# Strengthening health care in Canada post-COVID-19 pandemic

Linda Rabeneck[a], Chris McCabe[b], Mark Dobrow[a], Arlinda Ruco[c], Melissa Andrew[d], Sabrina Wong[e], Sharon Straus[a], Lawrence Paszat[a], Lisa Richardson[a], Chris Simpson[f], and Andrew Boozary[a]

[a]University of Toronto, Toronto, ON, Canada; [b]Queen's University, Belfast, UK; [c]St Francis Xavier University, Antigonish, NS, Canada; [d]Dalhousie University, Halifax, NS, Canada; [e]Division of Intramural Research, National Institute of Nursing Research, National Institutes of Health, Bethesda, MD, USA; [f]Queen's University, Kingston, ON, Canada

Corresponding author: **Linda Rabeneck** (email: linda.rabeneck@utoronto.ca)

## Abstract

The purpose of this policy briefing is to examine our health care systems through the lens of the COVID-19 pandemic and identify how we can strengthen health care in Canada post-pandemic. The COVID-19 pandemic has provided compelling evidence that substantive changes to our health care systems are needed. Specifically, the pandemic has emphasized structural inequities on a broad scale within Canadian society. These include systemic racial and socioeconomic inequities that must be addressed broadly, including in the delivery of health care. We make recommendations about what we can do to emerge stronger from the pandemic. While these recommendations are not novel, how they are framed and contextualized differs because of the problems in our health care system that have been highlighted and exacerbated by the pandemic. The evidence is clear that socioeconomic circumstances, intergenerational trauma, adverse early life experiences, and educational opportunities are critical factors when it comes to health over the life course. Given the problems in the delivery of health care that the pandemic has revealed, we need a different approach. How health care was organized prior to the COVID-19 pandemic did not produce what people wanted and needed in terms of health care and outcomes. How do we emerge from COVID-19 with an effective, equitable, and resilient health care system for all Canadians?

To address health inequities and emerge from the pandemic with strengthened health care in Canada, we must consider how Amartya Sen's capabilities framework on social well-being can be operationalized to achieve better health care and health outcomes. Specifically, we address the need to:

1) strengthen primary care and improve access to primary care;
2) utilize a community-embedded approach to care; and
3) implement better integration across the care continuum, including integration between primary care and public health.

Coherent governance and leadership that are charged with realizing benefits through collaboration will maximize outcomes and promote sustainability. Only when we provide access to high-quality culturally competent care that is centered around the individual and their needs will we be able to make true headway in addressing these long-standing health inequities.

**Key words:** health care, health system, post-COVID-19 pandemic

## Problems that were known before and that have been highlighted as a result of the COVID-19 pandemic

We are more than three years into the COVID-19 pandemic, and by almost all accounts, it has bypassed categorization as an important generational event to constitute a once-in-a-lifetime historic event. The breadth and depth of the impacts of the COVID-19 pandemic are unparalleled over the last century. The extent to which the COVID-19 pandemic affects almost everyone on the planet is analogous to the emergence and evolution of the Internet, but with more direct health impacts. In the 100+ years since the last major pandemic—the 1918 influenza pandemic—much has changed: demographics, geopolitics, socioeconomics, and natural/social/medical science. Importantly, the nature of our health care systems and our understanding of the determinants of health are all radically different.

Health systems across the world have evolved significantly, with a wide range of governance and organizational arrangements, funding approaches, and service delivery models that are regularly compared and contrasted. Despite the diversity of health system arrangements, the global toll of the COVID-19 pandemic has been massive, and mostly agnostic to health system arrangements, whether measured in health outcomes ($N$ cases and $N$ deaths), health care utilization

(*N* vaccinations, *N* COVID-19 diagnostic tests, *N* hospitalizations, and *N* ICU admissions), health human resource burden, or broader social, economic, and political impacts. The Royal Society of Canada Task Force on COVID-19 is concurrently examining many aspects of the COVID-19 pandemic and how Canada should respond, including how our public health system can be improved to address the problems the pandemic has highlighted. This report examines what needs to be done to address long-standing health inequities to improve health outcomes and strengthen health care in Canada post-COVID-19.

## A brief overview of health care in Canada

Health care in Canada is characterized by a complicated mix of federal–provincial–territorial responsibilities for health and social care. Over the last 60 years, Canada has had important opportunities to make tweaks to our health care systems, with the introduction of Medicare in the 1970s, the increasing awareness of the social determinants of health much later on, and the establishment of the *Canada Health Act* (and its five principles: portability, accessibility, universality, comprehensiveness, and public administration) in 1984. There have been multiple federal and provincial reviews of the federal-provincial relationship for health care in Canada (e.g., Romanow Commission 2001–2002 and Kirby Committee 2004–2005 in Ottawa, and Fyke Commission in Saskatchewan in 2000–2001, Mazankowski Report in Alberta 2001–2002, and Clair Commission in Quebec 2000–2001) in the 1990s and 2000s that led to new funding agreements and partnerships between the federal and provincial/territorial governments. Governance, funding, and service delivery arrangements have gone through a number of transitions over that time, with periods of regionalization and centralization of health care systems, natural experiments with different health funding models both at the federal-provincial level and within health care systems (e.g., block, volume/activity, and quality-based funding), and regular efforts to reform and (or) better integrate various health care sectors (e.g., primary care reform). Despite these efforts, health system performance across Canada does not compare well with other high-income countries. The Commonwealth fund has ranked 11 high-income countries on health system performance for many years. Over the last decade, Canada has consistently ranked near the bottom on key components of health care system performance (Table 1).

Although most health care system analysts would agree that more needs to be done, it is rare that political, social, economic, and health circumstances overlap across the country. Consider that while calls for *Indigenous Truth and Reconciliation*, *Black Lives Matter*, and *#MeToo* movements have each attracted significant attention in Canada and (or) internationally over the last few years, the COVID-19 pandemic has been a substantially more disruptive event that provides a unique opportunity to rethink what health care should look like going forward. COVID-19 has provided compelling evidence that substantive changes are needed.

## Problems that have been further highlighted because of the pandemic

The COVID-19 pandemic has highlighted and exacerbated many long-standing health system issues and health inequities, including how fragile our health system and human resources actually were. The pandemic has emphasized structural inequities on a broad scale within Canadian society. These include systemic racial and socioeconomic inequities that must be addressed broadly, including in the delivery of health care. Structurally disadvantaged populations have worse health outcomes across the board and have now borne the greatest share of the burden of COVID-19. (Kolahdooz et al. 2015; Public Health Agency of Canada 2018; Walker et al. 2021) This is particularly impacting racialized, Indigenous, and 2SLGBTQIA+ communities (Charles et al. 2015; Greenwood et al. 2018; Haviland et al. 2020; Walker 2020; Schreiber et al. 2021). The response to COVID-19 was patchwork across the country and required extraordinary efforts of individuals and groups and does not reflect a broad system wide response. The evidence is clear that socioeconomic circumstances, intergenerational trauma, adverse early life experiences, and educational opportunities are critical factors when it comes to health over the life course. (Public Health Agency of Canada 2018). When thinking about how to emerge from the pandemic with stronger and more resilient health care systems, these inequities must be addressed preferentially.

## Demography of exclusion

The pandemic has shown us that the ways in which we care for our more vulnerable people; the very old, very young, and those living with factors that lead to marginalization need to change. Older adults, particularly those living in long-term care, were disproportionately impacted in the first waves of the pandemic (Liu et al. 2020). For example, 37% of long-term care residents infected with COVID-19 during the first wave of the pandemic died from the virus in Canada (Canadian Institute for Health Information 2021; Comas-Herrera et al. 2022), and residents of long-term care homes accounted for almost 80% of all COVID-19-related deaths in Canada in 2020 (Waldner et al. 2021). Contributing factors act on many levels, from their individual frailty and immunosenescence to living in crowded conditions with under-resourced care to lacking rigorous regulatory oversight of the long-term care sector and reliance on caregivers who themselves tend to be undervalued and underpaid (Andrew et al. 2020; Picard 2021).

The pandemic has also exposed the health systems' failures in addressing the links between health and social factors. For example, the ambulance offload and crowded Emergency Department issues that have led to crises in pre-hospital and emergency care (Jones 2022) and have received so much attention during the pandemic are also no accident when viewed through the lenses of population aging, structural inequities, and multiple interacting health and social factors. This is an example of system failure to deal with the reality of who needs health services. The response that "these people shouldn't be here" is not appropriate; when people are

**Table 1.** Commonwealth fund survey results for 11 high-income countries.

| | AUS | CAN | FRA | GER | NETH | NZ | NOR | SWE | SWIZ | UK | US |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Commonwealth fund 2021 results** (based on 2018–2020 surveys) | | | | | | | | | | | |
| Overall ranking | 3 | **10** | 8 | 5 | 2 | 6 | 1 | 7 | 9 | 4 | 11 |
| Access to care | 8 | **9** | 7 | 3 | 1 | 5 | 2 | 6 | 10 | 4 | 11 |
| Care process | 6 | **4** | 10 | 9 | 3 | 1 | 8 | 11 | 7 | 5 | 2 |
| Administrative efficiency | 2 | **7** | 6 | 9 | 8 | 3 | 1 | 5 | 10 | 4 | 11 |
| Equity | 1 | **10** | 7 | 2 | 5 | 9 | 8 | 6 | 3 | 4 | 11 |
| Health care outcomes | 2 | **9** | 10 | 8 | 3 | 4 | 4 | 6 | 6 | 1 | 11 |
| **Commonwealth fund 2017 results** (based on 2014–2016 surveys) | | | | | | | | | | | |
| Overall ranking | 2 | **9** | 10 | 8 | 3 | 4 | 4 | 6 | 6 | 1 | 11 |
| Access+ | 4 | **10** | 9 | 2 | 1 | 7 | 5 | 6 | 8 | 3 | 11 |
| Care process+ | 2 | **6** | 9 | 8 | 4 | 3 | 10 | 11 | 7 | 1 | 5 |
| Administrative efficiency+ | 1 | **6** | 11 | 6 | 9 | 2 | 4 | 5 | 8 | 3 | 10 |
| Equity+ | 7 | **9** | 10 | 6 | 2 | 8 | 5 | 3 | 4 | 1 | 11 |
| Health care outcomes+ | 1 | **9** | 5 | 8 | 6 | 7 | 3 | 2 | 4 | 10 | 11 |

sick, they need to be able to access care. We need to design our health care and social systems to properly fit the population's needs.

Given the problems that the pandemic has revealed, we need to entirely relocate the health policy debate. Relocating the policy debate means that we need to look critically at what communities want and what is needed to meet these needs? As we reimagine policy, we need to reimagine evidence—what is the meaningful evidence and who is creating or providing the evidence? How do we engage communities directly in creating the evidence needed to reframe policy? How health care was organized prior to the COVID-19 pandemic did not produce what people wanted and needed in terms of health care and outcomes. Instead, the pandemic has highlighted the impact of the numerous inequities that exist and remain unaddressed. What, then, is the vision? How do we emerge from COVID-19 with an effective, equitable, and resilient health care system for all Canadians?

## How health care in Canada is funded, organized, and delivered?

### Health care organization and financing in canada

The Canadian Institute for Health Information reports that Canada spent $308 billion on health care in 2021. This represented slightly over 12.7% of gross domestic product (GDP) and approximately $8000 per person. Canada's expenditure is higher than some OECD comparator countries (e.g., UK, Australia, and the Netherlands), but lower than others (e.g., France, Germany, and Sweden). Like all countries, it is massively lower than the US, which spent 16.8% of GDP in 2019. Typically, approximately 70% of Canadian health care is publicly financed, and 30% is from private sources. Around half of the private funding is out-of-pocket expenditure. Unsurprisingly, given the scope of the Canada Health Act, hospitals and physicians are two of the three largest expenditure categories, at 25% and 13%, respectively. Drugs account for 14%.

Health care expenditure on those aged 65 years and older accounts for 45% of total expenditure, and this group accounts for approximately 18% of the population. This means that, on average, health care expenditures are around $20,300 per person aged over 65 years and $5400 per person under 65 years of age.

The higher health care expenditures at older ages highlight some important points. One is that care costs tend to be the highest in the last year of life, at whatever age this occurs (Lee 2007). We are fortunate that in Canada, most people die at older ages. Another is that expensive care is not necessarily better care. For example, we spend a lot of money on dementia care that is not well suited to meeting the needs of people living with dementia (e.g., lengthy emergency department and hospital stays for crises that could have been avoided with better community and primary care) (Alzheimer Society of Canada 2010). Here coordination is key and underscores the need to act on the National Dementia Strategy to better understand optimal care and treatment models (Public Health Agency of Canada 2007). Similarly, people who are frail have many interacting medical and social challenges, and if these are treated in a "one thing at a time" medical model, outcomes suffer and other health problems may just be exacerbated, leading to increased personal, family, and societal costs (Muscedere et al. 2016).

Health care has been a responsibility of the provinces and territories since the Constitution Act of 1867. Prior to the Second World War, health care was primarily privately funded and provided. However, the second half of the 20th century saw a massive expansion in the role of government in financing and organizing citizens' access to health care. In 1957, the Hospital Insurance and Diagnostics Act provided for universal coverage of a defined set of hospital-based health care and diagnostic services, with the Federal Government covering 50% of their cost. Nine years later, the Medical Care Act provided for a 50% cost share for all physician services provided outside of the hospital. In 1977, the 50% cost share was replaced with a block grant to provide provincial and territorial governments with greater flexibility to match their expendi-

ture on health care to local priorities (Public Health Agency of Canada 1977). The current principles for government responsibilities for ensuring citizens' access to health care were enshrined in 1984 through the Canada Health Act. The Canada Health Act established five principles that provincial and territorial governments must abide by to receive health transfers from the federal government:

(1) **Public administration**: The provincial and territorial plans must be administered and operated on a non-profit basis by a public authority accountable to the provincial or territorial government.
(2) **Comprehensiveness**: The provincial and territorial plans must insure all medically necessary services provided by hospitals, medical practitioners, and dentists working within a hospital setting.
(3) **Universality**: The provincial and territorial plans must entitle all insured persons to health insurance coverage on uniform terms and conditions.
(4) **Accessibility:** The provincial and territorial plans must provide all insured persons with reasonable access to medically necessary hospital and physician services without financial or other barriers.
(5) **Portability**: The provincial and territorial plans must cover all insured persons when they move to another province or territory within Canada and when they travel abroad. The provinces and territories have some limits on coverage for services provided outside Canada and may require prior approval for non-emergency services delivered outside their jurisdiction. (Government of Canada).

However, the organization of care through the Canada Health Act creates a complete disconnect between revenue from the federal government and service delivery, which is the responsibility of the provinces and territories. The use of vague terminology such as "medically necessary" is also problematic, as there is no valid or broadly accepted definition of what is considered to be medically necessary.

It is notable that these principles enshrine the primacy of bureaucratic control, which is beholden to political masters and has made publicly financed care more responsive to physicians and hospitals than patients. This primacy is reflected in the allocation of spending, as described above. If we, as a society, wish to change our conceptualization of health, and hence what health care budget dollars should be invested in, the principles of the Canada Health Act might contain some unintended but significant barriers to that change. These may include a lack of accountability at the individual and organizational levels, and a lack of system integration at the local/community level where it matters most.

## Health care delivery in Canada

With financial support from the federal government, the delivery of health care services is largely decentralized and the responsibility of the provincial and territorial governments. This creates a disconnect between the source of funds and accountability for quality, access, and volume. Health care services for some specific groups of people are, however, managed and delivered by the federal government (eligible Indigenous people, Canadian Armed Forces, veterans, those in federal prisons, and some refugees) (Martin et al. 2018). Each province/territory dictates how care is delivered within their regions and what constitutes medically necessary services, as long as it abides by the five principles. Primary health care serves as a gatekeeper, as it constitutes the first point of contact for most people needing health care services. Primary care services are mainly delivered by family physicians (and increasing numbers of nurse practitioners), who typically work in private/group practice or within an interprofessional team setting, with the majority operating as independent contractors through a fee-for-service reimbursement model. Through primary care providers, individuals can access more specialized services, which are usually delivered in hospitals.

Hospitals are mainly overseen by hospital boards, and overall budgets are dictated by the provincial/territorial ministries of health. Hospitals are publicly or privately owned, operating as not-for-profit corporations. Specialist care is delivered in hospitals or through outpatient specialist care. While the Canada Health Act has prioritized physician and hospital services, more and more care is now being delivered in home and community settings, and capacity issues at hospitals also show that we have not invested sufficiently in hospital or health human resources. Individuals can access home and community support services through referrals and assessments, though coverage, eligibility, and availability of services vary across jurisdictions. Delivery of home care and community services is largely provided by numerous private, non-profit, and not-for-profit agencies/facilities that are contracted with or funded by the provincial/territorial government.

Public health is provided through collaboration with municipal, provincial/territorial, and federal levels of government. Delivery of public health services is undertaken by public health units, which administer health promotion and disease prevention programs within their local regions, though other sectors like primary care also perform some essential public health functions, including health promotion and immunization. Each health unit is generally governed by a board of health, which acts as an autonomous corporation and reports to the local board of health. While examples of close collaborations between primary care and public health exist, this is typically not the norm across the country (Valaitis et al. 2020). It is also important to note that public health spending in 2022 represented approximately 5.3% of total health care spending nationally (Canadian Institute for Health Information 2022).

Given this historical and operational context, it is clear that public health, primary care, and acute care are generally planned at different policy tables and resourced with different budgets. This siloing leads to challenges in responding to a public health crisis such as the COVID-19 pandemic, but also to challenges in non-pandemic times. One example is the resourcing of routine immunization programs, where even vaccines that are found to be cost-saving have too large a budgetary impact to be covered in prevention budgets, leaving the sequelae of the costs of potentially preventable illness to be drawn from the deeper well of acute care budgets. Other

examples include population health promotion such as access to healthy food and opportunities for accessible physical activity, where it seems more palatable to pay for the downstream costs of preventable illness than to pay to avoid them in the first place.

## Capabilities framework and community-embedded approach to health and health care

### Capabilities framework

The World Health Organization's definition of health is explicit that health is not just the absence of disease or infirmity (World Health Organization 1948), but consists of complete physical, mental, and social well-being. Many of the determinants of health will be outside the scope of hospitals, physicians, and other health care providers. These broader social determinants of health are within the scope of public health, but the public health system specifically in Canada is much more sparsely funded than the health care system. To identify the important determinants of a model of health that includes social well-being and hence the scope of services that might be required to support it, we need an operational model for social well-being. One of the most substantial and closely examined models of social well-being is Amartya Sen's Capabilities. Sen's (1999) framework consists of four key concepts: functionings, capabilities, agency, and freedom.

*Functionings*, Sen states "…reflect the various things a person may value *doing* or *being*". He goes on to observe "The valued functionings may vary from elementary ones such as being adequately nourished and being free from avoidable disease, to very complex activities…such as being able to take part in the life of the community…" (Sen 1999).

*Capabilities* are defined as opportunities to enjoy functioning. Hence, realized well-being is dependent upon the combination of functionings and capabilities. An individual's capability is captured by the "…alternative combinations of functionings that are all feasible for them to achieve".

*Agency* requires that it be the individual citizen who can judge their own achievements using their own values and objectives.

*Freedom* is the combination of functionings, capabilities, and agency. Freedom requires that citizens have the agency to make choices between functionings—i.e., to take advantage of the full range of their capabilities.

Several authors have sought to develop Sen's Capabilities into a more operational framework, identifying specific functionings that can be used to assess, in a qualitative manner, the extent of social well-being using a Capabilities lens. The most fully developed of these is likely the work of Nussbaum (2009), which identified the following 10 functional capabilities; i.e., real opportunities based upon an individual's personal and social circumstances (Box 1).

While the conventional conception of health that is the focus of hospital and physician-led care—the absence of disease and infirmity—is clearly present in these functional capabilities, there are many components of Nussbaum's model of so-

cial well-being that are outside these concerns. For example, disease and infirmity are a very small subset of the threats to life, and the freedom of movement inherent in bodily integrity is outside the scope of health care, as conceived of in the Canada Health Act. Nussbaum's functional capabilities relate to the broadest scope of societal institutions, and community assets.

Considering health and health care beyond COVID-19, it is important to recognize that COVID-19 has shown us the vital contribution of the structures of our social institutions and community assets in determining the health of different communities and populations within Canada. We have the opportunity to re-imagine the objectives we set for our health care systems. Placing social well-being on an equal footing with physical and mental well-being, as the WHO proposed in 1948, and as alluded to in the Lalonde report (Lalonde 1974), is an attractive first step. However, to do so using public financing mechanisms will likely require revisiting the Canada Health Act and a broader conception of health, including all dimensions of public health, because hospital-based and physician-led services are not designed for the production of such richly defined health.

### Health equity and a community-embedded approach to health and health care

To address the underlying health inequities that have been highlighted during the COVID-19 pandemic, it requires a health equity lens. For example, the PROGRESS+ (place of residence, race/ethnicity/culture/language, occupation, gender/sex, religion, education, socioeconomic status, and social capital) approach represents factors that stratify health opportunities and outcomes and can be used to inform equity considerations in health care (O'Neill et al. 2014). It has been modified over time to include personal characteristics associated with discrimination (e.g., age and disability), features of relationships (e.g., smoking parents), and time-dependent relationships (e.g., respite care) that may lead to inequities. (O'Neill et al. 2014). This approach relates to the theory of intersectionality, which explores the complex nature of the intersection of social factors (e.g., age, education, and gender) and their interaction with compounding power structures (e.g., media and education systems) and forms of discrimination (e.g., ableism). Intersectionality was developed by Black feminist scholar Crenshaw (1991) and is rooted in a long history of Black feminist scholarship. More recently, Hankivsky et al. (2014) have used it to develop an intersectionality-based policy analysis approach to capture the multi-level interacting social locations, forces, factors, and power structures that shape human life, health, and health care. It represents a useful approach to ensuring that these intersecting factors and systems of power and privilege are considered when developing health care interventions and models for care delivery. We will not be able to produce the system change and optimize health disparities without addressing this approach.

As such, we need to adopt a patient- and community-oriented approach to health and health care. Delivery of care should be designed in ways that are supportive and inclusive of patients and their caregivers, where patients are wel-

**Box 1.** Nussbaum's (Nussbaum 2009) functional capabilities.

**Life**
Being able to live a complete and satisfying life into old age. Not having life cut short or being made such that it hardly seems worth living.
Not everyone has a good life. People scrape by in humdrum and dismal situations. They may be regularly threatened and may have their life cut short unnecessarily.

**Bodily health**
Living with good health, and not in a state where ill health seriously affects the quality of life. Having access to medical help as needed. To have good food and be able to exercise in ways that sustain health.

**Bodily integrity**
Being able to go where you want to go. Being free from attack and abuse of any kind. Being able to satisfy healthy bodily needs.

**Senses, imagination, and thought**
Being able to use all of one's senses. Being free to imagine, think, and reason. Having the education that enables this to be done in a civilized, human way. Having access to cultural experiences, literature, art, and so on, and being able to produce one's own expressive work. Having freedom of expression, including political and religious.

**Emotion**
Being able to become attached to other things and people outside of ourselves, loving and caring for them. Experiencing grief, longing, gratitude, and justified anger. Not being subject to fear and anxiety or blighted by trauma or neglect.

**Practical reason**
Being able to consider and develop an understanding of good and evil, and to think critically about the world and one's own place in it. Being able to live with one's conscience.

**Affiliation**
Being able to associate with others, living with them, and acting for them. Showing concern for people in general and interacting with others. Having sympathy and compassion and acting to help people. Seeking justice and making things right. Protecting others and the rights of people, including freedom of speech and freedom from fear.

**Other species**
Being able to live with the full range of creatures and plants that inhabit the world around us. To be able to enjoy nature and appreciate its beauty.

**Play**
Being able to laugh, play games, and generally have fun. Not having one's enjoyment and recreation criticized or prevented.

**Control over one's environment**
Being able to participate in political activities, making free choices, and joining with others to promote political views. Being able to own property and goods on the same basis that others do so. Being able to seek and accept work and to be treated reasonably at work. Being free from unwarranted search and seizure.

comed, informed, and listened to, and patient perspectives are integrated every step of the way. Communities have multiple diverse strengths from their lived experiences, which can be harnessed to improve patients' experiences and health outcomes. Patients, caregivers, and communities can work closely with providers and healthcare systems to help shape how these structures can better meet their needs. It is also clear that a focus on resilience and community strengths is critical as we aim to support population health and preventive measures. The capabilities framework, purposefully combined with a community-embedded approach to health system design and policy, creates a powerful strategy for addressing health inequities. In the next section, we contextualize this work with examples of how to mitigate inequities.

## Contextualizing the capabilities framework to address inequities

A community-embedded approach to care involves a relational process where providers genuinely engage with pa-

tients, and patients are empowered to harness the strengths of the community to improve health (World Health Organization 2020). In this approach, patients and the broader community become central to the process of care and are intertwined. When we conceptualize health in this manner, we look at the patient as an extension of their community, and thus emphasize the interdependencies of the broader set of factors and actors that influence health. This promotes a sense of responsibility for each other and reinforces the notion of multiple sectors working together to achieve good health outcomes while considering the entire community or eco-system.

The COVID-19 pandemic has illuminated the inadequacy and limitations of our current health care system, especially the need to strengthen primary care and mechanisms addressing the social determinants of health. From a health system perspective, no health challenge—whether it is addictions, mental health, complex chronic illness, inappropriate prescribing, inequities in health, access to care in rural communities, increasing health care costs, or Indigenous-

specific racism and discrimination in health care—can be successfully addressed in the absence of responsive, effective, efficient, and integrated primary health care, informed by the highest quality evidence. Responsiveness to individual and community needs is the driving force shaping primary care service delivery. The recent external review of federally funded pan-Canadian health organizations (PCHOs) recommended that PCHOs "partner with the provinces and territories to accelerate the emergence of comprehensive, integrated publicly funded health systems centered in primary care" (Forest and Martin 2018). Similarly, in 2017, the federal, provincial, and territorial health ministers agreed to work together on "spreading and scaling evidence-based models of home and community care that are more integrated and connected with primary health care" (Government of Canada 2017). Delivering on these commitments to integrate primary care using a community-embedded approach is how we can emerge from COVID-19 with a more effective, equitable, and resilient health system.

## Community-embedded approach to care

A prime example of the community-embedded approach to care includes the establishment of the First National Health Authority (FNHA) in British Columbia (BC) (Gallagher et al. 2015). The FNHA was created by and for First Nations across the province to undertake transformative change and address the long-standing health inequities experienced by First Nations in the province. Working in partnership with Health Canada, the BC Ministry of Health, and regional health authorities, FNHA provides health care services and wellness programs in collaboration with First Nations communities and provides governance, leadership, and oversight for these services (Gallagher et al. 2015). What is especially unique about the FNHA is that it integrates all aspects, including health care funding, service delivery, and public health, focusing on health promotion, disease prevention, and primary care. Moreover, the services provided by FNHA are based on the First Nations' holistic view of health and wellness, which aligns with the *Capabilities framework* and includes mental, physical, emotional, and spiritual health in addition to social, environmental, cultural, and economic facets of health and well-being.

In this approach, there is true partnership in all aspects of care between various levels of government, the FNHA and First Nations communities of BC with self-determination and ownership. Every aspect of the FNHA is rooted in the concept of *reciprocal accountability*, which highlights that the well-being of a community as a whole is influenced by each individual's contributions and actions. In this approach, every individual is able to contribute and share in the community's achievements and challenges. A community-embedded approach to care would also align with a wise practices versus best practices model (Calliou and Wesley-Esquimaux 2015), where community-based knowledge is used to guide care versus always relying on best practices, which have been developed with a biomedical model in mind. Providing integrated community-embedded care that is also culturally safe is a cornerstone of the FNHA approach

and a real-life example of how community-embedded models of care can operate within the Canadian health care system.

## Strengthening primary care

To further address long-standing health inequities, we will require staged, multi-temporal strategies in primary care. While focusing on prevention of disease and risk or lifestyle modifications is essential, the results of these efforts will not substantially change the health needs of Canadian populations for years, if not decades. Therefore, strengthening primary care now to meet the immediate needs of those who are most disadvantaged is critical. Individuals from disadvantaged groups face many barriers to accessing primary care, including not having a regular primary care provider, not being able to easily book appointments, not being able to afford time off work to attend appointments, difficulties in navigating the health care system, access to reliable transportation, and health care literacy, to name a few. Moreover, there is also a long history of mistrust in health care institutions and providers by certain groups (Black, Indigenous) due to the racism and mistreatment that these groups have endured and continue to endure in these spaces.

## Better integration across the care continuum

Working within an interprofessional team context to provide culturally competent and non-judgmental care centered around the individual and their needs will be instrumental to this approach. The needs of individuals who are from disadvantaged groups are complex and will require a shift in primary care culture to focus on also addressing the social determinants of health. Better integration between primary care and hospitals, and home and community care, as well as public health is needed to facilitate this process and improve health outcomes. Integration and working in teams support working within one's full scope of practice, task shifting, and providing care/support for those with multiple chronic illnesses/multimorbidities. Evidence also shows that interprofessional teams provide better care and outcomes, including for complex patients (Lee et al. 2021; White-Williams et al. 2021). We must therefore emphasize the recruitment, retention, training, and development of clinicians working individually and in teams who can deal with the challenges presented by multiple interacting health and social issues. We also need to reimagine who is part of the interprofessional team and expand our definition to include those outside of health care clinicians that can still make a difference in the care pathway, such as peer patient navigators, community health workers, and advocates (Viswanathan et al. 2009; Corrigan et al. 2014; Freund et al. 2014). In addition to better integration in care delivery, we need to focus on the integration of data holdings and funding to avoid the disconnect between funding and delivery. This complexity is the norm, not the exception, and support should be designed around this fact.

To facilitate better integration, we must also consider the technological dimension of these systems. Improving population health and health care systems requires accurate data. Data are vital to understanding inequities, exploring

how these inequities influence health and well-being, and informing and evaluating health outcomes and interventions to build a stronger and more equitable society. Health information systems must be linkable across various sources of patient, epidemiological, clinical, and administrative data. Incorporation of patient-reported experiences, outcomes, and sociodemographics with clinical and other data across primary health care can strengthen the technological infrastructure. Moreover, we need data that will allow us to better understand health inequities and be able to act on them, including race-based data. Drawing on these and contextual data could be used to establish shared meaning and agreed-upon interventions for patients, their caregivers, and communities. Only when we provide access to high-quality, culturally competent care that is centered around the individual and their needs will we be able to make true headway in addressing these long-standing health inequities.

## Summary and recommendations

The COVID-19 pandemic has been a vehicle for exposing a myriad of health system issues, including health inequities that have been well documented and remain unaddressed. We need to modernize the definition of health within Canada's publicly funded Medicare to one that does not rely merely on the absence of disease or infirmity, but rather considers one's functional capabilities and social well-being. To address these inequities and strengthen health care in Canada post-COVID-19, we will require multiple strategies that place the needs of individuals at the center because hospital-based and physician-led services are not designed for the production of such richly defined health. We also need to consider how to address the disconnect between funding and service delivery, the lack of integration and focus on the social determinants of health. The Working Group's three specific recommendations to address health inequities and emerge from COVID-19 with strengthened health care in Canada are as follows:

### (1) Strengthening primary care and improving access

To address health inequities among groups that experience the highest burden of disease, we need to strengthen primary care to improve access now by addressing barriers to care and building trust between patients from socially disadvantaged groups and the health care system. Strengthening primary care is also needed to effectively deal with the changing needs of the population, namely those with multiple morbidities and those who have become increasingly vulnerable due to structural barriers and multiple intersecting determinants of health. Access to primary care can also facilitate the delivery of preventive care services, which are imperative for addressing health inequities. Relying on emergency departments for "just-in-time" care promotes a reactionary approach, where the focus is on addressing imminent acute care needs with little opportunity for prevention. Better access to primary care can also promote personalized approaches to preventive care based on an individual's risk for chronic disease. Finally, we also need to strengthen primary care by emphasizing the recruitment, retention, training, and development of clinicians

and promoting team-based models of care that move away from fee-for-service models and focus on patient-reported outcomes. The start to strengthening primary care could include the broader implementation of team-based models, the value for which we saw even during the pandemic (Agarwal et al. 2021).

### (2) Community-embedded approach to care

Providing high-quality, culturally competent primary care that is integrated within a community-embedded approach will be critical if we are to address health inequities. When we view and treat an individual as an extension of their community, we can then emphasize the interdependencies and broader set of factors that influence health and impede social well-being. A community-embedded approach to care requires true partnership and collaboration among multiple sectors, including government, service providers, and communities. This work should be guided by the concept of *reciprocal accountability* so that individuals and communities are empowered to engage actively in their health and well-being rather than act as passive recipients of treatments and interventions.

### (3) Better integration across the care continuum, including integration of public health with primary care

The COVID-19 pandemic response has exposed the need for better integration across the care continuum, including the integration of public health with primary and acute care, supported by health information systems. Currently, public health units are responsible for delivering programs and services according to local needs and priorities, but they operate as a distinct and separate entity from primary and acute hospital care. An integrated system between public health and primary care will foster a population health approach that can respond to population health needs, while seeking to promote health and achieve health equity. This integrated approach will be better positioned to address social determinants of health through collaborative community-embedded approaches for targeted health interventions. Trusting and inclusive relationships, shared values and governance, effective communication, and role clarity are needed to facilitate better integration. Coherent governance and leadership that are charged with realizing benefits through collaboration will maximize resources and promote sustainability. Better integration through a community-embedded approach involves having communities directly define and identify their needs and letting this guide the allocation of resources/finances (integrated budgets) accordingly to promote collaboration between public health, primary care, acute care, community pharmacy, and all other aspects of the system. There are also the tensions of working within a biomedical model, which may not be reflective of the needs of communities, and the siloes of not implementing a health in all policies approach (Tonelli et al. 2020), which would help address some of the existing health inequities.

# Article information

## Editor
Russel MacDonald

## History dates

## Notes
This report is dedicated to the memory of Dr. Ainsley Moore, Professor, Department of Family Medicine at McMaster University.

Disclaimer: This article was prepared while Sabrina Wong was at the University of British Columbia. The opinions expressed in this article are the author's own and do not reflect the view of the National Institutes of Health, the Department of Health and Human Services, or the United States government.

This paper is part of a collection entitled "RSC Task Force on COVID-19".

## Copyright

## Data availability
This is a policy briefing and therefore the data availability statement is not applicable.

# Author information

## Author contributions
Conceptualization: LR, CM, MD, AR, MA, SW, SS, LP, LR, CS, AB
Data curation: LR, CM, MD, AR, MA, SW, SS, LP, LR, CS, AB
Methodology: LR, CM, MD, AR, MA, SW, SS, LP, LR, CS, AB
Project administration: LR, CM, MD, AR, LP
Supervision: LR
Writing – original draft: LR, CM, MD, AR, MA, SW, SS, LP, LR, CS, AB
Writing – review & editing: LR, CM, MD, AR, MA, SW, SS, LP, LR, CS, AB

## Competing interests
The authors declare there are no competing interests.

# References

Agarwal, P., Mukerji, G., Laur, C., Chandra, S., Pimlott, N., Heisey, R., et al. 2021. Adoption, feasibility and safety of a family medicine-led remote monitoring program for patients with COVID-19: a descriptive study. C Open [Online], **9**(2): E324LP–E32E330. Available from http://www.cmajopen.ca/content/9/2/E324.abstract

Alzheimer Society of Canada. 2010. Rising tide : the impact of dementia on Canadian society. Executive summary. Dementia, 1–24.

Andrew, M., Searle, S.D., McElhaney, J.E., McNeil, S.A., Clarke, B., Rockwood, K., et al. 2020. COVID-19, frailty and long-term care: implications for policy and practice. Journal of Infection in Developing Countries, **14**(5): 428–432. doi:10.3855/jidc.13003.

Calliou, B., and Wesley-Esquimaux, C. 2015. A wise practices approach to Indigenous community development in Canada. Restorying indigenous leadership. 31–59. [Online]. Available from https://img-thebanffcentre.netdna-ssl.com/cdn/farfuture/yo5QWfiRoD3OK8CQDNiLm0S7PoA1XVC2RnYzInFABd8/mtime:1496435632/sites/default/files/Lougheed Leadership/Research/Indigenous/2_Chapter_1.pdf.

Canadian Institute for Health Information. 2021. The impact of COVID-19 on long-term care in Canada: focus on the first 6 months [Online]. 34p. Available from http://www.scie-socialcareonline.org.uk/the-impact-of-covid-19-on-long-term-care-in-canada-focus-on-the-first-6-months/r/a116f00000UuXxWAAV.

Canadian Institute for Health Information. 2022. National health expenditure trends, 2022 – Snapshot.

Charles, C., Haaland, M., Kulkarni, A., and Webber, J. 2015. Improving healthcare for LGBTQ populations. Canadian Federation of Medical Students, Ottawa, ON.

Comas-Herrera, A., Marczak, J., Byrd, W., Lorenz-Dant, K., Patel, D., and Pharoah, D. (eds.) and LTCcovid contributors. 2022. LTCcovid international living report on COVID-19 and long-term care. LTCcovid, Care Policy & Evaluation Centre, London School of Economics and Political Science, doi:10.21953/lse.mlre15e0u6s6.

Corrigan, P.W., Pickett, S., Batia, K., and Michaels, PJ. 2014. Peer navigators and integrated care to address ethnic health disparities of people with serious mental illness. Social Work in Public Health, **29**(6): 581–593. doi:10.1080/19371918.2014.893854.

Crenshaw, K. 1991. Mapping the margins: intersectionality, identity politics, and violence against women of color. Stanford Law Review, **43**(6):1241–1299. Available from http://www.jstor.org/stable/1229039. doi:10.2307/1229039.

Federal-provincial fiscal arrangements and establishing programs financing act [Online]. 1977. Available from https://www.canlii.org/en/ca/laws/regu/sor-78-587/93154/sor-78-587.html.

Forest, P.-.G., and Martin, D. 2018. Fit for purpose: findings and recommendation of the external review of pan-Canadian health organization – summary report [Online]. Available from https://www.canada.ca/content/dam/hc-sc/documents/services/health-care-system/reports-publications/health-care-system/findings-recommendations-external-review-pan-canadian-health-organization/findings-recommendations-external-review-pan-canadian-health-or.

Freund, K.M., Battaglia, T.A., Calhoun, E., Darnell, J.S., Dudley, D.J., Fiscella, K., et al. 2014. Impact of patient navigation on timely cancer care: the Patient Navigation Research Program. Journal of the National Cancer Institute, **106**(6): dju115. doi:10.1093/jnci/dju115.

Gallagher, J., Mendez, J.K., and Kehoe, T. 2015. The First Nations Health Authority: a transformation in healthcare for BC First Nations. Healthcare Management Forum, **28**(6): 255–261. doi:10.1177/0840470415600131.

Government of Canada. 2017. A common statement of principles on shared health priorities. pp. 1–3. Available from https://www.canada.ca/content/dam/hc-sc/documents/corporate/transparency_229055456/health-agreements/principles-shared-health-priorities.pdf.

Government of Canada. Canada Health Act.

Greenwood, M., de Leeuw, S., and Lindsay, N. 2018. Challenges in health equity for Indigenous peoples in Canada. The Lancet, **391**(10131): 1645–1648. doi:10.1016/S0140-6736(18)30177-6.

Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., et al. 2014. An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity. International Journal of Equity in Health, **13**(1): 119. doi:10.1186/s12939-014-0119-x.

Haviland, K.S., Swette, S., Kelechi, T., and Mueller, M. 2020. Barriers and facilitators to cancer screening among LGBTQ individuals with cancer. Oncology Nursing Forum, **47**(1): 44–55. Available from https://pubmed.ncbi.nlm.nih.gov/31845916. doi:10.1188/20.ONF.44-55.

Jones, A. 2022. Ontario suggests ways to reduce ambulance off-load delays. Toronto Star.

Kolahdooz, F., Nader, F., Yi, K.J., and Sharma, S. 2015. Understanding the social determinants of health among Indigenous Canadians: priori-

ties for health promotion policies and actions. Global Health Action, **8**: 27968. doi:10.3402/gha.v8.27968.

Lalonde, M. 1974. A new perspective on the health of Canadians. Vol. **32**. Minister of Supply and Services Canada, Ottawa, ON.

Lee, J.K., McCutcheon, L.R.M., Fazel, M.T., Cooley, J.H., and Slack, MK. 2021. Assessment of interprofessional collaborative practices and outcomes in adults with diabetes and hypertension in primary care: a systematic review and meta-analysis. JAMA Network Open, **4**(2): e2036725–2036725. doi:10.1001/jamanetworkopen.2020.36725.

Lee, M. 2007. How sustainable is Medicare? A closer look at aging, technology and other cost drivers in Canada's health care system [Online]. 34p. Available from Available from http://www.policyalternatives.ca/sites/default/files/uploads/publications/National_Office_Pubs/2007/How_Sustainable_is_Medicare.pdf%5Cnhttp://scholar.google.com/scholar?hl=en&btnG=Search&q=intitle:How+Sustainable+is+Medicare?A+Closer+Look+at+Aging,+Techno.

Liu, M., Maxwell, C.J., Armstrong, P., Schwandt, M., Moser, A., McGregor, M.J., et al. 2020. COVID-19 in long-term care homes in Ontario and British Columbia. Canadian Medical Association Journal, **192**(47): E1540LP–E15E1546. Available from http://www.cmaj.ca/content/192/47/E1540.abstract.

Martin, D., Miller, A.P., Quesnel-Vallée, A., Caron, N.R., Vissandjée, B., and Marchildon, GP. 2018. Canada's universal health-care system: achieving its potential. The Lancet, **391**(10131): 1718–1735. doi:10.1016/S0140-6736(18)30181-8.

Muscedere, J., Andrew, M.K., Bagshaw, S.M., Estabrooks, C., Hogan, D., Holroyd-Leduc, J., et al. 2016. Screening for frailty in Canada's health care system: a time for action. Canadian Journal on Aging, **35**(3): 281–297. doi:10.1017/S0714980816000301.

Nussbaum, M.C. 2009. Creating capabilities: the human development approach and its implementation. Hypatia, **24**(3): 211–215. doi:10.1111/j.1527-2001.2009.01053.x.

O'Neill, J., Tabish, H., Welch, V., Petticrew, M., Pottie, K., Clarke, M., et al. 2014. Applying an equity lens to interventions: using PROGRESS ensures consideration of socially stratifying factors to illuminate inequities in health. Journal of Clinical Epidemiology, **67**(1): 56–64. doi:10.1016/j.jclinepi.2013.08.005.

Picard, A. 2021. Neglected no more: the urgent need to improve the lives of Canada's elders in the wake of a pandemic. Random House Canada.

Public Health Agency of Canada. 2007. A dementia strategy for Canada. Available from http://www.cutaactu.ca/en/public-transit/publicationsandresearch/resources/IssuePaperNo.22_ANationalTransitStrategyForCanada.pdf.

Public Health Agency of Canada. 2018. Key health Inequalities in Canada [Online]. 1–437pp.Available from https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/science-research/key-health-inequalities-canada-national-portrait-executive-summary/hir-full-report-eng.pdf.

Schreiber, M., Ahmad, T., Scott, M., Imrie, K., and Razack, S. 2021. The case for a Canadian standard for 2SLGBTQIA+ medical education. Canadian Medical Association Journal, **193**(16): E562LP–E56E565. Available from http://www.cmaj.ca/content/193/16/E562.abstract.

Sen, A. 1999. Development as freedom. Oxford University Press, New York.

Tonelli, M., Tang, K.-.C., and Forest, P.-.G. 2020. Canada needs a "Health in All Policies" action plan now. Canadian Medical Association Journal, **192**(3): E61LP–E61E67. Available from http://www.cmaj.ca/content/192/3/E61.abstract.

Valaitis, R.K., Wong, S.T., MacDonald, M., Martin-Misener, R., O'Mara, L., Meagher-Stewart, D., et al. 2020. Addressing quadruple aims through primary care and public health collaboration: ten Canadian case studies. BMC Public Health, **20**(1): 507. doi:10.1186/s12889-020-08610-y.

Viswanathan, M., Kraschnewski, J., Nishikawa, B., Morgan, L.C., Thieda, P., Honeycutt, A., et al. 2009. Outcomes of community health worker interventions. Evidence Report/Technology Assessment (Full Report), (181): 1–144, A1-2, B1-14, passim.

Waldner, D., Harrison, R., Johnstone, J., Saxinger, L., Webster, D., and Sligl, W. 2021. COVID-19 epidemiology in Canada from January to December 2020: the pre-vaccine era. Facets, **6**: 760–822. doi:10.1139/facets-2021-0029.

Walker, J.D. 2020. Aging and frailty in First Nations communities. Canadian Journal on Aging, **39**(2): 133–144.

Walker, M.J., Meggetto, O., Gao, J., Espino-Hernández, G., Jembere, N., Bravo, C.A., et al. 2021. Measuring the impact of the COVID-19 pandemic on organized cancer screening and diagnostic follow-up care in Ontario, Canada: a provincial, population-based study. Preventive Medicine, **151**: 106586. doi:10.1016/j.ypmed.2021.106586.

White-Williams, C., Shirey, M., Eagleson, R., Clarkson, S., and Bittner, V. 2021. An interprofessional collaborative practice can reduce heart failure hospital readmissions and costs in an underserved population. Journal of Cardiac Failure, **27**(11): 1185–1194. Available from https://www.sciencedirect.com/science/article/pii/S1071916421001548. doi:10.1016/j.cardfail.2021.04.011.

World Health Organization. World Health Organization Constitution. 1948. [Online]. Available from https://www.who.int/about/governance/constitution.

World Health Organization. 2020. Community engagement: a health promotion guide for universal health coverage in the hands of the people. World Health Organization, Geneva.