Ontario Medical Association

525 University Avenue
Suite 300
Toronto, Ontario
M5G 2K7

Tel: (416) 599-2580
Fax: (416) 599-9309
Inwats 1-800-268-7215

Section on Rural Practice
Peter Hutten-Czapski Chair
293 Meridian, Box 3000
Haileybury ON P0J 1K0
(705)672-2442

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Dr Jim MacLean - Lead
Health Results Team - Primary Care Reform
Ministry of Health and Long Term Care
1075 Bay Street, 9 th Floor
Toronto, Ontario M5S 2B1

Dear Dr Jim MacLean

As Chair of the OMA Section on Rural Practice I would like to thank you very much for your work on the Family Health Teams. I and many rural doctors are excited about the prospect of these teams coming to help us deal with rural areas of the province. At the same time we are concerned that the same barriers that have rural Ontario serviced at literally two thirds of the urban GP to population ration [1] will limit the applicability of this initiative.

I would like to bring to your attention several suggestions that may have your program best serve rural and underserviced Ontario.

1. Have a sliding scale for health provider remuneration based on increasing isolation.
2. Have preference for proposals from areas that are underserviced for health providers
3. Be mindful not to destabilise rural hospitals when awarding funding
4. Be open to proposals from groups ineligible for PCR funding

Need for a Rurality Scale for Alternate Health Providers

In September of this year four recent RN(EC) graduates were making public their concerns on CBC radio that there was no work for them - *in the city of Sudbur*y. There certainly were openings in nearby Timmins, New Liskeard, Moose Factory and West Parry Sound. The last post just vacated by a nurse practitioner who relocated, as it happens, to Sudbury. [2]

In a recent survey of Nurse Practitioners done by the province by IBM consulting it was found that only 29% of non-practising NPs are willing to relocate, and 79% of those willing to relocate indicated that salary and relocation packages are factors to consider in relocating. [3]

The scale can be simply tiered with, say additional funding of 10-20%, applied for provider salary to communities over 80 Km away from a city of over 50,000 population or on a gradual scale such as the Rurality Index developed by the province in the Underserviced Areas Review (unpublished). An additional amount of funding, say 30% of the base, is needed to be built in for recruitment and relocation and needs to flow even *before* the person is hired.

Need to Have Preference to Proposals From Underserviced Areas

The section realises the realpolitik that will have FHT's in every part of the province in April. However there is no excuse not to put them where they are most needed, and to distribute them so that the greatest number of people can benefit. Underserviced areas are also the most likely to be willing tochange and may have made previous unsuccessful application for funding for registered nurses of the extended class.

Need should be determined by existing shortage of physicians and listing on the UAP. At lower priority should be proposals from areas that have high turnover and have been listed on the UAP in the past. Lowest priority should be proposals from those who already have nurse practitioners or other health care providers on staff who are looking for additional funding, not change.

Provider Mix and Rural Hospitals

In 2000 the Ontario Region of the Society of Rural Physicians pointed out in a paper that "In rural Ontario there is no getting away from the fact that you need doctors to run the hospital. To make them stay you have to remunerate them well, especially for the difficult services in remote areas, and provide sufficient numbers so that they don't burn out. To introduce nurse practitioners doesn't make sense unless there are at least five doctors sharing call for the hospital. Above this number, you can introduce Nurse Practitioners for the ambulatory work without risking the hospital."[4]

Special care should be made to examine proposals from communities with a hospital trying to recruit health providers of any stripe, not to destabilize their ability to recruit family physicians to help run inpatient and Emergency Room services. Unless they have a full compliment of physicians, or at least five running the hospital, you may not be helping sustainibility. In some situations what you really need is a doctor to help with hospital care **and** primary care **and** on call.

Allow Proposals From Those Excluded from PCR

There are many rural doctors in this province who remain on FFS or are in FHG's that are too small and isolated to form FHN's or are ineligible for CSC/NGFP APPs. These practitioners need to be allowed to apply for FHT funding. To encourage cooperation between providers, it is essential that the payment schemes for each provider don't engender competition, and such proposals will require funding mechanisms for the physician to be paid for consultative work with alternate health providers, and for the loss of "easy money" lower acuity and complexity cases that will be triaged to other providers. Such payments may include sessional fee, and/or consultation fees paid to the physician.

Sincerely

Peter Hutten-Czapski MD

[1] In 2002 Ontario has a GP to population ratio of 1,068 (urban) and 1,458 (rural). The Society of Rural Physicians srpc.ca/numbers.html
[2] Barner, Nancy. Argyle hunting again for nurse practitioner. Almaguin News August 18, 2004 Vol. 119 no. 34 web. 33-4
[3] IBM Business Consulting Services. Nurse Practioner Survey www.health.gov.on.ca/english/public/pub/ministry_reports/nurseprac03/app_d1.pdf
[4] Society of Rural Physicians of Ontario - Primary Care Reform - A Rural Perspective January 27, 2000