

Stronger together - primary care and public health

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I am a family physician. I am a public health advocate. I am a health systems researcher. Now I am a "frontline worker". I have witnessed care in COVID-19 assessment centers, long-term care centres, group homes, outpatient primary care clinics and hospitals. What I have seen is troublesome. Family physicians are no longer the first point of access to care, destabilized by the lack of mandate and resources by the Ministry of Health and lack of integration with public health, to address the emerging health needs of our society.

Family physicians and primary care providers are best suited to be the first point of access in the health care system for patients. For many reasons this is no longer happening since the arrival of COVID-19. The most obvious reason is the disconnect between public health and primary care. We must learn from this experience to ensure that the relationship between primary care and public health is strengthened now - not only to overcome COVID-19, but also to guarantee the health and well being of our communities for the future.

Despite having experienced SARS within living memory, we have been complacent. Although investments were made when memories were fresh, **cuts to public health were imminent again last year**, highlighting a decline in the perceived value of our public health sector. Once again, we are in a situation where the public health sector is overwhelmed and lacks the human resources to manage the innumerable responsibilities at hand. Family physicians and community primary care providers are best suited to support public health functions. Yet, it is not happening even though both are mandated to serve similar functions - namely, health prevention, protection, promotion, and surveillance of defined populations.

85% of Canadians have a family physician with whom they have a relationship and receive ongoing care. It seems obvious that family physicians are optimally placed to continue to provide care to these defined populations during a pandemic. This role is even more critical for the most vulnerable (patients who live in long-term care homes, group homes, and the homeless, to name a few). Unfortunately, to date, the COVID-19 model of care has been for the Ministry of Health to facilitate first-line care through hospitals and secondary and tertiary care settings which are not accustomed to delivering primary care in the community.

While working in COVID-19 assessment centres, it became clear that most are set up as **vertical programs** associated with hospitals. Indeed, they are critical programs that have been developed and implemented quickly to address an emergent need. However, they are structured to offer only testing, with limited support to address the rest of the issues facing concerned patients. Patients need assessment and reassurance to distinguish symptoms that mimic or may be exacerbated by COVID-19, such as congestive heart failure, chronic pulmonary obstructive disease, and/or coronary artery disease. They also require management of their presenting health concerns, whether COVID-19 or not. History has demonstrated, repeatedly, that vertical programming fails our patients and fails our communities. Disease-specific programs to fight TB, HIV-AIDS, Ebola and now COVID-19 do not work in isolation, nor should our responses. Patients who present to testing centers deserve comprehensive and holistic care using a patient-centred approach, more now than ever.

The disconnect between primary care and public health was again evident when supporting a group home struggling to cope with a possible COVID-19 outbreak. As a family physician, I was independently unable to

obtain nasopharyngeal swabs or testing requisitions despite contacting multiple public health units. Rather, all residents of the home were intended to go to an assessment centre for testing. The residents of this home were medically complex and many wheel chair bound. Taking them to an assessment center definitely seemed less safe than having in-house testing. Family physicians and primary care providers who normally care for individuals in congregate settings, including long term care homes, retirement homes, group homes and homeless shelters should be provided with the tools to complete the testing, minimizing travel, further exposure and safety risks for the most vulnerable. Continuity of care can also be ensured, education delivered, and risk mitigated.

Furthermore, the integration of roles and skillsets among public health and primary care could facilitate seamless and comprehensive care. For example, training primary care providers in **Infection Prevention and Control** (IPAC) empowers frontline providers who are already embedded within congregate settings to implement new protocols, with possible immediate impact on reducing infection spread.

There are critically important roles for all health care sectors to play in response to the COVID-19 pandemic, including family physicians and specialists, primary, secondary, and tertiary care alike. However, family physicians and primary care have been sidelined in this fight. We can be an integral part of the response, and that is best achieved by implementing systems that integrate both primary care and public health. The changes needed to accomplish this need not be complicated but do require streamlined communication and collaboration between public health, hospitals, and primary care. It necessitates a fundamental change in how leaders prioritize public health and health care delivery and funding. It also requires a greater commitment to primary health care by governments, which also includes public health and addressing the broader determinants of health through ensuring health in all policies.

For far too long, primary care and public health have worked in silos in the Canadian context. As a family physician who believes whole-heartedly in all aspects of primary health care, I know we can do better. Primary care and public health must be integrated - if not now, when?

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