

Primary care outreach in Markham, Ont

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Historically, Canadian family physicians have operated out of their own clinics, providing excellent primary care to patients who come through the front doors. More recently, health care delivery has moved away from older models of paternalistic, physician-centred care and toward patient-centred care. At the same time, there are ongoing efforts to maximize efficiency in our resource-limited health care system. One approach that could be integral to the future of health care delivery in Canada is primary care outreach.

Health for All is a new family medicine teaching unit in Markham, Ont, affiliated with the University of Toronto in Ontario. In addition to delivering and teaching excellent primary care, the new team is committed to global equity and social justice. When the team is up and running with a full complement of residents, the unit will serve 10 000 patients, and the aim is to proactively seek out patients who would otherwise have difficulty navigating the health care system. In September 2010, as part of my Fellowship in Global Health and Vulnerable Populations at the University of Toronto, I set out to help Health for All identify the underserved populations in Markham and the barriers to accessing primary care that existed.

During a 1-month period, I met with representatives of community groups in Markham, senior administrators at the Markham Stouffville Hospital and the Town of Markham, and leading public health experts and primary care advocates in Toronto. Given that up to 75% of the population in areas of Markham are immigrants (and up to 65% speak neither French nor English at home), I expected that these would be the people who had difficulty accessing primary care, and that ultimately they would welcome a presentation on how to access primary care services.¹ The reality was quite different.

Underserved

In 2001, the National Centers of Excellence in Women's Health identified axes of oppression for women in accessing primary care in the United States: age, sexual orientation, socioeconomic status, gender, race, and ethnicity.² After my community visits and interviews, I added people with disabilities and stigmatized populations to my list.

Contrary to my preconception that people would not have family doctors, the impression I got from discussions with medical experts and community leaders was that most people in Ontario who want family doctors have them. In fact, 90% of Ontarians reported having regular medical doctors, 95% of Ontarians with chronic conditions reported having regular medical doctors, and few reported experiencing serious barriers to accessing primary care.³

This is not to say that barriers to access do not exist. The *healthy immigrant effect* is a well-documented phenomenon in which new immigrants, on average, arrive in better health than native Canadians and, over time, their health declines until it converges with that of the Canadian-born population.⁴ In fact, the 2001 Canadian Community Health Survey found greater use of general practitioners by visible minorities, yet considerably lower use of cancer screening tests such as prostate-specific antigen testing, mammograms, and Papanicolaou smears.⁵ The only group I encountered who did not have equal access to family doctors was the homeless and underhoused; for example 75% of clients of a Markham identification clinic had family doctors compared with 95% of the general population.⁶ Other underserved groups identified included the lesbian, gay, bisexual, and transgendered community; patients with palliative diagnoses who had been discharged from specialist care in Toronto; and young, pregnant teenagers not living at home. With a longer time frame for the project, many other underserved groups in Markham almost certainly would have been identified.

A variety of barriers to access emerged, which I grouped together under language, cultural, informational, cost, and transportation categories. These categories were not mutually exclusive.

Language barriers manifest in patient inability to convey health concerns in English, patient inability to interpret medical directions, and physician inability to comprehend health concerns.⁷ A considerable barrier that I have witnessed time and again training in Montreal, Que, northern Ontario, and Toronto is the inadequacy and unacceptability of interpreter services. Patients are generally expected to convey their health concerns through family members, often grandchildren. While specific immigrant or refugee health centres have evolved in Ontario with ethnocultural-specific staff support workers and interpreter services, there remains room for improvement in this area.⁸

Informational barriers can exist to navigating the health care system, as well as to educating patients about health-related issues and recognition of the need for care. For example, in China hospitals provide primary care. New immigrants often assume that the same is true here and have no concept of what family doctors are or the services they provide. In addition to language and cultural informational barriers, illiteracy and cognitive impairment are pervasive barriers to dissemination of health information.

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Among those older than 16 years of age, 42% of Canadians and Ontarians, and 48% of Torontonians, have literacy levels below that required to cope in a modern society.⁹

While Canada is widely revered for its universal health care system, cost remains an important barrier to accessing primary care. Many providers are unfamiliar with the Interim Federal Health Program for new refugees, who then face substantial costs that should be covered by the program.⁴ In Toronto, 18% of homeless people have never had health insurance and 31% do not have health insurance cards.¹⁰ Even with the Ontario Health Insurance Plan, many people cannot afford medications, equipment, eyeglasses, and dental care. Some of these patients get labeled as noncompliant, further compounding their access issues. Geographic access to family physicians can be poor and public transit can be costly and difficult to navigate, particularly for elderly and infirm patients. Of course, the discussion of cost would not be complete without addressing the issue of physician knowledge of the social determinants of health, and their lack of awareness of patients' income levels, housing status, and personal circumstances.

While evidence suggests—and community leaders in Markham agree—that immigrants have access to family doctors, ethnocultural barriers can influence the acceptance of preventive care, screening, and treatment. New immigrants tend to integrate in a functional way, but only go to see doctors when they are suffering. It takes generations to change behaviour when it comes to regular check-ups, antenatal care, diet, exercise, smoking, and stress management. Also, the illness experience differs considerably among cultures, and patients might describe their symptoms in terms of the Taoist concepts of *yin* and *yang*, or believe that hostile spirits or curses are the root cause of their illnesses. Provider awareness of these cultural differences is essential to caring for these patients adequately.¹¹


Overcoming

While a multitude of barriers to accessing primary care in Markham were identified, it was abundantly clear that there is great potential for the new family medicine teaching unit to actively address these barriers. The seeds for community partnerships have been sown; a vision retreat hosted by the Health for All team was well attended by many community leaders, patients, and hospital and municipal administrators who were interviewed for this project. The desire for community-based services expressed by many of these groups was supported by the findings of the 2003 nurse–community health advocate study, where barriers to access were reduced substantially by providing assistance with transportation, accompaniment to secure health services, interpretation and translation of health information, advocacy, information about local resources, and education about health and self-care.¹²

One success story in primary care outreach comes from the family medicine teaching unit at St Michael's Hospital

in Toronto, where family medicine residents spend 6 weeks at Seaton House practising with marginalized populations in shelters. This experience plants the seeds of social justice in family medicine trainees and aligns with the CanMEDS–Family Medicine role of health advocate.

A local success in Markham involved a community-based group that provided services in various community settings including Sikh temples, mosques, and churches. In partnership with the Markham Stouffville Hospital, a diabetes screening and education program was carried out and was a resounding success in the eyes of both the providers and the patients. Unfortunately, the resources did not exist to carry the program forward, leaving community members frustrated. This model for bridging the gap between mainstream programs and difficult-to-reach populations should be considered for future primary care initiatives while being mindful of the need for sustainability.

Health for All has initiated a process of proactively identifying barriers to accessing primary care in the community and reaching out to community groups, the Town of Markham, and other health care professionals to build partnerships and identify opportunities to connect with and care for underserved populations. While there are many challenges to this approach—not the least of which is the identification of new resources and the potential realignment of existing resources—the Health for All team is well positioned to take a leadership role, in partnership with the community, in establishing primary care outreach in Markham. 

Dr Taylor was a Fellow in Global Health and Vulnerable Populations in the Department of Family and Community Medicine at the University of Toronto in 2010 and 2011. He is now practising in Sioux Lookout, Ont.

Competing interests

None declared

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