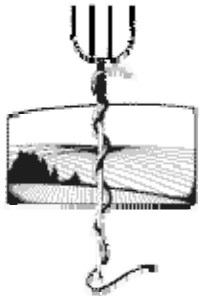

Primary Care Renewal - Rural Perspectives on Templates

A Discussion Paper of the SRPC Ontario Region
March 7th, 2001

How is Rural Different?

Why an Urban Capitation Rate is Not Appropriate for Rural Family Medicine Primary Care Networks.

Rural care is fundamentally different from primary care in urban areas as it is now practiced. A CMA study has shown that rural physicians, on average, practice procedural and cognitive special skills at a rate of twice what the average urban primary physicians does. Rural family doctors have higher workloads, work longer hours, provide a greater range of services, in a greater variety of settings, refer less, admit to hospital and care for inpatients more, and do more minor assessments and fewer intermediate assessments, than their urban colleagues.

Rural patients work in dangerous industries such as farming, forestry and mining, have lower mean income levels, are more likely to drink and smoke, and have greater morbidity and mortality. With no local specialists to share workload and responsibility a greater responsibility falls on the rural family doctor who is, literally, on the spot.

While ICES has found that the vast majority of very high billing (capped) family doctors reside in the golden horseshoe, the high workload and on-call responsibilities sometimes result in high incomes under Fee For Service in many rural areas. How can a PCR practice in the country, where greater responsibility and greater patient morbidity exists, be as attractive as one in Ottawa if the income is the same, and the call responsibilities are lessor?

Will you successfully persuade all doctors in a small town (all are needed to maintain a viable call group) to sign on to PCR at a capitation rate designed to get even 40 or 50% of urban doctors to sign?

If all doctors in a town are pressured into signing-on to allow for an acceptable on-call frequency, it follows that these practices will never be as attractive as those in a larger mixed environment where some physicians can "cherry pick" (overtly or not) and send high-demand patients to other providers on FFS, or to walk-in clinics or the Emergency Room.

Despite the special attention and pilot funding available, the only rural site chosen for piloting PCR, Wawa, withdrew. Physicians in Wawa supported PCR, but could not sign an agreement that would reduce their income. Under FFS they were paid for the increased morbidity of their population and the secondary level care services that they provided. The PCR template was based on urban capitation rates that did not take this into consideration, even when you excluded hospital services.

This failure highlights that even if Primary Care Reform is a solution for inefficient doctoring in the cities, it is not suited for dealing with the problems of under doctoring in the country. However if we only make urban PCR practices attractive this will further worsen the maldistribution of family physicians, and thus a rural template needs to be fashioned.

Towards a Just Template

We feel that the following solutions are socially progressive, promote good family practice, and can be easily incorporated into template design. The suggestions are in two parts, one for ensuring structural integrity of PCR, and second for population based morbidity rating.

Making PCR work

The concepts of high continuity of care, providing basic secondary care limiting the need for referral, and treating the entire community including the really sick and problem patients, involves a lot more work for the primary care doctor. This work is done every day by rural doctors by necessity, and many good urban family doctors by choice. Unless good medicine is rewarded in PCR under special incentive, neither the urban doctors who provide this level of care, nor rural doctors such as those in Wawa, will want to convert to PCR.

A) Capturing the Population

Regardless of actual disease state and intensity every physician recognises that some people on his or her list are more problematic and utilise more resources than others. To a certain extent, fee for service compensates physicians for the increased resources used. PCR does not and thus there is a potential selection bias for physicians to leave difficult patients out in the FFS pool during the registration process.

The worst case scenario is where half the population (the healthy ones) are rostered, and sick and problem patients are left to a FFS pool shrunk by conversion (conversion is the budget that will follow patients into PCR). Thus incentives should be structured so that regions and communities are rostered “en masse” and not patients by the cherry. A bonus can be linked to the percentage of the designated community enrolled. By capturing the population family physicians become a resource to the community.

When the PCR group of physicians and nurses sets out to provide care to the community as a whole, rostering is not necessary as registration can be simplified and done for the community as a whole with eligibility determined by geographic boundaries as with rural APP’s.

B) Supporting Comprehensive Care

Even if the whole community is captured in the primary care network, there are still ways that work can be shifted into the FFS pool. Even today many specialists receive consultations that leave them scratching their head as to why it was not dealt with at the primary care level. We want to build a system that encourages consultations that are worthy of the time and expertise of the specialist. In "tidy your room allowance" groups will receive incentive to do appropriate work "in house." This can be monitored by the number of referrals. By supporting comprehensive care we will encourage utilisation of the family physician, who is a skilled practitioner.

Alternately, if monitoring referral rates is not acceptable another mechanism will be needed to recognise that in rural areas, especially those in the north, have extremely limited access to specialists. In these areas rural family doctors provide outpatient cognitive and procedural services that are normally provided by specialists, in addition to primary care. One option is to adjust the capitation rates upwards in rural

areas depending on the local availability of specialists.

C)Supporting Continuity of Care

While double doctoring occurs in rural areas, it is more of a problem where there is a greater physician to population ratio. It would be cruel to have rural physicians pay for the disability of being underdoctored by discounting their capitation rates to account for the level of double doctoring in urban areas.

D)After Hours Coverage

Most rural environments have existing structures where the family doctor is already involved in 24 hour coverage arrangements for their patients and the hospital at high call frequencies. Because of the need in rural areas to have a physician available for high acuity emergencies such as heart or trauma, a doctor will have to be on call and would not be able to delegate this work to a nurse practitioner. This adds an additional burden to rural PCR than urban PCR and needs to be recognised. In "if it ain't broke" PCR must avoid requiring duplication of on-call. The rural PCR doctor should continue to deliver both hospital services and coverage for their patients simultaneously.

Morbidity-Based Funding

PCR capitation rates currently account for differing morbidity by age and gender only.

A) Aboriginal Issues

There is one recognised visible minority whose morbidity and mortality cannot be approximated by PCR payments based on stratification by age and gender of the majority. Half of these original peoples reside in the cities and the other half on home reserves with significant mobility between. Most rural and urban doctors have few natives in their practices, but some devote a large part of their practice to this needy group.

Areas that deal with Aboriginal patients will have a high frequency of: 1) patients without identifying documentation (including birth records of any type); 2) high patient mobility; 3) lack of registration with provincial health care plans like OHIP; 4) patients with treaty rights with the federal government which supercede any provincial medical plan. Physicians rendering care to Aboriginal patients should not be penalised by any system of 'patient-counting' or workload estimation without accounting for the nature of such a medical practice. One must take care in registering any Aboriginal patient in a care agreement as it may be a violation of their treaty rights. Thus PCR in such environments would be best agreed upon a reserve by reserve process.

In "looking first to the first nations" registration should occur by a special mechanism after consultation with the band leadership. Capitation rates for this recognised segment of the population should reflect the resource intensity that they need and deserve. By dealing with aboriginal issues we can ensure that family physicians will be able to reach this population.

B) Poverty

Poverty knows all races and is pervasive both in urban cores and the rural peripheries. All physicians are well aware that poverty both increases the likelihood of disease and reduces the prognosis. In "healing the poor" a bonus can be applied to PCR practices that cater to these special populations. The bonus can be based on Statistics Canada census determination of income level for the community.

Conclusions

1) Any PCR template which is not adjusted for rural realities will not be accepted in rural areas. Designing a PCR model that is only attractive in urban environments will result in a worsening of the serious problem of maldistribution of physician services within the province.
2) Many urban doctors provide comprehensive care beyond the PCCAR basket by choice. Rural physicians provide this care by necessity. A significant shortage of specialists in rural areas and urban regional referral centres has downloaded a significant amount of secondary care to the rural general practitioner. With a relative shortage of rural family doctors, continuity of care is almost a given. In addition the rural doctor's duties include more-or-less obligatory ER duty, hospital in-patient care, nursing home care, and special skills such as obstetrics, surgery, and anaesthesia.
3)Rural patients are poorer and sicker.
4)Rural doctors should be rewarded for the required increased efficiency, workload and responsibility by an increased capitation rate or other incentive.
5)A good template that rewards primary care groups to provide high continuity of care, being a resource to the community, and takes advantage of the high skill levels of nurses and family doctors, should be attractive for family doctors anywhere.

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This work is based on a paper done by the Ontario Medical Association Section on Rural Practice led by Ian Park with parts used with permission.