

# **Ontario Medical Association Primary Care Reform: A Strategy for Stability**

## **CHAPTER I**

### **Why Primary Care Reform?**

The Canadian health care system has grown rapidly, and the increase has been attributed to a number of reasons:

- the rise in the number of health-care professionals per capita
- increased utilization of institutional services, which are by far the most expensive component of health-care.
- the rapidly-aging population

### **Payment Modality Trends in the 1990s**

In early September 1995, Jeremiah Hurley completed for the CMA a review of payment modalities and specifically addressed the question of what we have learned in the last five years.

Hurley stated that "Canada has resisted developing new and innovative ways to fund physician services and to remunerate physicians." Although some would perceive this as an impediment to progress, others would view it as stability in the present health-care system, where funding in the past has been dependent on federal transfer payments. At this time, however, proposed remedies in many provinces are genuinely fundamental, as Canada joins a host of other industrialized countries in exploring fundamental restructuring of its health-care system. The policy objectives have now surpassed mere cost-containment initiatives, as a number of provinces, prompted by fiscal deficits and governments guided by different electoral mandates, have begun restructuring their health-care systems to improve resource management.

The changes represent a potential watershed in Medicare's history as the provinces embark down divergent paths for planning. They may indeed provide an interesting natural experiment regarding the effectiveness of these alternate approaches as they challenge the principles of the Canada Health Act. There are many who believe that if the Federal government abdicates responsibility for payment, it will no longer be the spokesperson for provincial initiatives in health-care planning and restructuring.

Similarly, physician practice patterns and payment have changed dramatically in the industrialized centres over the last 50 years and the rate of change is gaining momentum.

While solo practice fee-for-service remains the predominant model in Canada, the introduction of the model, A model presented for the reorganization of primary care and the introduction of population-based funding, presented in Victoria, British Columbia to the provincial Deputy Ministers of Health prepared by a Working Group chaired by Dr. Miles Kilshaw, signalled the start of the various provincial governments' true commitment to reform.

Canada may be viewed by some as relatively stable in its present mechanism to fund physician services and remunerate physicians. Critics would argue, however, that Canada lacks innovative ways in which to develop new concepts of management. Using international data analysis of the present status of primary care in Canada, which places Canada as having one of the best systems in the world, would lead us to be cautious in concluding that there are significant problems with remuneration of such designated services. Nevertheless, criticism has been levelled at the current system.

There remains, however, a major gap in our knowledge with respect to the interaction between the funding mechanism applied and the manner in which medical practices are organized. The complexity of

payment methods is extreme and they unfortunately do not neatly divide into simply FFS, capitation, or salary. When reviewing the literature and setting up a particular organizational structure, every attempt must be made to balance prospective elements that put physicians at financial risk (such as capitation) with retrospective elements that reduce the risk but which are frequently seen to have undesirable incentives (such as increased throughput with FFS).

### **General Trends in Non-Fee-for-Service Organizational Models**

1. Any organization, such as a Health Maintenance Organization (HMO) or Health Service Organization (HSO), may be funded on one basis (e.g. capitation) but physicians may be paid on another basis, for example, salary or FFS.

2. There can be no doubt that payment methods, whether FFS, capitation or salary, have important effects on the level, mix, and distribution of services provided. The effects, however, depend on how much risk is borne by that provider and the range of services included.

3. When reviewing Health Maintenance Organizations in the US, two studies, Manning et al. and Luft, are noteworthy. Although the studies were not without methodological problems, such as self-selection of physicians and confounding of payment with other practice characteristics, they have a number of interesting features:

1. HMO patients appear to have less hospital utilization and were more frequently treated in the ambulatory setting.

2. HMO patients used approximately the same amount of ambulatory care as FFS patients.

3. HMO physicians appeared to have greater patient loads; however, HMOs frequently employed non-physician personnel at the same rate as FFS practices. This is qualified by the statement that the HMOs did not do this with regular frequency.

4. HMOs attempted to deliver an increasing emphasis on preventive services, but were not particularly stronger in this area than FFS solo practice.

5. Depending on the definition of the quality of care, HMOs appear to deliver care that was similar to that provided in the FFS sector. It is also important to note that in a review of FFS and CHC practices by Abelson and Lomas, CMAJ 1990, the results revealed that "few differences exist between HSOs, CHCs and FFS practices in their approach to, and conduct of, the selected disease prevention activities," as recommended by the Canadian Task Force on the Periodic Health Examination.

The conclusion is therefore that careful consideration must be made before assuming that HSOs or CHC practices are more efficient than the present solo FFS model in emphasizing the delivery of preventive health-care. Further to the discussion of comparing hospital utilisation and HSO practices before and after the change in HSO funding, and compared with utilization matched with the eleven characteristics of FFS practice during the same period, Hutchison et al, CMAJ, noted that,

"no statistical significant differences in the rates of hospitalization were found between the matched HSO and FFS practices, either before or after switching to the HSO funding."

It thus becomes apparent that the overall workload and allocation of time among activities is influenced at least as much by the organizational factors as by the payment method. This statement is made with the qualification that the evidence used to support such a conclusion is in fact generated from different countries with settings distinct from Canada. As described by Theodore R. Marmor, professor of politics and public school at the Yale School of Organization and Management, in a presentation to the American Society of Law, Medicine and Ethics (September 1995), the ethos and expectations of the Canadian public make Canada distinct in the western hemisphere. There can be little doubt that Canadians consider universal health-care the jewel in the crown of their social programs. In addition to the

interest expressed in the economy and job security, health care is of utmost concern to the average individual.

Quality of care can be high within a variety of delivery systems. For example, as in the Canadian health-care system, primary care provision ranks extremely high in satisfaction in Denmark, yet both countries are remarkably different in terms of their organizational structures and payment methods.

Finally, and perhaps most importantly, the degree of physician satisfaction can be high under all the various systems. According to Relman, there is strong concurrence that,

"no one wants to be taken care of by an angry or demoralized physician, but rather a competent, well-informed, compassionate provider who will have no incentive to do more or less than is medically-appropriate for each patient, and who practices in facilities with adequate resources and good management."

Physicians should be compensated in ways that encourage neither over nor under-use of resources, but no payment scheme or organizational structure will serve as a single solution for all potential problems presented. In other words: one size does not fit all.

### **Is Primary Care Essential?**

As articulated by Barbara Starfield in the article, "Is primary care essential?" primary care has been widely acclaimed as the backbone of a rational health-care system. Others have seen rationing of primary care services as an anachronism in the present medical era, denying and delaying specialist attention or access to speciality services. In this discussion paper, the Physician Advisory Group has attempted to answer a number of difficult questions, for example, how to define primary care, for example:

- what is primary care?
- which primary care services are provided by specialist and primary care providers?
- what are the roles and functions of primary care providers and how may they be measured?
- how many primary care personnel are needed and in what organizational setting?
- how can physician and consumer accountability be enhanced in the provision of primary care?
- what are the ways and means to look at the redistribution of primary care providers to address services and support services?
- how may primary care health providers play an enhanced role in the promotion and prevention of disease for specific populations?
- what are the mechanisms to link providers with the community?
- is there current research to support evidence-based decision-making goals?
- what incentive can be employed for payment methods and modalities to enhance cost-effectiveness, quality care and appropriate resource allocation?
- how can information technology be used in a primary care setting to improve quality of care and the management of data sets?

These are but a few of the issues addressed in the report and form the basis for a thoughtful and stimulating discussion for organized medicine, consumers, and government on the provision of primary health-care services.

### **The Definition of Primary Care**

There have been a number of definitions of primary care. The World Health Organization used over 100 words to describe primary care in its 1978 Alma Ata Declaration, an excerpt of which appears below:

"Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the

country's health care system of which it is the nucleus and of the overall social and economic development of the community...It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process...Primary Health Care addresses the main health problems in the community, providing promotive, preventive, curative, supportive and rehabilitative services accordingly."

The Institute of Medicine Committee on the Future Definition of Primary Care defined primary care as,

"the provision of integrated accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients and practising in the context of family and the community."

Both of these definitions include a number of common elements. Primary care may be defined in terms of the provider responsible for the service; it may be considered as a particular level of service provision as opposed to secondary or tertiary care; or it can be defined as those services provided at the point of first-contact. A fourth way of considering primary care is that of a practice environment, rather than a set of services or a specific professional discipline. With the goals of accessibility for all first-contact care; comprehensiveness or the ability to handle a number of problems; coordination of service provision; continuity, and accountability.

### **Primary Care Components**

The desirable features of primary care include:

- first contact
- continuity or longitudinality
- comprehensiveness
- coordination
- family-centredness
- community-orientation
- accountability

Primary care is frequently perceived as the point of first contact with the health-care system. This could involve an assessment by a physician, chiropractor, optometrist and others at a separate facility. The need for primary care services is identified when the public must access the system. Each year, 75-85% of people in the general population require only primary care services. In other words, referral to secondary care settings or short-term consultations account for only 10-12% of patient services, and referral to tertiary-care settings only 5-10% annually. The key to the first-contact process involves reasonable access to the provider of choice by the consumer.

The second important component of first-contact care is that of the continuity of ongoing care, that is, person-focused care over a period of time which is assessed by the degree to which the provider and population agree on their mutual association, and also to the extent to which individuals in the population relate to that provider over time for all but their referred secondary and tertiary care. This is frequently referred to as the longitudinality of care.

Comprehensiveness requires that the primary care provider offer a range of services broad enough to meet all the common needs in the population.

Coordination requires an information system that contains all of the patients' relevant health-care data. At present, this referral is frequently made by means of hard copies (i.e., letters), but the speed at which information and data processing is done today would indicate that the need for restructuring is apparent. This will impact on the patient/doctor relationship and will therefore be addressed in a later section of this report. Nevertheless, it is a key role for the provider to be involved extensively in the coordination role.

Finally to be addressed in more detail is the issue of accountability by both consumer and provider.

### **The Primary Care Provider**

Notwithstanding alternative approaches to the primary care environment, primary care is still most often defined by the type of practitioner who delivers it. In Europe and Canada, the primary care provider remains the general and family practitioner, whereas in the United States, the providers of primary care services extend to include internists, paediatricians, obstetrician/gynaecologists and psychiatrists. Indeed in Canada there are large systematic differences in the training experience of general practitioners and family practitioners, which also attests to the differences specifically in terms of outcomes for primary care provision. Primary care physicians are not solely responsible for a specific primary care approach, such as prevention, diagnostic and therapeutic services, health education, counselling, or even minor surgery, since such alternative health care providers as midwives and nurse practitioners, as well as speciality care physicians, such as cardiologists and ophthalmologists, emphasize a primary care approach.

Primary care is perhaps usefully seen as,

"an approach to providing primary care rather than a set of specific services, with its practitioners or facilities judged on a degree to which they implement this approach."

Focusing on the approach to primary care allows for different types of practitioners, nurses, physicians, and others, to function as teams competing for the designated provision of primary care services. Training programs in primary care must emphasize different aspects of the practice of primary care in order for their graduates to excel in the provision of such services.

### **Physician Training**

The current training program and principles endorsed by the College of Family Practice of Canada (CFPC) exemplify this goal by attempting to systematically train physicians to emphasize those aspects of practice. In 1993, the College of Family Practice implemented the requirement that all graduates in primary care must complete two years of postgraduate training. The OMA continues to wholly endorse this training requirement.

### **Physician Resources**

What is the appropriate number and distribution of primary care providers required in a general populace? A broad range of opinions differ on the proportion of providers necessary for the adequate provision of primary care. The goal in Canada has been to attain an approximately even split between GP/FPs and specialists, whereas in the United Kingdom, the proposed target has been 70% primary care providers. At the present time, reliance is on demand-oriented projections that reflect the current state of practice, rather than rational planning. There are two reasons for this occurrence: first, there is a general lack of epidemiological data pertaining to the community required to perform such calculations. In the future, such information may be available as the result of improved data collection from new information technologies. However, the current best guess' is that 75-85% of the general population will require only primary care services within a period of a year. Secondly, the projected requirement ratio of 75-85% needs to be tested empirically, and will vary from place to place depending on the cultural milieu. For example, fewer primary care services are sought by or received by the those residing in northern Ontario in comparison to the populace in southern Ontario. This difference may be due to the fact that the population requires and is more demanding of the health-care system, simply because it is more accessible in southern Ontario.

There can be little doubt, however, that primary care services based on care provided by general and family practice physicians is certainly less costly than primary care that is provided by specialists. Rosen et al has shown that both the appropriateness and the outcome of tonsillectomy and adenoidectomy were better when patients were referred to specialists by primary care physicians than by self-referral. In 1945,

Bokken demonstrated the threshold effect, which in simplistic terms means that self-referred patients frequently have a higher rate of interventions than referred patients.

Another, but not intuitively obvious problem with determining the number of personnel required for the delivery of primary health-care services is the increasing sophistication of populations. It is evident from the consumer movement that there is now more choice in the type of primary care specialist for the problems facing the public as either patients, clients or consumers. For example, back pain and headache are frequently treated at the patient's election by the chiropractor as first-contact care.

Furthermore, the primary care provider is often presented with patient health concerns that are not, and may never be, resolved through definitive diagnosis. This may result in the need for ongoing support and management of the individual in his or her social setting. An example of this is spousal abuse. Studies reveal that 28% of abused women presented to their family practitioners with bruises, headaches, broken bones, and undiagnosed vague abdominal pain. The approach to such a problem is not limited to the biological disease itself, and may never be resolved as a definitive diagnosis.

### **Cost-effective Alternative Health Care Providers**

Cost-containment continues to be a goal of health-care restructuring. As a result, considerable research has evolved around the cost-effectiveness of substituting primary care doctors with alternative health care providers.

A review of the literature by Maynard and Richards suggests that between 30-70% of tasks performed by doctors may be performed by nurses.

However, the authors emphasized that it is very difficult to generalize about the results of effectiveness and cost effects. According to the authors, merely substituting a "lower-grade" provider to do the same task as a "higher-grade" provider can not be considered in terms of unit cost of labour alone. Maynard and Richards suggest that even if the outcomes are the same, the time taken to perform the tasks and subsequent number of tasks performed may be substantially different. Consequently, policy directions must be carefully considered before adopting such substitutions.

Recognizing the excellent work undertaken by Dr. Tim Kerr for the Canadian Medical Association on the cost-effectiveness of substitution of care, the Physician Advisory Group has not elaborated further on this topic.

### **The Relationship of Primary Care Physicians to Other Non-Physician Providers**

The relationship between physicians and other providers will depend upon the setting in which primary care is given, the nature of the primary care services, the nature of the scope of practice, and the skill sets of all caregivers involved. This will be dependent not only on the relationship and the skill set defined in legislation but also on the particular interest and abilities of individuals working within the general scope of practice of the profession.

The relationship between physicians and allied health care providers, and the contribution of most other providers, were described in detail in the late 1980s in Perspectives. Most of the relationships defined in that publication remain unaltered in the broad spectrum of care in Canada. The Regulated Health Professions Act (RHPA) provides another basis for understanding the various skill sets of providers, but it is much less able to accurately describe the present activities and inter-relationships between professionals. Rather, it presents a baseline or a minimum number of activities which may be performed by various providers.

## Four Models of Care

### 1. Team

The team approach to care can provide excellent service for a patient under many circumstances. Teams at their best work as a group to find consensus in the interests of patient care and patient safety. With one person acting as a meeting coordinator, input is sought from the various providers in order to reach a final recommendation on the care provided for the individual. This often works best where the condition being treated is chronic, and there is no curative or final outcome. There may be a multiplicity of factors involved in patient care which require different skill sets to be brought to bear, and all of the factors from the various bodies of expertise need to be balanced and meshed into a coherent care plan for the patient.

The team approach is a particularly appropriate model of care for palliative and chronic disease situations. The ongoing care of the patient requires continual re-evaluation of the various factors affecting care, and integration synthesis into a continuous unfolding tableau of care.

### 2. Most Responsible Provider

In many situations, primary care may be carried out by one provider. In these cases, the most responsible provider assumes full responsibility for the condition of the patient. This provider may be the final common pathway for decision-making and recommendations for care due to the nature of the condition. This entails assuming a great deal of responsibility, and requires the continual vigilance on the part of the most responsible provider to ascertain whether other skill sets as required are being used and integrated into the care plan.

Midwives, for example, assume a high degree of responsibility for their clients. Midwifery, a newly-regulated profession in Ontario, requires practitioners to be fully cognisant of when to avail themselves of the skill set of other professions and when to recommend a shift of primary care to either a secondary care level or to another primary care provider.

### 3. Most Responsible Physician

In many circumstances, a specific physician assumes the primary position of care for a patient and is consequently designated the most responsible physician. This frequently occurs in situations where the health condition of the patient is of a pressing nature with such overriding medical implications that the medical condition must be addressed as a matter of primacy.

The broad training received by physicians and the wide scope of practice sometimes makes them the provider best able to synthesize various inputs and integrate them into what may be a very challenging medical condition. The more pressing the medical health condition is, the more important it is to have a clearly integrated care plan with the activities of other providers evolving around a particular patient's medical condition.

### 4. Co-existing

In reality, health care is usually provided by a shifting blend of the above three models. Primary care should not be viewed as the care of an episode, but rather the ongoing and continuous care of a person's overall health and illness pattern to maximize the well-being of the individual. This is especially true with respect to terminal illness and palliative care. Episodes in the tableau of continuous care might require the shift from the team concept to direction by one most responsible provider until a new condition, stability or chronicity is achieved. For example, the inter-position of an acute surgical emergency may require all other physicians, nurses, physiotherapists and so on to be completely subject to the direction

of a surgeon for a short period of time in the interest of rigid and careful coordination through a single source in the interest of patient safety.

Following the acute condition, there might be a shifting locus as to the most responsible provider depending upon the condition at hand. However, the family physician is often the provider charged with the overall coordination of primary care activities.

### **The GP/FP Brain Drain**

The importance and emphasis of primary care within the United States' health-care system has resulted in explicit interest in primary care physicians in Canada. Indeed the appetite of managed care organizations for Canadian primary care physicians may be insatiable and will continue to be a critical factor in attracting primary care physicians from the present practice environment in Canada. The most recent data illustrating the net worth incomes of family physicians in Canadian dollars across the United States are included for consideration. There are some suggestions that the number of hours of work may be reduced by as much as 33% for American physicians in comparison to their Canadian colleagues. There can be no doubt that physician autonomy is sacrificed to some degree in the managed care setting, but there is also a high level of satisfaction with those who are content to make the change. Information is also included in the Appendix regarding the number of physicians who emigrated from Canada for perceived greener pastures' in the United States.

### **GP/Specialty Ratio**

Studies have repeatedly confirmed findings which reveal that the ratio of primary care physicians to population appears to be the only consistent predictor of age-specific mortality rates, even with the exclusion of such characteristics as rurality, the percent of female-headed households, education levels, minority status, and poverty rate. In addition there is an increase in effective care, coupled with a decrease of costs, as demonstrated by Welch et al, who found that expenditures for health-care among the elderly in the US, all of whom had insurance under Medicaid, were lower in areas of the county with higher ratios of primary care physicians to the population. In addition to this finding, at the clinical level case-control studies of hypertension have shown that those who are able to receive treatment for their uncontrolled hypertension through a primary care source, such as a physician or a facility, have reduced health-care costs and improved health-care outcomes. Indeed there is concurrence that countries with health-care systems that are more oriented towards primary care achieve better levels of health, higher satisfaction with health services among their populations, and lower costs of services overall.

### **The Gatekeeper Function**

Much has been written about the gatekeeping function as a fundamental aspect in primary care and about who should assume responsibility for this role as it relates to improving health-care status. The first contact feature of primary care implies that patients do not visit specialists without a referral from their primary care providers. The training and investigational imperative of specialists require a rational screening mechanism such as physician referral to ensure efficient and effective use of health care resources. Conversely, the potential negative effects of the gatekeeping function include the risk of under treatment or the failure to refer when appropriate to speciality care.

Frequently, debate about the gatekeeping role has led to discomfort with the terminology employed. The profession is in fact far more comfortable with the term coordinator in that the physician is responsible not only for the referral, but for the ultimate follow-up. The primary care physician can coordinate and support the patient's encounter with the secondary and tertiary levels of care, and thus help to alleviate anxiety and ultimately improve the clinical outcome. Although critics imply that gatekeeping also has negative connotations, such as undertreatment through failure to refer, Starfield et al suggest that such adverse effects are not in fact problematic.

In some circles, first contact with respect to primary care is regarded as a necessary choice, and therefore incompatible with a competitive approach to the delivery of health-care systems. Indeed, in a subsequent section of this paper it is suggested that rostering with the primary care provider of the consumer's choice is essential for patient accountability. A reasonable compromise to ensure free choice would be to maintain a sufficient supply of primary care physicians to permit such set choice as well as marked choices for primary care physicians' referral patterns in speciality care. Significant consideration must be given to particular areas of need, such as women's health and care for the disabled, in order to permit consumer choice and not impede or reinforce previous problems noted with the paternalistic orientation of provider care.

Comparisons of primary health-care service with a primary care orientation is associated with lower cost of care, higher satisfaction by the population, better levels of health, and lower medication use. This conclusion has emerged from a study in eleven countries in the mid- to late 1980s. As stated previously, there are six features of primary care which are recognized in a comparison of international health-care provision: first-contact: continuity: comprehensiveness; coordination; family-centredness; and community orientation based on community epidemiology.

Table 1 illustrates primary care rankings and includes an outcomes indicator. Although Canada remains number one in terms of satisfaction for the patients served, it remains somewhat intermediate with respect to the primary score and the four rankings. Of note, there were fourteen health indicators considered in the ranking, namely: low birth weight; neonatal mortality, postnatal mortality, total mortality, and life expectancy for males and females separately at several ages. The committee also acknowledges the importance of the report *Bringing the Pieces Together* by the five Chairs of Family Medicine, and the critical data that support primary care, particularly the five Tables included in the report. Notwithstanding these laudable statistics, however, Starfield has ranked countries according to their primary care score and compared them with outcome indicators illustrating the total health-care expenditures per head. Canada has characteristics of both and is correspondingly intermediate.

There has been considerable interest in the differences between countries included in the three groups illustrated in the Table, that is, countries with market health care systems, which are driven by demand, for example, the United States and Canada, and the other grouped countries in which the supplies are regulated according to the perceived needs of the resources, such as the UK and Denmark. Because Canada has characteristics of both, its score falls in a corresponding intermediate subgroup.

### **Health Policy Framework for Primary Care**

In order to have an overall framework to determine appropriate models, payment mechanisms and organizational structures, the committee sought a policy direction appropriate for the 1990s. After completing a review of the literature, the committee adopted as a guide the policy direction expounded by Shortell and Reinhardt in *Health Policy Framework for the 1990s*. It is not within the scope of this discussion paper to review policy direction or expand on the points presented, but these principles have been incorporated into the report. The seven principles are:

- 1.health policy changes should be incremental and interdependent in their effects on other policies;
- 2.health policy should be patient-central;
- 3.health policy should articulate the balance between communitarian values in health insurance versus individual wishes and expressions of autonomy;
- 4.health policy should promote explicit clinical management systems;
- 5.health policy should promote fiscal and clinical accountability;
- 6.health policy should have flexibility to encourage innovation in accountability criteria and provider incentives;

7.health policy should anticipate implementation issues, mid-course corrections, and input from those directly affected.

### **Integrating Workplace Health in Primary Care Reform**

Traditionally, physicians in the primary care setting have concentrated on diagnosis and treatment of illness and injuries. A comprehensive health care model was detailed in the June 1995 issue of the Ontario Medical Review. This model included health and wellness promotion, prevention, diagnosis, treatment, rehabilitation, counselling and advocacy, but did not address one of the strategic issues confronting organized medicine with respect to the workplace, that is, the element of "return to function, return to work." This issue must be emphasized separately in any new model to clearly identify to society in general and to patients in particular that treatment is not complete or successful until the patient's return to gainful employment or to previous function has been accomplished.

#### **The following is a summary of the differing perspectives of the current labour environment.**

1.Primary Care Physicians. Physicians are frustrated with a process that does not fully support their patients. They face fierce competition from allied health care practitioners, and are threatened by a potential loss of income as a result of the current fiscal crisis.

2.Employers. In the 1980s, recognizing that the WCB was poorly managed and that the amount of unfunded liability was increasing, advocacy groups formed to respond to this issue. The focus of blame for this increasing debt burden was directed at physicians because of their perceived compliance in the casual provision of doctors' notes, as well as their general lack of awareness regarding the cost to industry when they did not promote "return to work function."

3.Government. The Federal government is concerned with the injury incidence rate. In Canada, 1.2 million workers are annually injured on the job at a cost of \$5.3 billion in associated pension and benefits, in addition to the \$2.2 billion expended on physician services.

4.Patients/ Workers. The inability of injured workers to return to their former level of function or timely return to gainful employment results in prolonged recovery, which may in turn lead to loss of self-esteem and promotion of chronic illness behaviours.

5.Private Insurers. Private insurers have recognized the need for increased physician support and participation in bringing workplace-related health costs under control. In a 1995 report, Liberty Mutual stated that:

"organized medicine has to address the question of whether physicians wish to expand their knowledge and expertise and competently take on an active role in early return to work or whether they would prefer to limit, minimize or completely give up this role with an associated loss of power and source of income."

Positive feedback to the OMA Policy on Timely Return to Work indicates that the OMA is moving in the right direction by supporting this concept. Society looks to the leadership of the OMA to further develop and integrate this concept in the reform of the physician's role. Primary care physicians are the best coordinators for patient care because they follow the suggested comprehensive model and treat patients in accordance with the most current scientific evidence.

Gaps in the medical model that need to be addressed include the following:

1.Treatment results for a patient's illness or injury should not be considered satisfactory until "return to function return to work" is achieved (i.e., care-mapping).

2.Organized medicine must address the lack of education on worker rehabilitation and at all stages of a physician's career.

3.As a result of current social policy and economic changes, physicians must identify non-OHIP revenue sources.

4.Physicians must respond to feedback from consumers in order to be effective care coordinators, and must be willing to implement continuous quality improvement to the primary care system while maintaining the highest ethical standards.

The role of physicians is constantly expanding. Physicians no longer focus solely on the provision of medical care for their patients but in response to patient demands are forced to assume a greater role as patient advocates. Because of changes to the social fabric of society due to increased unemployment and other stressors affecting the physical, emotional and mental health of the population, patients have increasingly turned to their primary care practitioners to supply the social security net desired. This is a crucial issue in today's environment of unrest and uncertainty: since work traditionally comprises over half of an employee's waking hours, lack of work or insecurity regarding job retention can have a devastating effect on the individual's sense of value and self-esteem. When this sense of insecurity is compounded by illness or injury, inappropriate prolonged absence from work is a significant problem which generates an enormous human and financial cost to society. Absenteeism causes loss of control and predictability in the workplace and an escalation of employee-replacement costs which is unacceptable in today's fiercely competitive business environment. Regardless of whether business programs are directly or indirectly tax supported, "benefit programs must be free of abuse or mismanagement if a healthy economic/business/employment climate is to be sustained."

It is imperative that the impact on all parties affected by illness or injury must be minimal. The timely re-integration of injured employees into the workplace is dependent on the availability of proper medical support and a flexible, informed and supportive work environment.

To facilitate this process, and in an effort to reduce the financial and human toll occasioned by illness and injury, the OMA developed a position paper in support of timely return to work programs and the role of the primary care physician. The timely return to work model of disability management developed encompasses the following elements:

1.When the patient is off work due to sickness or injury, the patient would bring an employer's proposed return to work program to his/her physician.

2.The physician provides objective reports on impairment (according to the World Health Organization definition, impairment is "any loss or abnormality of psychological, physiological, or anatomical structure or function"), medical restrictions, and other supporting advice to the employee.

3.The employer offers the employee a plan for returning to suitable work in a timely fashion.

4.The employee and management have a primary responsibility to initiate a timely return to work which incorporates input from the physician.

5.Management control of "sick leave" abuse is through work place "culture" and timely return to work programs, not medical certification.

In conclusion, as stated in the OMA policy,

"the timely return to work model of disability management seeks a shift away from control of abuse by a passive reliance on physician certification to a proactive model where employee and employer work together and use objective medical input from the employee's personal physician."

Primary care reform should focus on the roles best-served by primary care physicians, recognizing that some of these are as have not been emphasized in the past. As stated by Evans, Barer and Marmor in the article, Why are some people healthy and others not?,

"The pace of change varies with the degree to which prevailing system of beliefs has found expression in the structure and practices of professional organizations whose participants' interests are threatened by change".

The summary of the role of the occupational and environmental physician in the timely return-to-work process is appended to this report.

### **Acute Care Shift: Will There be a Crisis?**

The restructuring program of the Metro Toronto hospitals is illustrative of the complex, intensive endeavours occurring in the hospital sector to address fiscal constraints. The forty-four Metro hospitals have a combined staff of 54,000 full-time and part-time employees; the combined budgets now exceed \$2.9 billion. With the announcement of the cuts in transfer payments in early November, which resulted in 10% reductions in each of the upcoming fiscal years and combined with a 20% reduction in provincial funding, it is entirely feasible that acute care providers will be faced with a crisis in the community. The impact of such reductions at the community level will be experienced as episodic illness, previously addressed in the emergency setting, as well as the lack of access to institutional-based care because of reductions in hospital admissions and will shift the burden of acute care provision to primary care physicians. Although hospital restructuring has not been addressed in detail by the Physician Advisory Group in this discussion paper, it is an integral component of any health care reform. When reorganizing the manner in which health care services will be delivered to consumers, a comprehensive reform initiative with strategic alliances at all levels of care will be essential in order to prevent such a crisis from occurring at the local community level. Primary care agencies staffed by physicians and allied health care professionals may well be the future site of delivery of health care in urban centres.

### **Mental Health Care Reform and the Role of the Primary Care Provider**

Mental health care services in Ontario have come under close scrutiny in the past few years. Initiatives launched by the previous government to reform mental health care services unfortunately did not include consideration of the role of the family practitioner in the delivery of these services in the primary care setting. As identified by the OMA,

"government has not to date adequately addressed the means by which sick people will receive treatment under a reformed system. It also fails to acknowledge that physicians play, and will continue to play, a vital role in the treatment of mental illness."

Meeting the needs of patients with respect to mental health care is, however, an integral part of primary health care. The prevalence of psychosocial problems in the ambulatory care setting population is approximately 40%, while the prevalence of psychiatric disorders is slightly lower at 25 percent. The family practitioner is the sole provider of care for approximately 40% of these individuals.

Unfortunately, although the prevalence of mental health problems is high, the detection rate by primary care providers for mental health problems in a community remains relatively low at 50 percent. This rate does increase substantially if the individual has either had a previous history of psychiatric disorder or if the family physician is knowledgeable about how to access appropriate resources to manage psychiatric problems. The treatment and support provided by family physicians to patients requiring mental health care can be enhanced by means of a partnership with psychiatrists in the provision of advice and direction with respect to patient management plans. The OMA concurred with the findings of the Graham report, which identified the services and supports deemed essential to achieve a comprehensive, community-focused mental health system. Items not incorporated from the Graham report included identification, treatment and community consultation - activities cited by the OMA as essential to adequately care for mentally ill persons.

In many communities, psychiatric referral rates are very low, reflecting a deep frustration on the part of family physicians who find access to mental health services for

their patients extremely difficult. Long waiting lists, especially for private psychiatrists, prevent many patients from accessing specialty services in a timely manner, and consequently place a greater burden of care on the primary care provider. In addition, some community psychiatrists have avoided securing hospital privileges and have opted not to participate in emergency case evaluation for serious acute mental illness. A recent study utilizing focus and discussion groups of family physicians located in seven communities in the province identified significant frustration and physician dissatisfaction with respect to the lack of access to psychiatric services in comparison to other medical specialties.

The consumer movement has had a significant impact on psychiatric service access. The ability of patients to self-refer to mental health service units has resulted in a deterioration or even discontinuation of care coordination by the primary care physician. If the patient chooses not to disclose such information to their physician, the family physician may never be aware that the self-referral has either occurred or that a patient is taking psychiatric medication. US studies have revealed, however, that patients may prefer to be treated in the office of their own family physician if a comfortable doctor/patient relationship is established. Additional studies suggest that enhanced training of the family physician and reasonable access to pertinent information with respect to managing the patient's psychiatric illness will enhance the family physician's ability to provide much-needed psychiatric care.

The following observations have been made by the Physician Advisory Group in regard to the provision of primary care services for mental health care.

#### 1.Primary Mental Health Care Services

Primary mental health care services are appropriately provided by family practitioners in an ambulatory setting. Every attempt should be made to educate primary care physicians to be receptive to participate in the delivery of such services to their patient population.

#### 2.Secondary Mental Health Care Services

Secondary mental health care services are accessed through a referral process by the primary care provider to a community-based psychiatrist. Free-standing mental health clinics may also provide an access route to secondary psychiatric services should the patient be uncomfortable in seeking a referral from their family physician. Every effort should be made, however, to coordinate the referral process through the primary care physician if the patient is comfortable with the release of such information.

#### 3.Tertiary Mental Health Care Services

Tertiary mental health care services are provided in either a tertiary hospital setting with a psychiatric team, or a specialized psychiatric service clinic. These services may also be accessed through a referral process.

In conclusion,

1.the primary care provider must play a central role in ensuring the delivery of community mental health care services and securing appropriate referrals when necessary.

2.The primary care provider must be able to access support and advice from secondary and tertiary psychiatric specialists with respect to cases they are directly managing. This access may be in the form of telephone consultations with psychiatrists or visits in the office setting.

3.It is essential that psychiatric services or programs for secondary and tertiary psychiatric services are available that are responsive to the needs of the primary care provider and patients as required.

4.New models and concepts to secure access to mental health care services at the time of need must be explored by primary care and specialty providers alike

in order to reinforce the skills of the family physician and their specialist counterparts to enhance service provision.

5.The Physician Advisory Group supports models that improve continuity of care and promote seamless access to appropriate support, advice and back-up when available.

## **GP/FP Terminology**

The abbreviation GP/FPs' is used throughout this report to denote general and family practitioners. Although no distinction has been made between the two, some clarification is required.

The distinction between general and family practitioners can be subdivided into four categories:

### 1.Training

The Ontario College of Family Physicians provides a certificate of proficiency in the practice of family medicine following a two-year training program and the completion of an examination. Currently, physicians who do not complete a certification in family practice are unable to practice as they are not granted a license. Physicians were previously able to practice with licensure following the completion of one year of residency training in the area of general and family practice. Regardless of whether the physician has certification in family practice, many physicians have areas of restricted speciality and interest, such as GP psychotherapists.

### 2.General versus Specialty Practice

The category of GP/FP may simply refer to all non-specialists.

### 3.Professional - Political Perspective

From the perspective of the Association, the OMA Section on General and Family Practice is comprised of the combined representation of all non-specialist practitioners. The Executive of the College of Family Practice meets with the Section to discuss policy decisions. While much of the Section's representation is comprised of Family Practitioners, the OMA recognizes that there is additional representation from primary care providers with sub-specialty interests in the GP Psychotherapy Section, the Section on Emergency Medicine, and those representing walk-in clinics. In summary, the representation of primary care providers within the OMA is an extremely heterogeneous mix similar to that of speciality providers

### 4.Continuity and Comprehensiveness

For the purposes of this document and regardless of whether or not the physician is a general practitioner or family physician with certification, the OMA primary care reform strategy refers to those physicians who provide a broad range of primary care services which incorporates the twin concepts of continuity and comprehensive care. The purpose of this discussion paper is to serve broadly all primary care physicians as important cost-effective health care providers.

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