—Randy Lee, MD, CCFP, FCFP
Program Director
Family Medicine Residency Program
The Scarborough Hospital
Department of Family and Community Medicine
University of Toronto
by e-mail

Time to establish a successful model

In response to the articles[1,2] on primary care reform in the February issue of *Canadian Family Physician*, we would like to highlight another model.

By working with multidisciplinary teams in community-based and community board–directed centres, family physicians in Ontario community health centres (CHCs) have offered comprehensive health care that directly meets the needs of the community for almost 30 years. They provide the "basket of services" identified by both the Provincial Coordinating Committee on Community and Academic Health Science Relations and the Family Health Networks as appropriate for primary care sites. Within the CHC model, family physicians are encouraged to practise in a manner consistent with the four principles of family medicine. They are able to devote their time to fully using and expanding their range of clinical skills within the physician-patient relationship and to being a resource to a defined community.

Traditionally, CHCs are well placed to deal with high-needs patients with complex physical and mental health problems, as well as patients who experience barriers to accessing primary care. Health promotion, prevention, and care can be practised in a patient's environment through use of team models and a community outreach approach.

A range of primary care services, including housecalls, nursing home visits, and obstetrical services as well as expanded services, such as chiropody, counseling by social workers, nutrition counseling, and lactation support, can be offered by various team members. Physicians in CHCs also have the opportunity to participate in developing and implementing innovative programs to promote good-quality primary care (eg, the community diabetes education program).

This model works well for physicians, patients, and communities. Physicians are paid a salary with stipends for on-call and obstetric and hospital work and receive a full benefit package. Holiday and study leaves are paid. There is administrative support for finding locum tenens physicians. Physicians can work together in larger groups to ensure a range of clinical services and on-call coverage are available.

In this era, when new and established family practitioners are moving away from providing comprehensive cradle-to-grave care to a defined population, CHCs offer an attractive alternative. They also offer an alternative for patients who are increasingly frustrated by the fractionation of care inherent in the fee-for-service system. We suggest that it is time to look at an established and successful model.

—Dona Bowers, MD, CCFP, FCFP
—Alison Eyre, MD, CCFP
—Frances Kilbertus, MD, CCFP
—Laura Muldoon, MD, CCFP
Ottawa, Ont
by e-mail

References

1. Mulligan PK. Capitation: the wrong direction for primary care reform [editorial]. *Can Fam Physician* 2002;48:233-5 (Eng), 244-7 (Fr).
2. Rosser WW, Kasperski J. Argument for blended funding [editorial]. *Can Fam Physician* 2002;48:236-7 (Eng), 247-9 (Fr).

...

I am a little perturbed by Rosser and Kasperski's[1] apparent naïvety in regard to human (ie, doctor) nature and health care funding. They seem to assume that the very doctors who are moving into walk-in clinics because of the easier lifestyle and better remuneration will suddenly come running back to full-service general practice just because the payment model (but not necessarily the pay) is different.

Surely the simple way to entice these same people into making housecalls, hospital visits, and doing obstetrics and complex patient care is to adequately reward this type of work. I think most will agree that, if the fee for a housecall was dramatically increased, the market would respond by closing the walk-in clinics and having teams of doctors driving around (or even being driven) armed with their doctors' bags and cellular telephones. Surely this makes more practical sense than trying to change a whole system to one that is producing no better results (and certainly no better doctor morale) elsewhere.

—Paul Mackey, MBBS (MELB), DRANZCOG, DA (UK), CCFP, FRACGP
Fort St John, BC
by e-mail

Reference

1. Rosser WW, Kasperski J. Argument for blended funding [editorial]. *Can Fam Physician* 2002;48:236-7 (Eng), 247-9 (Fr).

...

I would like to express my grave concerns about the proposed expansion of family health networks in Ontario and of primary care reform in general.

The family health network model looks good in theory, but in reality it is a disturbing blueprint for large-scale reform. Its stated intention is to support doctors to provide comprehensive care in a manner that will be beneficial to patients and financially remunerative to family physicians. The success of this model, however, is based on the premise that most patients are relatively healthy and will not put too great a demand on their family doctors. But is this realistic in a population that statistically is aging and thus is characteristically going to be predominantly female, low on financial resources, and chronically ill?

As a family doctor working on the front lines of patient care, I am terrified by this model. I serve patients who are, by the nature of their health

FOR PRESCRIBING INFORMATION SEE PAGE 992 ➛