

# On caring: Preliminaries of a comparative study of Primary Health Care in Brazil/Canada

## O Cuidado na Atenção Primária à Saúde: Preliminares de um estudo comparativo Brasil/Canadá

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### **Abstract**

This text has three basic objectives: First it focuses on the processes of policy-making and institution-building in Primary Health Care in Brazil and Canada. The second objective is a preliminary appraisal of the basic, common, and differentiating points between the two countries with regard to such processes; finally, the third objective seeks to briefly discuss the role of Brazilian and Canadian physical therapists in health care teams, comprised by allied health professionals. The first part of this study highlights PHC in Brazil, with a particular interest in the ways and means adopted by recent health assistance models that emphasized, or believed in, the role of the physical therapist. The next section deals with PHC in Canada, in a summarized way. The recent Brazilian and Canadian literature on this central topic was important for this text; in addition official documents and discussion papers were used. In conclusion, the authors claim that PHC in both countries, including many other regions of the developed and developing world, require the integration of services into a systemic (though not asphyxiating) matrix. The authors also stress the need for health promotion nationwide, and, in particular, a special attention to the role of physical therapists in the operation of health care teams in family health and PHC.

**Keywords:** Primary Health Care; Health Promotion; Brazil; Canada.

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## Resumo

O texto aborda os processos de constituição e institucionalização da Atenção Primária à Saúde no Brasil e no Canadá; os pontos de interseção e de distanciamento entre os dois países; e a inserção profissional dos fisioterapeutas brasileiros e canadenses nas equipes multidisciplinares. A primeira parte deste estudo focaliza a atenção primária no Brasil, os caminhos e estratégias de reorientação do modelo assistencial e o papel que coube nesse modelo, de modo crescente, ao fisioterapeuta. Após situar o contexto nacional, o tópico seguinte trata da atenção primária à saúde no Canadá e da atuação deste profissional nas equipes primárias de saúde. No exercício absolutamente preliminar de contrastar as duas experiências nacionais, a brasileira e a canadense, foi utilizada a literatura nacional e estrangeira sobre a temática central, além de documentos e *discussion papers*. O texto procurou chamar a atenção para a necessidade e importância da participação de fisioterapeutas nas equipes multiprofissionais e as diferenças na atuação deste profissional tanto no Brasil quanto no Canadá. Desnecessário acrescentar que os autores intentaram não uma “análise” comparativa, mas, sim, uma breve exposição sobre contrastes e semelhanças nos rumos da atenção primária, ao longo da história mais recente desses dois países.

**Palavras-chave:** Atenção Primária à Saúde; Promoção da Saúde; Brasil; Canadá.

## Introduction

This paper discusses the formation of policy and institutionalization of Primary Health Care (PHC) in Brazil and Canada, including the points of intersection and distance between the two countries, and the professional performance of Brazilian and Canadian physical therapists in multidisciplinary teams. Primary health care is the focus of this work, expository in nature and pointing out clues or basic indications for a comparative analysis. On the other hand, by focusing on primary care, we will give special emphasis to the limits and achievements of teamwork, and the building of links and partnerships between health professionals participating in multidisciplinary teams.

Primary care is understood as the first contact of the individual in a health care network and arises from the need to expand access to health services to large parts of the population that are unable to obtain health care. The operationalisation of this model implies reorganizing the system based on the idea of “horizontality” of health care, which can allow, through integration with other levels of care, a continuing assistance to the population. (Starfield, 2002; Brasil, 2006; WHO, 2008; Mendes, 2011).

However, in order to ensure continued support to the population, it is necessary that health systems face challenges of a changing world – social, educational, economic, epidemiological, and health changes (WHO, 2008).

One of the biggest challenges is the phenomenon of an aging population, which has triggered changes in the epidemiological profile, with an increase in the incidence of chronic degenerative diseases and functional disability, in addition to the increase in demand for health services and medication use. The increase in life expectancy, and, consequently, of chronic diseases, has been generating new demands for health services, particularly in the interdisciplinary quality of primary care.

Service models in primary care increasingly appear as effective strategies to improve the access of care to people in need and, at the same time, encourage teamwork and continuity of services. It is important to emphasize that the performance of primary care in health care demands a new approach on the part of the professionals, now from the perspective

of prevention and health promotion. In addition to the provision of care, there is a need for a professional/patient relationship mediated by solidarity, social support and, especially, by a partnership between the members of multidisciplinary teams.

The work in the area of health care is a collective work that needs to be carried out by several health professionals that perform specific actions. In this context, it is important to search for strategies that will allow the true interaction and partnership in teamwork that meets real social needs.

## Scenarios and contrasts

The Canadian scenario is enlightening. The comparative view brings us to the key points of the theme. Canada has invested in strengthening its primary care system, with a focus on community, and at the same time encourages the process of de-hospitalization and decreasing the length of stay in hospitals; policies and programs seek effective strategies to ensure access to care, and the improvement, efficiency and continuity of services.

In countries with universal and inclusive health systems, such as Canada, the issue of primary care in health is related to political decisions. In that country the discussions on this topic have been around for a long time: dating back to 1960 and crystallized in the so-called Lalonde Report, published in 1974, as well as later, in the Ottawa Charter of 1986, a national and international reference in action program for the Promotion of Health.

In Brazil, the origin of these health debates is still relatively new, beginning at the end of the military regime, when the first signs of political openness allowed the emergence of a movement for a “new health reform.” According to a recent interpretation (Dowbor, 2009), in the cracks of the system and without proposing profound changes in the sector, a new collective, reform-minded actor emerged, “despite the conflicting interests of the private sector of medicine” (Dowbor, 2009, p. 186). This incipient motion, since the first years of the 1980s, points to the need of health policies to universalize and decentralize services.

The National Health Conference (*Conferência Nacional de Saúde*), in March 1986, which marked an era as the “8th NHC”, guided the creation of the

Unified and Decentralized Health System (*Sistema Unificado e Descentralizado de Saúde*), by the Ministry of Health. This movement anticipated the SHS in 1998, the Single Health System (*Sistema Único de Saúde*), that the new Constitutional Charter enshrined and that reflected claims of important segments of civil society. Sanitarians, intellectuals, teachers and health professionals were anticipating, for the Unified Health System, a more humane and socially inclusive health care. Dowbor (2009) notes the increasing integration of the municipalities in debates and legal documents on the levels of care - basic, medium and complex. The preparation of the 9th 1992 Conference had the participation of key municipal secretaries of health. “Municipalization is the path” was its watchword. From then on, “their capacity to focus on sectoral policy could be observed through standards issued by the MOH (Ministry of Health)” that had been operational, since 1990, to the performance of “SUS”, as the new system was known (Dowbor, 2009, p. 205).

However, while internationally the discussion was focused on concepts and new approaches in health promotion, the provision of primary care, and the composition of multidisciplinary teams, in Brazil, the biggest concern was the organization and structuring of a universal health care system that would surpass the precariousness and the absence of national coverage made available to anyone and able to match the needs of the communities abandoned. The bureaucratic structures, at the centralized level in the health care sector, would have to give way to concrete expression of regional diversities through decentralization and municipalization. It was necessary, on the other hand, to overcome clientelistic interests, nepotism and the dispersion of resources, which could accompany the processes of municipalization.

## Partnerships and metaphors

A challenge faced today, which began in the initial years of operation of the Family Health Strategy (FHS) for accredited municipalities and the UHS, or SUS, was the collaboration of health professionals in order to overcome old standards and quite crystallized domination within the “world of professions” (Santos; Faria, 2010). The need to promote the use

“of methods that would stimulate multidisciplinary care” (Peduzzi, 2008) has established itself in the field of human resources in health care; the health team as a collective actor in the work process should take precedence over individual action and the strongly hierarchical, invariably under control, and undisputed authority of physicians (Peduzzi, 2009).

The partnership between professionals from primary care teams was highlighted in this discussion. Note, first, that the concept of partnership in Brazil is not usual to designate relationships between professionals in PHC. The international literature talks about this term as a metaphor loaded with meaning. Eva Boxenbaum (2001) addresses the issue from various angles, and is quite innovative in her approach. What we may observe in the field of public health is the required use of a metaphor, or better, the employment of metaphors in order to assign the qualities or qualifications that are, in fact, absent in the field. The **universal** access to services is certainly a metaphor, an analogy about the state of things yet to be achieved. Thus, if we talk about integrated teams, we can refer to the metaphor of **partnership**. The term “partnership” is increasingly understood in a multidimensional and dynamic sense. Their meanings were thoroughly discussed during the Canadian health reform. In Quebec, the debates on the type of community care models, or on public and private financing, express a concern with regards to partnerships (Boxenbaum, 2001).

The concern with the employments or “symbolic uses of metaphor” is present at the important work of Boxenbaum, for whom the analogies between concrete and ambiguous situations, in the field of health care, refer to the theme of partnerships. According to the author, the metaphors can impact the structure and practices of health care and that certain terms, such as partnership, become ideas; as in the relationship between users and “providers” of health, the metaphor “imposes a structure of meanings within a given field, expressing not only speech, but also action” (Boxenbaum, 2001, p. 17). The partnership, or the work as a team, should be implemented in practice; the actors involved should be aware of the impact of their actions, which should be joined, for the improvement of the quality of services.

## Multidisciplinary work and teamwork

The questions concerning the composition of primary care teams and integration among its members are subjects of discussion and debate, as they are both areas of implementation and barriers to primary care. Feuerwerker and Sena (1999) distinguish multidisciplinary work from team work. According to the authors, “they are not synonyms. They are related concepts.” The multidisciplinary work requires the production of knowledge, the exchange of knowledge and experience, the production of practice, and the construction and maintenance of links between professionals and users. In teamwork, there is the sharing of planning and tasks between the professionals involved.

Primary care has been gaining strength and the capacity for the integration of multidisciplinary teams, under the two approaches or facets proposed by Feuerwerker and Seine, offering solutions that are important. The production of partnerships, however, requires an intense effort on the part of health care professionals and the contribution of programs. Health systems are faced with the need to redefine their priorities and the health care professionals are faced with questioning themselves about the scope of their practice. The development of partnerships between the members of the health care team is vital, especially for community care models.

In an important work, Marina Peduzzi refers to the international literature on primary care, particularly the work of Barbara Starfield (Peduzzi, 2008; Starfield, 2002). Starfield is a reference in the field. Her work addresses the intense pressures on teamwork, as a result from numerous imperatives such as the aging population and the increase in chronic diseases. The Brazilian scene in this sense is not unique (Peduzzi, 2008).

Sharing the planning and tasks between health care professionals and health services is vital to the consolidation of primary health care in this country. The team work and multidisciplinary team constitute the basis of the proposal of health care transformation. However, the fragmented health care systems are still hegemonic in Brazil (Mendes,

2011). They organize themselves, in general, isolated and without connection between the teams. In these systems, “the primary health care does not communicate fluidly with the secondary health care and these two levels also do not articulate with the tertiary health care, nor with the support systems, nor with the logistic systems” (Mendes, 2011, p. 50). In light of these characteristics, these systems are incapable of providing sustained, expanded, and problem-solving care to the population. It is worth noting that the difficulty and challenges of teamwork are also linked to the fragmented, hospital academic training of health care professionals (Feuerwerker, 2003; Araujo et al., 2010; Faria; Silva, 2013).

Although the discussion of partnerships in the PHC scenario involve the various professionals who make up the team, focus on the physical therapy profession redirects the discussion to privileged contexts of primary and home care. The analysis of the Brazilian context and Canadian narrative guides this topic.

## **First steps: Physical therapy in PHC and the teamwork to provide care**

With the emergence of primary health care as the organizational model, the participation of the physical therapist has required the development of new skills that go beyond the individual care and specialized services. This line is defended by the Ministry of Health. Ragasson et al. (2011) point out that the actions of the physical therapist must be integrated into teams and can plan, monitor and implement: policies, programs, courses and research which intersect with the field of Public Health. It should be emphasized that in 2011, Ordinance or “Portaria” no. 2,488 from the Ministry of Health has introduced a new edition of the National Policy of Basic Care. According to the said Ordinance, with regards to the primary health care teams, the different professional qualifications and the linkage between the health professionals are necessary to expand the capacity to care for the population (Brasil, 2011b).

The literature has highlighted the multiple possibilities of physical therapy in PHC: health education, home care, epidemiological research, academic ac-

tivities, attention to care, and intersectoral actions (Castro et al., 2006; Portes et al., 2011; Ragasson et al., 2011). To meet these challenges, the need for the development of new skills and the dissemination of new experiences during training are emphasized (Portes et al., 2011).

Neves and Acioli (2010) conducted a systematic review of scientific literature on the role of the physical therapist and his/her relationship with and within teams and concluded that a small number of publications backs this theme. In general, the publications come to highlight the role of the integrated physical therapist within the team, whose actions promote good health and prevention of diseases, based on the concepts of interdisciplinary and multidisciplinary. However, the specificities of the work were not explored by the studies, which may reflect the difficulties of insertion of the physical therapists in the FHS. One study suggests that full integration of the physical therapist in family health teams could prove to be a major contributing factor in the prevention and changing of the health care model: either by reducing the complexity of health care and public spending, by avoiding the increase of diseases and meeting unmet needs of the physical therapy service; or by the act of selecting and screening patients (Castro et al., 2006, p. 57). From the point of view of patient satisfaction, the work of physical therapy can still be directed toward the establishment of communicative and warm relationships, particularly through the household contact with patients (Costa et al., 2009).

Although incipient, what is sought, in the insertion of physical therapy in primary care and multidisciplinary teams, is to contribute to the democratization of the services provided to the communities (Veras, 2002; Rezende, 2009; Barbosa et al., 2010). This has been done in some municipalities of the country. These attempts, although timid, transcended the rehabilitation process and guided the practice toward social needs. The Health of the Family provided, in this sense, a health care model in favor of the participation of professionals in the construction of a broad and inclusive health care (Dalpoz and Viana, , 2005).

If we consider a study on the quality of life of individuals who used physical therapy services in basic

health units, Aquino et al. (2009) showed positive results in the areas of improvement of functional capacity and health in general. However, there has been little progress on some physical (pain, vitality), mental health and social aspects.

A promising direction would require a new profile of training and practice of physical therapy: called to serve in an interdisciplinary way, with a comprehensive look, combined with the other areas of health care, able to dialogue with the different levels of reality, and competent in developing skills and creative abilities. "The physical therapist, acting in isolation, cannot have an effect on all areas that affect the quality of life of public services users" (Aquino et al., 2009, p. 278). Examples of integrated performance in the field of public health are growing across the country and can stimulate the degree programs to value the knowledge that is learned by exercise and integration between different areas, academic and the so-called "popular knowledge". It is worth noting, however, that vocational training remains distant from the needs of the health system, integration of clinical knowledge and public health, a substantial reorientation of models and professional practices (Rocha et al., 2010).

The integration between physical therapists and community health agents has been recommended by numerous studies (Ribeiro et al., 2007; Loures and Silva, 2010). The present work highlights these partnerships, its limits and possibilities - in our view still unexplored. It was precisely this metaphor, or idea-force, idea-force, which should mark out the construction space of multidisciplinary action. The aforementioned studies suggest the possibilities of enriching partnerships favored by the continuing education of professionals in order to improve and expand the contact with patients and ensure "care" that early detects more urgent demands. The activities developed in extension projects, the actual pursuit of acting in the communities, integrated into the FHS, allow students to consider their training beyond rehabilitation and specialized character (Ribeiro, 2009).

Extension projects are notable for their strategic importance. The use of active methodologies or innovative teaching-learning is an important tool for the development of extension projects. To allow for

greater real interactions of the users, the students are directed to capture the "lived" experience of patients - their phenomenological dimension (Turner, 1974) - behind the processes that mark, sometimes dramatically, overcoming illness and the modes of existence. It is for students to learn to learn, to make decisions in difficult situations and scenarios and to work in a multidisciplinary team (Maciel et al., 2005). In this interactive work, the professional physical therapist should demarcate their own area of expertise, their unique or specific contribution, coming from its field of knowledge. You will need to face difficulties and challenges that include: changes in work routines and logical organization of the teams, the appreciation of popular knowledge, the management of epidemiological information to define the profile of the population served, and the ability to respond to unmet demands (Barbosa et al., 2010). The tendency toward a technicality or individual-based "welfarism", two mistaken guidelines, will have to be overcome (Silva; Ros, 2007).

Knowledge of primary care proposals and the principles of the health care system, both on the part of the students, as on the part of teachers, should be encouraged in the classroom, but few curricula include courses focused on the actions of comprehensive health care. The pedagogical projects direct the work of professionals toward activities that are predominantly technical, curative, and rehabilitative (Veras et al., 2004; Freitas, 2006). The human aspects of physical therapist/patient relationship are devalued. The future professionals are prepared to "repair" damage through techniques and protocols established. Little attention is given to patients' perceptions about the impacts of their disease, the suffering, and the experiences of the patients and their "ways of life."

## Home Care and teamwork

Another significant inclusion of physical therapy in primary care is directed toward home care services (HC), as a vehicle to accommodate the individual demands. Conceptually this type of service comprise coordinated actions developed by health teams in the home of bedridden patients for long periods (Rehem; Trad, 2005).

Thus, according to the Brazilian Ministry of Health, the practice of physical therapy must be part of the multidisciplinary home care team. This includes one, among the various aspects of primary care, and should take into account the clinical condition of the patient, the degree of dependence to functional activities, and the social and economic conditions (Lopes, 2003). This proposed type of home care, in this context, faces a more humanized practice, according to the needs of people, encouraging relationships between professionals and the community to improve the conditions of care and the continuity of care offered. Note the importance of teamwork in these various types of home care. For Feuerwerker and Merhy (2008), home care requires the participation of the entire multidisciplinary team and the construction of innovative strategies for assistance. Although the authors do not discuss the composition of the health care teams, they show that “home care is possible even in economically insecure environments and this can contribute effectively to the production of comprehensiveness and continuity of care” (Feuerwerker; Merhy, 2008, p. 180).

This modality of care encompasses all principles of primary care: team work, knowledge of reality and its social conditions, qualified listening of demands, continuity of care and humanized contact with the patient, prevention of sequelae, and health promotion.

The Homecare Program (Best at Home, “Melhor em Casa”), created in 2011 by the Ministry of Health, has been reinforcing the importance of teams in this modality of care. The Multidisciplinary Homecare Teams (MHT) include the participation of physical therapists, in addition to physicians, nurses and nursing assistants in the care of the patient with chronic diseases, patients with feeding tubes, dependent on mechanical ventilation, patients in the process of motor rehabilitation and newborns with low birth weight. According to data from the Ministry of Health, the Southeast Region accounts for the largest number of homecare teams, approximately 460 MHTs. The States most needy are: Acre; Amapá, Rondônia, Roraima, Tocantins, Sergipe, Piauí e Mato Grosso, which put together have around 50 MHTs.

In addition to the MHTs, the Best at Home Program also includes the Multidisciplinary Support

Teams (MST), consisting of at least three health professionals with higher education, chosen from among the following: physical therapist, nutritionist, dentist, social worker, speech therapist, psychologist, pharmacist, or occupational therapist (Brasil, 2011, 2012, 2013).

The practice of physical therapy seeks to recover the degrees of disability, promoting improvement of motor functions, sensory and neurological, and offering the patient greater dignity of care. De Freitas (2006) points out that home care is related “to the greater appeal for the justification of action” of the physical therapist. At stake, according to the author, is the search for a greater contact with the patients and the establishment of connections that allow knowing their realities, their experience before the processes of separation, crisis and reintegration in health and in sickness.

It is worth noting, however, that the issues concerning the composition of health care teams are still an obstacle in the recognition of the role of physical therapy in primary care. Costa et al. (2012), studying the distribution of physical therapists between public and private establishments in different levels of the complex health care system, found that the main types of establishments where physical therapists are used are specialized/ambulatory clinics and general hospitals. Considering the complexity of the process, only 13% of professionals recorded were linked to Primary Health Care, in comparison with 29% of hospital care and 57% of specialized outpatient care. In this scenario, we should add up within Brazilian municipalities the small number of physical therapists when compared to other health professionals in home care. An example of this scenario is the municipality of Maracanaú, in the metropolitan region of Fortaleza, Ceará, which had in 2009 a total of 51 Family Health teams, with an equal number (fifty-one) of doctors and nurses, 35 dentists and only 3 physical therapists (Costa et al., 2009).

In Brazil, the Law no. 10,424 of 04/16/2002 adds to the Health Law 8080 general health care and home care in the UHS (Lopes, 2003). Canada already includes home care in the Canadian Health Act since 1984 as an “extension of health services” in all Canadian provinces, and basic services have

opened space to physical therapy (Health Council of Canada, 2013), although they are not prevalent in health care - as will be seen later.

The action and involvement of physical therapists remain a challenge within the health care system in Brazil. Although the guidelines of the Ministry of Health for the composition of the health care teams encourage multidisciplinary teams, it is still a timid effort toward the incorporation of the so-called “other” professional categories (Rezende et al., 2009).

## Primary health care in Canada

A key aspect in the Canadian primary health care system is the attention given by the federal government and provinces to social contexts and local realities, which require the development of strategies for integrated and community-based care. The document that broadly outlines PHC in Canada, even if it is intended to closely evaluate the model in the Ontario region, is the Overview of Selected Primary Health Care Models (Cook; Kachala, 2004). This document highlights concrete experiences, but suggests possible horizons not yet achieved in the country. Primary care is based, or should be based on models of community care and concerted action; the question of “partnerships,” even if more promising than in Brazil, is still problematic.

In the so-called model of Professional Primary Health Care, the authors suggest that primary care is organized predominantly around family doctors and general practitioners, who work individually or in small groups. Rarely these professionals perform integrated assistance with other health professionals. This model, which is dominant in Canada, is further subdivided into two types of care: one in which predominate the “contact,” the “professional contact;” and in the another, the professional coordination. There is a tradition of government support to the leadership of the doctors who are responsible for this model (family doctors and general practitioners). Hence accessibility has been a strong point, according to the Report. As emphasized by the authors, precisely because it is a model of little tradition in relation to the government/health system, the alternative model of care, a community type model,

presents problems with regards to the accessibility of the population (Cook; Kachala, 2004).

Nevertheless, the community care model - Community Primary Health Care - provide the guidelines to the health practices in several Canadian provinces. This model, according to the Report, is still not fully integrated to the national health care system, unlike the “professional” type of model. The community model is based on health centers and is classified by the authors in two types, the “Integrated community model” and “non-integrated.” Both have very similar positive traits, such as the quality and effectiveness of services. However, the accessibility is a weak point in the particular case of the “non-integrated” model, which also presents problems for the continuity of services.

The integrated model anticipates a strong cooperation with the community. The services are offered by health centers in the provinces. They are accessible fulltime. The continuity, quality, equity and effectiveness of care are guaranteed by multidisciplinary health teams. They seek the cooperation between professionals in primary care and the services offered by hospitals. This model encourages professional integration.

The document suggests that the non-integrated model, hence its name, precisely lacks the mechanisms for specific integration (Cook; Kachala, 2004, p. 21-22). This model does not differ from the integrated through the range of services offered, but by certain insulating characteristics, and the lack of integration with the national health care system. Without referring explicitly to the political issues associated with Quebec, this form of non-integrated action is discussed in the text, which also includes references to the absence of integrated information systems.

## Support for primary health teams in Canada

According to the document *Primary Health Care and Physical Therapists: Moving the Profession's Agenda Forward (Primary..., 2007)*, there is strong evidence that the intervention of physical therapists in primary care teams produces important results. In this collective work, “indicators of evidence for



physical therapeutic interventions in research reports and other specialized literature, are presented in accordance with systemic results,...from the point of view of the provider,... from the point of view of the patient and of the conditions” (Primary... , 2007, p. 8), such as arthritis and osteoporosis. The goal is to incorporate the components of primary care to public and private assistance. The services are provided by multidisciplinary teams - “agents of health care” - that provide care on the basis of assessment of the health needs of local communities (Marriott; Mable, 2000; Health Council of Canada, 2005a). Among these agents, the physical therapist participates in the integration of local services.

Many provinces have encouraged the participation of physical therapists and other professionals in primary care (Soever, 2006). In several Canadian provinces, there are real experiences of community and multidisciplinary work. Community centers and home-based services play a prominent role, especially in Quebec, where the experience was especially innovative. Since 2004, community health centers and social services are in operation (CSSS, *Centres de Santé et de Services Sociaux*), as a merger between the Centres Locaux de Services Communautaires, the Local Community Service Centers, the Home Accommodation Centers (logements sociaux), and hospital care. In recent decades, the urban social movements influenced the creation of these centers, real references of integrated services (Carvalho, 2005; Conill, 2008).

Health Canada, or Santé Canada, is the Canadian ministerial of health body, responsible for the creation and financial support of the Health Council of Canada. The Council is an organizational tool, a non-profit organization with the autonomy to control accounts, ensure transparency and monitor the performance of national programs and services. Since 2005, under its responsibility, the population has access to the reports of the monitoring programs, including the activities of primary health teams in remote or difficult to access communities. The theme of multidisciplinary teams is continuously on the agenda; the most recent 10-year health plan, issued in 2004, expected to hit hit some ambitious goals over the decade, including the access of the population to the services offered by multidisciplinary

plinary teams (Health Council of Canada, 2005b).

The reports recognize that some dynamics or “team spirit” has sprung up within this official initiative (Health Council of Canada, 2005a, 2005b). However, if some provinces, such as Quebec, Alberta and Ontario, have adapted the multidisciplinary teams to the existing community health centers, there have been difficulties in the integration of care between family doctors and other health professionals. According to Carvalho, a Brazilian expert on Canadian health policies, a good part of doctors in Canada exerts its practice in clinics, alone or with other professionals, mostly medical doctors. Few exercise activities within community centers (Carvalho, 2005).

According to the reports of 2006 and 2007, only 31% of family physicians established a “formal agreement” of collaboration with other health care professionals; and 22% worked only with nurses. In the specific case of physical therapy, the data are hardly favorable : only 12% of family doctors established partnerships with physical therapists (Soever, 2006; Health Council of Canada, 2007).

An important issue, referred to in the report of 2007, which relates directly to multidisciplinary teams, is the increase of chronic diseases in the country. Cardiovascular diseases, cancer, hypertension, diabetes and chronic respiratory diseases are the most responsible for mortality in the world. Thus, the chronically ill, more than any other patient, requires multidisciplinary care. In 2008, according to the *Canadian Survey of Experiences with Primary Health Care*, only a third of the population had access to more than a “provider” of primary health care (medical doctor and nurse), and half of the population was assisted by family doctors without the involvement of other professionals (Health Council of Canada, 2008).

It is noteworthy, however, that if the official reports point out difficulties for the building of partnerships between health professionals and family doctors, they also draw attention to the evidence of improvement in the quality of life of people treated by multidisciplinary teams. The data collected among the users of services showed that: 42% felt that there had been improvement in their quality of life; 46% had acquired greater knowledge about

their life and health conditions; and 67% said they were capable of preventing future problems (Health Council of Canada, 2008).

A 2009 report, *Teams in Action: Primary Health Care Teams for Canadians*, provides data on the control of chronic diseases in the country and stresses the inclusion of other professional teams in primary health care. According to the report, “a primary care team maintains formal ties with specialties including the centers for Diabetes, Hypertension and Cholesterol; the Cardiac Clinical Function; the Program of Weight Monitoring; and centers of Mental Health and Chronic Pain” (Health Council of Canada, 2009, p. 16). It recommends the integration between multiple bodies of knowledge and proposed actions in order to encourage a reduction in the length of hospital stay of patients with chronic diseases and increase the adherence to treatment. It suggests further that primary teams should include physicians, nurses, social workers, physical therapists, occupational therapists, nutritionists, pharmacists, dentists and pathologists (Health Council of Canada, 2009, p. 12). The stress on the need to get access to services in problematic or remote locations is clear: “Teams are an effective instrument for the provision of services (...) (in rural areas, remote and less equipped, with insufficient number of family doctors)” (Health Council of Canada, 2009, p. 5).

The reports of 2011 and 2012 focus on the participation of the patients. According to the reports, almost half of the Canadian population actively participates in primary care. The teams are trying to work together with the patients in the development of a plan or guiding protocols to control and prevent disease. Within this perspective of “improved patient care,” the health professional establishes a “truly therapeutic” relationship with their patient (Health Council of Canada, 2011, 2012).

It is worth mentioning that the teams are formed by professionals from various areas, including the participation of physical therapists which is still in its initial stage. In the province of Ontario, for example, the nursing services represent 44% of home care and physical therapy services, 11 %. In the province of Nova Scotia, the difference is more significant; nursing represents 41% and physical therapy only 6% (Health Council of Canada, 2012).

A “discussion paper,” commissioned by the Canadian Physical Therapy Association and other professional institutions in the province of Alberta, entitled *Primary Health Care and Physical Therapists: Moving the Profession's Agenda Forward* (Sover, 2006), covers three fundamental questions for the whole country: the status of physical therapists in primary care; the barriers related to this professional involvement at this level of practice; and the opportunities related to the area of practice. The most important perspectives that guided the formulation of those questions in the paper were the following: from a political point of view (to influence and advocate for public or mixed models of PHC and establish strategies for the media); from the perspective of clinical practice (building models of practice focused on recent scientific evidence and maintain a dialogue with other health professionals and the public); and from the perspective of leadership (creating points of dissemination of information about physical therapy in PHC); these perspectives guided the analysis of the three issues raised in the discussion paper. The text stresses the positive impact of the role of physical therapists in PHCs as well as in other levels of practice. These views were confirmed through interviews with key informants. However, the paper points to the pressing need of professionals to seek the improvement of their practices and develop new caring skills.

The viewpoints that guided the analysis of physical therapy in issues of professional status, obstacles and opportunities also turned to the dimensions of education and regulation. With regards to education, the discussion paper highlights the importance of investment in the graduate programs and continuing vocational training, in order to meet the challenges in health care. In addition, the field work carried out by means of extension projects and active methodologies are considered important for the development of skills among students and professionals. Regarding regulation, the text proposes the need to review the legislative and regulatory frameworks in the light of new developments in the role played by physical therapists in PHC. This would include, according to the document: the adoption of specific and interdisciplinary disciplines; the need of accountability, that is, the focus

on emerging liability issues related to participation in multidisciplinary teams; and, finally, the aspects of delegation or assignment of functions to other members of the team.

## Final considerations

The two health systems follow along different tracks - in particular according to the scope of primary care as well as to the system "resoluteness," the latter being more effective in Canada than in Brazil. However, in both national proposals the concern with social citizenship, or universal access is quite prominent. In Canada, the physical therapist plays a salient role in facilitating access to care, and is one of the professions more organized and cohesive in the country, despite the different provincial contexts. However, it should be emphasized that one of the essential conditions of care is the action of interdisciplinary teams. The partnership metaphor that we have been discussing has greater resonance in the Canadian scenario, but should find, in the near future, its due place in the field of health professionals in Brazil, as a driving element, or a vital force behind, short term public policies.

The experiences developed in Canada and in other countries sought to prioritize the most urgent needs of the communities. These formed the theoretical and practical foundations of the Family Health Strategy in Brazil, created in 1994 and expanded over the first initial years. In this decade, representative and educational institutions related to physical therapy began to encourage the participation of professionals, assuring them a place at the primary care level (Freitas, 2006).

In recent years, in Canada, the discussion on the role of health professionals in primary care is receiving special attention. The principles encompassed in the Ottawa Charter about primary health care recognize that interdisciplinary collaboration and teamwork maximize the skills and competencies of all health care professionals for the benefit of their patients and improve the quality of service.

Much more than in the case of Brazil, in Canada the physical therapist has been considered an important actor in primary care. Though the methods of health organization, financing, and administration vary from province to province, many provinces have

created conditions for the participation of physical therapists in initiatives of primary care health care, in response to the increase of chronic degenerative diseases. In Brazil, even though the health policies and programs have encouraged the participation of physical therapists in primary care, these professionals still face the challenges of a fragmented training and the need for information and tools to increase their knowledge and enhance their performance. Changes in professional education may influence the adoption of new practices and promote integration within the model of primary care in the near future.

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### Contribution of authors

Faria participated in the design of the study, the writing of the manuscript, the survey of the bibliography, data analysis and critical review of the literature. Alves participated in the writing of the manuscript, the survey of the bibliography, data analysis and critical review.

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