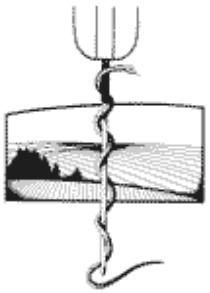
Primary Care Renewal Policy:

RECOMMENDED RURAL STRATEGIES

APRIL, 2003



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Society of Rural Physicians of Canada
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About the Society of Rural Physicians of Canada

The Society of Rural Physicians of Canada (SRPC) is the national voice of Canadian rural physicians. Founded in 1992, the SRPC's mission is to provide leadership for rural physicians and to promote sustainable conditions and equitable health care for rural communities.

On behalf of its members and the Canadian public, SRPC performs a wide variety of functions, such as developing and advocating health delivery mechanisms, supporting rural doctors and communities in crisis, promoting and delivering continuing rural medical education, encouraging and facilitating research into rural health issues, and fostering communication among rural physicians and other groups with an interest in rural health care.

The SRPC is a voluntary professional organization representing over 1,800 of Canada's rural physicians and comprising 5 regional divisions spanning the country.

"Nous soignons les régions- We care for the country"

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Primary Care Renewal Policy

Primary care is the health care system of first contact by the population seeking medical care. Primary Care Renewal (PCR) is a collection of potential delivery systems that share a patient centered and collaborative approach to ensure that the right services are provided by the right providers in the right places at the right time. Under the existing health care system, there are problems with primary care in many urban environments. The city dweller potentially has a choice between walk in, emergency department (ED), the family doctor, midwife, nurse practitioner, paediatrician, and gynaecologist for elements of their primary care. These professionals offer fragmented and therefore expensive and often uncoordinated care. Furthermore, there is limited dependable access to a continuity of care on a 24 hour, 7 day a week basis. It has been suggested that with primary care renewal, we could provide accessible high quality integrated and coordinated care. As an additional benefit, some have even claimed that this will also improve access for primary health care for the 9 million rural Canadians.

However rural family medicine differs from the current urban model. Rural family doctors have higher workloads, work longer hours, provide a greater range of services, in a greater variety of settings, refer less, admit to hospital and care for inpatients more, than their urban colleagues. Many rural Canadians already benefit from having a designated family doctor that offers them a complete basket of health services 24 hours a day, 7 day a week.

Rural primary care, on a per capita basis, is one of the most efficient health care systems in Canada. Furthermore, as an integral part of their rural practice most country doctors provide services such as obstetrics and inpatient care, which in the city, specialists usually handle. In some settings, these other services form the vast majority of the work that these doctors do.

The current developing urban model of nurse practitioners is anteceded with decades of experience of outpost nurses in rural Canada. These nurses have provided, with physician backup, quality office based health services to populations. This model is mature and functioning well for Canada's most isolated communities.

Despite this apparent success of rural primary care, there are systemic problems that need to be addressed. The Society of Rural Physicians has been working since 1997 on the issues of rural primary care renewal and collaborative practice. In 1998 we convened a national policy conference "Nurse practitioners and Rural medicine: Voices from the field" http://www.srpc.ca/librarydocs/NPpolyco.htm This was followed by our discussion paper from the Ontario region on Rural Primary Care Reform in 2000. In 2001 the Ontario region developed a discussion paper regarding primary care templates for rural primary care.

Our concern is that PCR, and particularly some of the suggested models, can risk the stability of the existing fragile rural health system. By an emphasis on office work that adds competition and fragmentation and leaving hospital work and other services unsupported, rural PCR will threaten the viability of existing services. This will reduce access, worsen patient outcomes, and risks increasing overall costs.

Our vision is that primary care renewal can be done in a way to support and maintain the rural health care system. If primary care renewal is done in a way to support existing acute care community services, improve preventative care services, and reduce the maldistribution of health practitioners, it can do great good for Canada’s rural citizens.

This paper explores concepts from a national rural perspective to enhance and renew rural primary care.

A Starting Point -- The Rural Health Care System

Rural Canada has about 20 percent of the employed Canadian workforce, 31.4 percent of the Canadian population and over 99.8 percent of the nation's territory.

It is a highly diverse economy and society, from its coastal regions to its agrarian heartland. Canada's rural natural resources provide employment, forest products, minerals, oil and gas, food, tax revenue and much of our foreign exchange.

While 31 percent of Canadians live in rural areas, only about 17 percent of family physicians and about four percent of specialists practice there.

A mean rural population density of one person per square kilometer creates unique and special requirements for the delivery of health care. This density coupled with the need to provide acute interventions in the "golden hour" of trauma, and the other time based standards that save lives, indicate that health facilities need to be located near the people.

In Canada many isolated small populations exist that need care. Some of these villages and towns either lack local access to health care or depend on outpost nurses or doctors (often itinerant) that provide care limited to regular office practice. Some of these centers are unlikely to be able to support higher level services such as emergency department, inpatient and obstetrical care, although there are notable exceptions.

Slightly larger centers support these additional services. The only practitioner type that can provide concurrent obstetrical, inpatient and emergency coverage is the rural trained family doctor. This becomes viable and efficient when the practitioners number at least 4 with a minimum population base ("catchment") of about 5,000 people. Obviously lesser populations can be sustained at such service level with subsidy with the same number of physicians at lesser efficiency. With additional training these practitioners can support common anaesthetic and surgical services such as appendectomy and caesarean.

Specialists start to be supported in larger rural centers with catchment of about 15,000. In this size level solo consultants in general surgery and internal medicine can be found. Even there the consultants have to be broader in scope than conventional city training yields. By example rural general surgeons need to provide caesarean, and orthopaedic backup for the population, skills not taught in contemporary general abdominal surgery training programs.

Maintaining solo specialists requires substantial support from the family doctors who need to provide the vast majority of urgent and after hours care in the intensive care unit, the maternity case room, and the emergency department. When such cooperation and division of the workload is not done high burnout is the result.

Groups of surgeons and internists occur in larger regional centers of about 50,000. These centers usually still depend on generalist support of hospital functions.

The Rural Health Care System -- Issues that might be addressed through PCR

The issues of services to a defined or rostered population, continuity of care, 24 hour coverage, and coordination and efficiency of care are not major issues in the rural health care system. The foremost issue is that of maldistribution, where rural areas experience difficulty recruiting and retaining an equitable share of professionals.

Rural primary care renewal is an opportunity to preferentially distribute additional health care professionals into areas that need them the most. This would primarily be nurses and physicians but would also be other health care professionals as needed.

Rural communities also struggle with finding enough personnel to go beyond acute care to achieve high uptake of preventative measures. Much of the scarce medical resources need to be spent on dealing with the high morbidity found in rural areas including high rates of diabetes trauma and heart disease. When most of the time is spent by necessity in treating those problems there is a significant lack of capacity to deal with antecedent causes such as adolescent obesity, farm safety and smoking.

Rural primary care renewal is an opportunity to enhance capacity to help address the determinants of health in these regions.

Rural primary care renewal is an opportunity to support broad based general practice.

Principles of Rural Primary Care Renewal

1. Primary care renewal needs to be implemented in a way to preferentially distribute additional health care professionals into areas that need them the most.
2. Additional professionals such as nurse practitioners should have adequate preventative and public health training to help increase community capacity for wellness.
3. There should be a national process to develop guidelines for the scope of practice of nurse practitioners.
4. There is an enhanced skill set and education required by nurse practitioners.
5. The activities within the role of nurse practitioners may vary by location.
6. Funding models must be developed to enhance cooperative and collaborative care within PCR groups. Competition must be avoided. Legal responsibilities and liability must be delineated.
7. Funding models must ensure that existing hospital and acute services are supported and enhanced.
8. Rural PCR needs to support the broad based generalist practice. Physicians should be offered incentives to learn more skills and provide broader services. Ideally most if not all of the physicians should want to provide support for inpatient, emergency obstetrical, and educational services as applicable for the community.
9. A community focus needs to be applied for PCR to ensure that vulnerable individuals are included in the delivery model chosen for the community.
10. Comprehensive primary care, regardless of payment mechanism, requires incentive to maintain the physician patient relationship, ensure high continuity of care, provide basic secondary care limiting the need for referral, and treat the entire community including the really sick and problem patients.
11. A mechanism will be needed to recognize that rural areas, especially those in the north, have extremely limited access to specialists. In these areas rural family doctors provide services that are normally provided by specialists, in addition to primary care
12. PCR must avoid requiring duplication of on-call. The rural doctor should be able to simultaneously cover hospital and clinic call.
13. PCR must recognize that there are special and high needs populations and that the funding mechanism must reflect these.
14. PCR funding models must be flexible in order to encourage the broad range of services provided by rural physicians.
15. PCR models should build in three-way accountability to include the responsibility of the patient to access care resources responsibly, the responsibility of health care professionals to provide a full spectrum of services to a defined population, and the responsibility of governments to ensure that this spectrum of services is accessible to rural populations. Governments should be accountable for stable recurrent funding and administration.

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