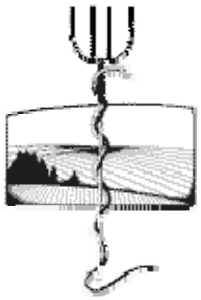

Society of Rural Physicians of Canada
Société de la médecine rurale du Canada

Central Region

2001, May 15
Hon. John Nilson
Minister of Health
Saskatchewan

Dear Sir:

Re Fyke Report

I am writing to you to offer you our observations and insights on the Fyke report. I am writing on behalf of the Society of Rural Physicians of Canada. The Society is a voice for rural physicians in Canada. The Central Region of the Society represents the Prairie Provinces.

Canadian rural physicians have found themselves on the front line of change in the health care system. We see the need for and support changes that improve the quality and access to health care for our patients. We also see the need for and support changes that improve the sustainability of services to rural Canadians.

We would like to be seen as partners in the process of change. We do not consider ourselves to be impediments to, or victims of change. Many rural physicians throughout the country practice in teams with other health care professionals, work with alternative systems of health care delivery, and participate in alternative payment mechanisms.

The Good Things about Rural Health Care:

Statistics Canada figures show that rural people are on average older and poorer. In spite of this, recent statistics from BC and Ontario show that rural people cost medicare substantially less than urban people. It is tempting to attribute this to difficulty in accessing the system. It is, however more likely that this is due to the following reasons:

· Rural people get a larger portion of their total health care from their local physician than urban patients. Urban patients get their emergency and secondary care from physicians other than their primary providers. Urban patients have easier access to specialists. Multiple providers increase redundancy and costs. Rural physicians are not only primary care providers but secondary and occasionally tertiary care providers. The cost differences are dramatic. It should be possible to generate these statistics for

Saskatchewan also.
· There is a rural culture that includes careful use of public resources.

By applying specialist-based secondary services to rural Saskatchewan, you are applying an urban solution to a rural problem. This will probably generate urban costs.

Quality:
A restricted definition of quality is offered in the executive summary. It is "the best job possible with the resources available". The public would see this as a definition of "efficiency" If we are unable to deliver quality services as the public understands the word, we should do the best we can with what we have and not solve the problem by redefining quality.
As is mentioned in the report, there is an erroneous public perception of quality in the system. A common source of stress at the primary care level is the collision of patients' expectations of quality with the realities of the system. We should be clear to the public on what the system can and cannot do for them.

Hospital Closures:
It is unlikely that further wholesale hospital closures will save any more money than the first round did several years ago. The unit cost of the community hospitals is usually less than that of regional hospitals. When a patient is in a hospital at a significant distance from home, there is a tendency to keep the patient in hospital longer as the patient cannot get back as quickly or easily if complications develop. The greater distances also make homecare more expensive and less available. Regional hospitals will have to be expanded appropriately. Patients will not stop getting sick if the hospital is farther away.
If adequately staffed and equipped, smaller hospitals can generate better outcomes. It has been shown that with obstetrics, better outcomes are achieved overall when obstetric services are provided in the community. The community care centers will be faced with drop-in emergencies no matter how extensive the public education campaigns are. It will be impossible to ethically refuse these patients and make them travel to a regional emergency department. This will create an untenable situation for the providers as our second greatest source of litigation is emergency work. It will be an even greater source if this care is provided in the absence of resources.
Talk of hospital closure becomes a self-fulfilling prophecy. Closure is publicly considered, major maintenance stops, services stop being improved, the hospital provides less services, patients start going elsewhere, physicians leave and the hospital can no longer be economically justified. You should appropriately space the community care centers in communities of adequate size. They should be adequately equipped to provide emergency services, low risk obstetrical services and short stay medical services in addition to the inpatient services proposed. They should supplement and complement services provided at the regional hospital as part of a process of regionalization, but not centralization.

Primary Care Networks and Teams:
Rural physicians are, for the most part, team players and would look forward to

formalizing the relationships. Unfortunately, in the report the roles of the primary care providers and the composition of the teams are not defined. The report does not recognize that rural physicians are multi level care level providers, not just primary care providers. Because of this, rural physicians have difficulty seeing how or if they will fit into these networks and teams.

The fee for service system for remuneration of physicians may be equally suitable with some modifications. For example: it would need to recognize committee work and consultations with non-physician providers.

Those of us that have been practicing in primary health care teams recognize that the teams require leadership by someone with a broad base of knowledge, otherwise the activities of the team degenerate into each provider advocating for their narrow focus of skill and interest.

In a rural environment, it is more appropriate to have the team members practice to the greatest breadth of their abilities. Although they should also work to the maximum of their abilities, exclusively emphasizing this would make the team larger and more inefficient. Large teams with each specialized member practicing to the pinnacle of their skillset might work in an urban setting, but would be inefficient in a rural setting. To use their full skillsets to maximum efficiency and quality, nurse practitioners need physicians handy and physicians need acute care and emergency services handy.

Regional Hospitals:

It is unlikely that you would be able to get sustainable complements of specialists for these centers. There are many rural physicians who have acquired additional skills in surgery, obstetrics, anesthesia, and aspects of internal medicine. They would not be able to provide the full range of specialist services, but would be able to provide the more common procedures.. Saskatchewan is well known for the advanced training that it provides for family physicians to provide cesarean section services. With such capacity rural hospitals have shown that they are able to keep 99% of their maternity cases and have outcomes equal to those of specialty centers.

The Society is working with the College of Family Physicians of Canada and with specialist organizations to standardize training and maintenance of competence in these additional skills.

These physicians with additional skills are and will be a valuable resource to you. These physicians do not see a role for themselves in the system that is proposed. You should take steps to be sure that you do not loose them to other provinces.

Emergency Services:

Statistics are provided in the report to demonstrate the effectiveness of a telephone triage system. What the report fails to note is that telephone triage is already being provided free by rural hospitals. Most patients who are unsure of their needs do call their local hospital for advice and get the benefit of a nurse’s opinion and that of a physician if the nurse feels it is appropriate. For that reason we expect that the proposed system will not demonstrate any savings in rural Saskatchewan, even though it has demonstrated effectiveness in urban settings. Our members from Northern Ontario noticed that such a system actually increased referrals to the emergency

department. That is understandable because someone who is unaware of local resources, customs and personalities is now giving the advice.

Wellness, Illness and Aging:

Wellness efforts prevent some diseases, delay others and detect others earlier. They have less effect on the more expensive and chronic diseases such as dementias, cancer and arthritis. By allowing people to live longer, wellness efforts will increase the incidence of these diseases. We fully support wellness as part of the primary care team's mandate, but you should not expect to see cost savings from it. Illness and old age will continue to be with us.

The report gives, as evidence of poor quality in the system, the fact that most of our health care activities do not improve the health of the population. Caring for the ill and the old will not improve the health of the population. It is likely to worsen the overall health of the population by keeping the old and the ill alive and functioning longer. We cannot abandon these people because our care for them fails to improve the health of the population. The ill and the old are us, or will be us, regardless of how healthy we can be now. How well we care for these disadvantaged people is a measure of how socially advanced our society is. It is also a measure of the quality of our health care system.

Yours truly,

David P O'Neil
The Central Committee
Society of Rural Physicians of Canada

Cc: Hon. Lorne Calvert, Premier
-This document may also be viewed at www.srpc.ca