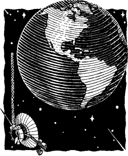

Features

Chroniques

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Solutions prove elusive as Ontario seeks alternatives to FFS in remote areas

Michael OReilly

The search for a lasting solution to Canada's chronic medical staffing problems in rural and remote areas continues to elude the people sitting on both sides of the negotiating table.

For Dr. Michael Sylvester, there's nothing to negotiate — the only issue is physicians' quality of life. "All we want is a life that is livable," says Sylvester, a family doctor in the small Northern Ontario town of Marathon. "Towns like ours sell themselves as terrific places to live and work, which they are. But the reality is that once they move there, they don't have the time to enjoy the very things they came for."

Perhaps Graham Scott, former Ontario deputy health minister and author of the 1995 "Scott report" on the crisis in rural medicine, said it best: "What's a rural doc? Someone who does 3 times the number of procedures as their urban counterparts, works longer, makes tougher decisions and tougher calls, and gets paid less."

In recent years Ontario has made great strides in the search for a permanent solution. However, Dr. George Macey, a dentist who serves as vice-president of the Northwestern Ontario Associated Chambers of Commerce, explains that the primary thrust of the Scott report was to get rural and remote physicians off the fee-for-service [FFS] treadmill and onto a more sustainable method of payment. "FFS is simply not sustainable," he says. "It inevitably leads to burnout and crisis. We want to move beyond that, but we need a change in public policy at the provincial level."

Ontario is offering some alternate payment plan (APP) options to remove rural and remote doctors from FFS payments. The first, a community-sponsored contract, is aimed at towns with 1 or 2 physicians. It guarantees a doctor a set income when FFS billings drop below a minimum.

This model is successfully solving the problem for many tiny communities, and for larger centres FFS continues to work well. But for towns in the middle — those needing 3 to 7 doctors — the story is somewhat different because of the revolving-door problem. Doctors come and go at a dizzying rate because, according to Macey, the system is not geared toward long-term service.

"It comes down to a critical-mass argument. We need X number of physicians in each community to make health care in our towns sustainable over the long run. At this time the ministry only seems interested in talking about minimum levels, not sustainable ones."

For these "middle communities" the government is offering a globally funded group practice agreement (GFGPA). It provides primary care funds to a community group practice, which then pays its staff, including doctors, for their services. This is the model that Scott and doctors like Sylvester, who heads a group called Physicians for Northwestern Ontario (PNO), are asking for. But while the principle is sound, the details leave the doctors wanting more.

"Their numbers are based on a minimum level of physicians," says Sylvester. "We want a sustainable number. What's the point of putting time and effort into a system that is doomed to fail once again?"

Sylvester says Ontario's GFGPA offer is based on having too few doctors per community. According to PNO, the government is using data from the province's Underserviced Areas Program. "These are minimum levels, not sustainable ones," Sylvester complains. "They were never meant to be used in this way."

Despite repeated attempts, the Ministry of Health would not discuss the basis for the GFGPA. The only response came from communications coordinator

Dr. Bill Sutherland: "Nobody down there really cares about us"

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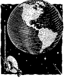

Suzanne Violette, who said the ministry would not discuss these negotiations but would fax an official brochure.

The GFGPA experience to date seems to bear out the problems outlined by doctors. The first, and until recently only, GFGPA was signed by a group of doctors in the small town of Manitouwadge; within months 2 of the 3 doctors had left, heading for greener pastures in towns covered by the other alternate payment plan, a community-sponsored contract.

"They left because the workload, overhead expenses and income were significantly better than what we got out of the GFGPA," explains longtime Manitouwadge physician Bill Sutherland. He says he tried to negotiate a better agreement with the ministry, but officials were unwilling to change a thing. So, with literally years of unsuccessful recruitment behind him, he signed.

The GFGPA has helped Manitouwadge recruit doctors, but keeping them is another matter. "It wouldn't take a lot of changes to make it work," says Sutherland. "The money is certainly there in the amount they spend on locums. I just think nobody down there really cares about us in the North."

To deal with this problem, the 38 doctors belonging to PNO, in cooperation with the Northwestern Ontario Associated Chambers of Commerce, have developed a "Northern Vision" of primary care services in rural and remote areas. It presents a new way of thinking about physician services in remote areas and raises the principle of a "critical number" of doctors. It also argues that rural medicine is different, and in many ways more demanding, than practice in urban centres. "We wanted to shift the government's attention toward a sustainable solution, not just a continuance of the crisis-to-crisis system we have now," explains Sylvester.

Ontario Health Minister Elizabeth Witmer received this "vision document" in a meeting last May, and Macey says she appeared to agree with the philosophy. In the end, however, she said the ministry had no money because the Ontario Medical Association (OMA) refuses to convert any funds from FFS to APP.

"Conversion" involves shifting money from one pool of funds to another. The current OMA agreement states that there shall be no conversions from FFS to APP. However, when the document later discusses the fast-tracking of APPs, the agreement refers to money "from fee-for-service conversion."

"As I told the minister, it is a tad muddy," says Macey. "This is the issue we seem stalled on. Everyone says we're on the right track, but when it comes to money they point the other way. We're like the ping-pong ball between the OMA and the ministry."

"What's a rural doc? Someone who does 3 times the number of procedures as their urban counterparts, works longer, makes tougher decisions and tougher calls, and gets paid less."

Dr. Michael Thoburn, the OMA's executive director of professional services, says conversion is a "complex issue" that has remained unsolvable at the bargaining table. "In theory if I'm doing the same work and the conversion is correct, then I'm going to make the same amount of money and we can just convert it over to the APP pool. However, that's all in theory."

In practice, the OMA is concerned that APP doctors will see fewer patients, and the unseen patients will then be forced back into the FFS pool to be seen by doctors whose billings are already capped at a maximum amount. "Somebody somewhere is going to end up holding the short end of the [billing] straw."

The real problem, says Thoburn, is the out-of-date data used by the Underserviced Areas Program. He says the numbers may have been accurate "back in the days [when we were] workaholics who worked until we dropped dead," but they are no longer valid for today's physicians. Referring to 2 recent *CMAJ* articles (1997;156:1593-6 and 1998;158:1516-7), he said Marathon is a perfect example of this change.

In the end, however, Thoburn says it is not conversion or incorrect data that pose the main problem — he says there is simply a lack of will, and perhaps interest, on the government's part. "The size of the ministry is such that the bureaucrats who actually understand this complex problem are not at the level where they can make meaningful decisions. Once it gets there you have people who don't understand the problem, so nothing gets done."

Recently there has been some movement on the part of the government and OMA, and a few communities appear to be closer to signing an amended GFGPA. Mike Sylvester says he is pleased with the progress but fundamental issues must be resolved before PNO will come aboard.