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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 Provinical 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.

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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).

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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.

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

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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

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care needs, tremendously time-consuming. I see patients suffering from HIV disease, drug addiction, chronic illness, psychiatric problems. I see patients whom many doctors do not want to see. They would certainly not want to see my patients under the capitation model that the family health network espouses. I provide good and essential care. And I am not alone.

I spend the necessary time with each patient, and I see people as frequently as is necessary. This will not be rewarded under the proposed model. Because of the longer time that I spend with patients, I have a small practice. I could not possibly manage 2000 patients with high needs. The proposed family health network, while it does financially "nod" to the timely demands of comprehensive care, is helpful only in practices that have enough "easy" or healthy patients to balance out the more demanding ones. But my practice, as in many inner-city centres, does not come close to balancing out. Health policy research has shown repeatedly that low-income people have more chronic illnesses and as a result, require more health care services. Even with the financial incentive provided for more demanding patient loads, I would not be able to afford my private practice.

While I might find more reasonable compensation at a community health centre, my patients would have to find a family health network doctor who would be able to accommodate their greater needs. These patients would find, furthermore, that community health centres, which are principally oriented to serving complex patients, are too busy to accommodate more patients. Even now, before these changes take place, many community health centres are unable to take on new patients, except, for example, earmarked populations, such as the homeless.

The fee-for-service model could be reformed. I suggest that OHIP codes be updated to reflect time-consuming tasks, by increasing the number of codes that reflect time units. This is already in place: counseling, psychotherapy, HIV, and palliative care are all compensated by time taken, rather than service provided. Add housecalls, telephone calls, and care for the chronically ill and elderly to this list. Doctors can document the time taken (indeed, this is already an expectation). Policy makers can then be assured that potential abuse is curbed and cost ceilings are maintained, as there are only so many time units in a day.

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I suggest that community health centres be expanded, especially in the wake of these reform initiatives. I also have great political reservations about primary care reform. I worry that family health networks are yet another step toward privatization of health care. Family health networks represent the wide-scale introduction of managed health care in Ontario. It is not surprising that these networks meet with government approval, given receptive attitudes toward privatization and given that debates about user fees, private hospitals, and OHIP delisting that fosters a two-tiered system of services are currently encouraged. We need only look to Britain and to the United States to see the danger we are getting ourselves into.

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Treating persistent cough: caution!

I read with interest the Practice Tip by Peleg and Binyamin[1] regarding treatment of persistent cough with lidocaine and bupivicaine. I have occasionally found inhalation lidocaine helpful in palliative management of cough related to intrathoracic disease. The potential loss of a gag reflex is noted as a side effect.

I would, however, disagree with their statement that no other adverse effects have been reported. McAlpine and Thomson[2] have noted that inhaled topical lidocaine causes bronchoconstriction in a notable proportion of asthmatic patients. Groeben et al[3] have suggested that, although both intravenous and inhaled lidocaine greatly attenuate reflex bronchoconstriction, there is a high incidence of initial bronchoconstriction after patients use inhaled lidocaine. They subsequently suggested the possibility of using lidocaine along with salbutamol to prevent the initial bronchoconstriction seen with lidocaine alone.[4]

Given that a chronic cough is commonly associated with undiagnosed or undertreated asthma, treatment with inhaled anesthetic agents could be dangerous and should likely be undertaken only in carefully selected circumstances.

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