The Community Health Centre Model: What the literature tells us

Community health centres (CHCs) have been an effective but under-valued model for delivering primary health care[1] for decades in Canada and the US. One of the unique features of the model is its strong focus on the social determinants of health and preventing acute illness among groups who are more likely to experience poor health and suffer from chronic conditions, including low-income people, ethno-cultural communities, Indigenous peoples, and frail seniors.

So what are community health centres? CHCs are non-profit primary care organizations that provide integrated health care and social services, with a focus on addressing the social determinants of health. Five commonly accepted characteristics include:

1. CHCs provide team-based inter-professional primary care that includes a range of health care and social service providers, including social workers, family physicians, nurse practitioners, nurses, dieticians, occupational therapists, clinical pharmacists, physiotherapists, respiratory therapists, cross-cultural health brokers, First Nations elders, mental health counsellors, and outreach workers, among others.

2. CHCs integrate medical care, mental health and substance use services, health promotion and chronic disease management programs. Many CHCs also provide vision and dental care.

3. CHCs are community-governed and responsive to the patients/members they serve. This means that they are legally established as non-profit societies or co-operatives and provide open membership to their patients (who are members of the organization). It also means that patient-members can participate on the board of directors and in other parts of the governance of the organization.

4. CHCs actively address the social determinants of health such as poverty, access to housing, education, language barriers and other factors that have a direct impact on health. CHCs take an upstream approach intended to prevent illness and promote wellnessthrough advocating for public policies that address the upstream determinants of health, including fair taxation, living wages, decent working conditions, safe and affordable housing and quality public services.

5. CHCs demonstrate commitment to health equity and social justice through a community development approach. They recognize that disparities in health status among the population are socially, economically, and institutionally structured—and that these disparities are avoidable and unfair.

As BC moves to support a role for CHCs within a larger agenda for reforming primary care, what can we learn from other jurisdictions where CHCs are integrated into the broader primary care system? How can we support CHCs in BC to be leaders in improving the quality of care for the entire health system?

Lessons from community health centres in the United States and Canada

In both Ontario and the US, where the CHC sector is much larger than in BC, research clearly shows the benefits of CHCs in improving health outcomes, access to care, and cost-savings for higher-needs populations.

Learning from the United States

In the United States, CHCs emerged in the 1960s based on the work of community health and civil rights activists, who fought to improve the lives of Americans living in poverty and in need of health care. The first two CHCs were established in 1965 with the creation of the federal Community Health Centres program. This program was mandated in the Economic Opportunity Act of 1964 as part of America's "War on Poverty." Not surprisingly, the federal CHC program has a strong focus on addressing the root causes of ill health—the social determinants of health. The program also requires that at least 51 per cent of CHC board members must be patients of the clinic.

Today in the United States, there are approximately 1,370 CHCs across the country, delivering care to almost 28 million people. This large, non-profit and community-governed sector plays a vital role as the social safety net for the broader primary care system. In the US, CHCs serve predominately publicly insured (i.e. Medicaid or low-income) or uninsured patients. More specifically, US CHCs serve the following patients:

- 82 per cent of patients are uninsured or publicly insured and, therefore, CHCs provide care to a large share of the publicly funded health system in the US;
- 36 million patients are homeless;
- 91 per cent of patients are in, or near, poverty; and,
- 63 per cent of patients are members of racial/ethnic minority groups.

CHCs provide care to a disproportionate number of higher-needs population groups. US CHC patients suffer from chronic conditions at higher rates than the general population, and yet CHCs achieve higher rates of hypertension and diabetes control than the national average. At the same time, they are able to provide more preventive services than other primary care providers. A 2009 literature review of five peer-reviewed studies concluded that US CHCs were associated with lower health care costs. Some of these cost studies found that CHC patients had lower rates of emergency department visits and hospitalization than non-CHC patients.

Learning from Ontario

In Canada, CHCs grew out of local community organizing, especially in low-income areas where community members identified the need for better access to comprehensive primary care services. At the time there was concern about containing public health care costs, as

the dominant fee-for-service physician compensation model was placing pressure on provincial health budgets—a challenge that remains today.

The first Canadian CHC was established in Winnipeg in 1926. Today there are approximately 300 CHCs represented by the Canadian Association of Community Health Centres. A quarter of these are located in Ontario where CHCs have a long history of growth and sustained support by government including core funding of just over $400 million in 2016/17 and $96 million in additional funding from other sources (e.g. foundations, other provincial ministries and other levels of government). Ontario CHCs serve about 500,000 patients each year—typically patients with more severe mental health illness and chronic health conditions, and higher levels of morbidity and comorbidity. The patients of CHCs in Ontario also tend to come from lower income neighbourhoods with a higher proportion of newcomers and those on social assistance.

Evidence of the value of Ontario's CHC model is provided in research studies from 2009 and 2012 comparing Ontario's 75 CHCs with the other primary care models in Ontario. This research shows that CHCs are more effective in managing chronic conditions, reducing emergency visits,[5] and improving access to care for people with serious mental health issues.[6] As a 2012 study from the Ontario's Institute for Clinical Evaluative Studies (ICES) concludes, CHCs "stood out in their care for disadvantaged and sick populations and had substantially lower emergency department visit rates than expected."[7] This suggests that CHCs may be a more cost-effective model for providing primary care, particularly for high needs, vulnerable populations who are high users of health services.

CHCs in Ontario are globally funded to cover all operating and staffing costs which means that physicians are paid a salary in the same way as other staff. The global funding model has been critical to their success of the CHCs in Ontario because it gives the CHC considerable flexibility to hire staff and develop services appropriate to the specific needs of their patient population as community needs and demographics shift. It also opens up opportunities for them to develop innovative funding partnerships to support new community initiatives, sector-wide improvement strategies and needed infrastructure.

This summary is an excerpt from "The importance of community health centres in BC's primary care reforms: What the research tells us." This article was written following a workshop on CHCs held on February 1st, 2019 and co-sponsored by the BC Health Coalition and the BC Centre for Policy Alternatives. The workshop included a broad range of community non-profit and health sector organizations including health professionals, immigrant and newcomer-serving organizations, the Ministry of Health, Divisions of Family Practice and Health Authority representatives, the First Nations Health Authority, seniors' organizations, the BC Rural Health Network, and leaders from the CHC sector in BC. Participants heard how CHCs in Ontario, Saskatchewan, and Oregon provide responsive, team-based primary care that is community-led and that has proven very effective in addressing the unmet needs of vulnerable populations as well as the broader neighbourhoods and communities where they are situated. The article is co-authored by Andrew Longhurst and Marcy Cohen.