

June 2007

Submission to the BC Ministry of Health

“Conversation on Health”

**FAMILY PRACTICE RECOMMENDATIONS**

**FOR**

**BRITISH COLUMBIA’S  
HEALTH CARE SYSTEM**

**Society of General Practitioners of British Columbia**





# Society of General Practitioners of British Columbia

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### Summary

While it may be a cliché to say that health care in this country is in a crisis, the public quite rightly continues to complain: the average person has a tough time even finding a family doctor; most wait times for surgery, specialty consults and investigative procedures have increased; provincial health care costs continue to rise.

As governments confront these pressing problems, one key solution is often overlooked: Supporting and making better use of the family doctor (general practitioner).

Medical care delivered by family doctors is the foundation of our health care system. Unfortunately, this foundation is crumbling.

Numbers tell the story:

- Of the 30 most developed nations in the world, Canada ranks 26th for the number of physicians per population.
- More than 3.6 million Canadians and 150,000 British Columbians do not have a family doctor.
- Some 20 percent of B.C. general practitioners plan to retire or move within the next five years, and 80 percent are over the age of 40.
- The number of general practitioners providing maternity care has dropped to 20 percent of all GPs in BC.
- The majority of medical school graduates now ignore family practice in favour of specialty training. In the past, more than 50 percent of graduating medical students chose a career in general practice; today that figure has dropped to 29 percent making it their first choice.

**The single biggest threat to the efficiency, effectiveness and sustainability of British Columbia’s health care system is the decline in the number of family doctors and the failure of the health and education systems to recruit, train and retain family doctors to attractive, long-term careers.**

The Ministry of Health’s recent steps (2006 BCMA Agreement) to increase the remuneration of family doctors are positive and welcome. The Primary Health Care Charter, recently released by the Ministry of Health, is also a welcome attempt to formulate a long term vision for a strong and sustainable primary care system. The challenge now will be to sufficiently promote and strengthen these first steps in order to overcome the rapid aging and exhaustion of the family doctor workforce. The SGP believes that the proposed measures, as outlined below, are among the most effective and affordable ways that government can improve health care for all British Columbians.

# Recommendations

## 1. Recruit and retain more family doctors

- a) Increase the number of medical school seats and postgraduate training positions for Family Medicine.
- b) Make changes to the selection of medical students to admit more applicants who demonstrate an aptitude for and interest in family practice.
- c) Make changes in medical school curricula to maximise the length of the Family Medicine clerkship to encourage more students to choose family practice as a career.
- d) Encourage more community family doctors to become involved in the education of medical students and residents by compensating them appropriately for their clinical teaching.
- e) Attract more medical students to general practice by remunerating general practitioners at a rate competitive to specialists.
- f) Attract more family physician graduates into practice by assisting them with the start-up costs of a new family practice.
- g) Attract more medical students into Family Medicine with incentives to assist in reducing student debt load.
- h) Provide more training for general practitioners to acquire the advanced skills needed to better serve patients in their communities. Remove barriers that prevent physicians from temporarily leaving their community practices to undertake this training.
- i) Retain those general practitioners already in practice with a more substantial increase in compensation and annual increases thereafter for the rising costs of running a medical practice.
- j) Maintain general practitioner involvement in hospitals and nursing homes by acknowledging the important contribution the GP patient relationship makes to the overall care of the patient.

## 2. Improve practice support for family doctors who care for patients with chronic disease, disability and terminal illness

- a) Create ways to bring nurses, social workers, dieticians, mental health counsellors and other helping professionals into networks with existing family practices to make it easier for family doctors to coordinate multidisciplinary services for their patients.
- b) Establish electronic connectivity standards for communicating patient information between family doctors, hospitals and other health professionals.
- c) Subsidize the hardware and software acquisition and ongoing support required by family doctors to maintain electronic connectivity with hospitals and other health professionals.
- d) Strengthen and build new community-based patient education programs that promote wellness, prevention, and chronic disease self-management. Ensure that community family doctors are involved in the planning and management of these programs.

## 3. Improve patient access to investigations, specialty care, supportive services and care facilities

- a) Increase the availability of home nursing and home support services
- b) Increase the availability of mental health and addiction counsellors
- c) Encourage general practitioners to use all their expertise for the benefit of their patients by ensuring the availability of support staff, equipment and facilities for their use. This would include:
  - increasing access to acute, rehabilitation, psychiatric and long term care beds
  - increasing operating room capacity in community hospitals to reduce surgical wait times and to provide emergency obstetrical support
  - increasing diagnostic imaging capacity (such as ultrasound, CT and MRI) in every region, removing barriers to general practitioners ordering these tests and using mobile and remote technology where possible to reduce travel for rural residents.

## **Background: The Value of General Practice**

### ***Proven benefits***

The world-wide evidence is clear. Health systems with a strong emphasis on primary care are more cost effective. They also have better health outcomes and do a better job of providing health care to all socio-economic classes<sup>2</sup>. Nations with a high ratio of general practitioners to population have:

- lower per capita health care costs,
- lower rates of hospitalisation and medication use,
- healthier, happier populations, and
- lower mortality from lung disease, cardiovascular disease, and cancer<sup>3</sup>.

People without a regular family doctor are 3.5 times more likely to end up in the emergency room<sup>13</sup>. In England it has been estimated that each additional general practitioner per 10,000 population is associated with a 6 percent decrease in mortality<sup>4</sup>.

### ***Superior Training***

Primary care is complex. The general practitioner will see many patients who do not have serious disease. At the same time, he or she must be able to diagnose and treat rare disorders<sup>6</sup>. Being able to reliably distinguish signs and symptoms of benign conditions from more serious ones is a valuable and important skill that saves lives and saves money. With 10 years of training, the general practitioner is the best-trained health care provider to deal with the uncertainty and complexity of primary care.

### ***Diversity of Skills***

The broad training received by general practitioners allows them to provide a broad spectrum of care to people of all ages. General practitioners perform a wide variety of procedures including surgery, anaesthesia, midwifery and obstetrics, and provide emergency and trauma management. Their training enables GPs to provide mental health, preventative medicine, nutrition and lifestyle counselling<sup>6</sup>. The general practitioner is able to identify the health needs of the community and adapt to meet them in all these areas and more including:

- sports medicine,
- cancer therapy management,
- acute and chronic disease management,
- palliative care,
- geriatric care,
- home and nursing homes care,
- hospital services,
- comprehensive maternity care , and,
- emergency room work.

This flexibility and diversity of practice style is a great strength of general practice and should be supported and nurtured.

### ***Team Leader and Essential Role in Primary Medical Care***

There are four main features of primary medical care services:

- 1) first-contact access for each new need;
- 2) long-term person-focussed (not disease-focussed) care;
- 3) comprehensive care for most health needs; and,
- 4) coordinated care when it must be sought elsewhere<sup>3</sup>.

The general practitioner is the leader of the health care team. With the patient, the family doctor chooses the most appropriate provider and coordinates the patient's overall care by the team members such as specialist physicians, surgeons, nurses, therapists, counsellors, and educators. Without the family doctor acting as coordinator, the care of the patient with complex needs can easily become fragmented. This puts the patient at increased risk of adverse effects. Studies in the United States that show that people who have a family doctor have better health outcomes<sup>3</sup>.

### ***Therapeutic Alliance***

Over time, as general practitioners build long-term relationships with their patients, they are able to take the patients' personal, family and cultural values into account. This holistic doctor-patient relationship has been proven to maintain good health, optimally manage chronic disease, and hasten the recovery from illness and addiction. Patients who regularly visit a specific family physician receive more appropriate preventative care, have fewer diagnostic tests, receive fewer prescriptions, and have fewer emergency department visits and hospitalizations<sup>3</sup>.

### ***Advocacy***

The general practitioner is a true advocate for the patient. This is increasingly important as our health and welfare system becomes more complex and costly. The long term relationship and therapeutic alliance that exist between GPs and patients means the GP develops intimate knowledge of an individual patient's needs. The GP can then use that knowledge to help the patient navigate the system and have those needs met.

### ***Accountability***

Physicians are held to the highest level of accountability. They adhere to the Canadian Medical Association Code of Ethics, and in B.C. their professional conduct is regulated and monitored by the College of Physicians and Surgeons of British Columbia. They are also subject to various Acts of the Federal and Provincial Governments and those who maintain hospital and nursing home privileges are subject to Health Authority Medical Staff Bylaws, Rules, and Quality Assurance Reviews. Physicians are also legally liable for meeting a reasonable standard of care. General practitioners continuously update their knowledge and skills, most through formal re-certification programs by the College of Family Physicians of Canada. Most importantly, the physician is ultimately accountable to his or her patient.

### ***Maintenance of the Primary Medical Record***

All health care providers keep a record of their interactions with patients, but the family doctor maintains the most comprehensive longitudinal record. This record is extremely important for the patient with multiple chronic diseases or complex needs. Appropriate consensual use of this comprehensive record prevents duplication of investigations and services and thereby benefits both the patient and the healthcare system.

### ***Public Health Support***

Family Physicians are often the first point of contact for the public when issues of public health are a concern. In addition to providing well child immunizations to a significant proportion of the population, family physicians support the public through general influenza immunizations and monitoring for first appearance of communicable diseases. Family Doctors were at the front line in the SARS outbreak and are the main source of information for the citizens of British Columbia when concerns arise about such illnesses as meningitis, whooping cough and influenza to name a few.

### ***Educational Services***

In addition, general practitioners are an important resource for public health advice and teaching, often serving on committees that monitor the quality of health care in their community. They are also involved in the training of medical students and Family Practice Residents in many communities.

### ***Supplemental Services***

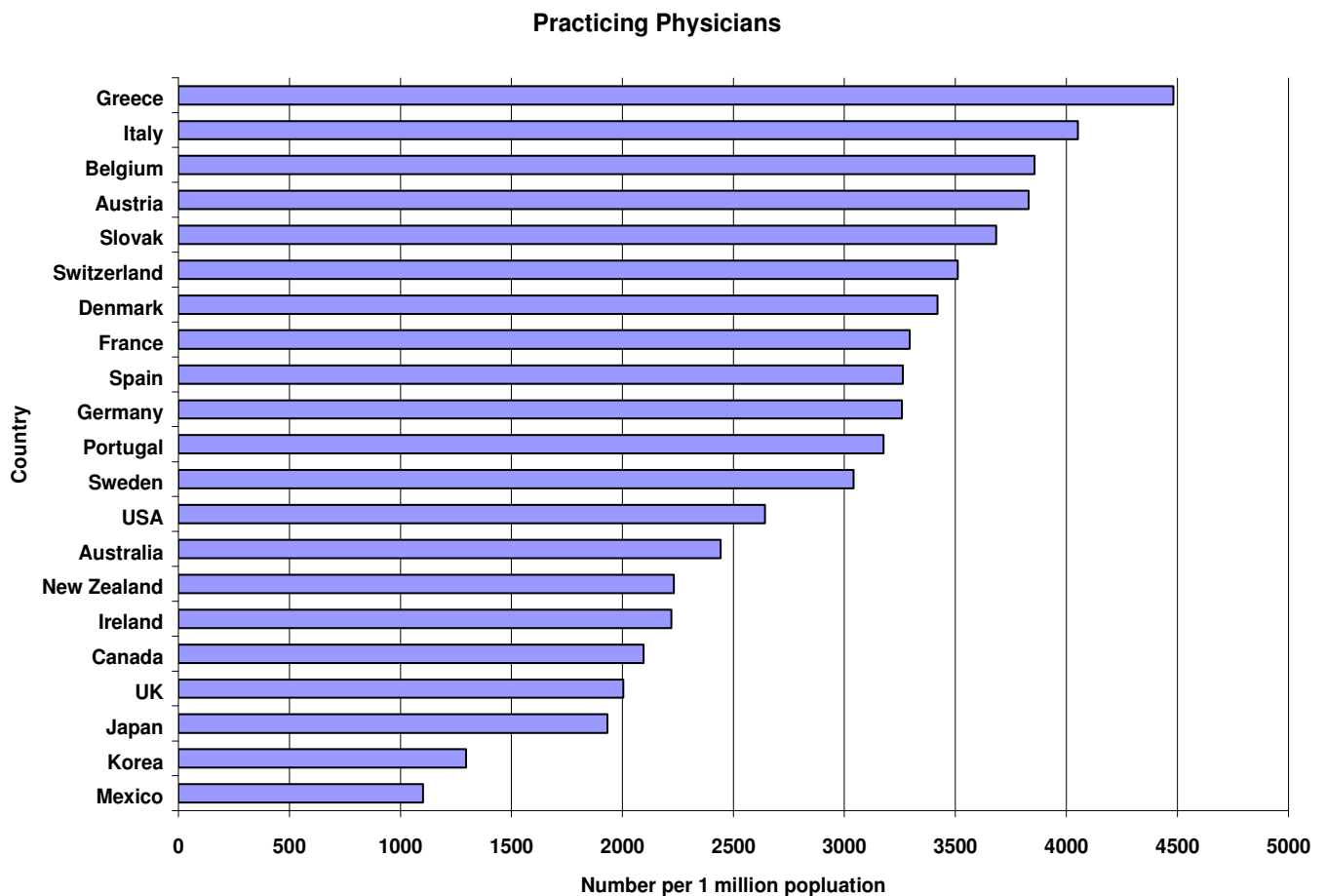
General practitioners provide many additional valuable services to their patients that are not considered "medically necessary" by the BC health plan (MSP) and thus the responsibility for payment lies with the patient or requesting third party. Some of these services include driver medicals, employment and insurance exams, wellness physicals, preventative health and life-style counselling, and completion of benefit forms.

## Background: A Crisis in Numbers

Canadians rely on their family doctor for their primary health care. When surveyed, 85 percent say that they or an immediate family member have visited their family doctor in the last 12 months<sup>12</sup>.

Unfortunately, this access is becoming increasingly difficult. Of the 30 most developed nations in the world, Canada ranks 26th for the number of physicians per population<sup>5</sup>. In 2003, 3.6 million Canadians did not have a family doctor and 1.2 million of these were actively looking for but unable to find one<sup>1</sup>. Fewer family doctors are accepting new patients now than five years ago<sup>9</sup>.

**Figure 1: Supply of physicians in OECD Countries** from Simoens et al, OECD Health Working Papers, Organization for Economic Cooperation and Development, Jan 2006



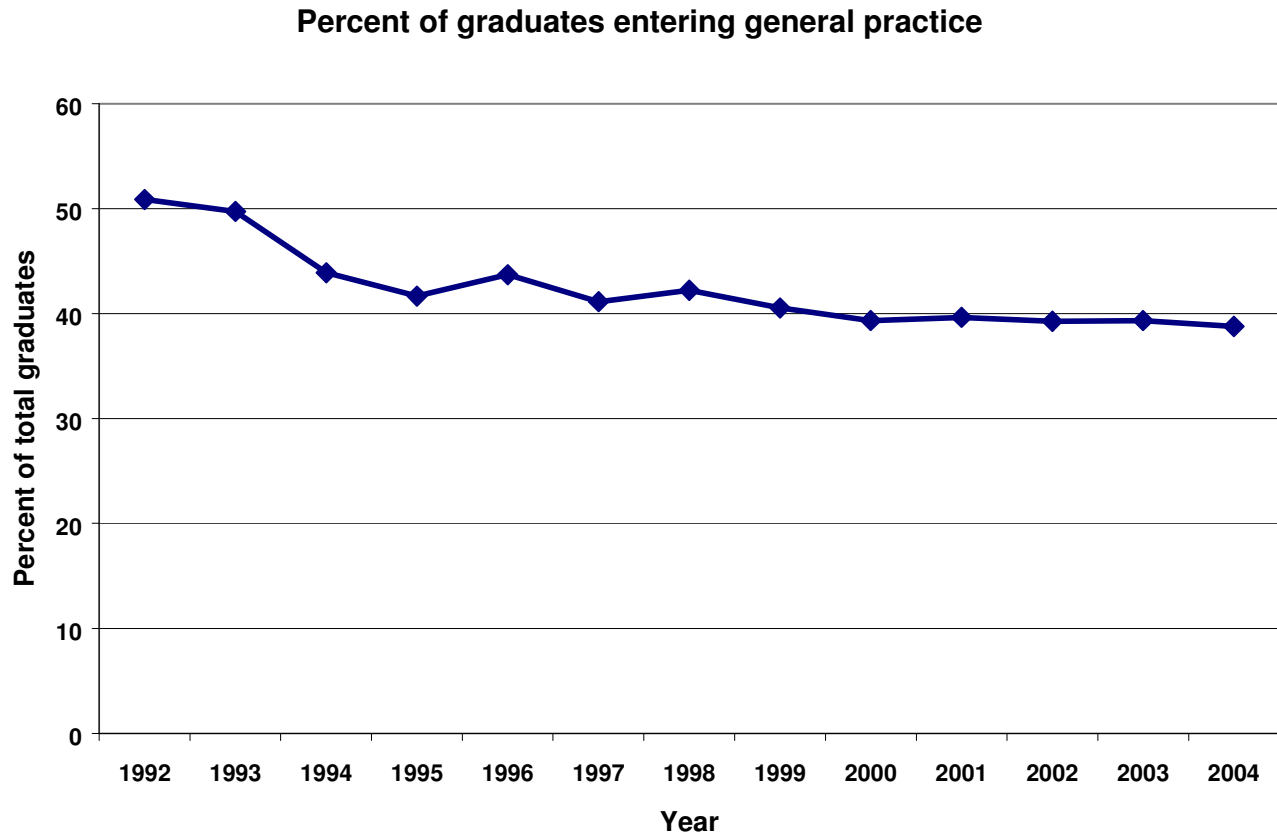
In British Columbia, 80 percent of B.C. general practitioners are over the age of 40 and 20 percent plan to retire or move within the next five years<sup>7</sup>. Many of those are unable to find anyone to take over their practices, leaving many “orphan patients.” More than 150,000 people in B.C. are now without a family doctor and this number is growing.

Twenty years ago, more than 50 percent of graduating medical students chose a career in general practice. This proportion has declined dramatically over the last two decades. In 2007, only 29 percent of graduating medical students in Canada picked family medicine as their career of first choice<sup>11</sup>. In 2005, of the total 1,508 residency positions available for the first round of the CARMS, 930 were for specialty positions and 578 for family medicine. When these residents complete their

two-year family medicine programs at least 25 percent pursue other special interests rather than a career as a family doctor<sup>10</sup>.

**Figure 2: Number of new physician resident graduates entering practice** from Canadian Medical Association Research Directorate "Physician Statistics"

[http://www.cma.ca/index.cfm/ci\\_id/40849/la\\_id/1.htm](http://www.cma.ca/index.cfm/ci_id/40849/la_id/1.htm) (Accessed March 2006)



Not only are there not enough general practitioners currently in practice, there is an accelerating retirement from the profession. Furthermore, as fewer medical graduates choose family practice, these physicians are not being replaced. It is the informed opinion of the Society of General Practitioners of British Columbia that the four main reasons for this are:

- 1) Inadequate remuneration
- 2) Difficulty accessing necessary care for patients
- 3) Increasing complexity of care, and,
- 4) Inadequate number of training positions

### **1. Inadequate remuneration**

The costs of a medical education have increased dramatically in the last 10 years. Many students are incurring debts of more than \$100,000 by the time they graduate. Subsequently, there is great financial pressure on students to choose a career path that will maximize their income.

The majority of Family Physicians in BC receive their majority source of income through "Fee-for-Service" from the Ministry of Health through the Medical Services Plan. Over the last several decades the BC Medical Services Plan (MSP) fee schedule, from which the majority of general practitioners in BC are paid, has failed to keep up with inflation. Time, intensity and complexity associated with an aging and growing population is only now beginning to be recognized with incentives developed by both the GP Services Committee and the Society of General Practitioners of BC. Because of rising

office expenses, rent and staff salaries the net income of office-based general practitioners has been declining. Meanwhile, the gap between the average billings of general practitioners and that of specialist physicians has progressively widened<sup>21</sup>. Consequently, a specialty career has more financial appeal to medical students than a career in general practice.

Many everyday services provided by the family doctor are only partially paid or not paid at all by the MSP schedule. These include:

- Coordinating the care of complex patients
- Accessing basic services for all patients,
- Maintaining comprehensive medical records,
- Provision of 24 hour community based on-call services, and
- Communicating with concerned relatives and caregivers of patients.

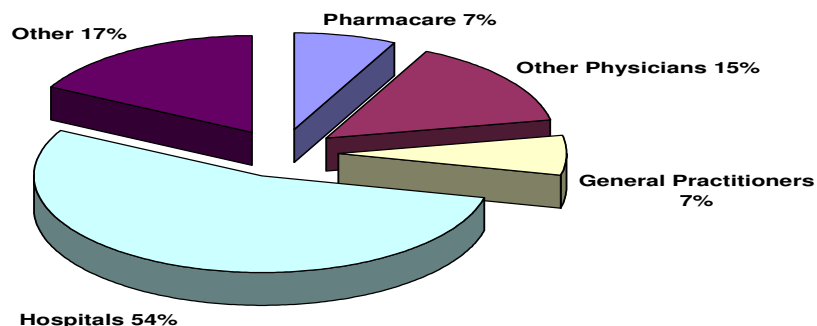
Consequently, general practitioners have been shifting their practice pattern away from this traditional type of care to less intense work such as the brief episodic care provided in walk-in clinics<sup>10</sup>.

Recent targeted payments to general practitioners for the traditional type of care are appreciated but are still preliminary and not comprehensive as many areas of medical care are not covered under these targeted incentives. These new fees will narrow the gap between the average billings of general practitioners and specialists but it is too early to see if this will affect the retention of family doctors, let alone the attraction of newer graduates.

While there has been some move toward alternate payments (non-fee for service) for family physicians dealing with complex needs of select groups of patients there must be a link in the payment rates with the time, intensity and complexity of managing these patients in community clinics.

General practitioners in B.C. see more than 80 percent of the population annually and provide the bulk of primary medical care services in this province while expending only 7 percent of the provincial health budget<sup>19</sup>. Most of these patients never need to access secondary, tertiary or quaternary care. GPs can play a significant role in preventing chronic illness and maintaining the health of British Columbians and this would significantly reduce long term costs to the health care system. It would be faster and much less costly to further support existing primary care family practices rather than create a complicated new primary care delivery system.

**Figure 3: British Columbia Public Sector Health Care Spending 2004** from Economics Department, British Columbia Medical Association, March 2006



## **2. Difficulty accessing necessary care for patients**

The much-publicized problem with surgical wait lists frustrates physicians as well as patients, but these are not the only access problems. There can be unacceptable waits for investigative procedures like CT and MRI scans, and long waits to see specialist physicians, mental health counsellors, and others. In many cases the Family Doctor must provide specialized services and manage increasingly complex conditions while patients await assessment and recommendations. Rural patients may be additionally burdened by the need to travel long distances to receive services. Too often, the family doctor is required to search and negotiate through several layers of bureaucracy to get enough home support for patients, to find a long-term or acute-care bed, to obtain funding so the patient can afford his or her medication, or to arrange transfer to another city, province, or country for care that is no longer available locally. This often adds hours of work to the already lengthy day for the GP.

## **3. Increasing complexity of care**

Our high standard of living, public health initiatives, and advances in medical care have combined to make us live healthier, longer lives. However as we age, we are more likely to develop one or more chronic diseases such as hypertension, heart disease, diabetes and arthritis that require ongoing medical management. When surveyed, 42 percent of Canadians report that they or an immediate family member suffer from a chronic illness<sup>12</sup>. Responsibility for coordinating care for these diseases appropriately rests with the family doctor, but this is complex and time-consuming work. Furthermore, pressure to achieve efficiencies in hospital care has resulted in shorter hospital stays and earlier discharge of ill and convalescing patients into the community without a concomitant increase in home nursing and support services. This has also greatly increased the family doctor's workload.

A commonly mentioned solution is for health professionals to co-locate to better provide care for patients as a team. Team based care is not a novel idea and family doctors have been doing it for years. There is some potential for improvement. When surveyed, physicians, nurses, and pharmacists agree that the inability to easily share information, their separate practice locations, the extra time required to communicate with each other, and the lack of financial incentives to do so can be barriers to optimal multi-disciplinary care<sup>12</sup>. However, information to date has not shown that co-location of providers is the answer. Enhancing communication of the members of the healthcare team can be done without requiring movement of members to the same physical space.

## **4. Insufficient number of training positions**

This province and this country are not training enough general practitioners. The decisions by governments to reduce medical school admissions by 10 percent and reduce family practice residency positions by 30 percent because of recommendations contained in the Barer Stoddart report of 1991<sup>17</sup> are only now being recognized as mistakes. Recently medical school enrolments have been increased but there are still not enough medical student and post-graduate family medicine positions available. Canadian medical schools graduated only 1897 new doctors in 2005, not nearly enough to address the current gap. 1405 of these participated in the Residency Matching process with only 578 positions available to train Family Physicians for the entire country<sup>11</sup>. It is estimated by the BC Medical Association that BC alone needs more than 400 new physicians each year<sup>20</sup>.

Some medical schools consistently produce a higher percentage of general practitioners than other schools<sup>12</sup>. We recommend that medical schools make training family physicians a priority. Evidence shows that pre-existing aptitude and interest of medical school applicants are significant factors in their later career choice of family practice or specialty training. Furthermore students who undertake longer Family Medicine Clerkships during medical school are more likely to choose family practice. The conclusion is that a medical school that wants to train family physicians can increase its likelihood of success with a few simple changes: screen medical school applicants for their aptitude and interest in family practice and implement a family medicine clerkship of the maximum possible duration during medical school. At the post-graduate training level, the number of family practice residency positions should be increased relative to specialty residency positions. Furthermore,

creation of more re-entry positions for family physicians to return for specialty training would encourage more graduates to "try" family practice for a few years.

While advanced training of general practitioners in skills such as complicated obstetrics, Caesarean section, surgery, anaesthesia is necessary, especially in rural Canada<sup>14,15,16</sup>, other skills such as endoscopy, palliative and geriatric care, addiction medicine and mental health are helpful in urban areas as well. There are currently only limited training programs available in some of these skills with those positions available often being difficult for practising family doctors to access.

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