Toronto's G20 one year later

Missed opportunity for a Canadian contribution to global health

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As we mark 1 year since world leaders gathered in Toronto, Ont, for the G8 and G20 summit, we reflect on a missed opportunity. When the world looked to Canada for leadership in solving urgent global problems, instead of overzealous security and a lacklustre maternal-child health initiative, we should have showcased a uniquely Canadian solution to the challenge of global health—a domestic resource, which if exported and adapted abroad, could improve or save billions of lives worldwide: Canadian family medicine.

All countries, from the wealthiest to the most impoverished, can learn something from the Canadian model of primary care. Family medicine, as a cornerstone of strong primary care, has been repeatedly shown to contribute to better health outcomes and to more cost-effective health care around the world.[1,2] While not every country enjoys our good fortune—abundant natural resources, a well-educated population, and a stable democracy—every country could benefit from applying elements of the 4 principles of Canadian family medicine to their primary care systems.[3]

Family physicians are skilled clinicians

Canadian family physicians are more than general practitioners. They are specialists in primary care who have completed 2 or more years of competency-based specialty training. They are skilled, broad-thinking problem solvers, anchored in generalism and trained to address complex and undifferentiated health issues. The depth, breadth, and quality of care provided by family physicians effectively alters the nature of specialty medicine, allowing specialists to see only those for whom a consultation is truly indicated. Unlike some other high-income countries where general practitioners are mere gatekeepers, Canadian family medicine specialists are competent to care holistically for patients from cradle to grave. They are comfortable with a range of roles, procedures, and interventions—from suturing lacerations to dynamic psychotherapy; from foreign body removals in the emergency department to steroid injections in a pain clinic; from obstetrics to palliative care. Countries can only improve their primary care infrastructures by developing and investing in family medicine as a specialty—specialists in generalism.

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The patient-physician relationship is central to the role of the family physician

The Canadian public values the role of the family physician. Canadians have unique relationships with their family doctors based on trust, history, and mutual responsibility. Even where excellent specialist care is available, Canadians seek the care, advice, and engagement of *their* family doctors. Countries can achieve a high ratio of family physicians to specialists by investing in the human resources for primary care, ensuring that everyone has access to a team that includes well-trained family physicians. The Canadian doctor-patient relationship provides a uniquely rich conduit for the transfer of information, the application of preventive measures, and the enhancement of adherence to jointly developed care plans. More than a utopian goal, the doctor-patient relationship translates into longer and healthier lives.

Family medicine is a community-based discipline

Family physicians have relationships not only with their patients, but with their communities. The family physician's practice is both a window into the health needs of a community and a set of tools to address them. Family medicine training recognizes the role of values in shaping this relationship and cites *social responsibility* as the animating driver of physicians' work. Family physicians see patients in their homes, hospitals, nursing homes, and offices as part of a network of health professionals. Because we are not competing with fellow physicians or other health professionals (such as nurses, physiotherapists, and occupational therapists), we have every incentive to collaborate with them to care for our patients. The ever increasing emphasis on interprofessional care is part of family medicine training, and is encouraged and rewarded by the health system. It is cost-saving and it is in the best interest of the patients. Through family health teams, the family medicine specialist remains at the centre of this broader network of shared care.

Family physicians are a resource to a defined population

Family physicians in Canada are unique in the world. They are private practitioners, not government employees, billing a single public insurer for the care provided. As such, they effectively function as independent and

trusted stewards of scarce health care resources, advocating for patients without fear of reprisal, and they can orchestrate health system changes from within. This translates into considerable independence and control over their practices and fosters a culture of professionalism, allowing family physicians to assume leadership and advocacy roles in their communities and nationally. Family physicians are trusted by their patients to have only their best interests in mind and by the government to make wise decisions and not abuse the great responsibility with which they have been entrusted.

Of course, the true secret of Canada's success is our government-administered, universal, accessible, transportable, and comprehensive publicly funded health care system. While most countries will not be able to replicate this system, understanding why it so important for health—not only health care—can be helpful in moving toward better health for all. The evidence and literature on the merits of equity-based publicly funded health systems is overwhelming.[4] For Canadian family physicians, the principles of the Canada Health Act listed above have a number of tangible effects. In a privately funded system, physicians compete for patients and have no stewardship over the collective health care resources. Consumer demands and the ever present threat of lawsuits tend to drive overprescribing and overtesting, raising the cost of medical care and medical liability insurance, and putting patients at risk of overdiagnosis and harmful interventions. By not competing for patients, Canadian physicians can be honest with patients and provide them the best evidence-based and patient-centred care. They have every incentive to provide patients with the preventive knowledge they need to stay healthy and away from their clinics, hospitals, imaging machines, and emergency departments.

The World Health Report on primary health care in 2008 emphasized 4 areas of reform to achieve health for all: service delivery, universal coverage, public policy, and leadership.[5] While many Canadians reading this article might have a few constructive comments or an example of how our principles are more lofty than our practice, the Canadian system of primary care has much to teach the world in each of the World Health Report domains. Rather than showcase our crowd-control prowess or even our beautiful lakes (real or faux), next time we must show the world what Canada has to contribute to global health—the specialty of family medicine.

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Competing interests
None declared

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References

1. Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within Organization for Economic Cooperation and Development (OECD) countries, 1970-1998. *Health Serv Res* 2003;38(3):831-65.
2. Macinko J, Starfield B, Erinosho T. The impact of primary healthcare on population health in low- and middle-income countries. *J Ambul Care Manage* 2009;32(2):150-71.
3. College of Family Physicians of Canada. *Four principles of family medicine.* Mississauga, ON: College of Family Physicians of Canada; 2006. Available from: **www.cfpc.ca/Principles**. Accessed 2011 Mar 3.
4. Canadian Doctors for Medicare [website]. Toronto, ON: Canadian Doctors for Medicare; 2011. Available from: **www.canadiandoctorsformedicare.ca**. Accessed 2011 Apr 14.
5. World Health Organization. *World health report 2008: primary health care (now more than ever).* Geneva, Switz: World Health Organization; 2008. Available from: **www.who.int/whr/2008/en/index.html**. Accessed 2011 Mar 3.