

Aligning the policy-created gardens of Canadian primary health care

Toward a new access landscape

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Between 5.4 and 6.5 million Canadians are unattached to a family physician (FP).^{1,2} In the absence of demand-side adjustments that seem both physically and politically unlikely in the context of Canada's aging population, considerable government spending and policy innovation has focused on increasing the availability of primary health care (PHC) but not necessarily the number of practising FPs. FP-focused efforts to increase the supply of PHC have included: the commissioning of new medical schools or increases to the spaces and supports for FP training at existing schools³⁻⁵; efforts to recruit and license foreign-trained doctors^{6,7}; efforts to combat the early retirements and moves to part-time practice^{8,9} that originate in FP burnout¹⁰ and dissatisfaction with paperwork requirements¹¹; and a sustained focus on delivering care through teams of providers led by FPs instead of individual FPs.¹² This team-based care (TBC) approach is emphasized in provincial policy across the country and envisions interprofessional groups collaborating to expand the availability of PHC as each team member practises at the top of their licensure.¹³

Garden models for TBC

Policy efforts notwithstanding, investment to increase the number of FPs has not kept pace with Canada's population growth. The medical school graduation rate per population places Canada among the lowest in the Organisation for Economic Co-operation and Development.¹⁴ Alongside this protracted underinvestment, provincial governments have enacted policies to increase PHC availability through non-FP means.¹⁵⁻¹⁷ These policies created more potential members for PHC teams, adding to an already confused landscape.

If the aim of FP-led teams is to have members increase capacity and improve the work experience of FPs,¹² definitions of what, and how expansive such teams ought to be varies considerably in practice.¹⁸⁻²⁰ Operationalization of TBC (ie, team composition, structure, connection, and daily governance) has proved to be as varied as it is challenging to achieve under FP leadership.¹² Outside of that leadership, a range of provincial policies have added nurses, pharmacists, and other non-FP primary care providers to this underdefined team environment. In what follows, we discuss in more detail these policy-driven adjustments to the primary care team environment using the analogy of

2 styles of garden. This analogy differentiates FP-led and allied health provider-led approaches to TBC, and examines strengths, weaknesses, and complementarity as potential solutions to the primary care access crisis.

French classical garden

The well-known, FP-led French classical garden of the Patient's Medical Home (PMH) is a PHC-delivering team with a long policy and scholarly history of design and deployment. These well-ordered parterres have spent 20 years as an ideal mode of PHC delivery, and assume team leadership falls to doctors. The transfer of that ideal into everyday practice has been challenging. French classical gardens are, unsurprisingly, resource intensive to maintain, requiring constant attention and fertilization if they are to look and function at their best.

As well as being underdefined at the operational level and expensive to sustain, the French garden is more a feature of the medical education system than clinical practice. FP learners have consistently noted that, on graduation and entry into clinical practice, they encounter a mismatch between the French garden ideal and the reality of fee-for-service medical practice.^{12,21,22} In provinces where alternative payment models were introduced to support FP-led teams, the French garden approach was shown, across all levels of patient complexity,¹³ to reduce patients' use of expensive emergency department resources²³ while increasing physician job satisfaction.²⁴

Successfully operationalizing FP-led teams to improve care access and quality hinges on more than just payment reform.²⁵ Team members must also bring a particular understanding to the meaning of FP leadership. Successful French gardens arise when team members abandon physician-centric doctor-with-helpers mental models,²⁶ replacing them with a first-among-equals approach.²⁶ With a new generation of PHC-focused medical schools developing curricula to instill these mental models, and provincial governments in Ontario, Quebec, and Alberta committing resources to building on the PMH,²⁷⁻³² there is much promise here. However, the French garden approach will struggle to attach 6.5 million Canadians to care.

Dividing unattached patients by an FP roster size of 1200 yields a need for 5400 new family medicine graduates to meet the current care access shortfall. Given that most FPs in British Columbia and Ontario roster fewer

than 1200 patients,³³ this calculation is optimistic and does not account for future population growth while also assuming the continuation of older practice patterns and rates of FP retirement or attrition.

The French classical garden may have a head start when it comes to design and limited implementation, but there will not be enough physicians to helm these teams. As such, it is important to consider the English wildflower country garden alternative.

English wildflower country garden

The English wildflower country garden—a patch of what might be mistaken for weeds, and not so much designed as conjured into existence by policy activity—represents allied health provider-led PHC without an FP leader. English garden teams, whether they originate in animus toward physicians, ideological commitment to a free market, or a genuine desire to respond to the PHC access crisis, have been empowered through a range of public policies and payment systems. For example, ad hoc payment reforms and changes to legislation have allowed nurse practitioners to not only prescribe medication to patients, but also own and operate PHC clinics.^{34,35} Similarly, pharmacists were empowered to prescribe medication to patients for a range of minor ailments that were formerly the exclusive purview of FPs.³⁶ Corporate and independent pharmacies moved to provide PHC and now offer patients a range of counseling and complex care management.³⁷⁻⁴⁰

These examples illustrate how policy changes ensured elements of preventive and comprehensive PHC are not being delivered exclusively by FP-led teams, and how the resulting English garden might easily be mistaken for a patch of weeds. If defining and operationalizing a team-based approach within the classical French PMH proved challenging, then the term is almost meaningless here in the English garden; it would be a euphemism for the balkanization of PHC work if applied.

None of the team members in an English garden are connected to one another in a way that would ensure a pharmacist's assessment and medication prescription would be included in a patient's electronic medical record at their FP's clinic. Beyond communication and data sharing issues, there are the thorny problems of professional turf guarding that, patient centrism aside, contribute to a near total absence of collaboration or other team-like behaviour in the English garden.

Research and policy to connect the gardens


Is the next step to apply weed killer, halting wildflower progress and focusing on the orderly but underdefined, expensive, and limited plantings of the French garden PMH? Or is the dysfunctional English garden a candidate for less radical policy activity? In contrast to the French garden's demands for tending, the English garden may well prove, with the correct policy incentives and

adjustments, to be self-fertilizing. With little evidence currently available on the relative costliness of the 2 garden styles, there is much guesswork here. That said, the present patch of weeds may be able to derive beauty less from perfectly straight lines and FP leadership, and more from rich combinations of colour as teams are empowered to work out the best way to deliver PHC together with legislation, developmental supports, and payment models.

There is a risk to putting all of our gardening energy and resources into the classical French design. If we do not spare time and focus for the weedy, publicly funded English gardens, we increase the chance Canada will move toward a tiered health care system with private-pay options. Innovative disruption theory suggests that when an incumbent organization or method—like the French garden approach to TBC—struggles to deliver service at an affordable price, competitors will emerge, disrupting and segmenting the market.

Bringing the 2 types of gardens into functional alignment and delivering PHC to all Canadians will require more serious conversations about governance, financing, and the installation of collaborative mental models than has taken place to date. On the 40th anniversary of the *Canada Health Act*, there have been calls for major reforms to the legislation and underlying social contract,⁴¹ with a specific eye to including other primary care clinicians beyond FPs as insured services.⁴²

As policy research and efforts to merge the 2 types of gardens moves forward, some wildness will be introduced into the PMH as some order and collaboration is introduced into the highly uncollaborative wildflower chaos of community-delivered PHC. If that work is done in a way that privileges French gardens and their FP leadership, it will deny the reality of how many doctors our system can maintain or fund. If English gardens are privileged, then free market competition—albeit inside a single-payer system—is likely to raise objections of privatization. However, if we do not attempt to merge the 2 types of gardens at all, the health care access crisis will continue.

Specific policy design considerations should include focal attention to building data infrastructure and education interventions that support teamwork across the gardens; driving efficiency through local flexibility and accommodation of patient need; ensuring billing models encourage, rather than discourage, comprehensiveness in care, regardless of where it is accessed; creating scopes of practice and governance regimes that balance access options with safety; advancing legal frameworks for record keeping and responsibility to support efficiency and access across the gardens; and, finally, preparing for the changes that artificial intelligence is bringing to the management of data and complexity in PHC. 

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Competing interests

None declared

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