Observations on primary health care in Ontario, Canada

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SUMMARY. The Canadian health care system has developed very differently from that of its neighbour, the United States of America. It has a publicly financed and administered universal insurance plan which provides good access to high quality medicine, free at the point of delivery. Increasing costs, however, mean that painful political decisions on health will have to be made. Experiments with alternative means of financing primary health care provision and the Canadian approach to postgraduate education may offer useful ideas for general practice in the United Kingdom.

Introduction

SINCE 1965, Canada has been committed to a universal hospital and physician insurance plan to finance its health care system.[1-3] Funding is shared by the federal and provincial governments although care is provided by the private sector. This is a very different system of health care from that which has been developed by Canada's close neighbour, the United States of America.

The Canadian health care system is relatively inexpensive — in 1984 personal health care expenditure was $27.9 billion US, 8.5% of Canada's gross national product or $1115 US per capita. These figures compare very favourably with those of the USA where personal health expenditure totalled 10.6% of the gross national product in 1984, or $1580 US per capita, of which 41.4% was derived from public sources. Approximately 75% of total health care expenditure in Canada is covered by the publically financed health programmes and the remainder — adult dental care, non-prescription drugs, costs of long-term care and other items — is financed by private means. The system aims to ensure that every Canadian citizen is eligible for high quality health care which is free at the point of service. The health insurance schemes are administered provincially, although funded approximately equally by federal government and individual provinces. The actual provincial programmes vary slightly but under the medical care act of 1966 they are all obliged to conform to basic guidelines laid down by the federal government and the exact interpretation varies according to the perceived needs of each province, determined by resources, geography and population.

Cost effectiveness

The Canadian system of health care is probably one of the most cost effective in the world and from 1982 to 1987 costs were maintained at approximately 8.5% of the gross national product while the cost of health care in the USA rose from 10.2% in 1982 to over 11% (estimated) in 1987.[4] This difference is almost completely accounted for by three components: costs of administration, payments to hospitals and payments for physician services — 0.59%, 4.18% and 2.07%, respectively of USA gross national product versus 0.11%, 3.48% and 1.35% for Canada in 1985.

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Provincial health insurance plans are publically administered and operated on a non-profit making basis. The administration costs of the tax-financed Canadian system are much lower than the American system. The provincial health ministries control hospital costs by setting overall operating budgets for hospitals and all hospital capital acquisitions require provincial approval from the ministry of health. The provincial ministries of health also control physician fee schedules by periodic negotiations with the provincial medical associations. Because all Canadian citizens are covered by the system the rate of escalation of fees has been contained but individual physicians are able to maintain a high degree of professional autonomy.

Difficulties facing the health service

There are now signs, however, that the health insurance programme is under pressure. Canada faces a massive budget deficit and the government is trying to reduce this by cutting public sector spending, including a reduction in the rate of growth of federal transfers of funds to the provinces to finance health care. Additional problems include demographic factors, increasing consumer demand, the high costs of medical technology and a continuing emphasis on expensive hospital care. Hospitals are operating under tight budgetary constraints and this is provoking intense public debate about increasing waiting lists and areas of underfunding. However, as yet, the government has not acted decisively to constrain consumer demand or impose controls on the providers of health care, thus leaving untouched the basic economic incentives that drive health insurance plans. Obviously any moves to cut back health care provision would be very unpopular with both physicians and patients and the law banning extra billing (the right of physicians to levy fees higher than those reimbursed by health insurance, the difference being met by the patient) passed in 1984 provoked a strike by physicians in Ontario.

Another difficulty facing the Canadian health service is the over supply of physicians and the problem of physician distribution, with too many doctors in training but too few prepared to practise in the remote rural areas. Medical school enrollment has been reduced, controls introduced to limit immigration of doctors and provinces are currently employing different strategies to induce doctors to practise in the less desirable parts of the country.

Many of the physicians I met while visiting Hamilton, Ontario expressed the fear that government attempts to constrain costs will test Canadian commitment to the existing totally tax-financed medical service. Many felt that modification of the Canadian health care system was necessary, either towards the British system, with increased central control and regulation or towards the entrepreneurial system in the USA by privatization. It will be interesting to see what happens over the next few years.

Organization of primary care

Primary health care in Canada has traditionally had the family physician as doctor of first contact, as in the UK, with specialists acting as consultants. However, Canadian family physicians also have a relatively large involvement in hospital care, particularly in rural areas. Ontario is Canada's most populated province (nine million people) and the Ontario Health Insurance Plan is representative of those in other provinces. Most Canadian family

doctors operate on a 'fee for service' basis and the schedules of fees are negotiated by each province in consultation with the medical profession. However, this is a complicated way of paying for medical services and is open to manipulation by individual physicians. The government of Ontario provides two alternative mechanisms for paying for primary health services: a capitation payment system in the form of health services organizations of which there are 27 to date in Ontario,[5] or funding by a global budget to run community health clinics, usually established in areas of high need, especially inner city areas and so far there are 13 in Ontario, including four multiservice clinics.

The aim of these alternative methods of organizing and financing primary health is to broaden the scope of primary and community health services and to achieve a reduction in the more expensive hospital care. They should also encourage health promotional activities, which are poorly paid for in the 'fee for service' system and allow effective use of other health care professionals in the family practice setting.

Health services organizations have two sources of income. The first is a capitation payment for each listed patient in the practice with valid health insurance; the annual capitation rate is based on the previous year's experience in the 'fee for service' system and is weighted according to the age and sex of the patient. The second payment, the Ambulatory Care Incentive Program, is a potential supplement based on the hospital usage of the listed patients, determined by comparing the rate of hospitalization and duration of stay for patients of a given health services organization with the average experience for the population of the relevant hospital district. In theory this should encourage the family physician to use community resources as a substitute for hospital inpatient care.

The community health clinic was pioneered by the centre in Sault Ste Marie.[6] The physicians are paid a salary and the clinics run by a local community board. Community health clinics are mainly sited in inner city areas with mobile populations of low social class with high unemployment rates, high immigrant populations and an excessive workload of psychosocial problems. My overall impression of practices with alternative payment mechanisms was that they are more likely to employ other skilled health professionals and to operate health education and screening programmes than a fee for service practice but to date no official audit has been carried out to prove conclusively that these alternative methods of payment do improve primary health care provision.

The Ontario Ministry of Health is continually assessing its policies and looking for ways to improve health care in the province. A consultative health care planning document for Ontario published in 1983 described the inadequacies of present primary and hospital health care and highlighted areas needing reform.[7] A report of the Ontario Health Review Panel[8] released in June 1987 pinpointed three key issues where attention should be focused in the next few years: (1) the need to strengthen the role of the individual in enhancing personal health and making informed choices about health care, (2) the need for new funding approaches and organizational arrangements to encourage the use of outpatient and community based health care programmes, and (3) the need to develop a clear strategy for health in Ontario. Certainly, in recent years the emphasis of health care in Canada has been moving towards prevention.

Impressions of general practice

I visited various family medicine practices in the area around Hamilton, a thriving steel town on the shores of Lake Ontario. In general, the morale of the general practitioners was very high. They enjoyed clinical freedom with few constraints and a relatively high earning capacity — the average income of a general practitioner was $86 000 US in 1985–86, which is approximately 74% that of medical specialists. Most general practitioners were in group practices and their health centres are well appointed and equipped, possibly because they need to attract their patients, who can easily 'shop around' for medical care. General practitioners in Canada seem to have virtually unlimited direct access to high technology investigations including computerized tomography scans and ultrasound. The usual arrangement of consulting rooms appears to be the provision of at least two identically equipped rooms per general practitioner and for the doctor to move from room to room to see his patients. This makes for streamlined consultations but also requires large premises with expensive duplication of equipment. Office hours tend to be from 09.00 to 17.00 hours with relatively few clinics offering evening or weekend surgeries. There was virtually no home visiting for chronic illness by the physicians I met and patients are often seen by their family physician in the emergency room of the local hospital rather than at home for out of hours consultations. Group practices tend to organize themselves into larger groups for on-call arrangements.

The number and range of attached staff varied from practice to practice. Several practices employed nurses in extended roles but their exact job descriptions were not the same. The Caroline group in Burlington pioneered the use of nurse practitioners over 15 years ago and they play an important role in that practice.[9] Educational programmes for nurse practitioners in Canada have now been suspended, although there is political pressure by the nursing profession to revive them.

Most practices owned computers but the extent to which they were used varied widely. Some practices used them solely for billing purposes, others just to keep a list of their patients. Some had sophisticated systems which held age, sex and disease registers, organized the appointment systems and recalled patients for follow-up or screening.

The extent of screening programmes varied widely among practices from no organized screening to extensive screening using computers for recall of patients. The same controversies exist as in the UK regarding opportunistic versus planned screening.

Unlike their British counterparts there is the almost universal possession of hospital privileges whereby family physicians are able to admit patients directly to hospital themselves and continue to care for them while in hospital. However, the prevalence of obstetric privileges is declining, as many family physicians are opting out because of the high cost of medical insurance for doctors involved in intrapartum obstetrics and the unsocial hours involved. It is estimated that only 25% of births in Ontario are now supervised by family physicians. This is creating a crisis in the obstetric service and it has been suggested that the training and licensing of midwives may help resolve the crisis. There is also much controversy regarding the adequacy of training in obstetrics for family medicine residents in Canada who plan to practise intrapartum obstetrics in rural areas, although the College of Family Physicians of Canada and the Society of Obstetricians and Gynaecologists have made recommendations on minimum training requirements (Livingstone RA. Ad hoc committee report on training programs in Canada in obstetrics and gynaecology for primary care physicians, 1983).

General practice education

The Canadian College of General Practice was established in 1954 and subsequently became the College of Family Physicians of Canada. It is concerned with supervision of the training of family physicians, continuing medical education for general practice and monitoring the development and future direction of family medicine. Specific training for general practice came about when the College of Family Physicians of Canada

established pilot family practice training programmes at the universities of Calgary and Western Ontario in 1966 and subsequently developed a certification examination in 1969. Currently all 16 medical schools have departments of family medicine and training programmes at postgraduate level. In 1984 there were 44 000 physicians in Canada of whom 50% were specialists. Of those working in family medicine, 8000 were members of the College of Family Physicians of Canada. Membership of the College is open to any physician who wishes to join but to maintain membership doctors have to complete at least 50 hours of approved continuing medical education per annum. Certification, which is voluntary, is obtained by examination of eligible candidates and a 'maintenance of certification' programme must be undertaken every five years. The latter is an educational programme which aims to assist candidates in reviewing their current knowledge of primary care literature. It involves the keeping of a practice log and the completion of a self-assessment examination after which the College sends detailed educational feedback so that the participant can address shortfalls in knowledge. This would appear to be an idea worth copying in the UK for improving the standard of continuing medical education of members of the Royal College of General Practitioners.

The Canadian residency programme in family medicine usually lasts only two years, including internship, which is probably not long enough. In particular, the obstetrics and gynaecology experience seems inadequate for those residents planning to be involved in total obstetric care in isolated rural areas. However, there is no doubt that the family medicine programme I observed at McMaster University Hospital, Hamilton, is more closely tailored to the needs of future general practitioners than most British schemes and in theory is planned around the residents' educational requirements rather than filling vacant service jobs. The residents are closely supervised with frequent evaluation of progress by both teachers and the students themselves and there appeared to be a willingness to modify the programme where shortfalls had been demonstrated. The behavioural science teaching was an important component of the course and addressed such important issues as human sexuality, terminal care and the dying, and strategies to deal with psychosocial problems. Considerable emphasis was placed on the development of interviewing and counselling skills. There was widespread use of videotaped interviews and two-way mirror consulting rooms in teaching residents and monitoring their performance. The final examination for membership of the College of Family Physicians of Canada includes the use of role play for assessment of clinical skills as well as written and oral components, perhaps something which should be included in the MRCGP examination in the UK.

Conclusion

At present the Canadian health care system seems to combine the best of both worlds, with rapid access to high quality, technologically advanced medicine free at the point of delivery, and, so far at least, with reasonable financial costs. Canadians are justifiably proud of their system but it is not without its problems, the major one being that the financing of the health service depends on a continuing high level of economic growth and the costs of the service are now beginning to outstrip the ability of the country to pay. Some unpopular political decisions lie ahead. Canadian physicians look with dread to the prospect of the increased state control and financial constraints they see in the UK but they are also alarmed by the alternative, a system more like that in the USA with its gross inequalities of health care provision. British general practice would do well to examine the way Canada, and Ontario in particular, is experimenting with alternative methods of provision of primary health care in view of the changes here.[11,12] We may also learn something from looking at the Canadian approach to postgraduate training for family medicine and the system of the College of Family Physicians of Canada for encouraging continuing medical education for general practitioners.

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