence of the already mentioned multi-professional teams points to the main hurdle to more holistic care for the Canadian population. Furthermore, the virtual lack of free oral health (28% of Canadians report not going to the dentist due to costs vs. 20% of the international average) increases the evidence of holistic care, combining with the non-coverage of other health professionals (physical therapists, psychologists, speech therapists, etc.). The increased coverage is urgent[4] for the improvement of the system. On the other hand, FDs have an excellent clinical training which allows them to do a great job. Also noteworthy is the homogeneity of this training in a vast territory and with reasonably diverse cultural realities. As comparison in the issue of scope of care, the Brazilian inherent multi-professional nature of the ESF, including oral health coverage approaching 50% of the population[22], stands out within the Unified Health System (SUS). But, interestingly, in the province of Ontario, the attempt to fund the training of FHTs proved to be expensive and with results below expectations[5,23], evidencing the intricate nature of the proposed system changes.

Objective data to assess care coordination are more difficult to find. Despite the increasing adoption of electronic medical records[24], making them compatible is always a considerable challenge. No province has come up with the creation of a single medical record that could be used at all levels, although Alberta has made progress in this regard[5]. Ontario also has several projects, led by "eHealth Ontario", highlighting the "ConnectingOntario ClinicalViewer", a system that allows medical professionals to access reports of community appointments and services provided, laboratory and imaging tests of the leading hospitals in the province, as well as information on medicines provided by pharmacies for any patient enrolled in the provincial system[25].

But the integration between different caregivers and an efficient transition between them requires more than a single medical record. Ontario is embarking on an ambitious project, the OHT, which seeks to potentially integrate all actors involved in the health care of the population, with fourteen areas included in the initial document, ranging from primary care to rehabilitation and complex care, including diagnoses, community support services and palliative care, among others[7]. In the last few months, the Ministry of Health ('MoH' – in Canada the provinces use the term ministry which is equivalent to our secretariats) has invited providers to establish groups and apply for funds and approval. Of the more than 150 proposals submitted, 31 were initially approved (with 43 other groups encouraged to develop their projects better) and had to submit a complete proposal[26], delivered last October. I am part of one of these 31 groups ('North Toronto') that decided to prioritize elderly care at first, to be followed by mental health care and children/youth[27]. Responsible for a population of around 180 million people, the proposal is detailed and includes the integration of the leading information systems used by the partners. Some seven to ten groups are expected to be chosen, at the end of 2019, to form the first OHTs[28] officially.

Despite a high receptivity on the part of the providers, the proposal faces criticism, especially concerning the many concerns regarding its governance[29].

Traversing the questions presented, I would like to comment on two more important aspects of the Canadian health reality. One of a more acute and critical nature, the other more intricate, chronic, and highly symbolic. The first re-

fers to the growing number of older adults occupying hospital beds while waiting for a place in a nursing home (residence for the elderly). These are people who are unable to return to their homes after hospitalization, even with support (sometimes irregularly provided) at home. Their numbers have broken records in the province of Ontario[30], and naturally, lead to a consequent increase in patients on stretchers in the emergency rooms waiting to be admitted. The so-called "hallway medicine", familiar to us Brazilians, shocks us when seen in a country like Canada, to the point of taking my generation of doctors to long debates when we witnessed this reality in scenes from the award-winning Canadian film of 1986, directed by Denys Arcand, "The decline of the American Empire". More than thirty years later, the situation is still prevalent in large cities like Toronto and Montreal. The evident need to build more homes for older adults has found a 'soft' response from the government[31] and it is not going to catch up any time soon.

The second phenomenon that has clearly been shown to be requiring more substantial and adequate investments is that of the inequity existing between the living and health conditions of indigenous populations compared to the non-indigenous population[32]. It is clear that the necessary interventions transcend the health limit, and involve changes in the social determinants of health to modify an unacceptable situation[4] in a rich country such as Canada.

So, in conclusion, Canada has a health system that stands out for primary care founded primarily on the work of family doctors who ensure an excellent level of longitudinality. Its distribution throughout the country allows very reasonable access to the population, although some inequality persists. Access to same day or within 24-48 h appointments remain problematic. Solid training allows doctors a wide range of care in the clinical area, but the small number of multidisciplinary teams limits expanded health interventions. Continuity of care is notoriously deficient, but efforts have been concentrated on improving it.

In a country that has led the list of countries with the best quality of life in the world[33] for the fourth consecutive year, specially when we know that its public health system contributed to this highlight[34], it is interesting to note how magnifying lenses allow us to see that there is still much to be done. However, the system may suffer from the old saying that the "good is the enemy of the great", as the authors already cited here argue[5]. In other words, in a very functional system, the pressure from citizens for changes to occur is less present. And the intricate nature of the Canadian federal system imposes needs for sophisticated negotiations, somewhat inhibiting the advance of the agenda of changes. But some of the proposals, described in the body of this paper, shows how a government that believe in a universal health system and is committed to improving it can make a difference, further improving ~~of~~ a health system that is still a global model.

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