Backgrounder on Community Health Centres

What is a Community Health Centre?

A community health centre (CHC) is a legally incorporated, non-profit society that provides health and related social services tailored to the needs of the communities it serves. A community can be geographic – for example, an area within New Westminster. Or it can be a group of people with shared health needs, interests and characteristics; for example, refugees who have experienced trauma from the countries they have fled, Indigenous people, new immigrants or various other ethnic or cultural groups. The Umbrella Co-op fits into this latter category.

CHC's are community governed with an elected board that oversees their work. Community governance is a central value of CHCs because it provides a vehicle for the interests and concerns of the community to be reflected in the programs and services CHCs provide. It also facilitates community capacity building to improve health outcomes by addressing the upstream causes of ill health as well as promoting equity and social justice.

CHCs provide integrated, coordinated primary care services to treat a range of medical conditions. But they also focus on programs that deal with the underlying causes of ill-health – what is commonly referred to as the social determinants of health. This involves health education, wellness promotion, illness prevention, health advocacy, and a range of other community initiatives designed to promote the health and well-being of the population CHCs serve.

A central characteristic of CHCs is inter-disciplinary, team-based, integrated care that takes advantage of a wide range of different health professionals, including physicians, nurses, nurse practitioners, physiotherapists, nutritionists, community workers, translators, health educators and others. For example, every one of the 75 CHC's in Ontario employs at least one nurse practitioner. Some CHSs, such as REACH in East Vancouver, also have a dental clinic, a pharmacy and a partnership with a multicultural centre. CHCs also locate all staff in one facility. This is important in ensuring good face to face communication and collaboration among members of the team, thus minimizing the 'silos' characteristic of many health professions.

Typically, CHCs are publicly-funded and employ medical and allied health professionals on salary rather than on fee-for-service, although in BC this approach is underdeveloped. Almost all clinics in BC remain dependent on physicians remunerated through fee for service, whereas in Ontario, for example, all doctors working in CHCs are on salary.

CHC's make extensive use of a wide range of health professionals. Often patients need to see someone other than a physician to address their health needs. Nutritionists provide advice on diet, psychologists on mental health challenges, physiotherapists on exercise, pharmacists on drug reviews, counsellors on mental health, social workers on accessing community services and so forth. CHC's normally employ staff with facility in a number of the languages spoken in their communities, enabling them to provide

culturally sensitive services to patients whose first language is not English. There is also a great advantage for patients to have all these services under one roof.

Team based, interdisciplinary practices make better use of the different skill sets of various health professionals, a benefit that is enhanced when these practitioners are working together in a collaborative way. Salaried health professionals can spend time with patients to assess their overall health requirements rather than treating each patient's health issue as a separate problem requiring a separate visit, thus providing a more comprehensive approach to care, an approach that is also beneficial to patients who expect that a consultation will deal with their overall health status. In other jurisdictions, such as Ontario, CHC's provide after-hours and week-end health services to meet the province's goal of providing 24/7 access, significantly reducing the demand on hospital emergency departments by CHC patients.

CHCs are an effective vehicle for delivering health promotion and prevention because their approach is designed to address the broader social determinants of health. Because of their close relationship with the community they serve, CHCs are well suited to work with schools within their catchment areas to provide health education. By employing community workers, they are also able to engage in health promotion with a wide range of culturally diverse organizations, targeting disadvantaged groups for special attention where needed. This outreach focus is supported by the governance structure of CHC's which normally reflects the diversity of the communities they serve and thus gives them an understanding of the issues of concern to in those communities.

CHC's provide an opportunity for physicians who do not want to work in walk-in clinics or set up their own primary care practice to have a salaried position instead. Currently, in BC physicians do not have this choice, outside hospitals and specialized agencies. Many physicians - and particularly recent graduates - want to focus their energies on practicing medicine. They see the problems of working in a walk-in clinic with its emphasis on volume and its lack of continuity of care. They also see the problems with setting up their own business, finding premises, hiring staff and all the other tasks associated with running a practice. But these are the limited options they have if they want to do family medicine. CHC's provide them with the opportunity to work on salary, a choice which many physicians would like to have, but one which is currently not available to them in BC.

Today, there are over 300 CHCs across Canada that meet the defining characteristics outlined above. Ontario and Quebec have the most developed CHC sector, while BC and Nova Scotia are the least developed in Canada. There are now 75 CHCs in Ontario, in contrast to the initial 10 originally set up in the 1970s. The Ontario government has made them an integral part of the province's primary health care strategy and allocates just over $400 million, annually, to them according to a 2017 Auditor General's Report. By contrast, BC has only one CHC, REACH, that meets all core CHC criteria.

What is the Evidence that CHCs are a Good Model for Delivering Primary Health Care?

There is an extensive research literature documenting the advantages of incorporating many of the principles that CHCs embody. The benefits of interdisciplinary approaches have been discussed

extensively in the academic literature for many years, the WHO's 1978 Alma Ata Declaration providing a major stimulus to research on this issue. Canada's Romanow Commission focused extensively on the advantages of team-based approaches that utilize the full scope of the training of a variety of different health professionals:

For individual Canadians, primary health care means they have access to a team or network of health care providers working together on their behalf to co-ordinate their care across different aspects of the health care system from counselling them on how to stay healthy or quit smoking to treating illnesses, providing hospital care, following up with home care services, or monitoring people's use of prescription drugs. (Romanow Commission, p. 117)

The Commission also noted that the fragmentation of primary care into distinct 'silos' was a major barrier to providing the kind of integrated, coordinated care that it believed was needed to address many of the problems of Canada's primary care system. Community health centres provide a solid platform for the kind of integration Romanow recommended.

In a 2005 report, the Health Council of Canada recommended expanding the use of multi-disciplinary teams and specifically identified Community Health Centres as an example of where this approach can be effectively applied. (Health Council of Canada 2005, p. 50)

Another feature of good primary health care is health promotion. In their 2009 review of four primary care delivery models in Ontario, Hogg et. al found that CHCs were more likely to engage in health promotion activities with their patients than the other models they examined:

"The likelihood of a health promotion subject being discussed and the number of subjects discussed in the reference visit were significantly higher in CHC practices than in practices in the other models. Several health promotion subjects were more likely to have been discussed in a CHC visit." (Hogg et. al. p. 170.)

The authors also found that CHCs used nurse practitioners and nurses much more extensively in providing clinical services. Nurse practitioners were the main health provider for 22% of CHC patients. On average, time spent by clinical staff with patients on their visits was also significantly longer and patients visited CHCs more frequently.

In their 2011 review of primary care reform in Canada, Hutchison et. al, noted that three studies that had examined the effectiveness of CHCs had found that they "...performed better than fee for service practices and two capitation-based models in chronic disease management, health promotion, and community engagement," while one study concluded that they were less efficient than other models of delivery (Ibid. p. 266). Hutchinson et. al. also noted that the Ontario government had expanded the number of CHCs significantly since 2004/05, establishing 21 new centres. By the time of their study, Ontario's 73 CHCs were employing over 300 physicians, 290 nurse practitioners and over 1,700 allied professionals, engaged in health promotion, community development and clinical activities. (Hutchison et. al. p. 266).

In 2012, Glazier, Zagorski and Rayner of the Institute of Clinical Evaluative Sciences compared five different primary care delivery models in Ontario during the period 2008/09-2009/10. After reviewing health outcome indicators for 11.8 million Ontario residents they concluded the following:

"The CHC model appears to play an especially important role in Ontario for disadvantaged populations. A continuing influx of immigrants to Ontario and growing income inequalities suggest an increasingly important need for care in these populations. Other research has found that health care at CHCs is associated with better chronic disease management and geriatric care, more comprehensive care and greater community orientation. The current analyses find that CHC care is also associated with lower than expected ED visits" (Glazier, Zagorski et. al. (2012) "Comparison of Primary Care Models in Ontario by Demographics, Case Mix and Emergency Department Use 2008/09 to 2009/10." Institute of Clinical Evaluative Services, March.)

The 2017 Ontario Auditor General's (OAG) report on CHC's noted the extensive utilization of interdisciplinary teams in the province's CHCs:

The type of health care that CHCs provide is called inter-professional health care. With this model, patients can obtain a full range of health care all under one roof from a team of health-care professionals, which may include a doctor, a nurse practitioner, dietitians, chiropodists (foot specialists) and physiotherapists, and another group of professionals who support clients, such as health promoters, health-system navigators and social workers. (OAG Report, p. 188)

While the report was critical of the Ministry of Health for not establishing a more rigorous process for evaluating the relative costs and benefits of the various primary care models in place in the province, it also noted that of the 76 health sub-regions in the province, 35 still did not have a CHC indicating that it saw a significant gap in the coverage of this approach to providing health care services in Ontario. The OAG's report also noted that funding for CHCs had increased by 114%, from $187 million to $401 million, in the 10 years to fiscal 2016/2017 while the number of patients had increased correspondingly. (OAG Report, p. 189)

There is also evidence that many younger physicians would like to move away from the traditional fee for service model of remuneration. A 2012 mixed methods study of the preferences of newly practicing physicians in BC by Vanessa Brcic and Margaret McGregor found that "...71% (93 of 102) preferred non-fee-for-service practice models and 86% (110 of 132) identified the payment model as very or somewhat important in their choice of future practice." (p. 275) The CHC salary model provides this option.

CHCs are not a replacement for all other forms of primary health care. But they can play an important role, given that they are embedded in the communities they serve, follow an interdisciplinary approach and focus on addressing the social determinants of health while providing quality primary health care.