



Primary Care Reform - A Rural Perspective

A Discussion Paper of the SRPC Ontario Region
January 27, 2000

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Under the existing fee for service payment scheme, it is said that there is insufficient coordination to ensure that the *right* services are provided by the *right* providers in the *right* places. It is evident that there are problems with primary care in many urban environments. The city dweller has a choice between walk in, ED, the family doctor, midwife, paediatrician, and gynaecologist for elements of their primary care. The providers offer fragmented and therefore expensive and often uncoordinated care. Furthermore, with the exception of the ED, there is limited dependable access to care on a 24 hour, 7 day a week basis. It has been suggested that with primary care reform (PCR), we could provide accessible high quality integrated and coordinated care. As an additional benefit, some have even claimed that this will also improve access for primary health care for the 1.6 million rural Ontarians

To date, in Ontario there have been at least ten major models, and several large PCR pilot projects. There has been considerable discussion *about* PCR and its promises, and *between* proponents for each of the plans. Who are we to believe?

To this simple rural doc, I think that most models of primary care reform can be characterized in three sentences

- 1) Patients are enrolled to a provider
- 2) The provider is accountable for a defined basket of ambulatory services
- 3) A group of providers will provide 24 hour access 7 days a week

Rural physicians, find it hard to understand the controversy over these tenets as the vast majority of rural docs, defacto have their patients enrolled to them (the patients have nowhere else to go), they provide all the listed ambulatory services as a matter of course (there is no one else in town to provide them), and they work in virtual groups to provide 24 hour 7 day a week coverage.

Furthermore, in the country we have to do much more than just provide ambulatory care. A good third or more of our time is spent at the hospital. In fact the existing fragile rural hospital is a model for coordinated community based services. Each of the proposed PCR models is significantly flawed by failing to take this into account.

The lack of sufficient flexibility in the PCR pilots to allow for hospital services, is the reason why the only rural hospital pilot, Wawa, dropped out. This failure to accommodate the rural context is a graphic example on why rural input into the design is essential for formulating a successful PCR model for rural

communities.

While most PCR models are quiet on rural implementation, the strength of the Health Services Restructuring Commission (HSRC) plan is that it has some specific suggestions. It starts well with suggestions for additional support for hospital services in rural areas to include specifically obstetrical deliveries, ED work, anaesthetic services, surgery assists and visits as most responsible doctor to homes hospitals and long-term care facilities. But rural doctors have been left scratching their heads on how the HSRC expects a rural or remote hospital in a town of 5,000 to provide all these services plus primary care with only 1 or 2 physicians, no matter how many nurse practitioners get hired..

Take Blind River. It has a population of 3,200 and draws from nearby Algoma Mills and Iron Bridge for another 1600 population. Currently it has 4 doctors who are trying to recruit a fifth, as they are overworked and doing too much call. Its doctor to population ratio is 1:1250 which means they make do with a third less GP's than the Ontario average, but this is better than the rural norm. In the HSRC model 2 or 3 of the existing doctors will become redundant and you would hire 2 or 3 nurse practitioners to replace them. To cover the hospital you will have to convince a doctor to carry the beeper every minute and never leave town. Not stated in the report but you could hire 2 extra doctors as hospitalists. There wouldn't be enough work to hire any more, but by trying to run a call schedule for the hospital with half the number of doctors will increase already high burn out rates.

Nonetheless, we need reform in the country as much as people do in the city. Fee for service in its current implementation is not working for us. By the government's own numbers, underserved areas are looking for 415 doctors this year, over a four fold increase from 1996. The problem lies not in the needs of the primary care side but in the need to provide those more difficult hospital duties.

In rural Ontario there is no getting away from the fact that you need doctors to run the hospital. To make them stay you have to remunerate them well, especially for the difficult services in remote areas, and provide sufficient numbers so that they don't burn out. To introduce nurse practitioners doesn't make sense unless there are at least five doctors sharing call for the hospital. Above this number, you can introduce Nurse Practitioners for the ambulatory work without risking the hospital. To encourage cooperation between providers, it is essential that the payment schemes for each provider doesn't engender competition.

Dealing with the entire picture of the rural medical crisis has become forced the Society of Rural Physicians to think outside the existing box, and to seek natural allies at the grass roots levels, so that we can find solutions.

In early 1998 we organized a national policy conference with and about nurse practitioners, to help define the issues and roles. Not surprising, issues of isolation and need for professional support are as important to rural NP's as rural doctors.

In 1998 the Ontario Region coconvened with PAIRO an expert group that developed "From Education to Sustainability - A Blueprint for addressing physician recruitment and retention in rural and remote Ontario." This provides a comprehensive guide from highschool through retirement to address rural physician shortages.

In 1999 the Ontario Region, in conjunction with the OMA Section on Rural Practice, and building on the blueprint, developed an implementation plan for Rural Medical Practice support called "A Fair Share for Rural Health"

In 2000 the Ontario region has joined with community, business and labour leaders to form the Negotiating Ontario's Well Being Alliance. The NOW Alliance has a 12 point Rural Health Action Plan which we know can be applied to FFS or other funding mechanism, including those proposed under PCR. These proposals are needed to support services such as inpatients, emergency, obstetrics, surgery and anaesthetics that, in one person can only be delivered by that swiss army knife of clinicians, the rural doctor.

Lets take obstetrics as an example. In Ontario in 1986 there were 460 rural generalists who attended births. Now there are less than 250 FP/GP's left who provide this service. Because there is practically no one else in rural Ontario to provide this service, there are at least 30 hospitals who have closed their obstetrical wards because of lack of medical personnel. There are at least 3 more hospitals in Northern Ontario that are down to one MD who does all the deliveries at the hospital (Manitouwadge, Chapleau, Kirkland Lake) When the remaining Family Doc who provides this service leaves Kirkland Lake this spring, 170 women will have to travel two hours in *good weather* to Timmins for delivery.

The NOW Alliance suggests that the province provide community based funding to hospitals for this service in a way so that the most vulnerable hospitals with the greatest personnel shortage, have the greatest incentive to attract new or existing physicians to provide the service. This can be accomplished for all rural hospitals in Ontario with under 0.1% of the physician services budget as detailed in the "A Fair Share for Rural Health" document.

Plans to deal with inpatient care, anaesthetics, and surgery are provided with full costing, in similar manner, as well as other specific recruitment and retention measures. We know that with these measures, not only will we be able to get PCR to work, but we will also be able to provide needed services to many rural citizens.

However, unless we can recognize and act on the fact that rural medicine is distinct, and needs specific and flexible grass roots solutions, we can reform primary care all we want and still not provide equitably access to primary care for all the citizens of Ontario.