NO.4

PROTECT.
STRENGTHEN.
EXPAND.

STRENGTHEN MEDICARE:

BETTER FRONTLINE CARE

Canadians need better access to primary health care.* Millions of Canadians lack a primary care provider and have to rely on walk-in clinics. Few primary care programs are integrated with social services and community development. Community Health Centres (CHCs) best address clinical care needs and the social determinants of health, yet are under-resourced in every province.

Canada lags behind many developed countries in coordination, after-hours care, wait times, chronic disease management, mental health, quality improvement, and electronic medical records,[1] as well as measurement and accountability.[2] Team-based care is under-developed, despite evidence that it improves health outcomes and saves money.[3]

Community Health Centres, which combine medical care with health promotion, social services and community development,[4] are the best way to meet these challenges.

- CHCs deliver better care for people with diabetes, heart disease and other chronic conditions.[5]
- Communities engaged in decisions about their health and local services have better health outcomes.[6]
- In the US, where the federal government is doubling the national CHC network, CHCs compare favourably on national measures of clinical quality and patient satisfaction.[7]

CHCs are a better way to meet health provider shortages than physician-dominated private practice, even with changes to physician reimbursement and other reforms.

CUPE calls on the federal government to:

Promote access to effective primary health care with funding for new and expanded Community Health Centres.

- Health policy experts have shown that we have enough doctors; they aren't working in the right places, in the right ways.[8]

"We talk about five million Canadians not having access to a family doctor, but they should have access to an integrated health care team where the first point of care would not necessarily be a physician."

Dr. Paul Armstrong, founding president of the Canadian Academy of Health Sciences[9]

- Health providers are drawn to underserviced communities when they can be part of a CHC team, with mutual support, working to their full scope of practice. Ontario has expanded CHCs into rural and northern communities that had difficulty retaining physicians in solo practice.[10]
- Many provinces are changing how they pay and regulate doctors, with mixed results. Community Health Centres care for disadvantaged populations with more complex needs and still have better outcomes than physician-led models.[11]

* Primary care refers to medical, nursing and other clinical services; primary health care includes a broader group of providers focused on health promotion and early intervention, prevention and mitigation of illness.

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- An Ontario-wide study found that CHCs served high-needs clients and had lower than expected emergency department visits than any other model.[12]
- CHCs are non-profit and usually governed by locally elected boards accountable to clients, funders and the community. Physician-dominated primary care clinics operate as private businesses, with less transparency, accountability or even connection to the local community.
- CHCs respond effectively to the social determinants of health such as income, housing and the environment.[13] Combined, social determinants are more important to health than biomedical and lifestyle factors.[14]
- CHCs are the only model that meets all of the World Health Organization's criteria for a high performing primary health care system: community participation, intersectoral coordination and a focus on the social determinants of health.[15]

The potential is huge. Currently, only 300 communities – mainly in Ontario and Quebec – have a CHC.[16]

CHCs are rooted in Tommy Douglas' vision and the Saskatchewan birth of Medicare, and many federal reviews and reports since have recommended a major expansion of CHCs.[17] Most recently:

- The Health Council of Canada recommends that CHCs "be pursued aggressively."[18]
- The Wellesley Institute, a leading health equity think tank, recommends that the federal government earmark $360 million to kickstart 140 new CHCs to serve over a million Canadians.[19]

The federal government has a role. The federal $800 million Primary Health Care Transition Fund (2000–2006) kickstarted new programs across the country, with conditions tied to the funding. We need a new fund, this time tied to Community Health Centres.

Primary health care based on the CHC model means better and more equitable health outcomes for Canadians. It also means more transparent, accountable and cost-effective health care, compared to the dominant clinical care and private practice physician models. A new health accord can achieve this public solution to strengthen Medicare.

No. 4 in a series of fact sheets on CUPE's health accord proposals

Find citations in fact sheet notes and fact sheet references documents online at **cupe.ca/health-care/public-solutions**