Access done right

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Dear Colleagues,

By the time you read these lines, the federal election results will be known and the CFPC will be continuing its advocacy with the elected government and all federal parties, as we have always done. We aim to advance conversations about the role of FPs in community care, including about the evidence of better population outcomes in health care systems that include FPs.

An important focus of our advocacy is on the role of FPs in supporting access to care. By this we mean "access to high-quality continuous, comprehensive care close to home."[1] Improvements in access have been modest in the past decade; 4.6 million Canadians do not have access to an FP or primary care team now, compared with 5 million Canadians 10 years ago.[2] A June 2021 Nanos survey of the public, commissioned by the CFPC, reveals that most respondents prefer to see their FPs even if they have to wait.[3] In a recent report comparing 11 high-income countries' health care systems, Canada's rank regarding the domain of access to care has improved slightly, now ninth as compared to 10th in 2017.[4] We remain 10th out of 11 overall in health care system performance.[4] What can we learn from countries that do better and what are some of the options for decision makers to consider?

Norway, the Netherlands, and Australia are active in 4 areas that, considered together, have a positive impact on access.[4] First, *universality,* defined as a service that is free of direct charge at the point of care, remains important. We need to continue to defend this principle. I note that the above countries are geographically smaller than Canada and have 1 main decision maker (as opposed to 14 governments, such as we have). The second area is investment in primary care to ensure that high-value services are equitably available. Canada has made some investment in primary care, but it has been patchy, often under the "pilot project" umbrella. Examples of investments with positive early outcomes do exist here. However, these investments need to be scaled up, sustained, and not put at risk with every election cycle. The third important area is reducing the administrative burden on patients and clinicians. While we are not facing this burden to the same extent as our counterparts in the United States, we all recognize—through our experience with the completion of forms, electronic medical records that do not have the end user in mind, the lack of interoperability of data systems, and multiple pathways and processes of care—that there are opportunities for improvement. Finally, investing in social services is a fourth way to positively affect access. Consistent investments in equitable access to nutrition, education, child care, community safety, housing, and transportation have been shown to reduce the demands on health care.

The CFPC is advocating in the following key areas[1]:

- In collaboration with the Canadian Medical Association, we are recommending the creation of a $2 billion Primary Care Access Fund to enable changes in the organization of family practice across the country to enhance accessibility using the Patient's Medical Home (**patientsmedicalhome.ca**) model of care.
- We are urging governments to provide long-term public support for virtual care to facilitate, for example, the development of standards of care (which would include an acknowledgment of virtual care's limitations and recommendations on how to incorporate it in the context of a holistic provider-patient relationship).
- We are engaging in an anti-racism journey, as an essential dimension of improving access.
- As appropriate, with input from several member committees and working groups, we advocate for the importance of addressing social determinants of health.
- We support pharmacare, as well as interdisciplinary models of care to enhance access to mental health care.
- We suggest it is time to broaden our approach to how we pay FPs, in a dynamic practice environment where complexity is the norm. I recognize that all payment models have their advantages and drawbacks. A modern payment model can and should support better access and enable better group arrangements for after-hours care, proactive care, and complex care.

Family physicians are committed to improving the quality of health care delivery, and this includes improved access. It is time that we stop blaming FPs for not being accessible. We need to recognize that resources are required to support them to organize their practices to enhance access. This should be an important priority for decision makers as we emerge from this pandemic.

Cet article se trouve aussi en français à la **page 791.**

References

1. *Strengthening health care—access done right.* Mississauga, ON: CFPC; 2021.
2. *Table 13-10-0096-01. Health characteristics, annual estimates.* Ottawa, ON: Statistics Canada; 2021.
3. *Canadians are seven times more likely to want care from their own family physician rather than a family physician they do not know. National survey.* Mississauga, ON: CFPC; 2021.
4. Schneider EC, Shah A, Doty MM, Tikkanen R, Fields K, Williams RD II. *Mirror, mirror 2021: reflecting poorly. Health care in the U.S. compared to other high-income countries.* New York, NY: The Commonwealth Fund; 2021.

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