CSP CADERNOS DE SAÚDE PÚBLICA
REPORTS IN PUBLIC HEALTH

**ESPAÇO TEMÁTICO: MÉDICOS NA ATENÇÃO PRIMÁRIA À SAÚDE**
THEMATIC SECTION: PHYSICIANS IN PRIMARY HEALTH CARE

# Primary health care in Canada: current reality and challenges

## A atenção primária à saúde no Canadá: realidade e desafios atuais

## La atención primaria a la salud en Canadá: realidad y desafíos actuales

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doi: 10.1590/0102-311X00178217

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Although the discussion refers to Canada as a whole, the provinces have their own health systems, with more or less significant variations between them. Equally relevant is that my perspective comes from working in just two provinces (Quebec and Ontario), specifically in an urban context.

Although the Canadian health system is universal, it does not necessarily cover all services. Contrary to Brazil's Unified National Health System – SUS (and its huge limitations notwithstanding), the Canadian system does not generally cover dental care, outpatient medication, or non-medical health professionals (physical therapists, psychologists, speech therapists, etc.). The exceptions vary considerably between the provinces, sometimes with partial coverage for children, older people, post-surgical procedures, "catastrophic" expenditures on medicines (exceeding 4% of the individual's income, for example), low-income individuals, people with disabilities, welfare recipients, etc. The fact that the SUS proposes broader coverage naturally does not mean that the Brazilian system is better, since access to the infrastructure offered by the two countries is on totally different levels. In a recent survey with the sophisticated Healthcare Access and Quality Index, including practically all the countries of the world, Canada ranks in the upper quartile, with Brazil close to the last countries in the second quartile [1].

Here in Canada there is practically no private health care model as we know it in Brazil. The existing legal understanding is that the state should be the provider. The majority of Canadians would simply repudiate the notion that a citizen's purchasing power can give him or her better access to health care.

In keeping with the most highly developed health systems, primary health care is the basis for the Canadian model. The key health professional in the Canadian system is the family medicine physician. Nurses with Master's-level training ("nurse practitioners") are starting to represent a certain proportion of primary health care professionals, working directly with the population, with either face-to-face or remote access to a physician. The family physician's work is highly centered on the clinic and focused on the individual, with a varied family perspective (since individuals choose their family medicine physicians, not necessarily all members of the family are seen by the same doctor). Contrary to expectations, interaction with other professionals, except for nurse technicians and administrative employees, takes place in the outpatient setting, essentially through referral and counter-referral. Teamwork is not the rule, although it is pursued by planners and is enjoying important growth. Community work, at least in the big cities, is due more to initiatives by the health professional than

functioning of existing networks. Recent redesigning of the "Public Health" hierarchical structure (agencies and institutions functioning virtually in parallel to the health care network) are attempting to correct this vulnerability.

Although the system is public, the physicians are still largely self-employed, as liberal professionals. Employees hired directly by the government are the minority and are largely concentrated in Community Health Centers, providing services to more vulnerable populations. University settings also have more medical professionals practicing jointly.

Canadian physicians are paid mainly on a fee for service basis. Although fee for procedure predominates, various other initiatives have emerged, especially in the last decades, such as the addition of "pay per capita" (according to the doctor's number of patients) or pay for a "basket of services", in addition to financial incentives for seeing patients "after hours" (after 5:00 p.m. on weekdays and all weekend) or for meeting targets, especially preventive indicators (percentage of children immunized, Pap smear and mammogram coverage rates, etc.). This substantially increases income for family medicine physicians, approaching that of their specialist peers, although the latter still earn substantially more.

Hospitals are also private, managed by foundations or equivalent structures, and they also provide services to the entire population and are paid by government. The source of the funds is mainly provincial, with an important (but downward) share coming from the federal government. Municipal funding is virtually nonexistent, contrary to the Brazilian model. In these hospitals, especially outside of the national and provincial capitals, treatment in emergency departments and wards is largely (if not exclusively) provided by family practitioners, with specialists only acting as consultants (they only have their own specific wards in larger cities). Family physicians also work extensively in obstetrics, palliative medicine, and anesthesia.

Specialists constitute the majority here in the province, although only in slightly higher numbers than family medicine physicians (in Ontario, 109 specialists/100,000 inhabitants versus 96 family medicine physicians/100,000 [2]). More than a fourth of the physicians in Ontario received their training abroad [1]. And according to the Canadian Institute for Health Information (CIHI), the number of physicians per population has grown in the last ten years [3].

A residency in Family Medicine takes two years (versus five years for most specialities). Special training is offered in emergency care, prenatal and childbirth care, and anesthesia (besides specific residencies in Obstetrics and Gynecology, Anesthesia), sometimes as a third formal year of residency, other times in the form of shorter courses.

The system assumes that each citizen has his or her own primary care provider (as mentioned, mostly physicians), which is nearly a reality in Ontario: 93.7% in urban areas, 94.7% in the countryside [2]. This professional is responsible for the person's horizontal follow-up and referral to specialists as needed. This "gatekeeper" role for family medicine physician means that patients do not have direct access to specialists, a characteristic of rationality that is accepted in nearly all universal health systems in the world.

Canada has a tradition of planning and designing its public policies, and suggestions to improve its health system are always appearing and are assessed according to evolving medical knowledge and world trends. Danielle Martin's [4] famous book proposes six "big ideas" to improve health for all Canadians: (1) ensure relationship-based primary health care (simply put, a primary care professional available for everyone); (2) bring prescription drugs under Medicare; (3) reduce unnecessary tests and interventions; (4) reorganize health care delivery to reduce wait times and improve quality; (5) implement a basic income guarantee; and (6) scale up successful solutions across the country.

In relation to the first big idea, the availability of primary care professionals for the entire population has become an even greater challenge in remote areas in the North of Canada, especially on Aboriginal reserves. Attempts to recruit Aboriginal students for Canada's medical schools [5] is an important initiative in the sense of providing health professionals to these areas, with the huge advantage that they would come from the local culture itself.

More universal coverage of medications is a longstanding demand that appears to be approaching reality. The recent initiative by the ousted Liberal government of Ontario to offer this coverage to the population under 25 years of age [6], is a milestone for the province. Other provinces are in different stages of the process, but "Pharmacare" (coverage of prescription drugs by the system) is a key item on the agenda of meetings with the provincial health secretaries.

The third idea involves quaternary prevention and finds echo elsewhere in the world, with the rapid expansion of the "Choosing Wisely" initiative [7] by dozens of countries (including Brazil) in just a few years. An estimated 30% of tests and health interventions in Canada are unnecessary, which gives an idea of the issue's importance. In Brazil, the irrational use of tests and interventions is a particularly acute phenomenon in the private health care system [8].

The fourth idea involves better coordination of care, potentially with a decrease in costs, including the use of quality tools, technology, and changes in the structure of the referral and counter-referral system. As an example of the ample room for improvements in the system, Toronto has no central regionalization for management of appointments with specialists. Professionals from the same specialty can offer appointments with wait times ranging from days to months, while the family physician cannot determine how to access the specialist with the shortest wait time. The health care professionals' liberal, self-employed practice acts as a barrier to greater rationality in the current system.

I see implementation of a minimum income program as the author's most brilliant and radical idea. Her book naturally applauds Brazilian Income Transfer Program (*Bolsa-Família*) and adds to a growing list of jurisdictions and politicians flirting with the idea [9,10], with increasing recognition that there will not be (or there are not?) jobs for everyone and that this is a legitimate way of ensuring people's dignity. Pilot projects have been launched recently in Ontario [11], and like the ideas cited above on other topics, a minimum income policy requires political support and investment to be expanded, should the results prove positive. Countless small Canadian projects in health that initially proved promising were unable to be expanded, and this is the challenge identified by the author in her last big idea.

From a more individual point of view, family medicine physicians face other challenges, two of which I would like to address briefly. The first, which has been identified for years but with few proposed solutions, is the difficulty in applying guidelines for care of patients with multiple comorbidities, especially older persons [12]. The inclusion of more family doctors in the groups that draft the guidelines is one suggestion. Another issue that I think is completely off the Canadian radars is the growing formalization of requirements relating to completeness of patient records. The systematic peer assessments done by our College of Physicians and Surgeons of Ontario (CPSO) are based almost exclusively on the assessment of patient records. Importantly, patient records are also currently used for purposes of certification, justifications for payment, auditing, legal action, research, etc., thus jeopardizing their basic function of concisely recording the physician-patient clinical encounter, with repercussions for physicians (who are burned out by excessive demands) and patients [13].

In short, we continue to practice as family medicine physician, with the huge challenge of continually improving and updating care for our patients, always seeking to combine an individualized clinical view while keeping apace with broader professional and social issues, fulfilling our responsibility to advocate for the population, an inalienable role in our profession.

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Submitted on 10/Oct/2017
Final version resubmitted on 02/Nov/2017
Approved on 08/Nov/2017