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The Family Physician: Gatekeeper to the Health-Care System

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OUR CANADIAN health-care system, it is plain to be seen, is changing, and its changes require a corresponding change in the role of family physicians. I foresee a role for family physicians as gatekeepers of Canada's health-care system, given that we can provide the health-care service to fill that role.

Translated into practical terms, this requires that we overcome the obstacles that face us in that role, and that we find the means to show governments that we can provide the leadership to work with them in a cost-effective manner.

To begin, let us consider the definition of the term 'gatekeeper'. This term, so my dictionary tells me, means "one who has charge of a gate". By implication, then, the first prerequisite of this office is simple: to be a gatekeeper, one must be at the gate.

I talk with many groups of lay people, and I am astounded at the observation which is commonly made, "We have a good family doctor, but it is certainly hard to get to him/her after 5:00 p.m. or on weekends!" The success of "walk-in clinics" can surely come as no surprise to us if our patients perceive that we are unavailable to them at night or on weekends. Certainly, if we are to constitute the entry point to the health-care system, we must be available to help our patients when they come to us or call on us for help. Of course, this does not mean that we physicians must be on call 24 hours a day to every caller, for we, too, need our time off. Nevertheless, when we accept a patient into our practice, we have a responsibility to be available when that patient needs us. If we cannot be available ourselves, we should ensure that another competent physician is readily available. And our patients should know who is available when we are off duty. This holds true, especially, for our patients who may be in hospital over a weekend when we ourselves are not on call.

As gatekeepers of the health-care system, then, we must be at the gate, and we are expected to take charge of the gate. Again, my dictionary defines a gate as "a moveable barrier situated at an entry to bar an exit from an enclosed system".

Have we Canadians an enclosed system of health care? We look with considerable concern at state-run, health-care systems in other parts of the world, where quality of care appears to be losing the fight with government bureaucracy, and where private medical plans are increasingly providing rapid and effective care for those who can afford to pay the premium.

We have a good health-care system in Canada, and although some fine tuning would improve it, I should be sorry to see a two-tiered system introduced, whereby a substantial premium paid to a private company would allow a financially élite minority of Canadians access to a better quality of health care than would be made available to those less well off.

Parliament passed the *Canada Health Act* to ensure that all Canadians would have equal access to our health-care system. The goal was to ensure that all Canadians, no matter where they lived, where they were when they needed care, or what their financial situation might be, would have easy access to the system. But the *Canada Health Act* did not cope adequately with the problem of funding our health-care system.

Is our health-care system underfunded? Some economists insist that it is not, given the fact that our provinces spend one-third of their budgets to keep the system going. And yet, all across Canada, we see Ministries of Health resorting to draconian measures to contain their health-care budgets. We see those budgets being limited to increases that amount to less than the annual increase in inflation. Indeed, we see some provinces reducing health-care budgets below the point at which they stood for the previous year, in spite of inflation and agreed-on salary increases for hospital staff. We see some provinces capping physicians' incomes and restricting billing numbers on the ground that some physicians are overusing the provincial medical plan. We note, however, that no provincial government is blaming the public for increasingly demanding services that 50 years ago would have been handled quite adequately at home by intelligent concerned parents.

It remains that, for whatever reasons, whether from underfunding or from overuse, we Canadians are faced with a health-care system for which government, which controls the funds, has taken over the financing, and hence the control, of the delivery of health care. And government has decided that we must put a stop to the growth of the health-care budget, which over the years has remained at just under 8% of our gross national product (GNP).

The Canadian public may be unaware as yet—unless they have tried to get a bed for elective surgery—that our health-care system is being increasingly enclosed. Physicians, however, are aware of this development, and while they resent it, they admit that infinite demands cannot be supplied from a finite source: the tax dollar.

This being so, someone has to decide who it is that we are to let through the gate of an increasingly enclosed

health-care system. The logical gatekeeper, in my view, is the family physician, and we must recognize the responsibilities that this choice places on the members of our profession.

That profession and Ministries of Health across this land are facing a crisis situation, and the only way that we, as physicians, can survive with any sense of autonomy, is to work out an accommodation with government. Otherwise, we shall be led around by the nose as government copes with each financial crisis as best it can. We must stop sniping at government from entrenched positions. We must avoid confrontation. We must collaborate with government in making long-range plans if we are to avoid becoming the scapegoat for recurring problems in the health-care field. Governments can be expected to welcome our help if we can show that we are willing to give help that is not based primarily on self-interest.

If we are to convince governments that we can and should help them to shape Canada's health-care system of the future, we must show the bureaucracy that we can practise in a cost-effective manner. In the *Journal of Family Practice*[1] we read that experience has shown that family physicians staff HMOs more cost-effectively than do specialists, for the former deal with patients adequately, using fewer laboratory and X-ray tests and fewer referrals to hospitals or specialist colleagues. That information should come as no surprise to health-care planners, for that is the way that most family physicians have practised for years.

Robert Gillette, writing in the *Journal of Family Practice*,[2] has stated:

> Certainly in the role of ambulatory care services, family practice is recognised as the rational supervisor of cost-effective service and preferable to special oriented hospital based treatment. This recognition is widespread and offers a great opportunity for family medicine to assume leadership in the gatekeeper field and to be involved in research and pilot projects as to how best to train residents and to help practising physicians to better fill this role. For this role should not be one of simply triaging patients at the gate, but one in which we meet them, assess and treat and follow their care when referral becomes necessary.

The *Canadian Medical Association Journal*[3] reported an experiment, conducted in Toronto, where a group of 9,000 patients were involved in a capitation method of payment. It was found that under 5% of patients coming to their doctor's office needed referral to specialists, but 61% of direct physician costs went to specialists for these services. The economists calculated the physician cost per patient seen as $9.00 per family physician as compared to $14.00 per specialist. It seems clear, then, that family physicians have a real opportunity to control some of the costs of health care by acting as gatekeepers, but to do so they must be aware of the cost of referrals.

We Canadians are seeing increasing pressure from pediatricians, internists and obstetricians to do primary care in their specialties. Charles Lobeck, writing in the *Journal of Continuing Education for Family Physicians*,[4] states that by 1990, there will be increasing competition between family physicians and pediatricians for primary-care patients, and he recommends that these two disciplines sit down now to talk about future co-operation in the use of residency slots. He states:

> In my opinion we need a consensus developed among physicians, legislators, ethicists, the courts and the public on the point that health care resources are finite and our ability to raise health care standards has surpassed our ability to pay for every conceivable service, and that a gatekeeper role is needed and is ethical, rational and . . . in the best interests of the patients we serve.

If cost effectiveness is our aim, should we be looking at other methods of payment for physicians? There is nothing sacred about fee for service. Perhaps we should be developing different methods of remuneration that more effectively reconcile this conflict between infinite demand and limited resources. We should probably look at other mechanisms for payment now in use: capitation, salary, global budget, or combinations of these methods, as well as improvements in fee for service. It may well be that a variety of options should be available, some of which will be more cost effective than others, depending on the particular situation. Within the past month, I have talked with a medical economist who believes strongly that we must look at other payment options if we are to do those things that we do best, but that the fee for service does not cover.

Dr. Blackburn, medical consultant for Blue Cross in the United States, has said that in his country, it is the employed salaried physician who is going to supply manpower mainstream for at least the next generation. This from the bastion of free enterprise, the South! But we are told that 50% of recent graduates of medical schools in the United States are now in salaried positions.

Some experiences in the United States have shown that where a large group of family physicians have accepted a capitation arrangement with a company, to look after a defined group of patients, problems have arisen. In such arrangements, the capitation sum is set annually, and costs of referrals and special tests are deducted from this sum. This makes the physician liable to the temptation to restrict referrals and tests, even in those instances where they are indicated. We must be careful that the payment system we choose will be in the best interest of our patients, for any system is open to abuse by the practitioner whose aim is to take advantage of that sytem.

Assuming that we family physicians are to be the gatekeepers of Canada's health-care system, what roadblocks do we face? There will be roadblocks, and we can see some of the problems if we study the experiences of those colleagues who are already discharging that role.

First of all, we shall need to maintain frank and open communication with our specialist colleagues and with our colleagues in the other health-related professions, for we all have a role to play, one for which we were trained. And all of us are needed if the system is to work effectively. But we shall fail unless we co-operate with one another.

Robert Gillette states, in the *Journal of Family Practice*,[2] that if we are to be gatekeepers, we must be cognizant of the nature of institutions: how they function and the nature of their political structures. As admitting and referring physicians, young doctors will face a far different aspect of hospitals than they faced as medical students or as residents. They will find administrators who control many aspects of their work, and specialists who make most of their income from doing special procedures, and who will not take

kindly to a family physician who decides that these procedures are not cost effective.

For we face a challenge, as a profession: With limited funds at our disposal, how do we negotiate with government and with specialist colleagues to preserve a solid share of health-care dollars for primary-care services? How do we prevent a small number of tertiary-care services from using a disproportionate share of health-care dollars without the imposition of some reasonable limits? That is one of the problems that we shall have to solve, one of the roadblocks that we shall have to overcome.

Another roadblock is that of litigation. It is early yet to determine the medico-legal risks of the gatekeeper role, but they may be substantial. And government may well have to take action to restrict litigation procedures in some way if we are to avoid the increased costs of practising defensive medicine.

Another roadblock has been the slowness of government to realize the need to expand postgraduate training for family physicians to a minimum of two years of residency training. The Wilson and Cox Reports have helped to make this need known, but a number of provincial governments are still slow to realize the long-term gain to the system in cost effectiveness that will be realized with well-trained family doctors. In my opinion, a well-trained family physician possessed of the confidence and competence that come with adequate postgraduate training is the most cost-effective factor in preventing overuse of the health-care system as it relates to physicians.

In a recent issue, *The New England Journal of Medicine* made the following comment:

> Health care delivery and medical practice [are] in a period of destabilization. The ethics of medical care are changing, and there is a real risk that important values may be lost. Whether or not they will be lost, will depend on the quality of medical leadership and the response of an informed public. We have been pursuing contradictory policies that add to our problems. The competitive market is an opponent, not an ally, of cost containment. When capacity increases, the boundaries of the system are expanded, duplication of costly services is encouraged, and the public is pushed to consume more health care services than it needs. Neither cost containment nor competition will ensure the maintenance of medical research or medical education on which further advances in therapeutics depend.

The Honourable Jake Epp has just introduced his framework for health promotion: "Achieving health for all". This is a good statement, and both the public and the medical profession must work toward achieving this goal, for as the Minister states: "Health is a basic dynamic force in our daily lives, influenced by our circumstances, our culture, our beliefs, and our social and economic environment."

That is a 'motherhood' statement with which we must agree, for we must preserve what is best in our culture and environment, and work toward removing those elements in these systems which damage health and add to health-care costs.

To this end, as McWhinney asks in a recent *Canadian Medical Association Journal*, "How can we best emphasize health promotion and community care?" He proceeds to answer his own question:

> Of all branches of clinical medicine, family medicine has most potential for health promotion, and yet there is little incentive in our present system for physicians to practise preventive medicine. Most health care dollars go to those performing procedures. There is little incentive for a family physician to work with nurses in health promotion, and there are few areas in the country where the attachment of public health nurses to a family practice is common.

And so change is required. Our whole world is changing rapidly, and so are our political and social structures. So are the attitudes of the public and the government towards health professionals. So are the attitudes of our young graduates toward our profession. Most recent graduates are no longer prepared to work a 60- to 70-hour week at the expense of family time. And I believe that they are right in their refusal to do so.

The public is not yet aware of some of these changes, and so we family physicians have a job to do in educating an increasingly sophisticated public about the changes required to make the health-care system more efficient and about the adjustments they will need to make, both in their expectations of the health-care system and in its use. Our patients must be helped to understand why we are performing a gatekeeping role, and especially so when they come asking us for unwarranted tests and unnecessary care.

We must convince governments of the fact that we are aware of the problems of financing health care, and that we have both a right and a responsibility to work with their representatives as we develop the most cost-effective way of delivering good care to our patients, who are also their constituents. In so doing, I think that we can convince our governments that the family physician is the natural choice for gatekeeper of our health-care system.

I also know that we must convince governments that as providers of health care, our primary concern is the welfare of the patient we look after, that we are searching for ways to make a good health-care service better. And to do that, we must be sure that governments know that we are not working with them in a self-serving capacity.

These responsibilities are a challenge, but a challenge that I believe we can accept and should accept as a College: to work out the 'kinks' that exist in our relationships, not only with government, but also with our specialist colleagues and our colleagues in the other health-related professions.

It is my hope that as we refine our role of gatekeeper, we shall be helping to usher our patients into a health-care system that is less and less enclosed. ◉

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