At a crossroads

The future of comprehensive care in Canada

Val Rachlis, MD, CCFP, FCFP

I was recently asked to present on the topic of "comprehensive care and continuity of care" at a national College conference. Initially I thought that it would be a rather straightforward look at what is happening to comprehensive care and the repercussions for continuity of care.

The more I looked at the situation and how it was being handled, however, the more confusing the topic became. What is comprehensive care? Has the definition changed and, if so, why? What does comprehensive care mean to our patients, to government, to established family physicians, and to our new members now graduating?

What is comprehensive care?

There are 2 broad concepts of comprehensive care that, although sometimes interchanged, are, in fact, totally different in many key respects. In 1996, a group of leaders of family medicine came together to develop a list of core activities for family physicians. It was a subcommittee of the Ontario Provincial Coordinating Committee on Community and Academic Health Science Centre Relations. Their list became known as the "PCCCAR basket of services." Within 4 years, it had become entrenched in general policy at many levels, including at our national College. What is crucial to this discussion is that this basket was almost completely office based and made all non–office-based activities purely optional and discretionary.

For example, the list states that palliative care can be delegated to a palliative care team, that hospital and home care should be provided where applicable and where possible, and that obstetric care could include arranging care by others. Almost no debate was generated by these policy decisions. Rather than being viewed as a diminution of what we once considered our traditional domains of care, this PCCCAR basket of services was advocated as a goal we should strive to achieve.

At about the same time, Ben Chan, working at the Institute for Clinical Evaluative Sciences, published a report[1] in the *Canadian Medical Association Journal* in which he examined the decline in comprehensiveness of primary care in Ontario from 1990 to 2000. He chose to define comprehensive care as "the extent to which family physicians worked in environments other than their primary care settings."

Reasonable arguments can be made to support each of these concepts of comprehensive care. What is important, however, is that there must be open debate. We must all be willing to reconsider our own preconceptions about comprehensive care and decide how we wish to define our specific subset of the medical profession. These decisions will be of substantial importance when we examine what, where, and how we teach our medical students and family medicine residents in the future.

Decline of non–office-based activities

In the decade of Chan's research, the proportion of family physicians in Ontario who worked only in their offices to the exclusion of all other venues had risen from 14% to 24%. Although women were more likely to be involved in obstetrics than their male counterparts, they had fallen behind in other areas, including work in the emergency department, housecalls, and hospital work. More ominously, the drop in all of these areas—due to the practice choices of both men and women—ranges from 7% to 17%.

Involvement in non–office-based activities was higher in smaller communities than in large urban areas; the 5 cities with existing medical schools had the lowest levels of non–office-based activities across the board. But by the year 2000, there were problems in every part of the province. More than half of urban physicians had excluded hospital work, while smaller centres had witnessed substantial erosion in their involvement in obstetrics and the emergency department. It was clear that older, established physicians were electing to work only in their offices, having served in these other roles for many years. Crucial to the discussion, however, was that the level of involvement among new graduates was already lower (except in the emergency room) than among older physicians, even though they were just starting their careers.

Across Canada, we have now been through more than a decade of initiatives aimed at enhancing primary care. Many of these initiatives have been directed toward manipulating and changing the way we are paid, rather than on areas of involvement we and our patients prefer and require. Many of these initiatives have also used the PCCCAR basket of services as a benchmark, implying acceptance of the potential end of non–office-based areas of care. That is not to say that rewarding family physicians for the comprehensive care they do in the office was not long overdue and that anything

that decreased the gap between specialists and family physicians' incomes was not to be applauded.

There are bonuses built into some of these initiatives to financially reward non–office-based care, but preliminary data from various models across the country indicate that, although established physicians might retain these activities to some degree, there is very little increase in uptake by new graduates. Are the financial carrots not big enough for our younger members? Perhaps, but there is likely much more going on than can be remedied by simply adding more money to the till.

Recent research by family medicine residents in Toronto, Ont, now makes it clear that they do not wish to be part of such activities as obstetrics and palliative care because they believe that they have not received sufficient training, that these types of work will reduce balance in their lives, and that they did not witness enough role models doing these types of activities during their training. They are telling us that so long as they can work in their offices for an acceptable income, augmenting that income by taking on more responsibilities is not a high priority.

Data from the National Physician Survey[2] and the recent report of the Canadian Institute for Health Information[3] indicate that only about 27% of graduates are now choosing family medicine. Although there has been an increase in the average number of services offered by those who continue to provide non–office-based care, the number of family physicians involved in these areas continues to decline. By 2003, across Canada inpatient care services were provided by 57.5% of family physicians, while obstetric care was provided by only 14.1%. Many of these services are being provided by family physicians in the middle or later years of their professional lives, raising questions about the future. For example, if the trend in intrapartum care were to continue, that 14% of the 27% of new graduates choosing family medicine would translate into 8 physicians out of a class of 200 providing intrapartum care, leaving many communities below critical mass for sustainability of this activity.

At a crossroads

So this leaves us with some very disturbing fundamental questions. Is it time to redefine comprehensive care? Perhaps our practices have become so complex and so busy that we simply do not have the time to get beyond our office walls any longer. Perhaps the system, particularly in the hospital sector, has become so uninviting that we have given up trying to make those institutions and the specialists who work there understand how important our presence is. Perhaps the baby boomers are simply getting older and the new generation has totally different priorities for what they want to accomplish in their professional lives. Perhaps government, our medical associations, and the public have a different concept of what they want family physicians to do in the future.

The future of family medicine in this country is truly at a crossroads. We, its advocates, providers, and defenders, must be at the forefront of this important dialogue, for there is another road we can take, if we so desire. We could decide that there was and is value in being part of that portion of our health care system that understands how important true comprehensive care is, not only to our patients and our community, but to our function as the bedrock foundation of the entire structure. Maybe it is not too late for us to state clearly that the PCCCAR basket of services is really only the bare minimum and our relationships with our patients extend so profoundly beyond the walls of our offices. Maybe we can re-create ourselves by sharing responsibility, with each other and with other health care providers for those non–office-based activities that once gave us so much pleasure, satisfaction, positive feedback from our patients, and self-esteem. We do not have to be all things to all people, but neither should we sell ourselves, and society, short.

Dr Rachlis *is Past President of the Ontario College of Family Physicians, an Associate Professor in the Department of Family and Community Medicine at the University of Toronto, and Director of Primary Care Initiatives at North York General Hospital in Toronto, Ont.*

Correspondence to: **Dr Val Rachlis**, *5 Fairview Mall Dr, Suite 260, Toronto, ON M2J 2Z1; telephone 416 497-6363; fax 416 497-7610; e-mail* **VRachlis@aol.com**

The opinions expressed *in editorials are those of the authors. Publication does not imply endorsement by the College of Family Physicians of Canada.*

References

1. Chan B. The declining comprehensiveness of primary care. *CMAJ* 2002;166(4):429-34.
2. College of Family Physicians of Canada, Canadian Medical Association, Royal College of Physicians and Surgeons of Canada. *National Physician Survey.* Mississauga, Ont: College of Family Physicians of Canada; 2004. Available from: **www.nps-snm.ca**. Accessed 2006 August 17.
3. Canadian Institute for Health Information. *The evolving role of Canada's fee-for-service family physicians, 1994-2003.* Ottawa, Ont: Canadian Institute for Health Information; 2006. Available from: **http://www.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_16aug2006_e**. Accessed 2006 September 26.

FOR PRESCRIBING INFORMATION SEE PAGE 1490 ➔