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The primacy of primary care: reading Romanow

For Roy Romanow, primary care is not merely a category of services. It is a doctrine. Primary care is "a preferred approach," he writes,[1] and "[t]he objective of moving ahead with primary care is nothing short of transforming Canada's health care system." Mr. Romanow's definition of primary care is almost as amorphous as his vision is grand, and he makes no clear delineation of the overlapping territory of primary care as family practice and primary care as public health. Rather, we are offered broad statements such as "Primary care is about fundamental change across the entire health care system."

In its emphasis on prevention and the determinants of health, Romanow's report follows the tradition of the WHO declaration of "Health for All" at the Alma Ata conference of 1978, in which the definition of "primary care" was expanded to embrace public health programs such as health eduction, sanitation and immunization.[2] For many Canadians, however, the locus of primary care is still the family physician's office. As Romanow discovered, we still want "strong and accessible primary health care services, and … a long-lasting and trusting relationship with a health care professional." Family physicians say their greatest satisfaction comes from direct contact with patients and from the practical application of their clinical skills. And it is this direct, personal and practical relationship that patients seem to want from their family doctors. So why are many family physicians "dispirited"?[3] Why are medical students choosing other specialties? Why are so many Canadians without a family doctor?

The erosion of the prestige of family medicine is spelled out in both the Romanow and the Kirby[4] reports: increasing specialization; the proliferation of new technologies; a focus on hospital care; and, we would add, the increasing sophistication of health care "consumers." ("If colonoscopy is recommended for screening, then why can't I just go directly to a gastroenterologist?") Our health system has evolved in a way that places the primary emphasis not on primary care, but on the hospital and the specialist. As a consequence, family physicians have become specialists in gatekeeping. They are given ultimate responsibility — "Follow up with your family doctor" — but not the resources or the credit to match. Too much of their time outside the examining room is spent managing the logistics of referrals — everything from home care to getting an early CT scan. And yet, family practice is arguably the most complex of all the medical specialties. It requires the broadest sweep of knowledge, an ability to "separate common non-specific complaints from significant illness,"[5] and an ability to relate well with patients and to work effectively with a wide range of other health professionals.

Firmly embedded in Romanow's tall order for primary care reform — 24/7 access to services outside the emergency department, the integration of information through electronic health records, and the elimination of wasteful redundancies — is the need for continuity of care. Enter the case manager, whose primary responsibility is to help patients navigate through "a maze of services and providers." Until now, this role has typically been performed by a family physician and a nurse. Romanow suggests that a medical or nursing qualification is not necessary for case management, provided that "access to required medical or nursing services" is not impeded. But will adding another level to an already cumbersome system be helpful? Is the solution perhaps more obvious: a lower physician–patient ratio, and more resources for administrative support?[6] It is an interesting irony that the holistic part of family practice, the traditional cradle-to-grave role of keeping in one's medical sights the patient as a complex individual in a complex social context, is becoming untenable. Is this really a transition that family physicians want to accept?

There is no single roadmap for the effective delivery of primary care: what is needed in downtown Saskatoon will be different from what is needed in Ile-à-la-Crosse. But Romanow hopes that a designated funding transfer ($1.5 billion for new initiatives) will persuade the provinces to bump primary care to the front of the reform queue. Rather than starting more pilot projects, he urges, we need to implement innovations now: "The desire for perfection is also an obstacle to change." Certainly, reaffirming primary care as the focus of our health care system — and, with it, the central role of the family physician — is plain common sense. The alternative is to watch our patients wander in a health care system stretched so thin that falling through its cracks becomes inevitable. — *CMAJ*

References

1. Romanow RJ. Primary health care and prevention. In: *Building on values: the future of health care in Canada*. Saskatoon: Commission on the Future of Health Care in Canada; 2002. p. 115-35.
2. World Health Organization. *Health for all: origins and mandate.* Available: www.who.int/archives/who50/en/health4all.htm (accessed 2002 Dec 16).
3. Sullivan P, Buske L. Results from the CMA's huge 1998 physician survey point to a dispirited profession. *CMAJ* 1998;159(5):525-8.
4. Standing Senate Committee on Social Affairs, Science and Technology. The health of Canadians: the federal role. Final report on the state of the health care system in Canada. Ottawa: 2002. Available: www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/soci-e/rep-e/repoct02vol6-e.htm (accessed 2002 Dec 16).
5. Rosser WW. The decline of family medicine as a career choice. *CMAJ* 2002; 166(11):1419-20.
6. Kilpatrick K. Clinic beats Romanow to the primary care punch. *CMAJ* 2003;168(2):210.