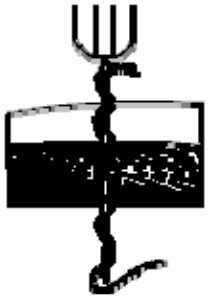

# Society of Rural Physicians of Canada
# Société de la médecine rurale du Canada

## A Fair Share for Rural Health at the Millennium

In follow-up to the SRP Ontario Region's "blueprint" document of 1998, the Section on Rural Practice of the OMA and the ON SRP have combined forces again to provide a grass roots implementation plan for areas of acute rural crisis. Member or not we welcome your comments.

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**Points addressed in "A fair share for rural health at the millennium"**

Areas of Concern:

- Settings with low volumes of services of high acuity make straight FFS payment for these services uncompetative.
- 15 rural obstetrical units have closed in Northern Ontario due to lack of MD personnel (Kirkland Lake will be #16 spring of 2000).
- There is a rapid attrition in FP-anaesthesia (practice life span only 5 years - CAS) despite many hospitals providing inducements.
- Surgical units have been closed in Englehart, Little Current, and many others, despite many hospitals providing office space and other inducements.
- Once closed, surgical services have not been re-established despite occasions of willing personnel (e.g. Both Little Current and Marathon have been unable to restart C/S services despite recruiting a willing FP with advanced training in cesarean section).
- Many rural hospitals have had difficulty getting family doctors to provide inpatient services, despite inducements.
- Many rural hospitals have had difficulty staffing ER rooms in unsociable hours, despite the Scott sessional fees.
- Increases in the FFS scale are unlikely to provide sufficient incentive for physicians to provide low volume services (e.g. rural obstetrics, anaesthesia call, inpatients, solo general surgeon on call) even if the rates are doubled.
- Programs need to be structured so that the settings at the most risk of closure get the most support. This means funding needs to be directed to the smallest, most isolated, but especially the settings with the least providers.
- An increase in overall rural physician numbers is unlikely in the short term, but influencing the existing rural physicians to stay and to provide specific services is an attainable goal.
- Groups of practitioners sharing call are more sustainable than individuals trying to provide 24h coverage themselves.

The Rural Section of the OMA and the Ontario Region of the SRPC suggest the following

- the Underserviced Areas Program and all other rural medicine support programs get redirected to support the smallest and most remote settings.
- the ER AFP be replaced with a comprehensive rural support package

- funding be program based for payment to call groups in low volume settings to provide 365 day coverage at ~$10/hr plus FFS (or similar AFP)
- within this funding envelope supported programs should be obstetrics, anaesthesia, general surgery, emergency room, inpatients, long service leave, maternity leave, amalgamation and informatics

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## Frequently Asked Questions

**What's wrong with the ER AFP?**

With a growing shortage of physicians, communities near large centres, that previously never had trouble finding doctors, are feeling the pinch. On initial rollout the ER AFP covered 27 needy communities in Southern Ontario with $37 million dollars in funding from the Ministry of Health. Under the program physicians in rural Georgetown, only 20 Km from Toronto, will get $150/hr to be on call. An equally busy doctor thousands of kilometres away in Northern Ontario will get $70/hour for doing the night shift under Scott Sessional funding. December 22 came an announcement that the funding program will be expanded to a further 58 generally smaller and more remote hospitals at a further cost of $60 million, but still a number of the smallest rural hospitals are not being offered this incentive.

The second problem is that incentives are not needed to support high volume services which are supported well by fee for service. Rural medicine is characterised by low volumes of essential services, so rural practitioners have to be true generalists. Scott already recognised low volumes as the reason why rural emergency rooms are not as attractive as settings that have economies of scale. What do you call a rural incentive program that gives you more money the larger the town you move to?

Furthermore, there are other low volume rural services that need support even more urgently than emergency rooms. Where is the support for rural maternity care, rural anaesthesia and rural general surgery? There are already over a dozen hospitals in rural Ontario that have had to close all three services due to a lack of trained and willing doctors. People who provide these services are even harder to find than the average rural doctor. Because these people are so vital to keep acute services going, it is essential that we support them. What do you call a rural incentive program that doesn't support services in genuine crisis?

This program has no consideration for the shades of rural. Rural and remote are a continuum. It is a lot harder to recruit for a solo practice 260 Km away from the next doctor, than for a hospital 150 kilometres away from an academic health science centre. What do you call a rural incentive program that, if it covered them, wouldn't know the difference between Pickle Lake and Pembrooke?

Finally the program is so richly funded that 2 physicians in Wallaceburg have quit their offices to work full time in ER (with almost no overhead they have almost doubled their income). What do you call a rural incentive program that draws physicians away from looking after inpatients, obstetrics, as well as regular office practice?

**How is the proposed ER support package different?**

The SRP - Rural Section proposal covers the entire rural hospital sector, and is graded so that the most rural and remote hospitals with equal ER volume get more funding.

The second thing is that with the requirement that funded physicians be local physicians that maintain an office, and in concert with the other program supports, the Wallaceburg syndrome, of physicians quitting their office and other hospital duties, will not happen.

**If this program just supports local physicians what about my locum?**

The program funding is directed to physicians that maintain an office. They have the control of that money locally as long as they guarantee coverage. If the local group is in agreement locums can be paid out of that money.

**Why do some groups get to provide less coverage?**

When numbers in the coverage group fall, there is increased stress. Hopefully increased funding per physician will allow for locum arrangements for 365/365 cover of anaesthesia, general surgery and so on, but if not, there should not be an obligation for physicians to undertake a responsibility for call beyond that which they feel capable of handling. Of course, funding is prorated to the amount of days that these services are contracted to be covered.

**Why does the OB grant require us to form an on call group?**

The program is not about having rural doctors make more money, but about making rural practice more sustainable. Being on call yourself 365/365 is stressful, even if you only do a few deliveries. The program not only encourages more providers to remain providing OB, but also is an incentive to form more co-operative structures that come with an on call group, to make the service sustainable.

One way the call group can help is by evening the load between providers. Ideally practitioners can rotate through a hospital based prenatal and postnatal clinic. Thus both patients and providers will have the opportunity to meet prior to the time of the delivery. The hospital base will also make it easier for the doctor running the clinic to go and attend to a delivery.

If equal sharing of the work is not appropriate in your environment, you can share the work in a non symmetrical fashion and still make OB more sustainable. This is automatic for the FFS style program and can be mimicked with the AFP.

To do it the group takes the AFP money and split it into two piles. One for the work proper and another for the on call. Whoever is on call gets paid out of the on call amount and whoever does the work gets paid the delivery out of the work amount. In such an arrangement it is crucial that the on call payment is sufficiently high, and the work payment sufficiently low (under $318), so that the physician on call will, in practice, do the deliveries in unsocial hours, and not feel hard done by the ones that another physician attends. If as stated it is not working out, have the person on call get paid for all deliveries in unsociable hours, regardless of who does the work.

**Isn't the rurality scale a bit simplistic?**

One of the virtues of the rurality scale that is used in the paper is the fact that it is simple to administer and provides for the most important contributors to rurality, size and isolation. Other stressors, such as number of providers, fall out in how the funding is distributed on a service basis, so if the service is short of medical personnel, more funding accrues to each physician. None the less the many communities in the "Rural level 3" tier are quite heterogeneous. The distance to a major urban centre with social

amenities, is another factor that might warrant recognition and help make the scale more valid. Health and Welfare and other researchers have been doing research on rurality indexes for medicine. As this work gets published there will be further revision of the scaling system. However, lack of a definitive study does not preclude the need to introduce such a scale to rural health planning.

**What about Community Sponsored Practices?**

The communities that have CSP contracts are usually too small or too close to other hospitals, to maintain obstetrical, anaesthetic and surgical services. Even if they are more isolated, the level of bonus if applied from these proposed schemes would be disproportionate due to the low maximum number of providers. Thus this proposal specifically excludes these communities.

In the few instances where CSP physicians provide these services in a neighbouring community, they are already paid a bonus under contract for this work. This bonus amount should be reviewed to match that of physicians in the other community. There is also merit in applying rurality indexation to the base contract.

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