REPORT OF THE FACT FINDER

on the issue of

Small/Rural Hospital Emergency Department Physician Service

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Ontario Ministry of Health
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EXECUTIVE SUMMARY

Small/rural hospitals ("hospitals") have in the past few years experienced difficulty in ensuring full physician coverage of their emergency departments ("ERs"). In order to maintain 24 hour service many hospitals have had to pay a "top-up" fee to their local physicians or retain outside agencies to provide the service. Local physician reluctance to provide ER coverage arises from two principal concerns: the desire to maintain a balanced lifestyle and poor remuneration for providing the service.

The examination of issues surrounding the provision of ER services in hospitals unavoidably led to an examination of the delivery of primary medical care in these communities. Physician supply, geographical location of hospitals, and the overlapping nature of medical problems addressed in hospital ERs and physician's offices all influence the range of solutions available.

When confronted with such difficult problems in the past the Ministry of Health ("MOH'"), Ontario Hospital Association ("aHA"), and Ontario Medical Association ("OMA") have generally found an effective compromise. Such compromises, while forcefully negotiated, were assisted by the confidence that there were sufficient public monies to help address the issue in question. Today's economic realities result in the parties having to seek solutions when the available public funding is shrinking. The initial reaction has been for the principal players to protect their existing positions and move away from compromise. This may be understandable, but not desirable. To protect medicare and the best interests of those in the health care system, it is essential to build trust and recognize that compromise can have a role when resources are shrinking.

For whatever reason the search for compromise failed, which necessitated the Fact Finding. Both the OMA and the MOH had legitimate grounds to dispute each other's view on where the responsibility rested for finding a financial solution. The OMA relied on the history of past practice which created an argument for MOH contributions to resolution of the problem. The MOH relied on the authority of the OMA to determine relative distribution of income within the profession.

In the absence of agreement berween the parties, I have concluded that the existing OHIP pool is the appropriate source of funds to adjust incomes of rural physicians and in particular, to address the proposed sessional fees for ER service. I have further concluded that the MOH should be responsible for the costs of bringing the underserviced areas up to the full complement of physicians from the average base of physicians serving in these areas over the past five years.

The overwhelming message arising from this exercise is the urgent need for the three principal parties that sponsored this report to find more constructive ways to work together. Without cooperative efforts at health reform the system will continue to be under stress and problems of tihiS nature will occur more frequently. The financial pressures will be sufficiently severe that failure to find co-operative solutions will encourage more arbitrary methods of problem resolution.

The Findings

General:

- The continued provision of basic physicians' services are at risk in most rural areas of Ontario;
- There is a strong sense of abandonment among rural physicians who believe they are without support on rural issues from the MOH, the OMA, the aHA, and the medical academic leadership;
- Rural northeastern and northwestern Ontario have consistently been underserviced, bur the situation is deteriorating as physicians are leaving and replacements are not forthcoming;

- While the degree of severity of the problem varies from region to region and municipality to municipality, there are service problems or threats of service problems in almost all small hospital settings;
- The tensions between local physicians, hospital boards, and the public in some areas are considerable, and are not only unhealthy in themselves, but their continued existence make their communities less attractive to new recruits;
- Fee for Service ("FFS") is adequate for physician incomes where there is both a heavy office volume and heavy ER volume, a situation not common in rural Ontario;
- FFS is not designed to recognize the service mix provided by most rural General Practitioners and Family Practitioners ("GP/FPs") not is it consistent with stability of service and flexibility of practice in underserviced areas;
- There is a crucial shortage of general surgeons and ofGP/FPs skilled in anaesthesia, emergency, obstetrics and psychiatry;

Rural Practice:

- Rural medical practice is different from urban and suburban practice.
- Rural physicians believe the differences are not fully recognized and contribute to a strong sense of dissatisfaction;
- Rural physicians on FFS must sacrifice income to maintain ER coverage without an income top-up. In some communities the daylight hours are competitive on FFS but almost universally that is not the case during the 12 hour overnight shift;
- There is a strong financial incentive for rural physicians to avoid ER on-call;
- There can be no physician stability in communities where the physicians are required to provide on-call more often than 1 in 5 in a hospital with a 24 hour ER service;
- There is a strong incentive in underserviced areas to avoid ER on-call if a balanced lifestyle is desired; and
- It is not desirable for physicians to do overnight or weekend on-call and then do office hours immediately thereafter;
- Rural medicine is not attracting adequate recruits because:

  (i) the pool of annual graduates is neither prepared for nor oriented to rural practice;

  (ii) rural medicine is not fully appreciated or encouraged in the academic settings;

  (iii) there is currently a substantial trade-off between income and a balanced lifestyle due to the additional pressures and responsibilities carried by rural physicians;

  (iv) in: underserviced areas while quantity of income is not an issue, the extra work and unrelenting demands deny a balanced lifestyle and lead to burn-out and instability;

  (v) it is difficult to maintain continuing medical education ("CME") and obtain co-operation and advice from AHSCs; and

  (vi) not enough family physicians are adequately prepared for the specific demands of rural practice and consequently are not comfortable about establishing themselves in rural areas.

Medical Education:

- Medical schools and Academic Health Science Centres ("AHSCs") are not oriented to rural medicine and unintentionally contribute to a negative attitude about rural practice;
- Medical schools and residency programs at AHSCs are not oriented to the urgent professional and physician needs of rural medicine; and
- Rural physicians do not have the necessary support available from AHSCs and the medical academic leadership to both enhance their skills on a regular basis and to aid them in patient management;

Hospitals:

In many areas local rivalries are encouraging hospitals to maintain 24 hour ER on-call when there is opportunity to consolidate services. Consolidation would provide a better pool of physicians, better coverage and greater medical stability in the region.

- Hospital medical and politicalleadership both locally and provincially often recognize the advantages in consolidation but in face of local opposition, do not have the will to proceed;
- Hospitals in co-oporation with District Health Councils ("DHCs") should play a greater role in facilitating relationships with AHSCs and in providing facilities and support for visiting specialists;
- Hospitals and communities must work together particularly in the smaller communities to ensure basic coverage is reasonably available; and
- Hospitals with less than 5 physicians in the catchment area should not require the operation of a 24 hour ER on-call.

Recommendations

Physician Incomes:

- Rural physicians must be competitively paid for their work and responsibility;
- A globally-funded group practice is the most desirable model for meeting the various needs of rural physicians and their communities;
- As there is no established and tested format for a globally funded group practice, the OMA and MOH should establish an immediate pilot project in the northeast or northwest with willing physicians;
- FFS should be replaced as the preferred funding mechanism in rural northeastern and northwestern Ontario with a Direct Contract Program ("DCP")) that would maintain physician independence and increase stability and continuity of service to their communities;
- A DCP containing specific benefits and requirements should be established immediately as the preferred method of physician remuneration in rural areas;
- The DCP should provide GP/FPs an income at least 20% greater than the provincial average in northeastern and northwestern Ontario, Bancroft and Barry's Bay;
- The DCP and/or globally-funded group practice are both suitable models for all rural areas of Ontario, but are essential in most of the rural northwest and northeast;
- Rural FFS physicians would be given priority to convert to DCP or to participate in globally-funded group practice provided they meet the requirements;
- Rural physicians that remain on FFS and are qualified would be entitled to claim a $70.00 hourly rate for the 12 hour overnight on-call duty in the ER and for each hour of on-call dury on the weekend from Friday evening to Monday morning and on official holidays;
- FFS physicians would be required to close their offices to practice until 2:00 p.m. the day following their overnight ER service;
- FFS physicians who meet all the requirements and serve afull on-call rotation would have their FFS incomes augmented by 5%; and
- FFS physicians who withdraw from on-call would lose their 5% augmentation in income.

Education:

- There should be a special designation for qualified rural FPs;
- 30% ofFP residency spaces should be dedicated to rural medicine;
- Speciality training for FPs must be increased;
- More existing residency slots must be dedicated to training general surgeons;
- Programs should be created to re-tool qualified urban FPs who wish to undertake rural practice and subspecialty surgeons who wish to be general surgeons;

- AHSCs should become affiliated with certain geographic areas of the province and develop permanent links and relationships with the small hospitals and physicians in the communities;
- An Ontario Rural Emergency Advisory Program should be established between the hospital in the affiliated community and the AHSC to provide advice and assistance to the rural physicians in patient diagnosis, and case management; and
- A Rural Hospital Consultant Access Program should be established to encourage the regular availability of visiting specialists in rural communities.

Hospitals:

- Rural regions, particularly in the north should organize around the population centre concept ("PCC). Under the PCC the area hospital would provide 24 hour emergency service and provide support to satellite hospitals and clinics within the region;
- Satellite hospitals should rely on the area hospital for 24 hour emergency on-call. The satellite hospital would have a special triage arrangement to ensure serious emergencies were readily transported to the area hospital;
- The area hospital should provide medical and allied health professional support for non-hospital satellite communities on an appropriate basis where a clinic has been made available by the municipality and it is prepared to pay travel costs for the visiting physician and allied medical personnel;
- Hospitals should work with their municipalities to raise funds necessary to support outreach programs from the AHSCs to ensure the delivery of more sophisticated medical services and medical support to the citizens and physicians in the hospital's catchment area. Funds would cover the purchase of communications equipment, travel expenses of visiting specialists, and local facilities for their use;
- Hospitals in close proximity ought to work with the DHC to convene- a public committee of physicians, board members, administrators and area residents to plan consolidation ofER service; and
- Hospital boards with the cooperation of the OHA, the OMA and the MOH must make a greater effort to provide public education on the appropriate use of ERs.

Communities:

- Small municipalities that wish to have clinics, encourage the attendance of a physician and have regular support provided from area hospitals should be prepared to make a contribution to the area hospital in terms of physical facilities and basic travel costs;
- Municipalities need to work closely with hospitals to assist them in establishing effective links with the AHSCs and in the provision of supporting visiting specialists;

Short Term:

- The MOH should maintain and exercise its discretion to approve out-of-province applications of physicians recruited to work in underserviced areas, provided that they meet the following requirements:
  (i) practice experience in rural medicine or fully trained for rural medicine;
  (ii) skilled in or prepared to pre-qualify in ACLS, ATLS, and PALS; and
  (iii) obtain hospital privileges and fully participate in on-call.
  (iv) Carry a non-FFS billing number granted on a restricted basis to ensure a guaranteed service period in the underserviced areas.
- The Ontario College of Physicians and Surgeons should be requested to consider methods to straighten the pathway for practice eligible experienced Canadian practitioners who agree to practice in underserviced areas; and
- The OMA, OHA and MOH should prepare a program to educate Ontarians both urban and rural on the appropriate Utilization ofERs.

INTRODUCTION TO FACT FINDING

Scope

The purpose of this assignment is to address the growing problems in maintaining and sustaining on-call coverage of emergency facilities by family physicians in small hospitals in rural Ontario. Small rural hospitals ("hospitals") were defined as those with less than 25,000 patient visits to the ER per year.

On-call coverage in these hospitals has been traditionally provided by general practitioners and family practitioners ("GP/FPs"). The last two or three years have witnessed the threatened or actual withdrawal of service from almost all hospital emergency facilities ("ERs"). In response, hospital boards either paid local physicians a "top-up" fee or engaged outside agencies to supply physician services ro ensure that their ERs remained open.

Rural physicians identify two major barriers, encountered in varying degrees of severity, to meeting the hospitals' ER needs: an inadequate number of physicians ro service area needs and relatively poor remuneration for covering the hospital ER, particularly overnight. In most areas of the province the two problems come together resulting in both balanced lifestyle and income issues for the physicians.

There is no disagreement about the fact that a problem exists. Indeed, the Ministry of Health ("MOH"), the Ontario Medical Association ("OMA"), and the Ontario Hospital Association ("OHA"), in instituting this fact finding acknowledge that there is a problem. The disagreement between the parties is more a question of how the problems can best be resolved and particularly, how the additional cost should be borne.

The fact finding could not focus entirely on the narrow issue of staffing within the four walls of the ER as coverage is very much a function of the delivery of primary medical care in rural communities. Indeed, the issues encompass a combination of circumstances - some that have developed over the past few years and others that have plagued some areas for decades. The problems are serious, approaching crisis proportions in some areas, and substantial reforms are required. Their complexity renders it impossible to propose meaningful reforms without recognizing that they will have wider implications in the system.

In undertaking this assignment I accepted as a basic premise that Ontario still supports universal coverage and would continue to reject the development of two-tiered essential medicine as long as there is sufficient funding to maintain quality in important health services. Further, the federal government under the *Canada Health lAct* severely restricts provincial flexibility to utilize outside funding.

Methodology

When I was approached to conduct this assignment in late October the urgency to find a resolution was impressed upon me and I was asked if I could complete it in three months. Given the need to consult the three sponsoring parties, meet with other interested parties, their communities, and with experts, it was clear that at least four months would be required and that this would stilllimit consultation.

I determined that I should initially meet with the sponsoring parties, consider background information, and then receive official position papers from the three parries. Once having had the benefit of the official positions I would visit centres in the affected regions to gain the perspective of physicians, hospitals, and interested citizens. 'This would require extensive trips to norrhern, eastern, central and southwestern Ontario. With this completed I would receive final submissions from the three parties and proceed to prepare my report.

Throughout this period I was to be free to consult with such other experts and health related committees, task forces, and members of the public that seemed relevant.

I sincerely tegret that more *time* was not available to meet with interested parties that were unable to meet the tight timetable. I trust that this shortcoming was adequately addressed by the openness to receive briefs and letters through February 1995.

The complexity of this assignment was made much easier to address by the cooperation of the MOH, aHA, and OMA. All were very responsive to my requests and ensured that I was provided with the information required. I always felt that whoever I dealt with was making a special effort to respond to questions and requests.

I also wish to thank those who agreed to travel with me around the province, and finally, to acknowledge the excellent work of Barbara Hibbard who efficiently and effectively coordinated the fact finding work.

CHAPTER Overview

To commence the assignment I considered the *Royal Commission on Health Services*, 1965 ("Royal Commission"). The following observations made by the Royal Commission remain very relevant today:

"This concentration of population in urban centres has required a similar concentration of service facilities, among them health services, and has also promoted the groWth of large hospitals serving as medical centres for treatment, teaching and research. The availability of these and other health services has stimulated their increased utilization. On the other hand, the decreasing proportionate *size* of our rural population has accentuated problems in the provision of an acceptable standard of health services in rural areas."

"Outlying settlements, however, cannot provide the resources to support an adequate level of services and facilities; help must be sought elsewhere. The problems of distance, then, are compounded by the relative emptiness of the land as we move northward from Canada's southern boundary. This can make the provision of services, whether health or any other, a costly undertaking. Services and facilities are concentrated in the areas with a relatively high population density." [1]

Medicare has been in place in Ontario for a quarter of a century. It was built with a recognition that the transfer from private health care to state-funded care would be a complex transition. The transition went well; indeed, so well that there has been a reluctance to address major reforms. Consequently, the system has grown rapidly in both cost and complexity without any fundamental reform of the basic structures that govern it.

The boast of Canadians that they have the best health care system in the world may well be true, but it contains some unacceptable inequities. The inequities identified by the Royal Commission have not been effectively addressed in some rural areas, notwithstanding the genuine efforts of different governments and substantial expenditures over the last twenty-five years. This lack of success does not suggest that the problems are intractable but rather that new policy approaches are required to replace and improve the structures created a quarter of a century ago.

All stakeholders in the system are in their own way, for their own reasons, reluctant to confront the demands implicit in the current economic environment. While this may be understandable, the simple truth is that unless Ontarians re-address the policy framework we will continue to see the decline of our valued health care asset. The policy reforms must start before the health care system becomes dysfunctional.

In 1965 there was far less medical technology and a substantial patient dependence on the GPIFP for most medical care. There was a greater equivalency in the pattern of practice of urban and rural physicians and in the expectations of patients. In the last 30 years patient expectation and practice patterns have changed, and there is considerable difference in the skills utilized and the needs base between urban office practice and rural general practice. The rural GPIFP will spend a great deal more time with a presenting patient where there are complex or potentially serious matters at hand. They will generally do work that would often be readily referred to available specialists in urban environments. They must also engage in more hands-on medicine involving substantial invasive procedures and stabilization of trauma.

[1] Royal Commission on Health Services. 1965

To recognize these differences and address social and financial issues that have developed around them requires real reforms and not tinkering at the edges of existing programs. To understand the basic barriers to consensus on the problems surrounding physician services in hospital ERs it is important to consider the social and economic environment that surrounds the principal participants.

CHAPTER 2 The Social and Economic Environment

It is not practical or reasonable to assign responsibility among the parties charged with delivery of health care to Ontarians without a thorough examination of the economic and social environment that governs the availability of public funds and those that rely on them. Indeed, attempting to provide financial resources to support solutions is a necessary part of identifying and addressing the practical and small "p" political considerations that have paralyzed the MOH, the OHA and the OMA in their search for a solution.

The total national debt of all governments in Canada is roughly equivalent to our gross domestic product. To stop the growth of our debt all governments are acting more aggressively to make substantial cuts and contain expenditures to curtail our budgetary deficits. Control of funding is not the exclusive preserve of the provincial government. The federal government has and will continue to transfer less money to the provinces. The provinces will, in turn, be constrained in the supply of resources to meet the demands of health programs, physicians and hospitals. This process has been underway for a number of years but with the February 1995 budget, all wishful thinking that these financial pressures would go away should now be put to rest. The most significant message lies in the many years of additional cuts that lie ahead.

Medicare has been and remains the most popular program undertaken by governments in Canada. An unintended consequence has been a great reluctance to introduce major reform for fear of destabilizing public support with obvious political consequences for elected representatives. These considerations impact on the enthusiasm of governments to bring about real reform in health care delivery and the frankness of opposition parties in their demands for change. Unfortunately, medicare is also the most expensive government program and is therefore an obvious and unavoidable target for restraints. Stakeholders in the system have responded by holding more tightly their allotment of scarce resources, perhaps in fear that any sign of weakness will signal a willingness to accept more cuts. In most jurisdictions these considerations have led to across-the-board spending cuts on health care programs with very little emphasis on program reform because these are seen to be politically threatening as they impinge on perceived entitlements.

The major political dilemma in this, however, is the recognition that real reform and priority setting are essential to preserve the essence of medicare in Canada. In the short run reform would inevitably lead to the abandonment of some programs that are of questionable efficacy but: command some popular support. Further, major changes will force a realignment of and within the major spending envelopes that have been sacrosanct. Difficult though these choices may be, they must be confronted.

The MOH, the OHA and the OMA are working with a framework of "entitlements" that have, over time, become less relevant to the evolution of health care. They must enter into a more cooperative and open exercise to realign themselves and the system for the future or they will continue to confront problems, such as those addressed in this report, but with increasing frequency and frustration.

Finally, in the search for solutions it is critical to recognize that the existing barriers are not the sole responsibility of hospitals, physicians and government. The public must recognize that they can be part of the problem in the way they utilize the system. Encouraging more rational patient utilization of the system not only requires greater efforts by governments, hospitals and physicians to educate, but it also requires a willingness of Ontarians to listen. Such willingness cannot be

encouraged without a concerted effort by all the parties to more widely and cooperatively engage in public health education.

In attempting to find solutions in this assignment I have concluded that there is no single policy solution and certainly no easy answers. The different circumstances dictate that new policies will have to be flexible to permit adaptation to different situations. This is essential if we are to be comfortable as Ontarians that we are taking all reasonable measures to address the effective delivery of primary medical care in rural and remote areas.

CHAPTER 3. The Mood of the Participants

In order to effectively assess the problems and the proposed approaches to solutions it is important to understand the current mood of each of the central participants.

The Physicians

Physicians are generally restive. They feel that they are being singled out by government as being responsible for many of the cost-related problems in health care. They believe they are caught between government pressures to provide more services for less money while addressing unrealistic and growing expectations from the public as to what they can and should do. In rural areas their mood is decidedly unsettled and very volatile. They believe they must work harder to maintain incomes equivalent to those of urban physicians and that they are harder hit by the impact of the Social Contract. In many areas their workload is radically increasing with the exodus of colleagues. Growing numbers are voting with their feet by seeking other geographical areas of practice. The anger and frustration is combined with a belief that their circumstances are ignored by the MOH, that they do not have sufficient political power to influence the OMA, and that their situation is not appreciated by their hospital boards.

This unease and dissatisfaction is teased by the conviction that there is an easy way out. The demand for FPs in the U.S. is considerable and the rurally skilled FP is a most attractive target. In this atmosphere it is easy for rural physicians to believe "the grass is greener" in urban areas and in the U.S. and consequently, many are vulnerable to medical recruiters and to offers from colleagues in urban and suburban practices. The Ontario College of Family Physicians is concerned that U.S. recruiting is taking a toll on smaller cities and suburban areas. If this is the case it creates even further options for rural area practitioners.

During the consultations some of the physicians were dearly under stress, others admitted they were in danger of or at the point of burnout, and many volunteered that they were planning to leave if the exercise at hand was unsuccessful in addressing their grievances, particularly in relation to a balanced lifestyle.

Hospital Boards and Administrators

The mood of most hospital officials, both volunteers and employees, was one of frustration. Most hospitals had reached short-term agreements to top-up or subsidize physician services for on-call in the ER, and in some cases for other hospital duties. Those that had not, with a few notable exceptions, had been approached and were negotiating or operating under a deadline to find a resolution. They were unanimous in the view that they were not funded to manage the situation and most but not all resented having to turn to the hospital budget to supplement the incomes of local physicians.

Almost all that had negotiated with their physicians and had some sympathy for their situations, were of the view that the negotiations had had a negative effect on harmony in the community. In some cases negotiations have resulted in permanently damaged relationships that will lead to further problems.

Most believed that the problem ought to be sorted out by the OMA and the MOH. Some were prepared to have an involvement in physician payment as long as they were specifically funded for it and it advanced their ability to attract physicians. The vast majority did not wish to be involved in funding physicians.

In the North hospital boards and officers expressed frustration at the apparent lack of any interest from physicians in coming to their communities.

The Community

Most community representatives were deeply concerned about the level of care available in their areas and were fearful about their ability to attract and retain physicians. In some areas there was deep frustration and anger that the hospital boards and local physicians had not succeeded in providing them with adequate coverage. In some chronically underserviced areas there was resentment that hospital boards were not doing enough and in others, concern that local doctors were discouraging recruitment to maintain income. Whatever the accuracy of specific complaints, their concerns were genuine and the negative atmosphere could only add to the already existing barriers to problem resolution.

Most municipalities rated emergency services as the number one priority for their local hospital and were particularly determined that a full service hospital was essential to their municipality, even in situations where another hospital that was bigger and better equipped was in a nearby community.

Overall Mood

Given the above assessment, there should be no surprise that the overall mood was negative and tensions were apparent in many communities. They felt the *issues* in question were well understood by the MOH, the OMA, and the aHA, and could not comprehend their failure to find an agreed solution. Many expressed scepticism as to whether the fact finding exercise would prove just another step on a path to futility.

CHAPTER 4 Introduction to Current Rural Practice

In considering the nature of the medical problems encountered in ERs in rural and urban areas alike, most (more than 80% is a conservative estimate) medical problems presented were of a type that could have been handled effectively in a physician's office during normal office hours. As a consequence, rural physician coverage cannot be examined in the narrow context of what occurs solely within the ER of the local hospital. Indeed as a practical matter, in rural areas unlike urban areas almost all the physicians will be involved in ER coverage; thus, a proper examination of the issues must take into account the availability and delivery of primary medical services within the hospital's catchment area.

Physician coverage in hospital ERs is, as a general rule, provided by several GP/FPs in private practice and not by hospital employed physicians. In some of the larger rural communities there is also a GP anaesthetist and a general surgeon. The GP/FP is the backbone of both the hospital and the ER. This stands in sharp contrast to most urban situations where the GP/FP will generally practice from an office, be readily backed up by a group of specialists, and not have hospital privileges.

The hospital serviced by rural GP/FPs generally has an ER volume of well under 25,000 patient visits per annum which rules out the financial viability of maintaining a permanent team of ER physicians. Consequently, the hospital is dependant on active community physicians who have privileges at the hospital and will assume their share of ER duties. This reliance can become very troublesome in communities that do not have physician coverage sufficient to ensure that physicians are not overworked. The ability to cover the ER 24 hours per day, 7 days a week is onerous when handled by fewer than 7 physicians without backup. This becomes even more problematic if one or more of the physicians is older, pregnant, sick, on holiday, or on a continuing medical education program ("CME").

A further frustration arises from the fact that the heavy demand on time and commitment in the ER is not adequately compensated for when compared with lost office hours due to low patient volumes at night in the hospital. With the fee schedule weighted to situations where practice is adequate to keep the physician busy, the conflict between ER duty and office hours can be considerable and awkward when the on-call physician is attempting to maintain income by doing his office appointments while having to go back and forth to the hospital on demand. Most physicians did not object to on-call duty per se, and many felt it was an important part of maintaining a skill base relevant to rural medicine. The issue was not ER duty, but the circumstances that surround it. The point was made by rural physicians time and time again that it was a significant financial loss to have to give up income from office hours to serve overnight hours in the low volume ERs. If the physician did not work the next day the overhead for the office would continue and the losses on the low volume ER and on office hours effectively dictated a days work for free. Any attempt to protect income resulted in the strain of having to maintain office hours as well as handle on-call. For the great majority the issue was not on-call but the strain on a balanced lifestyle of having to either support on-call and take no break from office hours or take a break and lose income. It is not desirable from either the perspective of the physician or from the patient to create an incentive to follow overnight ER with morning office hours.

There is a certain order of things which seems to govern the current situation.

1. ERs that have less than 25,000 visits generally cannot provide competitive revenues to match the lost physician office hours. This holds true if the area is overserviced, adequately serviced or underserviced:

i. if overserviced there will be little traffic in the ER;

ii. if adequately serviced (practices able to absorb normal patient demand) there will also be very limited traffic to ER, particularly overnight; and

iii. if underserviced the overall ER volumes may be adequate to be competitive during the day, but the demand will remain inadequate in the overnight period (i.e. 8 p.m. to 8 a.m.).

2. The lower the demand for the ER, the less remunerative it is for the physician to go on-call.

3. Physicians providing services in chronically underserviced areas rarely stay permanently due to the impossible lifestyle conditions in the form of lack of free time to relax with family, take a holiday, or engage in CME.

4. The circumstances outlined in (3) result in a negative environment for recruitment which further hampers the ability to provide adequate coverage on a 24-hour basis.

5. Physicians serving on-call in the low volume periods must either lose some income through sacrifice of some office hours or maintain office hours under less than optimal conditions.

The above clearly constitutes a major barrier to a balanced lifestyle and the income of physicians who are prepared to serve in the ER.

The North

There is a great mixture of quality in services available in northern Ontario. While some communities like Sioux Lookout, Dryden, Cochrane and Elliot Lake appear to have an adequate GP/FP physician supply provided for at the moment it is clear that they have little margin of flexibility and the loss of one or two physicians could put great pressure on the continuation of broad basic service now available. The weakest links in the larger rural centres in the north are the availability of general surgeons, GP anaesthetists and GP obstetricians. Other areas such as Red Lake, Atikokan, Fort Francis, Marathon, Nipigon, Smooth Rock Falls, Iroquois Falls and Terrace Bay are clearly underserviced, under strain, and in danger of losing more physicians. Smaller but substantial communities such as Hornepayne, Emo, Thessalon and Manitouwadge are underserviced and of a size that requires special consideration as they are not capable of supporting more than 1 or 2 physicians.

The situation at Moosonee is both unique and serious and is further complicated by federal, provincial, aboriginal and jurisdictional considerations. On the basis of the limited information provided to me, it appears that primary medical coverage is totally inadequate. Moosonee requires a special study involving these parties as the problems go well beyond the terms of reference of this report and involve two other key parties.

Deterioration in Supply

Most of the northeast and northwest are severely underserviced for primary medical services. Furthermore, the situation is deteriorating and requires immediate attention. To complicate matters, in a few areas there is an incredible dependence on workaholics. The workaholic can thrive in an underserviced area and provide quality work. The supply of workaholics is small and underserviced areas have had to depend disproportionately on their availability. It is an unreliable practice. Most physicians find the burden too much with the onset of middle age while a few remain apparently indestructible. (The former deny stability for the community for they will burnout and leave or simply leave to avoid burnout.) The indestructible physician is rare, impossible to identify, and in chronic underserviced areas can be a centre of controversy. Those who can maintain virtually non-stop practices and provide services over the long term without burnout do not

form even close to a sufficient pool to serve the needs of rural communities. Burnout is often a tragedy for the physician but it can also be dysfunctional for the community if the burned-out physician remains in place. The burnt-out physician tends to look inward and becomes less committed to the community.

Some communities that have been stable for many years are now losing physicians and others are unable to recruit or even to stir up interest. A few communities are so underserviced that this in itself discourages new physicians from even considering them.

The reasons are several and range from very hard to the very soft.

1. Areas that have long been underserviced result in physician burnout leaving only the occasional indestructible and dedicated "workaholic". It is difficult to find recruits for such centres as they can see no opportunity for a balanced lifestyle and see adjustment to the style of the in-situ physician as potentially daunting.

2. The loss or retirement of a GP anaesthetist will drive out the surgeon and may result in discontinuing any obstetrics and a snowballing down of services in what had been a well serviced community.

3. The presence of a general surgeon provides a feeling of equanimity to the other physicians and consequently the loss of the surgeon can be further destabilizing to the remaining physicians.

4. A sharp decline in the number of general surgeons available is impacting more severely on the north than elsewhere in the province.

5. The difficulty in recruiting out of province physicians as a result of new practice qualification requirements and concern over further initiatives to control physician numbers is having a disproportionate effect on the north. There is a widespread fear among medical students and recent graduates that if they go to remote northern areas and don't like it they will be trapped by impending policy changes.

6. Changes in licensure and provincial regulations governing residents effective Jul y 1995, have and will increasingly hurt the locum tenens market.

7. Family practice training of residents, other than those at the new Family Medicine North facilities in Sudbury and Thunder Bay, does not fully prepare rural FPs for the differences between the well supported general practice in the urban areas and the wider skills burden on GP/FPs in rural areas. This creates an immediate barrier for many young physicians who feel unprepared when exposed to the northern challenge.

8. There is a feeling that the U nderserviced Area Program ("UAP") is no longer effective in dealing with physician supply. Although generally supportive of the efforts of those in the program there is a conviction that it needs a major overhaul. Northerners believe that the physician recruitment program is not working and that more funds should be directed to bringing medical speciality services in on a scheduled basis rather than shipping patients out.

The South

The southeast and southwest of the province do experience physician supply problems but with a few exceptions they are not of the magnitude faced in the north. Nonetheless the problems are real and somewhat more complicated to address.

In a number of areas the physician shortage in the ER is related to too many hospital ERs to service rather than a serious shortfall in physicians for the catchment area. The demands of on-call in these areas influence a higher than desirable rurn-over of physicians.

Supply of new physicians is a problem and it threatens to get worse. Some of the reasons given above for the north also apply to the south and the service interdependency and dynamics are similar.

More specifically:

1. Areas that have long been underserviced result in physician burnout. It is difficult to find recruits as they can see no opportunity for relief.
2. The loss or retirement of a GP anaesthetist will drive out the surgeon and may result in discontinuing any obstetrics in what had been a well serviced community.
3. There is a general decline in the number of general surgeons available.
4. Changes in licensure and provincial regulations governing residents effective July 1995, have and will disadvantage short term ER coverage.
5. Family practice training of residents does not fully prepare rural FPs for the differences between the well supported general practice in the urban areas and the wider skills burden on GP/FPs in rural areas.

Many physicians who practice closest to urban areas, where physician availability is excellent and there is no meaningful threat to a balanced lifestyle, are desirous of avoiding ER work usually because they feel unprepared and have better specialist backup or because of its relative unprofitability compared to office work.

CHAPTER 5 Areas Requiring Policy Reform

Physician Payment

The principal method of payment for physicians is based on the fee for service ("FFS") codes in the OHIP Schedule of Benefits ("OHIP Schedule"). The functioning of FFS is clearly a barrier to the resolution of a number of problems in rural areas. In considering FFS in the conteXt of this report the observations are in relation to the efficacy ofFFS in rural areas and are not intended as a commentary on the use of FFS in other settings.

The OHIP Schedule primarily rewards physicians on the basis of specific services rendered. IfFFS codes are properly balanced they can effectively reward effort and commitment through volume of activity. Balancing is easy to imagine but virtually impossible to fully accomplish. With the changes in the nature of practice and with the variations between the structure of urban and rural practices of GP/FPs, the current OHIP Schedule no longer provides an adequate balance. FFS as it is currently structured does not fully recognize the pressure and time commitment ofGP/FPs in rural areas. As the OHIP Schedule only pays for services rendered to patients in the ER, it does not compensate for the hours of stand-by inactivity in low volume ERs.

FFS for the most part assumes a general similarity in GP/FP practice patterns. Today the OHIP Schedule has an office orientation. It does not address the different incentives that confront rural physicians who maintain their offices and service small volume ERs in hospitals. Consequently, FFS does not produce the competitive income necessary to support a sufficient level of physician service to properly address the full rural community requirement. Although the OMA has taken some steps to address how FFS responds to the changes in practice over the years, these changes have not kept pace with the rapid divergence in urban and rural practice. Indeed, some reforms have unintentionally widened the gap. When urban GP/FPs were losing their hospital privileges the schedule was adjusted to place a greater emphasis on office visits as opposed to hospital work. This was appropriate for urban but not rural GP/FPs.

In rural areas, beyond a one hour travel distance from a major urban centre, the ability ofFFS to produce equitable rewards for effort rapidly diminishes. The lack of speciality services dictates that rural GP/FPs must dedicate more time and carry out a broader range of procedures than their urban counterparts. Unfortunately, they cannot bill as effectively for their time and mix of services. In the case of a myocardial infarction, for example, a GP/FP would individually carry out several services that might be handled by two, three or four physicians addressing the same problem in an urban area. In cases requiring the movement of patients to regional centres or Academic Health Science Centres ("AHSCs") the physician may spend hours attempting to locate a bed and a receiving physician. In the process, the rural physician will assume added responsibility and be under greater pressure. Thus, they will spend more time with individual patients, get less money, and see a lower patient volume. To better compete financially with their urban and suburban counterparts they must generally see more patients in their offices and avoid ER duty.

The FFS structure is not only limiting in its application to rural ERs, it can also add to the problems already working against effective ER coverage. For example, where a community can support six physicians but has only three, if they are young and energetic or workaholics they can almost manage an on-call schedule of one in three, and they can generate a very high income. This can create an incentive for resident physicians to discourage new physicians from coming to the community even though there is sufficient patient demand to assure an adequate income. This approach is dysfunctional as it will lead to the loss of most of these physicians when the pressure becomes too much - often a function of age.

Physicians in an adequately serviced community that desires more colleagues to strengthen the depth of service or to permit them an acceptable on-call schedule run the risk that such a move would negatively impact their incomes. This environment may discourage them from taking the socially prudent steps that would ensure greater medical stability in the community. An example of this would be where there is a need to ensure the presence of a second GP anaesthetist to guarantee that the surgeon will remain functional. If this conflicts with a need (real or perceived) to maintain income, then there is a disincentive to recruit. This may in turn put the surgeon at risk and if the surgeon leaves, then obstetrics is at risk. Such human motivation not only puts the community at an immediate disadvantage, there is a sharply increased likelihood of physician burnout and instability in the physician supply which keeps the community at a substantial disadvantage. These are not theoretical findings. The citizens, physicians, politicians and hospital officials, not only made these observations, they provided illustrations.

Physicians were understandably cautious about the implications of abandoning FFS. The vast majority acknowledged the shortcomings of FFS and indicated an openness to consider alternative payment mechanisms, but not if they simply proved another way of status quo remuneration. The majority expressed concern about becoming salaried by hospitals or adopting an alternative that would limit their independence.

Some reform of FFS to address low volume ERs by paying a sessional fee would unquestionably help in some of the larger, well serviced areas where competitive income with office hours is the only issue. Reform ofFFS would not resolve the problems in most underserviced areas where balanced lifestyle issues are central.

Medical Education

Medical education provided by Ontario's medical schools and AHSCs is central to resolving the medium to long term needs of rural medicine. Changes are needed in medical schools, AHSC resident training programs and in their outreach to support rural physicians and community health.

Ontario's AHSCs are a provincial resource. They are funded not only to provide a regional service, but to support the needs of the province. Unfortunately, they have tended to focus on their local community and their role as a provincial resource has been secondary.

Modern medical education has become dominated by a need to keep abreast of rapidly developing technology and has consequently placed considerable emphasis on the development of specialists and sub specialists. GPIFP education has become more academic in its orientation and has been delivered in high technological and specialist-rich environments. While this has been beneficial in many respects it has had a negative and unintended effect on rural medicine.

Medical schools and teaching establishments have gradually become more isolated from the rural community's needs and the ties that should bind rural practitioners to them are scarce. The effect of today's academic medicine and post graduate residency is to ready FPs for urban practice while under emphasizing rural practice where the FP is not immediately backed up by a substantial cadre of specialists and sub specialists. More must be done in the medical schools and residency programs to recognize and acknowledge the value of rural practice and discourage the false image that it is somehow less relevant to the mainstream of medical activity.

Many of the relatively few young physicians recruited to rural areas on completion of their training are intimidated by the skill levels required to meet the challenges and responsibilities of a rural practice due to inadequate exposure to these areas during training.

Programs for FP residencies and speciality programs to qualify FPs in limited speciality areas such as obstetrics, emergency medicine and anaesthesia have little priority and speciality positions crucial to the maintenance of basic services in rural centres, such as true general surgery, have almost become extinct. The current low priority of these programs in the AHSCs can only exacerbate the critical shortage of rural family physicians, a shortage that results in inadequate access to basic primary health care services for the population in many rural areas. AHSCs must reassess programs that are not adequately providing for the requirements of 20% of our population.

There are a limited number of successful outreach programs operated by AHSCs and some important steps have been taken in Thunder Bay and Sudbury in the Family Medicine North Programs but they only constitute a modest beginning. Action must be taken quickly and decisively by the medical schools and the AHSCs to prepare physicians to address this important provincial need.

Ministry Capital and Operational Budgets

Another policy area that is not only inefficient but is counter productive is the traditional budgetary distinction between capital programs and operational expenditures, which has led to uncoordinated planning between hospital capital expenditures and manpower needs. This luxury should be discontinued to ensure more effective use of health dollars. For example, in some rural areas we have spectacular new hospitals with facilities and equipment that would make some neighbouring communities and even many wealthy U.S. communities drool with envy. The problem is they often do not address the local health priorities. State of the art birthing rooms and surgical theatres are of little relevance in communities where there are no anaesthetists and no surgeons. Capital expenditures that are blind to community priorities provide at best a frill benefit. In determining the hospital allocation for the community it makes little sense to spend the capital dollars in one way while the more serious health concerns lie elsewhere. Certainly no surgeon will come if there are no facilities bur equally will not come if other required physician services are not available or the population is insufficient to provide support. The fact that capital budgets are managed separately from other health transfers should not result in a less than rational approach to meeting the basic regional needs.

Hospital Location

In other areas there are hospitals in close proximity to each other providing full emergency services even though each has a low volume ER and insufficient physician supply. In most of these instances the location of the hospital is historical and totally unrelated to rational health policy. In almost all these cases proper ER rationalizations would lead to a more effective environment for physicians and thus, a more dependable range of services to the community. I was advised by several physicians and indeed by some hospital board directors and hospital officials that while they favoured some rationalization they did not feel they could pursue it given local opposition. In many cases plans we,re developed and considered bur abandoned due to local fears. Regrettably, no community is voluntarily prepared to sacrifice an existing hospital service to a neighbouring community even where it may provide them with as good or better facilities. While this may be understandable, that should not make it good health policy or provide justification for federal or provincial taxpayer's dollars.

Government Rural Health Policy

The MOH has not had a formal window on rural health and the issues that are specific to the needs of the residents of rural areas. The Underserviced Area Program ("UAP") has focused primarily on the north where unquestionably, the problems have been more serious. The UAP would benefit from a fresh mandate. Many of the programs it pursues were designed some rime ago, and not all have demonstrated that they are still producing the

desired effect. The existence of the UAP may now unintentionally further isolate other rural needs from the wider health care system.

The academic orientation to the urban areas has led to policy reforms with urban content without much consideration of their relevance to rural areas and to the north. The decision to establish a community Health Centre ("CHC") in Longlac without full co-ordination with the hospital in nearby underserviced Geraldton would have benefited from an area planning perspective. While the CHC has added resources to a badly underserviced area, it has also become a symbol of lack of co-operation and added to public discontent with the adequacy of health care delivery in the area.

To ensure changes in educational programs, the development of a coordinated rural medical framework, and better policy development for all of Ontario, the Ministry must be better geared to address rural health policy needs. This will require a total review of northern and rural programs and engage senior leadership.

Hospital/Community Role

Hospital boards are following traditional practices. For example, hospitals in almost every community stated that they had surveyed their communities and were told that the provision of 24-hour ER at the local hospital was the #1 priority. The implication was that that was sufficient reason to maintain the status quo.

While some hospitals and DHCs have begun the difficult process of area hospital reform, most gave no evidence that they were looking beyond their traditional practice of acting as champion for local expectations. While that is understandable it is no longer enough. The hospitals must consider their future role and become more visionary in their planning for services and less inclined to simply defend the status-quo. The question they must now address is what is the best strategy for serving medical and health needs through the local hospital and, where it is appropriate, to defer co area hospitals. Failure to address these questions will only lead to eventual grief for the physicians, the hospital, and the residents in the catchment area.

CHAPTER 6 Major Findings

Services are at Risk

The continued provision of basic rural physician services is at risk in most rural areas of Ontario. The problem is particularly acute where the municipal centre has a population of less than 10,000 and is located 100 kilo metres or more away from a major referral centre.

In the northeast and northwest of Ontario the problem of physician supply has reached crisis proportions that requires immediate action now, both to stop the outflow and to initiate permanent solutions.

Recruitment and retention problems are particularly severe in northeastern and northwestern Ontario. Medical practitioners are few and often far apart, long waiting lists exist in most physician's offices, and patients are frequently transferred many miles from home and family support for normally standard procedures such as childbirth, tonsillectomy and fractures, that in urban centres are provided at their local hospital.

The serious problems of the north should not, however, deflect attention from the more southern rural areas. The physician numbers are better in the south but they remain barely adequate in many areas and the issues of balanced lifestyle and adequate financial rerum are threatening the stability of service.

The support requirements expected of the medical education system, the provision of skill sets needed for rural medicine, the creation of a positive atmosphere towards rural practice, and the provision of relevant backup speciality needs are for the most parr working away from rather than towards the supply of these needs.

It would be no exaggeration to say that virtually all northern areas outside of the major centres, Sudbury, Thunder Bay, Sault Ste. Marie, North Bay and TImmins, are underserviced and lor under pressure in relation to primary medical services. U.S. recruitment initiatives aimed at FPs and which appear to address balanced lifestyle and monetary considerations have been drawing experienced physicians away from rural Ontario which compounds the more common and traditionallosses due to burnout and normal turnover. The same problems obviously discourage new recruits from filling the gaps.

Principal Findings (General)

Central Issues

There are four central problems that must be addressed:

1. underserviced areas llack of a critical mass of physicians to sustain a 24 hour ER and maintain a stable medical environment;
2. areas with an adequate supply of physicians but without sufficient activity in ER to make working there viable financially;
3. difficulty in sustaining a balanced lifestyle; and
4. inadequate academic preparation and support programs to prepare and maintain a sufficient physician complement in the rural areas.

Fee for Service

The FFS functions effectively to remunerate physicians when they have a full office schedule or when they are fully occupied in the ER with routine problems. With limited exceptions it does not provide the flexibility necessary to help the physician best serve the north. It is not much better suited to the other rural areas in the province.

Fee schedule provisions for hospital ER coverage are inadequate because:

1. Under the FFS system income is harder to earn in the rural setting.
2. Rural medical practice for GP/FPs demands a broader base of active skills than is required in the urban setting.
3. Rural medical practice should be funded differently from urban medical practice (GPs and FPs).
4. There is a strong incentive for rural doctors to avoid practice in hospital ERs, particularly those with less than 20,000 visits annually.
5. Most physicians serving the ER during low volume overnight periods must either lose income through the sacrifice of daytime office hours or maintain the daytime hours under less than optimum conditions.

While price is only one factor it is quite clear that rural physicians and potential recruits believe that the financial reward measured against work undertaken and time demands is not competitive with the urban areas of the province. That belief is compounded with the image of the heavy patient load and a heavy load of on-call coverage due to an undersupply of physicians. The circumstances suggest a social price that is too high and a financial reward that is too low. This image is obviously shared and indirectly reinforced in the university and teaching hospital environment and has a very negative influence on physician recruitment. No solution can escape matching lifestyle needs with an equitable income for services rendered.

AHSC/Medical School Education and Outreach

Changes in medical education are critical to solving the problems of the rural regions of Ontario. To ensure the availability of a physician pool interested in rural medical practice and to address the particular needs of the rural areas, a different approach needs to be undertaken by the existing medical schools and AHSCs. Currently:

- most physicians are inadequately prepared during residency for rural practice;
- medical school and residency training programs are not providing the necessary pool to avoid a rural ctisis; and
- rural physicians have difficulty accessing the AHSCs for the substantial technical and moral support that they require from them.

Rural Designation

The unique nature of rural practice should be officially acknowledged and appropriately supported within the academic community. The lack of special recognition is a barrier to the growth and image of rural medicine. Much more importantly, the failure to recognize and entrench rural training will rapidly deny hospitals and rural communities access to adequate medical care. There should be an FP designation based on the special skills required for rural practice. The rural practice designation would be maintained and enhanced through regular CME programs specially designed to strengthen rural practice.

The General Surgeon and GP/FP Specialist

There can be no more basic service expected in a hospital than the delivery of newborns. Local hospitals have been community birthing centres for generations. Yet today, it is not unusual in the north and other areas of the province for the local hospital to refuse to provide this service. To confidently deliver babies it is desirable, if not essential, for the mother and the physician to have the backup of a general surgeon and an anaesthetist in the event of complications. In point of fact, hospitals with substantial catchment areas of several thousand are

having to send late stage pregnant mothers to communities 100 kilometres or more away to await the birth of their child. This is not because there is a lack of adequate income for these physicians but because there is an inadequate supply of general surgeons and GP/FP anaesthetists available. Almost all general surgeons in the rural areas are over 55 years of age and almost none are currently being trained in Ontario. FP anaesthetists are being graduated at less than 6 per annum in Ontario. It is essential for a general surgeon to have an anaesthetist present to practice and vice versa if the GP/FP anaesthetist wishes to maintain the skill. It follows logically that a GP/FP obstetrician will see little future in a community without the other two colleagues. Even communities with these three skills have no stability due to the great demand for. these professionals and the fact that even the temporary loss of one will render the other of limited value and therefore dictate a further move. Without an increasing supply of all of these skills more and more rural areas will be forced to ship patients with routine requirements to major centres at great inconvenience and economic cost.

Outreach

The medical schools and the AHSCs are too isolated from the rural areas of the province. A "cross-pollination" of expertise between rural practitioners and AHSCs is not only in the public's interest, but it is in their mutual interest. The faculty in the academic institutions and teaching hospitals should spend time providing support to the rural regions. This would involve sharing their knowledge and experience with the local medical service providers through such vehicles as on-the-spot CME, telephone and computer hook ups, and the offering of clinic consult services in the rural communities.

To make the outreach programs successful and rewarding local municipalities and hospitals must share in the programs. This would entail offering a welcoming atmosphere, the provision of facilities for the visiting specialists, and the contribution of funds to special programs. By their participation they would be making a commitment to determining and ensuring that they have the level of medical care that is truly suitable for their citizens.

Rural physicians should spend time teaching at the AHSC, either similar to the part-time faculty position referred to in the PCCCAR Rourke report, or by invitation for seminar participation where they could share with academic centres the unique aspects of rural practice.

Successful outreach programs with full community and hospital participation are required for improved rural health care and would also assist in the recruitment and retention of skilled, commit1:ed rural physicians.

The above actions would increase the exposure of urban-oriented medical students and residents as well as those from rural and northern Ontario to the rural experience.

Recruitment Drain

Recruitment drain is an immediate threat to basic rural physician services and in general, the more remote the area the greater the threat. U. S. recruiting of experienced FPs is intense and demand will likely continue for some time. The broad skills that are found in rural physicians constitute a major plus and consequently, they are an attractive target for the recruiters looking for FPs for mid-sized towns and rural areas of the U.S. It should be noted that vacancies in suburban areas and smaller cities also create a draw from rural areas. While most physicians may prefer to remain in Ontario, sufficient numbers are attracted away to pose a real threat.

Steps to Reverse Deterioration in Recruitment and Retention

There are other more traditional reasons for recruitment and retention problems that must also be addressed if the situation is co be corrected:

- there must be a belief that there is no financial penalty for service;
- there must be opportunity to enjoy the balanced lifestyle that could attract many physicians to these areas;
- there must be well equipped medical physician clinics at the hospital or in close proximity to the hospital;
- there must be good continuing medical education available and the opportunity to take advantage of it;
- there must be assurance that physicians will be covered for CME and holiday time; and
- there must be access to the AHSC for professional support and guidance.

There must be adequate physician coverage to cover day to day work and locum tenens must be readily available to assist when temporary coverage problems arise.

Unresolvable Problems

There are other problems that cannot be solved except by increasing the supply in the pool of potential candidates co lessen the impact:

- spouses that cannot adapt co the rural lifestyle;
- physicians that cannot adapt to the rural lifestyle; and
- spouses that seek but cannot find satisfaccory employment.

Making Practice Attractive

To make rural practice attractive and competitive the GP/FP basic package for rural medicine should consist of:

1. Sufficient physician coverage co adequately service the individual community need.
2. 24-hour on-call coverage of the hospital ER that would result in an on-call of 1 in 5 or better.
3. Financial recognition of the greater breadth of responsibility.
4. Competitive income undiminished by ER duties.
5. 4- 5 weeks vacation per year.
6. 2-4 weeks continuing medical education per year plus the potential co take longer courses co enhance the skill base peculiar co rural communities.
7. Opportunity co grow certain medical skills in selected areas of expertise.
8. Adequate locum tenens support co facilitate vacation and CME availability.
9. Adequate arrangements for consultation with AHSCs and medical specialists both through telephone and telecommunication consultation.
10. Good clinical facilities.
11. Housing and relocation assistance.

Note: Not all of these would be required in all areas. For example, 10 and 11 are of more relevance in the more remote rural areas.

CHAPTER 7

Solving the Problems

It is instructive to note that in the past considerable policy effort and many special initiatives have been brought to bear on many of these issues. The problems are complex and must be addressed on several fronts, as past efforts on an issue by issue basis have been largely inadequate in terms of building stability in the availability and delivery of service. This chapter is divided into three sections. Section A deals with principal solutions, section B with short-term measures, section C with MOH organization and section D with progress to date.

Section A- Principal Solutions

Physician Incomes

High incomes for anybody paid from the public purse, no matter how indirect, are controversial. The fact physicians' incomes are high relative to most incomes should not be allowed to obscure the need to ensure they are competitively rewarded. The need for competitive income for physicians is not only important to maintain high quality medicine, it is basic to solving problems in underserviced areas and in ERs. Well trained, experienced physicians have a market value that extends beyond our borders. It would be a serious error to permit basic medical services to be at risk in underserviced areas by failing to recognize the incentives in incomes and benefits necessary to attract them. If skilled, mobile professionals cannot receive an acceptable market price for their skills in these rural areas they will often seek it elsewhere.

Area Physician and Hospital Support

With the long distances that must be travelled between communities, particularly in the north, a Population Centre Concept ("PCC") and area support plan seems to be the only feasible route to providing basic services. The northern communities can be divided into roughly two sizes- those that can support five or more physicians and those that cannot. With five or more there is a sufficient base to establish a good hospital plan that should provide solid area service.

The area PCC would be established around the area hospital that would serve as a centre to assist the satellite communities without a hospital or with a hospital that is unable to support a 24 hour on-call due to the limited number of physicians. The area hospital would support satellite health clinics where there is reasonable demand to warrant one. Where there is an existing hospital there would continue to be daytime clinics hosted by the hospital. The satellite community might have a resident physician and/or be supported by visiting physicians from the area hospital.

The PCC would provide greater continuity of service and would create a more mutually attractive support situation for the physicians in the area. The PCC would be helpful to the satellite communities that have a catchment area in the range of 1,000 to 5,000, do not have a hospital, or are more than half an hour away from the nearest hospital with a 24-hour ER. The physical plant would be provided free of charge by the satellite communities for either the resident physician, who would be part of the ER on-call team at the area hospital, or if rhere was no resident physician, then to physicians on a scheduled visit program.

The satellite hospital ot clinic would not tun an ER on a 24-hour basis. While this will provide some relief for the resident physician, nurses, and support staff, the physician would remain pressured by the knowledge that real after-hour emergencies would require action.

There are a number of these satellite communities that are too remote to be served by the PCC and that can justify a single resident physician. These are hard to service and have tended to rely on one or two physicians that have honed their skills in isolated parts of the world and are comfortable on the "front line". This is a scarce resource that is not currently being replenished. To address this need a longer term alternative that should be considered for quite remote communities would be to create a Medical Service Corps ("Corps"). This would be a special group of fully qualified physicians trained to special rural standards but with a long-term contract to serve the very remote areas. The Corps would be created through a small number of graduates from designated medical schools and residency posts. The complete cost of education would be borne by the Province, and the physicians would have a minimum requirement for service, possibly 10 years, be paid directly by the government, and receive pension and other benefits. It would also be open to established physicians who meet the required standards for rural medicine. This concept should attract a small but dedicated number of students and physicians. The concept has been used in other countries and bears special consideration.

A Basic Package for Rural Physicians (North)

In most of the rural areas of the north and in a few areas in the south such as Barry's Bay and Bancroft, the FFS system needs to be replaced in order to ensure quality and stability in practice. While existing FFS physicians should be permitted to remain on FFS, any new FFS should be discouraged to permit the creation of models that can effectively serve these areas. The OMA and the MOH should discuss the most effective transition process to meet these basic objectives.

Group Practice Model

The most appropriate scheme on paper would be a globally funded group practice model. The initial global amount would be established through consideration of a number of factors including total existing FFS funding in the area, other sources of physician income, the cost of additional physicians required, and successful capitation programs. The design would permit the independence of physicians while providing the practice unit financial flexibility to Utilize allied professional support such as expanded role nurses. The practice group would have an obligation to cover the hospital ER. This approach would provide the physicians greater personal practice flexibility while offering a better and broader range of services to the community. Physicians in the practice group would have to meet the basic undertakings required of the direct contract physicians outlined below.

While I believe this to be the most logical response there are at least tWo substantial barriers that must be addressed. First, some of the physicians already in place may find it difficult to pull together into a group practice; secondly, the Ministry has had considerable difficulty to date in finding a satisfactory funding policy for a group model.

In light of these considerations, I would urge the creation of a least one pilot project on the basis of a globally-funded group practice model as soon as a group of physicians indicates interest. The MOH and the OMA should begin negotiations to accomplish this objective with the aim of having an agreement in place by the end of the year.

Direct Contract

The most advanced alternate payment plan ("APP") with the potential for immediate use in these areas is the direct contract. While MOH/ OMA negotiations are not completed, they have developed a Direct Contract Plan ("DCP") that provides a basic APP to address the needs of rural communities in the north. The DCP has, in my view, the potential for much wider application in rural Ontario. While it does not require group cooperation similar to that for the group practice

model outlined above, the stability of a direct contract would encourage greater cooperation amongst area physicians and also open the door for them or the hospital to use allied health professionals without risk to income. The DCP would also address the challenge of attracting and retaining physicians as the income would be guaranteed and be substantially more rewarding than that of other FPs in recognition of the special circumstances. Direct contractors would not be able to bill FFS.

In my view, the DCP should contain the following:

Benefits:

1. Up to four weeks of expenses paid CME per annum;
2. Up to four weeks paid holiday with travel expenses equivalent to the price of two economy air fares return to Toronto per physician, increased to 5 weeks after 15 years;
3. Municipality or hospital clinical facilities would be made available rent-free. Where existing facilities are owned by physicians they could be sold to the municipality or have an overhead cost attributed to them, which would be maintained by the municipality;
4. On-call coverage of the hospital and ER would be required but not at a greater frequency than 1 in 5;
5. The physicians would continue to receive supplements for management responsibilities at the hospital such as Head of Emergency Services and Chief of Staff;
6. Locum tenens back-up would be guaranteed; and
7. Income at least 20% in excess of provincial average for GP/FP's with appropriate additional income augmentation for GP/FPs with speciality training.

Requirements:

1. A minimum of2 weeks CME for rural physicians;
2. The physicians would have to be qualified for Advanced Coronary Life Support ("ACLS"), Advanced Trauma Life Support ("ATLS") and Pediatric Life Support ("PALS") and maintain these skills through practice and CME;
3. The physicians would have hospital privileges and participate fully in on-call rotation in the area hospital and serve on medical committees;
4. The municipality and hospital would be party to the agreement for the purpose of establishing hospital and public health responsibili ties; and
5. Physicians who withdraw temporarily from on-call rotation without cause or the consent of their colleagues, which would not be unreasonably withheld, must give notice and have their income decreased by the amount of augmentation above the provincial average; and
6. Physicians with more than 20 years' in ER service in Ontario and who are over 55 years of age can withdraw from on-call with a 10% income decrease or limit their participation and accept a decrease proportionate to their new level of commitment.

Physicians currently on FFS

FFS physicians would be grandfathered and if they wish would have the priority option to convert to the DCP.

Physicians that choose to remain on FFS and meet and maintain requirements, (1) to (4) above, would:

1. Receive an augmentation of 5% in their FFS gross billings;
2. Receive a sessional fee of $70 per hour for the 12 hour on-call overnight Monday to Friday and for all duty during the weekend and on official holidays in lieu of FFS. The physician would not have office hours the day following the overnight ER on-call before 2:00 p.m. As an added incentive the physician could choose either the sessional fee or the FFS fees for the time period. This would, for example, provide the opportunity for a higher income during

busy seasonal periods in some vacation areas. Sufficient notice of intention to change options between the sessional fee and FFS would be required; and

3. Record ER service data for research purposes.

A Basic Package for Rural Physicians (South)

The circumstances are different in degree in southern Ontario. Virtually all communities are within 200 km of an AHSC and most areas have at least adequate coverage by FPs to serve the immediate needs of the population. While the rural areas in the south would benefit from the practice structures suggested for the north, more flexibility exists in potential solutions.

As in the north, the FFS system provides less incentive to FPs to be flexible to the broad based needs of rural communities. The group practice model with its built in flexibility and the direct contract model which can be tailored to physician and local needs are more appropriate.

The package of benefits and requirements under the DCP would be much the same, but the net income, while in excess of the provincial average would be smaller than that paid in the north.

In my view, the DCP (south) would consist of the following:

Benefits:

1. Up to four weeks of expenses paid CME per annum;
2. Up to four weeks paid holiday increased to five weeks after 15 years;
3. Municipality or hospital clinical facilities would be made available rent-free. Where existing facilities are owned by physicians they could be sold to the municipality or have an overhead cost attributed to them, which would be maintained by the municipality;
4. The physicians would continue to receive supplements for management responsibilities at the hospital such as Head of Emergency Services and Chief of Staff;
5. On-call coverage of the hospital and ER would be required but not at a greater frequency than 1 in 5;
6. Locum tenens back-up would be guaranteed; and
7. Income in excess in provincial average for GP/FPs.

Requirements:

1. A minimum of 2 weeks CME for rural physicians;
2. The physicians would have to be qualified for ACLS, ATLS and PALS and maintain these skills through practice and CME;
3. The physicians would have hospital privileges and participate fully in on-call rotation in the community hospital and serve on medical committees;
4. Municipality and hospital would be party to the agreement for the purpose of establishing hospital and public health responsibilities;
5. Physicians who withdraw temporarily from on-call rotation without cause or the consent of their colleagues, which could not be unreasonably withheld, must give notice and have their income decreased by the amount of the augmentation above the provincial average; and
6. Physicians with more than 20 years' in ER service and who are over 55 years of age can withdraw from on-call with an income decrease equal to half of the augmentation above the provincial average or limit their participation and accept a decrease proportionate to their new level of commitment.

Physicians currently on FFS in these areas would have the priority option to convert to the DCP, provided they meet the above requirements.

Continued FFS

The continuation of FFS in rural centres where the hospital catchment area supports less than 10 physicians poses some problems if a physician refuses to participate in ER on-call. Participation involves both qualification and recognition of the need to support colleagues. It is important that the incentive encourages ER participation as well as recognize the financial commitment involved. Many rural physicians made the point that good rural medicine required many of the skills maintained in rural ER work and that straight office practice without regular exposure to these skills was limiting. It is important that this be taken into account in rewarding rural practice.

For FFS physicians in most rural communities the following package should apply if they meet and maintain DCP requirements 1-4:

1. Receive an augmentation of 5% in their FFS gross billings;
2. Receive a sessional fee, in lieu of FFS, of $70.00 per hour for a 12 hour on-call overnight, monday to friday, and for all duty during the weekend and on official holidays in lieu ofFFS. The physician would not have office hours the day following the overnight ER on-call before 2:00 p.m. As an added incentive the physician could choose either the sessional fee or the FFS fees for the time period. This would, for example, provide the opportunity for a higher income during busy seasonal periods in some vacation areas. Sufficient notice of intention to change options between the sessional fee and the FFS would be required; and
3. The would record ER Service Data for research purposes.

Existing rural FFS physicians that do not have the skills in requirement (2) would be grandfathered for two years to obtain them.

While no physician in a rural area should be forced to have hospital privileges to practice it is important that the combination of the hospital practice and the on-call component are not underestimated as important elements in maintaining the skill set necessary for a rural general practice.

Limit Emergency Service

The close proximity of hospitals to each other in a number of areas creates additional complications for the establishment of an effective on-call. In order to increase physician stability, 24 hour emergency on-call should not be provided or supported by more than one institution within a 40 km radius of currently existing hospital facilities. Hospitals without 24 hour ERs would continue to function in accordance with a DHC developed rationalization program. There would be no reason for physicians to move from their established office practices so the only drawback would be slight inconvenience for some patients which would be offset by greater convenience for others and by better quality service at the ER.

There are several clusters of hospitals that should rationalize their hospital emergency services. The impact would not only address on-call but should also result in the availability of better service.

Some obvious examples are:

1. Chesley, Durham, Hanover and Walkerton;
2. Mount Forest, Palmers ton and Listowel;
3. Goderich, Clinton and Seaforth;
4. Winchester and Kemptville;
5. Carleton Place, Almonte and Arnprior;
6. Welland and Port Colborne; and
7. Cobourg and Port Hope.

Some of the above do not perceive they have any difficulty at the moment whereas others are definitely having problems. It would be wise for the hospitals to work with the DHC to plan now, even in those areas currently without difficulty that are underserviced. It is almost inevitable that problems will eventually occur and they should be handled without rancour in the community. When problems inevitably arise it is important that the OMA, OHA and MOH support rationalization as failure to do so

can at best delay the inevitable while almost certainly will increase the tension, anger and medical service instability in the area.

Academic Health Science Centres

In order to be relevant to the health needs of the rural 20% of the population a number of actions need to be taken by the AHSCs. Many of these will take time to put fully in place but given the real need for these programs, there must be no room for doubt that both the Province and the AHSCs are committed to these changes. There appears to be a willingness to address these needs within the AHSCs, but there are some long-standing medical and hospital practices in place that will be disadvantaged by a shift in some resources to a rural focus. This will create a reluctance by some to accept the necessary changes. The MOH and the Ministry of Education should underline their determination to ensure that the AHSCs become true provincial resources.

The "Rural" AHSC

In order for the AHSCs and the medical schools to successfully interact with rural hospitals and rural medicine there needs to be a more formal relationship. Each AHSC should be designated to become affiliated with an area of the province. That would permit many of the recommendations listed below to be more effectively developed and increase the mutual knowledge and respect necessary to berter serve the rural patient.

To achieve the objective of strong family medicine in rural areas several initiatives are required in the medical schools and AHSCs:

1. Divide the present Family Medicine Residency Program into a Family Medicine (General) designation, reflecting the current training curriculum, and the creation of a special Family Medicine (Special) designation which would embody in the training program all the programs, exposure and training necessary to equip physicians to be confident and comfortable with the challenges of rural practice. The "Special" designation for rural work would ensure appropriate academic standing for rural medicine and would provide the basis for both greater AHSC involvement in rural health and the study of rural health issues. Some helpful specifics for the general direction this training should take is outlined in the PCCCAR Sub-group on Human Resource Issues in the Provision of Emergency Health Services, chaired by Dr. James Rourke.
2. The training of family physicians should be expanded to provide more rural exposure and an increase in the allotment of residency spaces in the family medicine pool to 30% of the total.
3. To address the critical shortage of general surgeons, which in some instances is approaching crisis proportions, there must be an increased focus and allotment of spaces for specific preparation of general surgeons.
4. Increase in the number of spaces for speciality training for FPs in the areas of medicine which are in short supply specifically, in obstetrics, emergency, psychiatry and anaesthesia.
5. Greater promotional and program efforts must be made to recruit medical students from the rural regions of the province.
6. In order to provide timely relief in the rural areas of Ontario, a program to allow existing practitioners to equip themselves with a new or enhanced set of skills could be accomplished by the following steps:

   i. retrain interested sub-speciality surgeons back to general surgery. This would help alleviate the present near-crisis in the shortage of general surgeons in non-urban areas of the province; and

   ii. offer a program to retool qualified urban family physicians to rural family practice by providing additional training in emergency (including ACLS, ATLS & PALS), obstetrical, anaesthetics and psychiatric specialties to increase the pool of qualified, experienced physicians for rural practice.

7. There should be an immediate meeting of deans of medical schools, vice presidents of health science centres, heads of family medicine, and the MOH to assess the shortfall in FP specialities and general surgeons to reallocate training slots.

Ontario Rural Emergency Advisory Program

A 1-800 number would be established through a central system that would rotate rural physician calls through the AHSC roster. The system management would be done by a senior emergency physician with the responsibility to ensure calls are properly managed and responded to and would guarantee that the required service would be forthcoming on a timely basis. There should be a special billing code and billing numbers established to ensure that duty physicians are compensated for their time. The system would provide rural physicians with instant access to specialist support and guidance on everything from diagnosis to patient transport.

The service should be operated with fully qualified specialists only and not residents as the latter lack the experience and authority to deal confidently with the rural FP. By connecting certain communities to a specific academic health service centre there will, over time, develop a level of knowledge and mutual confidence between the physicians at the AHSC and the rural practitioners.

Regional Consultant Access Program

In order to provide greater speciality services in the rural areas while cutting down on patient travel and the associated economic costs, a program should be formulated betWeen the rural physicians, the hospital, and the AHSC to provide access to specialists on a regular basis.

The program would require the co-operation of the area physicians in booking appointments and the hospital in providing for facilities and staff back-up in order to bring visiting specialists to the hospital. The FFS system should amply reward the specialist for services rendered and to make the service competitive, the hospital should fund the cost of travel and pay a small retainer *fee* to the specialists to guarantee the service.

Section B- Short Term Initiatives and Considerations

Many of the above proposed solutions even if acted upon quickly would take *some* time to fully mature, particularly with regard to meeting *some* of the needs in the underserviced areas. The following are recommendations aimed at providing *some* short term assistance in the provision of servIces:

1. The MOH should maintain and exercise its discretion to approve out-of-province applications of physicians recruited to work in underserviced areas, provided that they meet the following requirements:
   (i) practice experience in rural medicine or fully trained for rural medicine; and
   (ii) skilled in or prepared to pre-qualify in ACLS, ATLS, and PALS; and
   (iii) obtain hospital privledges and participate fully in on-call rotation and participate on medical committees.
2. A non-FFS billing number would be granted on a restricted basis to ensure a guaranteed service period in the underserviced areas.
3. The College of Physicians and Surgeons of Ontario should be requested to consider methods to straighten the pathway for practice of eligible experienced Canadian practitioners who agree to practice in underserviced areas.
4. The OMA, OHA and MOH should together prepare a program to educate Ontarians, both urban and rural, on the appropriate utilization ofERs.

5. The MOH should provide assurance to physicians who undertake to practice in the rural areas that they are not going to be required to stay there by government decree.

While there is a recommendation that physicians should not be required to have an on-call of greater frequency than 1 in 5, it is not intended that it should be seen as an endorsement that situations with greater frequency than 1 in 5 should be discontinued at this time. With the implementation of the PCC and the filling of complement expected as a result of the proposed incentives, this onerous level of coverage could be abandoned. It would be inappropriate to recommend abandonment until the rest of the package is in place.

Section C- Ministry Organization

The Ministry of Health should create the position of Assistant Deputy Minister, Rural ("ADM(R)"). The ADM(R) would be responsible for rural health care policy and would playa leadership role in coordinating rural health initiatives involving the rural hospitals, the aHA, the OMA, and the AHSCs. Existing programs related to rural health in other areas of MOH would be transferred in order to ensure continuity and efficiency in rural programs.

This senior position is essential to ensure that the key elements of rural health care are recognized and promoted as an integral part of the Ontario health care system.

Section D- Progress to Date

Progress has been made in a number of areas aimed at resolving some of the problems already identified.

1. The OMA has, under *its* agreement with the MOH, initiated both a locum tenens plan and a CME program. Both are in the early stages of implementation. The CME program was widely applauded by physicians and has clearly had a positive impact on those who have taken advantage of it. While the locum tenens plan is sound in concept it appears to be having early difficulty in developing an adequate pool to meet the groWth targets and currently is unable to meet demand. Given the issues identified in this report, these difficulties are not exactly surprising.

2. Many of the northern municipalities, often in cooperation with the hospital, already provide good clinical facilities, housing assistance and special relocation incentives to attract and support physicians. These can be used as models to assist other municipalities in developing appropriate support programs.

3. Generally, the Ministry has ensured that hospitals in the underserviced areas have been modernized and well equipped and for the most part this *is* not a major problem.

4. There are and have been important but limited initiatives underway involving *in* various degrees all the medical schools and AHSC's with the objective of improving their outreach and involvement *in* rural and remote support programs. The recent focus of the PCCCAR sub-committees and the work of Dr. Robert McMurtry *is* encouraging.

CHAPTER 8

Finding The Money

The issue of finding the money is both the most difficult and most troublesome. As indicated in *Chapter* 2, the dilemma for all the parties to this exercise is the shrinking of funding and the resulting necessity co restructure the Ontario health care system. Each organization has different problems to address, but in all cases, the fundamental changes will be unsettling for all concerned. The time is right for the parties to this exercise to work together and to be motivated for a common cause as the principal basis for ensuring that their own cause is not lost. This means more common purpose in rationalizing hospitals, re-aligning income, eliminating medically unnecessary health coverage, and building new consultative frameworks that will permit more effective tripartite communication.

The problems around physician income are legion, not the least complicated by physician supply and distribution discrepancies. These macro policy issues are beyond the scope of this paper, but the failures of the parties in macro issue management are translating into unacceptable problems at the physician/patient level. Well trained physicians (Ontario physicians are among the best in the world) have an international market value. The policies governing medical incomes must be vigilant in tracking market forces to ensure that we are not educating our physicians to serve elsewhere. It is not in the interest of the OMA, the OHA, or the MOH, to permit a negative income environment for physicians.

Allocation of Costs

The failure of the OHA, the OMA, and the MOH to resolve the problems in addressing the issues around physician services to ERs has revolved primarily around the issue of who should pay for the solutions. In arriving at my assessment I have as much as possible attempted to reach conclusions based on past practice and existing agreements.

Responsibility for funding Physician Coverage of ER on-call in Low Volume Circumstances

I have been provided with no compelling reasons that support a concept that the hospitals of this province have been expected or should be expected to provide payment for the on-call duties of physicians operating under FFS. Hospitals have a responsibility to reasonably compensate FFS physicians who provide formal services to the hospital in medical management, but I have not been given evidence to find that this extended to the provision of on-call services.

The issue then is one between the OMA and the MOH as to responsibility to pay the costs associated with the resolution of the problems.

There is one fundamental question that must be addressed before determining the issue of financial responsibility between the OMA and the MOH. That question is whether the issue should be addressed on the basis of historical practice or from the perspective of strict legal responsibility.

The OMA takes the position that, in terms of past practice, the insistence of the MOH that all adjustments to income must come out of the $3.8 billion FFS pool ("existing pool") is both unreasonable and unfair. They argue that prior to the caps imposed by the governmenr and the-subsequent social contract requirements that the MOH recognized that they should contribute to the resolution of financial issues arising from changes in practice patterns and in the development of new codes. They argue that now the MOH is forcing every adjustment or reform into the existing pool and avoiding any recognition of responsibility to participate in financial solutions. For the OMA this is a crucial issue.

The MOH takes the position that the monies required to pay for rural ER services must be found within the existing pool. The MOH submits that the OMA, through the management of the fee schedule, directly and indirectly influences how much physicians performing various services in different parts of the province are remunerated and consequently, is responsible for distribution of income within the profession.

While the OMA position may well have merit in terms of equity, I cannot rely on historical practice as experience is mixed and it is also influenced by negotiation and law. As a consequence, I feel I must proceed on the basis of which party I believe bears the legal responsibility.

In their submissions the OMA denies that all physician funding must come from within the $3.8 billion FFS pool and points out that the MOH in many instances funds physician services from sources independent of the pool including incentives for physicians in underserviced areas. The OMA further states:

"...it would be unreasonable to expect the FFS pool to fund without additional monies those physician services which were not previously funded by the OHIP pool."

The key question is whether or not the existing pool has been deemed to cover remuneration for rural physicians who serve in hospital ER on-call. The MOH and OMA submissions make considerable reference to and draw conclusions from the contents of the OHIP Schedule and the OMA Schedule. The OHIP Schedule is the fee schedule of record adopted by regulation under the Health Insurance Act. The OMA Schedule is the official schedule of the OMA established through internal OMA processes involving the OMA Committee on Economics and the OMA Central Tariff Committee.

In general, the OHIP Schedule is based on the fee structure and relativity established in the OMA Schedule. It is notable however that while the OMA is the authority in determining the relative value of the services and reflecting them in the codes, there are distinct differences between the two schedules. The OMA has the technical skills to address the telative value of the various codes and the political responsibility of translating government allocations into income for the physician in the various OMA sections. The OMA is also the bargaining agent for most of the medical profession and for all the FFS physicians and therefore the OMA Schedule is also worded to reflect the political position of the medical profession It is therefore a statement as to what the OMA believes should be included in the OHIP Schedule rather than what legally must be in the OHIP Schedule.

In their submissions both the MOH and OMA address the wording and wording changes in their schedules to build their arguments as to which has the responsibility to address the question of remuneration for ER coverage. Neither has provided me with any materials that bear directly on the obligation to remunerate physicians in low volume ERs where there is insufficient service activity to appropriately remunerate the physicians for the commitment of time. It is notable that until recently there is no record of eXtensive negotiations on this issue over the last two and one half decades.

Indeed, until the *1990s* there was no evidence to suggest there was an issue of significance around payment for on-call responsibilities in the ER. The issue as it is now framed is whether the existing pool, which does pay physicians for their specific services rendered in the ER, is also accountable for supplementing incomes of physicians for service opportunity lost in ERs.

Unquestionably, the OHIP pool has covered specific services delivered in ER on-call since it came into effect. It has also recognized the appropriateness of providing a premium to recognize the financial inconvenience of calls in low volume situations.

The OMA, to support its position, refers to Note 45 in the OMA Schedule; which first appeared in 1983:

"When a physician is *required to be continuously present* in an emergency department *by virtue of a hospital by-law,* a retainer fee *may* be charged to the hospital when there is not sufficient patient volume to warrant the physician's constant presence. The amount of the retainer is negotiated between the hospital and the physician(s) providing the service." (emphasis added)

I do not find this particularly helpful to the OMA position. It was not included in the OHIP Schedule and has the status of a negotiating position that was not incorporated into the law. Further it would be limited to a hospital that utilized a by-law to force a physician to be continually present even though it is not warranted by the circumstances. In putting forward this position the OMA would appear to be appropriately concerned with a hospital making an unnecessary or unreasonable demand on the physician rather than pursuing a principle that the hospital should be responsible fot making up for limited fees flowing from a low ER volume. Indeed, as I understand the position of the physicians, the principal issue is the reality of being on-call that is most onerous and whether or not they stay at the hospital is influenced by other considerations.

I cannot lightly regard the importance of the OMA's authority to determine the allocation of the moneys within the existing pool. The power to adjust practice codes to provide a fair and equitable distribution of income across such a wide range of skills and activities places considerable, meaningful and valuable responsibility in the hands of the OMA.

Since the introduction of medicare the OMA has utilized two main philosophies to govern the allocation of funds in the pool, "fee for income" and "fee for service". Initially they emphasized a "fee for income" approach. This approach involved ad justing the "basket" of codes for each section to ensure the maintenance of a fair income distribution between the various sections. The theory was to use the relative weighting of the amounts assigned to each code to ensure each section an adequate income. This would take into account unofficial recognition of work particular to different practice groups.

In recent years, in light of perceived problems with the emphasis on "fee for income" as it related to the relative skills and responsibility of different practitioners the OMA shifted emphasis to the "'fee for service" approach with a greater weight given to fee relativity.

Both "fee for service" and "fee for income" have their advantages and disadvantages, but the struggle to maintain fee relativity on the one hand and limit earning disparities across practice sections unavoidably creates serious problems in addressing perceived fairness in distribution.

Whatever the effects at various times these adjustment philosophies had on GP/FPs it is clear that the OMA was in charge of the distribution of income between sections and on specific incomes experienced by physicians in different practice modes. Whatever the philosophy the OMA might have emphasized at any given point, there is no doubt that codes were at times used for income distribution, not just to reward the value of the specific service. Consequently, some activities were effectively compensated for on a global basis, not just item by item.

I attach great importance to the authority of the OMA to determine the allocation of funds, to emphasize one code over another, and to manage income allocation to various sections. Further, the on-call payment of physicians, in absence of evidence to the contrary, appears to have been covered by past allocation processes and until recentl y was not singled out for special attention. Consequently, in the absence of evidence that any special undertakings exist, I am left with the conclusion that the authority and responsibility for adjustments ofFFS physicians income as a result of an imbalance within the fee structure rests with the OMA and must therefore be met from the existing pool.

In reaching this conclusion there are implications to the OMA position that should not be ignored. The history of physician funding has been blurred. Compromises between the MOH and the OMA in

designing the OHIP Schedule have involved clear understandings both official and unofficial on how certain complex remuneration matters have been addressed. The OMA , as already noted, has traditionally covered areas of legitimate physician activity that did not fit within specific codes by augmenting those codes most relevant to the disadvantaged practice area. This practice was aided by MOH contribution directly or indirectly through the global adjustments and special programs. Clearly if the OMA believes that all future practice problems will not involve MOH cooperation, then more problems of this nature are virtually certain.

Both the MOH and the OMA had legitimate grounds to dispute the other's position which substantially delayed resolution of the issue. Perhaps it was unavoidable, but fact finding is a less desirable substitute to both parties tackling the larger issues of which this is but a subset.

This is a technical legal victory for the MOH. I believe that this process should not be seen as a desirable precedent for how their bilateral differences should be addressed in the current economic and policy environment. Every effort must be made by all parties to avoid prolonging the defensive solitudes that have formed among the stakeholders of Ontario's health care system.

Constantly choosing between a mixture of past practice and law and hard law will not be perceived as fair as the government has the final authority in determining the laws and regulations that govern the relationship and therefore will generally be in the stronger position. While such power is necessarily in the hands of government, it can be destructive to the relationship if it is always seen to be relied on in dispute settlements. I must express the hope that when future problems of this nature arise that the parties will put a greater emphasis on the mixture of past practice and law in attempting to find a constructive solution.

Responsibility For Costs of Additional Underserviced Area Physicians

The need to bring underserviced areas up to full complement will add costs to the system. The shortfall has been so great for so long in many areas that there has never been full funding committed to meet the cost of the full approved complement. I have been provided with no evidence that the difference between the average number of physicians in service and a full complement ought to be absorbed by the existing OHIP pool. Had the complement ever been filled and maintained in the past then adjustments would have been made to the OHIP pool to account for the additional physicians.

To determine the division of financial responsibility between the MOH and the OMA there should be a calculation of the difference in the number of active physician years in underserviced areas averaged over five years and the approved physician complement. In light of the lack of clarity in some of the statistics and to avoid unnecessary dispute the numbers should be audited independently of the MOH and OMA. Any new physicians added to fill the complement above the agreed base would be funded by the MOH.

Where an Ontario physician on FFS transfers to an underserviced area on other than a FFS basis then the FFS funds allocated to that physician would be converted to the APP funding base up to the value of the direct contract. Any difference between the gross amount paid under FFS and the direct contract value would remain in the FFS pool.

The MOH would have to fund the additional physicians through internal efficiencies and transfer of funds from other programs including UAP funds earmarked to support physician income. The scope of this exercise does not extend to advising on what the lesser priorities should be.

Sources of Revenue

The additional burden to the existing pool to meet the $70 per hour solution would be offset by:

1. savings as a result of no longer paying a fee for service during on-call; and
2. an additional offset of savings to FFS from the closure of practice during the morning at the end of the on-call.

The offset in item (1) would leave the existing pool with a shortfall. The offset in (2) should be sufficient to eliminate any substantial burden to the existing pool. It should be noted that the latter offset, while providing relief to the pool, is primarily influenced by the recognition by physicians that it is desirable to set aside office hours in these circumstances for both practice and lifestyle reasons.

Othet sources of funds to give appropriate recognition to FFS rural practice in terms of income could corne from various reforms in the programs offered and the fee schedule set by the OMA. While there are a number of ideas that could be considered, the responsibility for identifying the best course of internal distribution of funds remains at the discretion of the OMA and is beyond the scope of this exercise.

Educational Reforms

The realignment of residency positions will have to be catried out within the AHSCs existing budget. Should an AHSC not wish to carry its share of the rural program in all categories then the requisite number of residency positions would be offered competitively to the other AHSCs.

The communications system for the Ontario Rural Emergency Consultant Program and the Regional Hospital Consultant *Access* Program between the AHSCs and the rural hospitals should be funded as follows:

- a one time $2 million provincial grant would be available to assist the AHSCs and the local hospitals and physicians in their tripartite consultations and in planning the design of the computer and telephone communications systems;
- hospitals and their communities would raise the funding for their end of the system, including equipment and operation costs;
- collectively the hospital communities in the AHSC catchment area would fund the additional equipment costs at the AHSC end of the system; and
- the hospital communities would fund the travel costs for consultants that corne regularly to the community.

Hospital ER Rationalization

Where area hospitals agree to rationalize their ER services all savings realized would be applied 1:0 enhancing the quality of service in the area.

Population Centre Concept

The PCC initiatives to support the satellite health facilities would be funded as follows:

- if a local hospital is in place in the small community it will continue to provide current staffing and facilities with backup from the area hospital;
- if a local clinic is already in place it will continue to operate but in co-operation with the area hospital;
- if there is currently no local hospital in place and no clinic then the community may enter into negotiations wi th the area hospi tal for appropriate support; and
- travel costs of physicians and nursing staff to support the satellite would be the responsibility of the community.

Medical Corps

The cost of education of a Medical Corps physician and a living allowance would be paid by the MOH and on completion of medical training the physician would be paid by the MOH.

CHAPTER 9 Other Issues Raised

The concept of a nurse practitioner depends on the definition provided. The concept of a nurse practitioner contributing to rural health in the areas of community health, public health and family health counselling would probably be widely welcomed.

The concept of a nurse practitioner as an individual trained to carry-out less complex medical duties as an aid to physicians in dealing with the ER problem was not well received as there was a concern that under the FFS the nurse practitioner would make *it* financially less viable for the physicians and therefore perhaps cause them to leave. In addition, it was felt that in real emergencies the physician would still have to be called in and consequently, there would be little potential gain in achieving a balanced lifestyle. Most physicians agreed that nurse practitioners would be of assistance in grossly underserviced areas and could be an asset in a team approach that did not involve undermining physician income.

Midwives

The midwife concept is much less attractive in the rural settings. The issue revolves around the limited number of births and the need for physicians to maintain their skills. The midwife would have to compete for a finite number of births in the rural areas and could make the area less attractive to physicians or GP/OBS. To date there has been no pressure nor does it seem appropriate to encourage midwives to practice in rural areas.

Commercial Walk-in Clinics,

The commercial walk-in clinics were singled out by almost every group that made oral submissions as a prime example of non-essential medical service delivery at a high cose. They were seen as:

- providing "frill" medicine that increases the costs of the system disproportionate to the limited convenience they offer;
- adding to costly duplication within the *system;*
- encouraging bad consumer habits; and
- providing beneficial incomes based on providing services requiring little medical challenge.

Their strength is consumer convenience, but it is provided at a high cost to other family practitoners performing more valuable services. In a period of limited resources such non-essential convenience medicine is an indefensible drain on medical resources.

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