Future of family medicine in Canada

Four evidence-based strategies for health care transformation

Alan Katz MBChB MSc CCFP FCFP Alexander G. Singer MB BAO BCh CCFP

Winds of change are blowing across the primary care landscape in Canada. The College of Family Physicians of Canada's (CFPC's) Outcomes of Training Project would have led to a 3-year family medicine residency but has been paused for the time being.[1,2] In 2022 the Government of British Columbia made the dramatic announcement that it would offer a completely revamped compensation structure for family physicians that moves away from fee-for-service payment.[3] Many articles, from press releases to scientific literature, have highlighted the dire need to improve access to primary care in Canada.[4,5] The time for change is now.

To address the crisis in primary care that is affecting all parts of the health care system, family medicine must lead substantive efforts to build sustainable, high-quality primary care delivery. Reforms that lead to and support a robust and resilient health system at large must be adopted in a pan-Canadian fashion. When important changes are undertaken in some jurisdictions but not others there is a risk of exacerbating inequalities in physician supply that may cause new workforce maldistribution. We discuss 4 key evidence-based initiatives our discipline should champion and actively support.

Phase out fee-for-service payment

Our discipline should adopt funding models for family physicians that phase out fee-for-service payment and replace it with mechanisms to support team-based primary care delivery that is responsive to community needs.[6] Some funding models are barriers to change,[7,8] and without recognition that the current fee-for-service funding model does not serve the delivery of high-quality population-level care we are at risk of remaining stuck with a dysfunctional, uncoordinated, vastly heterogeneous primary care system. To achieve a robust, community-centric model of team-based care, the change that is required is revolutionary, not evolutionary. Several other experts have similarly made the case for precisely this type of radical adjustment from fee-for-service to alternative funding models for primary care.[9-11]

Rather than emphasizing quantity, the reorganization of primary care must emphasize quality of care. We must resource and build interdisciplinary primary care teams that can serve both existing practice populations and the estimated 6 million Canadians who do not have a family doctor.[12,13] These teams could also support rostering of patients, an important way to enhance continuity of care, which is known to improve outcomes.[14]

Promote real-time information exchange

Our discipline should promote policies, procedures, and tools that implement near–real-time information exchange that follow patients throughout the health care system.[15] We need to acknowledge gaps that Commonwealth Fund international surveys and Organisation for Economic Co-operation and Development reports have repeatedly observed in Canadian health care, such as long wait times, a lack of data, and overreliance on emergency care.[5,16,17] These challenges are exacerbated by our siloed data systems and policies that limit data sharing based on privacy concerns.[18,19] The protection of patient privacy must be balanced against the harms of not sharing information that could support patient care and improvement initiatives.[20] Reports from both the Pan-Canadian Health Data Strategy and the Ontario COVID-19 Science Advisory Table set out meaningful and practical steps that, if undertaken, could build this data infrastructure.[21,22] Federal legislation mandating electronic medical record interoperability, including a data access framework that supports an acceptable level of privacy protection, could be linked to specific federal health funding transfers.

Integrate primary care service planning and delivery

Primary care service planning and delivery should be connected with and integrated into other health and social services. The Fuller Stocktake report from the United Kingdom, published in 2022, provides insights into where to direct efforts in building an accessible and integrated health care system with primary care at its foundation.[23] It articulates 3 key roles of an effective primary care system: providing access to acute care services for ill patients, providing personalized team-based care for patients with chronic conditions, and decreasing mortality and morbidity through preventive approaches to care.[23] These fundamental roles must then be integrated into the broader system to maximize functioning and to support optimal patient outcomes and experiences. The report outlines steps designed to achieve an integrated and effective primary care system. And while the report was written for the United Kingdom, it is also applicable to Canada.

Adopting the approach from the Fuller Stocktake report would mean bringing together previously siloed teams and interdisciplinary professionals to do things differently. The report suggests that this approach is usually most powerful in communities of 30,000 to

50,000 people, where teams from across primary care networks—including primary care providers from different disciplines, social services staff, and home care staff—share resources and information to tackle health inequalities.[23] It would require fundamentally reorganizing our current approach to primary care and data accessibility to drive system-level decisions, planning, and service execution.[24]

Implementing the 3 aforementioned components of the vision outlined in the Fuller Stocktake report for integrated primary care would enable local systems to plan and organize complementary urgent and emergency care services, such as developing integrated urgent care pathways in the community.[25] Patients with greater vulnerability (either social or medical) should receive priority for more timely continuity-based care through the interdisciplinary team.[26] Access to both preventive and anticipatory care (eg, to support people with either moderate or severe frailty with no recent primary care encounter) is required to meet population needs in the community.[27] The overall goals of an integrated vision of primary care delivered through multidisciplinary family practice teams, such as those described in the CFPC's Patient's Medical Home vision, are to maximize people's well-being, maintain independence, and empower individuals to make decisions about their care.[28]

Provide supportive training

Training should support primary care leaders and team members in delivering high-quality team-based care. Family medicine residency programs need to move away from preparing residents for physician-focused responsive care to integrated team-based primary care that addresses the specific needs of their target populations. Therefore, we require training programs that produce future leaders in primary care who understand how to thrive with lifelong learning and curiosity and to help co-design the primary care teams that will deliver the high-quality services that are needed.[29] According to Kolber et al, the current generation of family physicians does "an impossible job … impossibly well" in meeting the challenges of the complexity of care they provide,[30] but they will need to acquire new skills to be able to function well in new types of practices. The dysfunction of the system around us must be acknowledged and we should drive improvements that promote the values and ethics that brought us into family medicine. Collectively, we must commit to making our discipline one that is attractive to students rather than one that is entered as a last resort.

Compelling circumstances often create urgency that leads to change, such as the rapid shift to virtual care during the pandemic, that is then followed by slow and gradual refinements.[31] Considering this, the novel primary care teams that will be formed must participate in ongoing quality improvement and undergo regular accreditation with oversight that focuses on the Quintuple Aim.[31] While the goals are clear, the world around us continues to change, which makes it imperative that our discipline continues to evolve as well.

The implementation of our vision and the necessary changes to primary care will not be easy to achieve. It will require a major cultural change at multiple levels and appropriate leadership, governance models, and approaches to evaluation and learning that support successful implementation. A fundamental aspect of the vision is a decentralized approach, which builds local community collaboration and planning that meet the community's needs while eliminating redundancy caused by overlapping responsibilities. Key changes that could facilitate this renewal include the following:

- providing federal transfer payments tied to specific population-based outcomes that include access to timely primary care for patients with acute and chronic conditions in community-based settings;
- incentivizing real-world outcomes, not just patient throughput;
- integrating provincial and territorial data systems based on supportive privacy legislation that enables patient-centric sharing;
- building integrated teams responsive to community needs and working across the spectrum of health and social services to deliver primary care that meets those needs; and
- providing the infrastructure, funding, and training needed to develop and sustain integrated teams that can offer appropriate access to community-based primary care, regardless of whether it is urgent, chronic, or preventive.

Conclusion

Almost all health care planning and funding in Canada currently focus on the acute care sector. At this time of fiscal restraint, leadership at all levels should redirect limited resources to the more cost-effective community-based planning and service provision. The human resource crisis facing health care in Canada will only get worse if we do not take the current crisis as an opportunity to fully reimagine how primary care is organized, delivered, measured, and improved. The CFPC needs to encourage family doctors to abandon existing models that promote siloed and disconnected practices and support them in building and leading dynamic teams that meet the health care needs of the communities they serve. At the same time, there must be a broad commitment to reinvest in the needs of communities with a focus on care delivered outside the walls of hospitals.

Dr Alan Katz is Professor in the Department of Family Medicine and the Department of Community Health Sciences at the University of Manitoba in Winnipeg, a clinician and health service researcher in Winnipeg, and a senior researcher and former director of the Manitoba Centre for Health Policy. **Dr Alexander G. Singer** is Associate Professor and Director of Research and Quality Improvement in the Department of Family Medicine at the University of Manitoba and Director of the Manitoba Primary Care Research Network.

Competing interests
None declared

Correspondence
Dr Alan Katz; email **alan.katz@umanitoba.ca**

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