Family Practice — World Perspective

Family-General Practice Models In Canada

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Canada is a vast country of 9.97 million square kilometers with a relatively small population of 28.8 million persons. Most Canadians live along the United States border and 80 percent live in urban areas. It is a multicultural country with two official languages, English and French.

The federal government in Ottawa includes an elected House of Commons and an appointed Senate. Health and education are largely under the jurisdiction of the ten provinces and two territories of Canada. Most tax revenue is accrued by the federal government, and there is a cost-sharing formula for transferring funds to the provinces and territories to support health care and postsecondary education.

Physician Resources

Fifty percent of the 55,000 physicians in Canada are family physicians, and they do almost all the primary care. The 16 medical schools graduate approximately 1700 new physicians each year.

Canada has a physician distribution problem, with physicians tending to concentrate in the urban areas. Family physician coverage in rural Canada is generally better than specialist coverage, but the country still relies too much on graduates of foreign medical schools to fill these vacancies. Each year approximately 500 international medical graduates who have not taken any training in Canada are licensed to practice in one of the provinces or territories.

Governments in Canada perceive that there are too many physicians. Recently, both undergraduate and postgraduate enrollments have been cut by 10 percent. The government approach has been to use raw data, and the medical profession currently is endeavouring to convince governments to adopt a more sophisticated approach that takes into account the aging population, the increasing number of women in medicine, and the fewer hours that physicians are working today than in the past.

Medical Education in Canada

There are 16 medical schools in Canada. Students have been able to enter the 4-year undergraduate program with a minimum of 2 years prior university education, but most now have a university undergraduate degree.

Canada has adopted a two-stream policy for postgraduate medical education. Students enter either a family practice residency program accredited by the College of Family Physicians of Canada or a consultant specialty program accredited by the Royal College of Physicians and Surgeons of Canada. Students are matched to postgraduate programs through the Canadian Resident Matching Service, which in 1994 successfully matched 92 percent of the applicants, with 76 percent obtaining their first-choice program. At the present time there are just enough positions to accommodate the graduating class, but future plans call for additional positions to allow for trainees switching streams, for remedial training, and for reentry from practice.

A minimum of 2 years of postgraduate medical training is required before being eligible for licensure, and a full portable license requires completion of residency training and certification by either of the two national colleges. The numbers of residency positions are adjusted to maintain the national policy of a 50:50 ratio between family physicians and consultant specialists.

The family practice residency programs are of 2 years' duration. Four months of elective time and the opportunity to take the 8 months of family medicine in different teaching practices make it possible for residents to plan their training to suit their anticipated practice setting. An optional 3rd year of training is available in emergency medicine, health care of the elderly, or special skills training for rural practice.

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Graduates of the family practice residency programs write the certification examination of the College of Family Physicians of Canada, which also provides a Certificate of Special Competence examination in emergency medicine for residents who complete the additional training. The current output of the family practice residency programs is approximately 700 per year. Certification is a category of membership in the College of Family Physicians of Canada, and certificants must maintain the qualification through a formal process of ongoing continuing medical education throughout their entire professional career.

The specialty programs of the Royal College of Physicians and Surgeons of Canada are 4 to 8 years in duration. The Royal College accredits specialty training in 52 disciplines. Comparable examinations are offered in the Province of Québec by the Corporation Professionnelle des Médecins du Québec.

In the 16 Canadian medical schools there are 511 geographic full-time family physician teachers and 85 full-time teachers from other disciplines. In addition there are 2178 part-time faculty, making a grand total of 2774 teachers, which is an impressive statistic considering that family medicine programs have only been in existence for the past 25 years. Because of its size, this group warrants special mention in a discussion of practice patterns in Canada. Teachers work in family practice teaching units in the medical schools, as well as in community-based teaching practices in a wide range of settings. In addition to resident teaching, the faculty members are involved in the undergraduate program and make a major contribution to family medicine research.

Practice Patterns in Canada

Most family physicians practice in groups. Canadian family physicians now work approximately 50 hours each week, 10 hours less than a decade ago. Group practice and better working conditions have made family medicine more attractive to women, and currently 59 percent of the women graduating from medical school choose family practice as a career compared with 42 percent of the men.

Most family physicians have maintained hospital privileges, but there has been a decrease in obstetrics to the point where now only 1 in 3 deliver babies. In general terms, the scope of a Canadian family physician's practice will vary inversely with the size of the community.

The urban family physician practicing in a large city will tend to do mostly office practice. Hospital involvement will be minimal, and the physician is less likely to do obstetrics. The emergency department will probably be staffed by full-time emergency physicians. Urban family physicians have the luxury to focus on special interest areas of practice and to refer patients more readily to consultants and other community resources. Patient care in the large cities is more fragmented because patients work some distance from where they live, multiple primary care providers are conveniently available, and the population has universal access to the Canadian health care system.

Family physicians in a suburban area or a medium-sized town with a community hospital will likely have more intact family groups in their practice. These family physicians will also have a busy office practice but are more likely to be involved in the hospital care of patients, might also work shifts in the emergency department, and are more likely to do obstetrics. There is usually an excellent working relationship with specialist consultants, but the local resources might be limited, which would require some patients to be sent elsewhere on occasion for specialized care. Family physicians in this setting are more likely to be involved with community activities and to serve as a resource to schools and community groups.

The family physician practicing in a small town or rural community might be the only physician available. The rural family physician is responsible for total care, which includes running the local hospital, delivering babies, looking after emergencies, and arranging transport for patients to specialty care when necessary. This physician might also provide some of the services normally provided by specialist consultants, such as anesthesia, Cesarean sections, and other surgical procedures. The major problems faced by the rural family physicians in Canada are being on-call too much, not being able to obtain coverage for holidays or continuing medical education, sometimes having to cope with medical problems beyond one's expertise, particularly when weather conditions prevent transport of patients, and being too closely tied to the community without enough time for personal and family life.

Canadian Health Care System

Medicare began in Canada 30 years ago. The present system is a single-payer model, administered by each provincial or territorial government, but having to meet the standards set by the federal government. Patients have first dollar coverage, free choice of physician, and universal access to the system. Physicians operating within Medicare must accept the fee established through negotiations between the medical association and the government as full payment for insured services. The health budget in Canada is approximately $60 billion per annum, and the physician share is approximately 15 percent.

Looked at briefly from the three perspectives of the payer, the provider, and the consumer, the following comments are relevant to the current situation in Canada:

- The government payer, particularly during this time of economic recession, is obsessed with cutting costs and is targeting physicians to take cuts in income and to justify the need for and cost-effectiveness of the services being provided. The payer is imposing caps on physician income, dropping from coverage some nonessential services, and restricting billing numbers to new physicians.
- The physician provider, working largely in a fee-for-service system, is caught between a hard cap on gross income and the rising costs of running a practice. Physicians are also under stress from increasing bureaucratic interference with the practice of medicine and increasing demands from patients who have no direct financial accountability for the services that they request.
- The Canadian public, as consumers of medical care, do not wish to lose the first dollar coverage, freedom of choice, and unimpeded access to the health care services that they need or perceive that they need. Patients feel threatened when economic constraints cause delays in accessing diagnostic or therapeutic services both in and out of the hospital. Canadians regard their health care system as a basic right and a cornerstone of the country's social structure.

Physician Income

There is a great deal of debate in Canada at the present time as to the best method of physician payment, particularly about the suitability of fee for service as a means of remunerating family physicians. In the fee-for-service model, family physicians earn an average of 70 percent of the income of specialist consultants. Fee for service is not a good method of payment for some of the valuable services provided by family physicians, such as health care promotion, patient education, and counseling. Furthermore, fee for service tends to reward the high-volume practitioner, and it is clearly apparent that volume beyond a certain point interferes with quality of care. Fee for service does have the advantage of maintaining motivation for family physicians to be available to their patients, particularly after hours, and to continue to provide a broad range of medical services.

Provincial governments in Canada have traditionally offered two alternative methods of remuneration, one a capitation system and the other a salary arrangement. Both have been monitored against the fee-for-service model and include penalties for patients seeking service elsewhere. Neither system has proved satisfactory, and relatively small numbers of family physicians have opted for alternative remuneration.

The College of Family Physicians of Canada came out with a proposal for a blended funding mechanism 2 years ago that attracted considerable attention, has recently been updated, and soon will be tested in pilot projects in different parts of the country. This proposal includes a basic salary that takes into account qualifications, experience, and scope of services offered. It also provides remuneration for office expenses and for the salaries of other health care professionals working with the family physician in a team relationship. The plan includes reimbursement for continuing medical education, vacation periods, insurance, and retirement pension. Motivation for the family physician is maintained by incorporating a resource-based relative value fee schedule formula and a fee-for-service component to reimburse for after hours and other "extra mile" services provided by the physician. The official position of the College of Family Physicians of Canada is that members should have the right to choose the method by which they are remunerated, and the current strategy is to make available viable alternatives to the existing fee-for-service system. Recent surveys indicate that 70 percent of Canadian family physicians would be willing to consider alternative methods of remuneration.

Future Trends

Family physicians will work in groups, which is particularly important in providing Canadian graduates to rural Canada, where the solo physician is no longer a viable practice option. Achieving this goal will require the amalgamation of existing small rural hospitals into regional centers capable of supporting a minimum of 4 or 5 physicians.

The team concept, in which family physicians work with allied health care professionals, such as nurse practitioners and midwives, will become a more prevalent group practice model. Job sharing, which is particularly attractive to women physicians, will be more common.

Managing information will become increasingly critical for family physicians and will force them to involve computer technology in both their patient care and continuing medical education activities. A commitment to quality assurance will be mandatory for all health care professionals.

Family physicians will need more knowledge of medical ethics and improved skills in patient education and advocacy. New technology is running ahead of our ability to deal with the ethical issues that it raises, and our patients are getting lost in the resulting confusion. Issues such as euthanasia will truly stress our coping skills.

As more medical education moves out into the community, and primary care research gains momentum, an increasing number of Canadian family physicians will become involved in teaching and research. This involvement will ultimately lead to greater professional satisfaction and improved quality of patient care.

Conclusion

Family medicine in Canada has been very fortunate. In a 1993 public opinion survey in Ontario (Decima Research), 97 percent of respondents indicated they had a family physician, and 76 percent stated that they were "very comfortable" with the relationship. The number of family physicians has never dropped below the 50 percent threshold, and our specialist colleagues have remained content doing consulting practice and not becoming extensively involved in primary care. As long as family physicians can meet the current challenges of health care reform, family medicine in Canada has a bright future.