Challenges facing efforts to strengthen primary health care

The Besrour Papers: a series on the state of family medicine in Canada and Brazil

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We are living in a global world—but most schools and books still tell us only parochial histories of one particular country or culture. The truth is that there are no longer any independent countries in the world.

Yuval Noah Harari[1]

It is hard to imagine countries more different than Canada and Brazil. Or is it? They lie in different hemispheres and possess very different climates, but they also share many similarities. Both are geographically vast (the size of the countries practically overlaps).*[2] Both share challenges of communication and transportation. And both thus must find creative ways to deliver health care to a large, dispersed, and diverse population.

A key message of the first iteration of the Besrour Papers, a series on family medicine and global health published in *Canadian Family Physician* beginning in 2015, can be summarized thus: Family medicine means very different things from context to context, and studying it on a global scale becomes challenging.[3] How do you collect data on a discipline that looks so different from continent to continent? In the series we tried to answer this question using different methodologies, including historical,[4] philosophical,[5] and narrative[6] approaches.

Strengthening primary care in Canada and Brazil

There is a question that is left hanging, however: How do we compare the collected data on family medicine across countries and continents? In this next series of articles, we will undertake a between-country comparison, comparing 2 countries that share parallel developments in strengthening primary care over the past few decades. Between-country comparisons are not new but are now more rigorous and more accepted as a method of generating new knowledge, especially to better explain health policy or health system phenomena.[7]

Brazil and Canada have a common interest in the promotion of family medicine as a key component of their health systems. Both nations are committed to learning from each other and have collaborated over the past decade on joint activities aimed at improving capacity in family medicine. In this milestone anniversary year of the Declaration of Alma-Ata (40 years ago) and the Brazilian National Health System (launched 30 years ago), we will begin, in this issue of *Canadian Family Physician,* to describe the successes and challenges in strengthening primary care in both countries.

The first article (**page 811**) identifies basic principles that are important to both systems, including in developing leadership in family medicine and in the new Brazilian primary health care strategy.[8] Capacity building has meant looking at multidisciplinary care in both contexts. But the authors propose that this must be balanced by trust as a key principle in any system. This includes developing trust with and between allied health team members, without disrupting trust between patients and their providers. A second level of trust in the system is just as important—preventing threats to the public provision of care. These tensions will sound familiar to many readers in Canada, and beyond.

Opportunities and lessons

Future articles will include commentary, research, and analyses that resulted from Brazilian-Canadian collaboration. Throughout the series, we will draw important contrasts and lessons from the comparison, rather than merely describing the systems in parallel. For example, one article in the series will compare current challenges facing both countries, including demographic changes and the plight of newly arrived migrant populations, as a lens to view the weaknesses of both systems. We will discover that mental health services are a weak point in both countries and that primary care reform is seen as vital to overcoming this in both settings.

Despite the vast geographic area and low demographic density in specific areas of each country (the northern regions of both), telemedicine capacity still has room to grow in both Brazil and Canada. Another article will contrast the different courses telemedicine initiatives have taken based on underlying legislative frameworks. In

*Canada is, in total, approximately 9.98 million km^2, while Brazil is approximately 8.51 million km^2. However, land mass (ie, the surface area of the country excluding bodies of water) compares more closely: 9.09 million km^2 versus 8.46 million km^2, respectively. Brazil is much more populous, however, with just over 200 million inhabitants compared with about 35.6 million in Canada.[2]

Brazil, it remains illegal to call a patient on the telephone to discuss medical advice. This has resulted in telemedicine being geared toward interpractitioner communication and rationing of waiting lists, with impressive results. In Canada, the focus has been on teleconferencing between physicians and patients in remote settings to save travel costs and facilitate access. More recently, e-consultation models have shown the power of interpractitioner virtual communication in Canada, and we can look at Brazilian models to guide us with scaling up.

The series will include original research contrasting primary care performance in Rio de Janeiro in Brazil and Toronto, Ont, in Canada using the Primary Care Assessment Tool. The Primary Care Assessment Tool scores in both cities were similar, but above the minimum desired, and the data suggest a greater heterogeneity in responses from Rio de Janeiro. The authors conclude that primary care still needs to be the focus of more investments to reach its full potential and they point toward strategies to improve access, continuity, and coordination of care, including using telemedicine models. One important lesson for Canada might be to take geographic catchment back into account when planning for health services.

Looking to the future

Another article will examine training for excellence in postgraduate programs and the experience of Rio de Janeiro in the development of a competency-based curriculum with the support of health professionals from Canada. Despite the collaboration, revealing differences remain between the countries. For example, certain family medicine residency programs in Brazil exist outside of the university structure, highlighting the importance placed on centralized planning.

Other contributions are in early stages, and we invite readers to share ideas and propose themes to be contrasted between the countries. It is easy to focus on one's immediate environment, full of familiar strengths and challenges. But this can lead to a false sense of comfort or even cynicism. Familiarity is a necessary prerequisite to efficiency, but it can also be a barrier to innovation. By looking beyond our own backyard, we come face-to-face with what else might be possible.

An overarching difference between the Brazilian and Canadian realities emerges: that of agency. Despite some familiar frustrations, family physicians in Canada still retain, by global standards, an unusual and large degree of autonomy and influence on their immediate work environments. The resulting heterogeneity can make organization and scaling up of primary care initiatives challenging. But physician agency in Canada also presents a unique opportunity for advocacy and influence at the system level.

We hope that both Canadian and Brazilian readers will enjoy this second Besrour Papers series. And we hope that lessons drawn from each context will help both practitioners and patients from the other. In our globalizing world, we are all much closer—and getting closer as time passes—than we realize.

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Competing interests
None declared

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