Keeping the front door open: ensuring access to primary care for all in Canada

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Primary care is the front door to our health systems. But for too many people living in Canada, that front door is now closed.

Before the COVID-19 pandemic, 4.6 million people in Canada did not have a regular family doctor or primary care clinician,[1] and the pandemic has made things worse. In Ontario, twice as many family physicians stopped work in the first 6 months of the pandemic compared with trends from the previous decade,[2] and a survey from spring 2021 found that almost 1 in 5 family physicians in Toronto were thinking of closing their practice in the next 5 years.[3] Fewer medical students are choosing family medicine and fewer family medicine physicians are choosing to work in comprehensive, longitudinal practice.[4] Furthermore, lack of access is not distributed equally among communities. Newcomers to Canada and those living in low-income or marginalized neighbourhoods were less likely to have a regular family doctor even before the pandemic.[4]

In related research, Rudoler and colleagues explore the popular theory that newer family medicine graduates are contributing to the family doctor shortage by choosing to work less.[5] The authors looked at data from 4 Canadian provinces and found no differences in median patient contacts by career stage; median contacts per family physician over the 2-decade study period decreased for all physicians in all career stages, not just early-career physicians. The authors hypothesize that reasons for this decline may include an increase in administrative workload, increase in patient complexity, changes in professional norms, different choices about work and different income requirements.

These findings imply that a larger family physician workforce will be needed to serve even the current population, let alone a growing and aging one. However, increasing the primary care workforce by training more family physicians will likely get us only part of the way to solving the problem given existing shortages and trends.

Canada's health systems needs to reimagine how family doctors work and are integrated into the system. All family physicians should work collaboratively in teams that include skilled office assistants and nurses, nurse practitioners, social workers and pharmacists. Team-based care is better for patients, clinicians and the system. Our research in Ontario found that patients of team-based practices were more likely to get recommended chronic condition care[6] and less likely to use the emergency department.[7] Sharing the care in a team can also enhance joy in work for clinicians[8] and, when done right, could increase the number of patients a family physician can care for.[9] Similar primary-care workforce challenges have led thought leaders in the United States and United Kingdom to call for expansion of interprofessional teams as part of the solution.[9,10] A recent survey of family physicians in British Columbia found that physicians ranked options to be in a team and direct funding for team roles as priorities for primary care reform.[11] Team members with different expertise are especially critical as patient complexity and disease comorbidity trend upward.

An expansion of team-based primary care should also be accompanied by payment reform. Professional associations and academics in Canada and the US have been advocating for a move away from fee for service — the dominant payment model for family physicians — to alternative payments like capitation or salary, which better remunerate providers for the care of patients with multimorbidity and psychosocial complexity.[12,13] Surveys indicate

Key points

- Primary care in Canada is in crisis; 4.6 million people did not have a regular family physician or primary care clinician before the COVID-19 pandemic and the situation is getting worse.
- Emerging evidence suggests that if primary care delivery does not change, a larger family physician workforce would be needed to serve the current population, let alone a growing and aging one.
- Interprofessional team-based care, coupled with payment reform, has the potential to improve primary care capacity, access and outcomes for patients, and provider well-being.
- Bold reforms could include neighbourhood-based clinics that employ physicians and have accountability to the local population and regionally organized after-hours care that would obviate the need for walk-in clinics and allow for better use of resources.

that physicians, especially younger graduates, would support such a shift.[11] Many physicians would also support a move away from the traditional small-business model of family medicine to one where they are employees with paid vacation and parental leave, and benefits that could reduce family physician burnout.[11]

Interprofessional primary care teams are far from the norm in Canada. Some provinces have made progress, but this progress has stalled, ostensibly because of government concerns regarding cost and return on investment based on limited and early evaluations. Teams have also not always been implemented with the objective of increasing clinician capacity, and average patient panel sizes have been shown to be lower for physicians working in teams than not.[6] Patient access to team-based primary care is also currently inequitable; Ontario data from 2016 showed patient attachment to primary care teams was lowest in areas of highest need.[14]

Primary care in Canada is in crisis. It affects the rest of the health system and the solution must be bold reform. Primary care should be considered a right and a necessity, similar to public education. When families move to a new neighbourhood, children are guaranteed a spot in a local school. Likewise, when people move to a new neighbourhood, they should be guaranteed a spot in a local primary care practice. Provincial governments should advance the creation of neighbourhood-based interprofessional family medicine practices, starting in areas of greatest need. The practices would be accountable for the needs of the local population. Family physicians and other team members would be employees with benefits. If they left, the practice would be responsible for replacing them and ensuring patients continued to have care. Several countries (e.g., Norway, Finland and the UK) have implemented this model of neighbourhood-based primary care. Existing family practice networks in Canada are a potential precursor on which such services could be built. Neighbourhood-based primary care could also facilitate better collaboration among primary care, community and social services, and public health, which can in turn improve health equity and optimize resource use.

Groups of family practices could organize after-hours care in urban and suburban areas, as in the Netherlands, where cooperatives of 50–250 primary care physicians provide after-hours care to populations of 100 000–500 000.[15] Access to care is via a single regional phone number, with calls answered by nurses who provide initial triage. Physicians are supported by information and communication technology and medically trained drivers who facilitate home visits. With regionally organized urgent and after-hours care, resources currently directed to walk-in clinics could be redirected to strengthening comprehensive, longitudinal family practice.

Everyone in Canada deserves access to primary care. Training more family physicians is not the only answer. It is time to boldly redesign our current systems with the goal of keeping the front door to the health system wide open.

References

1. Health Fact Sheets: Primary health care providers, 2019. Ottawa: Statistics Canada; 2020. Cat no 82-625-X. Available: https://www150.statcan.gc.ca/n1/pub/82-625-x/2020001/article/00004-eng.htm (accessed 2022 Oct. 21).
2. Kiran T, Green ME, Wu CF, et al. Family physicians stopping practice during the COVID-19 pandemic in Ontario, Canada. *Ann Fam Med* 2022;20:460-3.
3. Kiran T, Wang R, Handford C, et al. Keeping doors open: a cross-sectional survey of family physician practice patterns during COVID-19, needs, and intentions [preprint]. *medRxiv* 2021 Dec 21. doi: 10.1101/2021.12.20.21267918.
4. Brief on Primary Care Part 2: Factors affecting primary care capacity in Ontario for pandemic response and recovery. Science Table Covid-19 Advisory for Ontario; 2022. Available: https://covid19-sciencetable.ca/sciencebrief/brief-on-primary-care-part-2-factors-affecting-primary-care-capacity-in-ontario-for-pandemic-response-and-recovery/ (accessed 2022 Oct. 21).
5. Rudoler D, Peterson S, Stock D, et al. Changes over time in patient visits and continuity of care among graduating cohorts of family physicians in 4 Canadian provinces. *CMAJ* 2022;194:E1639-46.
6. Kiran T, Kopp A, Moineddin R, et al. Longitudinal evaluation of physician payment reform and team-based care for chronic disease management and prevention. *CMAJ* 2015;187:E494-E502.
7. Kiran T, Moineddin R, Kopp A, et al. Impact of team-based care on emergency department use. *Ann Fam Med* 2022;20:24-31.
8. Sinsky CA, Willard-Grace R, Schutzbank AM, et al. In search of joy in practice: a report of 23 high-functioning primary care practices. *Ann Fam Med* 2013;11:272-8.
9. Bodenheimer T. Revitalizing Primary Care, Part 2: Hopes for the future. *Ann Fam Med* 2022;20:469-78.
10. Anderson M, O'Neill C, Macleod Clark J, et al. Securing a sustainable and fit-for-purpose UK health and care workforce. *Lancet* 2021;397:1992-2011.
11. Hedden L, Banihosseini S, Strydom N, et al. Family physician perspectives on primary care reform priorities: a cross-sectional survey. *CMAJ Open* 2021;9:E466-E473.
12. Phillips RL Jr, McCauley LA, Koller CF. Implementing high-quality primary care: a report from the National Academies of Sciences, Engineering, and Medicine. *JAMA* 2021;325:2437-8.
13. Patient's Medical Home [website]. Toronto: The College of Family Physicians of Canada. Available: https://patientsmedicalhome.ca/ (accessed 2022 Oct. 21).
14. Glazier RH, Gozdyra P, Kim M, et al. Geographic variation in primary care need, service use and providers in Ontario, 2015/16. Toronto: Institute for Clinical Evaluative Sciences; 2018.
15. Giesen P, Smits M, Huibers L, et al. Quality of after-hours primary care in the Netherlands: a narrative review. *Ann Intern Med* 2011;155:108-13.

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