SPECIAL REPORT

New approach to primary medical care

Nine-point plan for a family practice service

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Since its creation almost 20 years ago, our national health care system, medicare, has become one of the strongest links in the often fragile chain of Canadian unity. Canadians consider our health care system a source of national pride, a symbol of a country whose citizens have a strong sense of the worth of being a caring, sharing community.

Medicare is a "national family value" that includes everyone, regardless of means. It is often cited as an important difference between our national identity and that of our giant neighbour to the south, the United States. Our national health care system has helped create our national identity.

Until recently, medicare was such an untouchable national institution that public discussion about the need to reform certain aspects of it was nearly impossible. Elected representatives who tried discussion quickly found out it was bad for their political health. Although the issue is still sensitive, it is now recognized as an important item on Canada's public policy agenda.

Just a decade ago, dialogue and debate on the national deficit were barely audible. Now the debate rages. Along with job creation, the deficit topped the list of voter concerns during the last federal election campaign. With increasing awareness of the worsening state of national and provincial debt, public attention turned to the health care system, which has been blamed for a great deal of our government deficit.

Media reports focused on four areas:

- possible changes that threaten reduced access to the health care system,
- the possibility of reduced services to consumers,
- health care cost as a contributor to national debt, and
- the possibility of user fees.

Health care is a large industry. It provides services to Canadians through a variety of provincial plans and employs hundreds of thousands of people. Does today's system, however, meet the needs of the population? Does it meet the principles enshrined in the original medicare legislation: accessibility, universality, comprehensiveness, portability, and public administration? Is it effective and efficient? Is it affordable? Are the originally enunciated principles out of date? Do we need to add new ones?

This paper is about primary medical care: the level of care at which people initially come into contact with physicians and, in most cases, with the health care system. In a recent survey of Ontario residents, 98% of people claimed to have a family doctor. Family physicians have extensive training as generalists. University departments of family medicine train them well and train them to work in the community and be responsive to community needs. Changes in primary health care will include the role of family physicians as the cornerstone of the system.[1]

What is wrong with the system?

We contend that we are not adequately meeting the principles of accessibility and universality. The system is inefficient and expensive. The mushrooming of privately operated ambulatory clinics and the prevalence of private laboratories suggest that the system is no longer under public administration. While the system is affordable to individuals, it places unbearable strain on provincial and federal budgets. By contributing to provincial and federal deficits in a country with one of the largest per capita debts in the developed world, we risk bankruptcy unless the status quo changes.

What is wrong with the primary medical care component? The current model does not ensure family practice services of predictable comprehensiveness.

Primary medical care providers have difficulty addressing population health issues. Incentives for tackling the broader determinants of health, such as poverty, homelessness, and domestic violence, or for creating prevention or early diagnosis programs do not exist for most practitioners. Much greater community participation in decision making is desirable and possible.

Accountability. The current system comprises purchasers, providers, and consumers. Under the Canada Health Act, purchasers are almost entirely federal or provincial governments. Providers are health professionals and, for the purposes of this discussion, those who provide primary medical care. Consumers are the public, who pay for health care through taxes or premiums.

These three groups of people act more or less independently of each other. There is little opportunity for one to be responsible for the actions of the others. The system is open-ended with governments unable to control costs except by limiting the number and activities of the providers or by reducing payment for a given service.

Lines of accountability are unclear. Providers are accountable to consumers as individuals; consumers can report concerns and complaints to a third party. Providers have no clear accountability to purchasers.

There is an urgent need to rationalize numbers, distribution, and mix of physicians. Lack of control and accountability in an open-ended system makes planning difficult. Any attempt to rationalize the system without addressing this central issue can lead only to further problems.

Coordinating care. Many types of health professionals deliver care, but it is difficult for any of them to coordinate care effectively. A patient can see a family physician during the day, go to a walk-in clinic in the evening, visit an emergency department late the same night, and then see a specialist the next day, each time with the same problem. Nonphysicians, especially nurses, are underused and undervalued in the primary medical system.

Numerous doctors and clinics attend to various aspects of health. Consumers assume, often incorrectly, that the services are coordinated, or at least aware of each other's activities. Ineffective coordination and consumers' lack of direction in moving purposefully through the system augment costs and provide piecemeal health care. In large urban centres some specialists, who should provide referral and consultation services, provide primary medical care, even without training to do so. American studies have shown that this not only is an expensive method of practice, but often leads to unnecessary duplication of services. A recent conjoint report of The College of Family Physicians of Canada and The Royal College of Physicians and Surgeons of Canada recommends that primary medical care be provided by family physicians working with other professionals and that secondary and tertiary care be provided by specialist/consultants.[2]

Physician distribution is uneven. Many areas are designated underserviced. Some have virtually no medical service.[3] How then can we honour principles of accessibility and universality?

Financial concerns. Financial incentives for physicians are based on an entrepreneurial, small business approach to providing care. Physicians concentrate in urban areas where education and services are accessible, income can be maximized, lifestyle is affluent, and spouses can find employment. Physicians are offered no incentive to provide comprehensive, continuous service. In fact, nine-to-five office-based practice is proportionately much more lucrative than providing continuous service.

The "market" supporting physicians is based on demand as well as need. It is limited by patients' perceptions of health needs (without relating them to costs) and not by patients' financial resources as in a conventional market-driven economy. The rapid proliferation of walk-in clinics, which offer convenience at a high cost for which the consumer is neither responsible nor accountable, represents entrepreneurship on a serious scale, both by physicians and private interests, funded by taxpayers.

Recent studies have indicated the need for a new look at some of our priorities in health care. The Premier's Council on Health Strategy in Ontario proposes the following priorities.[4]

- Shift the emphasis to health promotion and disease prevention.
- Foster strong and supportive families and communities.
- Ensure a safe, high-quality physical environment.
- Increase people's number of years of good health by reducing illness, disability, and premature death.
- Provide accessible, affordable, appropriate health services for all.

New direction

We need a strong system of family practice more effectively using the services of well-trained generalist family physicians working collaboratively with other professionals. A guaranteed family practice service

has never been more necessary. We propose restructuring the way in which primary medical care in Ontario and possibly other provinces is organized and provided. We will address problems inherent in the current system and propose a new model built upon the best features of what we have now. We hope our model will help other provinces as they reform their own health care systems.

Our proposed model is intended to:

- ensure comprehensive service,
- strengthen accountability,
- integrate population health care with individual care,
- address the determinants of health,
- enhance intersectoral collaboration and integration,
- improve health promotion and disease prevention strategies,
- improve access,
- revise the approach to mental health care,
- revise the approach to long-term care,
- integrate community service development,
- ensure equality of opportunity for healthy living,
- make the use of pharmaceuticals more cost-effective, and
- incorporate quality control.

We must add new principles. Not only must Canadians be insured for medical services, but medical services must be ensured. We must honestly address the issue of what services people need for creating and preserving good health and health care. All Canadians should be entitled to basic primary care, regardless of means or location. Providers of these services must be accountable for what they provide.

Population health. To address population health we must find ways to address the health of groups of people, whether small practice groups, communities, or large populations. We also need methods of promoting the broad determinants of health and reducing poverty, homelessness, and violence in the home.

Medical services must be integrated with other forms of primary care using multidisciplinary teams. These teams will work for illness management and for primary prevention and early diagnosis using proven approaches.[5]

Family practice services should be accessible to all Canadians whether they live in inner cities, suburbs, or remote regions. Many after-hours services are provided in hospital emergency rooms. This is costly and fragments care. Up to 85% of emergency-room care could be better provided by family physicians.[6-8]

Our system must ensure that the mentally ill and those with long-term disabilities receive equivalent care to others.[9] The chronically ill now frequently receive suboptimal care after leaving institutions.[10] As hospital and institutional care is discouraged, equivalent services must be ensured in the community within the primary care sector. Appropriate service must be provided for all, regardless of geography, sex, language, culture, or type of illness. Given our multicultural society, this commitment is substantial and requires innovation and cultural sensitivity.[10]

The cost of drugs will continue to rise. Proportionately, medication costs are higher than physician costs. A renewed primary medical system must ensure the appropriate use of pharmaceutical agents. Coordination is essential when individuals have several doctors prescribing for them. A recent Toronto study estimates that 20% of hospital admissions of the elderly are due to the adverse effects of medication.[11]

Quality control. Standards within general and family practice in Canada are not currently guaranteed. The medical profession mostly relies on publicly delegated self-governance and a rigorous code of ethics to ensure standards. Quality control is better implemented in the hospital sector. Without a mechanism for accountability, quality control in clinical practice in the community is sporadic, voluntary, and, at best, ad hoc. Only accountability and physician responsibility for a fixed population could promise any uniformity of quality control.

It would not be idealistic to consider a comprehensive system of continuous quality improvement in family practice. In Canada, there are many ways to do this.[12] The College of Family Physicians of Canada has developed and applied a method of practice assessment.[13]

As knowledge and technology develop ever faster, dissemination of information and guidelines becomes increasingly important. Registering practice populations allows the universal implementation of guidelines and their evaluation. Implementing a more accountable system would ensure more widespread use of currently established practice guidelines.[14]

Guidelines for common office problems are being developed by diverse organizations. British experience has shown how these can be developed by family physicians with community consultation at the practice level with demonstrable benefit to patients.[15] Outcomes can be determined within a practice and reported back to practitioners and their peers. The College of Family Physicians of Canada has taken an initiative in

this area in which electronic networks are a basis for reviewing medication use, monitoring preventive services, and managing indicator conditions.[16]

Tinkering with the current system will probably be expensive, frustrating, and in the end, fruitless. We need a new approach, incorporating ideas from other places where they have worked well. We should strive for the best system we can afford given our current financial situation.

Model: a nine-point plan

The model of family practice we propose would have nine features:

- practice registration,
- a system of blended funding,
- a local authority with fiscal responsibility for coordinating care,
- primary health care through multidisciplinary agencies,
- mandatory use of health targets,
- central health records,
- a computerized database,[17,18]
- a managed system, and
- a balance between preventive, curative, and palliative services.

Practice registration. Every person would be registered with a family practice organization from which all primary services and access to referred services would be obtained. These organizations could be traditional family practices in formal or informal groups, community health centres, health service organizations, or other types of primary care organizations that include family physicians' services. The essential feature would be that people would register with the practice and, in most circumstances, be expected to obtain all of their primary medical care, and access to secondary and tertiary components of the system, there.

People registered with such organizations would be able to change easily if dissatisfied or required to move. They could be registered with only one organization at any one time but would not be restricted to getting services only from that organization should their circumstances dictate otherwise.

Health insurance cards would stay with the registering organization, which would be required to maintain a central medical record on each patient. The record would belong to the province and be transferred to another organization at patient request.

Canadians would be entitled to locally available, 24-hour, 7-day, family practice care with health professionals on call. Medical ambulatory office services and home visits would be guaranteed to all. Such services would be systematically evaluated, and the use of practice guidelines, approved by the local authority, would be expected.

The family practice organization would coordinate all health care for its population of clients. People would on occasion, of necessity, have to obtain care elsewhere: near their workplaces, near their homes, when away from home, and in urgent situations. In these circumstances the registering practice would receive reports about the registered patient and be able to maintain ongoing effective medical records.

Practice registration and a computerized database

For the past 20 years, researchers in Ontario have worked to develop computerized data systems for family practice settings.[17,18] From these efforts some excellent systems have evolved. They are now available and functioning in university departments and communities.

The programs provide a variety of services including scheduling, billing, collation of various components of clinical information about every patient encounter, and information on history, risk factors, allergies, and preventive screening status for various conditions. Some systems provide automated prescribing features that can transmit prescriptions electronically to pharmacies and include drug interaction programs and programs that prompt physicians to improve the quality of their prescribing.

Until recently, physicians have had no incentive to adopt computer systems into their practices. The only practices in the province that required computer systems were Health Services Organizations and Community Health Clinics that must track practice populations.

In 1993, the Ministry of Health ordered all physicians to submit their Ontario Health Insurance Plan (OHIP) account billing electronically. According to the Ontario Medical Association, more than 95% of physicians in the province now have computer systems that are capable of producing computerized OHIP billing. This change means that all family practices in the province have the capacity to register their practice populations on a computer system. It also means that with minor software modifications they would be able to use software currently available in the province to enhance the delivery of preventive services and to improve prescribing.

Choice would be maintained. The only restriction on patients, not present in the current system, would be that they could not be registered with more than one organization at any one time. Change would be possible whenever patients chose. Access would be assured.

Blended funding. We need a new approach to funding family practice. The variety of funding models currently in use demonstrates that no one model is appropriate for all situations or for all types of care.

Funding recommendations are based on the following principles.

- Mechanisms for family practice services should be a function of the number needing service, not the number providing it.
- Funding should be influenced by local, regional, and provincial needs.
- Different aspects of care within the same practice should be funded different ways.

We propose a model of blended funding. The College of Family Physicians of Canada has created one such model, the "blended funding mechanism."[19]

Specifically, we propose that there be two budget components, one for individual health care and one for population health care. The size of the budget would depend on the size of the population and the political decisions that determine what proportion of our collective wealth be devoted to health care.

A practice organization would be entitled to funding from each budget component up to a ceiling determined by the number of people registered in the practice, demographics, health status, and practice location. How an organization's actual funding levels are determined would be negotiable. A practice could earn its income on a fee-for-service basis for individual care but per program for preventive or early diagnostic programs. Capitation could be combined with fee-for-service payments for certain services. Budgets would be negotiated with a local authority and could differ according to practice location and "domains of practice" (eg, a very isolated practice where obstetric and emergency services are the responsibility of the practice, or an urban practice with a large population of HIV-positive patients).

By these means providers would have an incentive to offer the

Blended funding

The blended funding concept has four income components: base salary, capitation, incentives, and fee for service. These four components could be mixed in different percentages.

Base salary. Each family physician would receive a base salary dependent on training and seniority. Pensions, holiday pay, and disability pay could be tied into a base salary system.

Capitation. Capitation income would be related to both the age and the risk index of the population cared for by the physician. An acuity index would take into account the age and general health status of the population being cared for. An inner-city population would have a much higher acuity index than a suburban, healthy, middle-class population. Capitation would provide higher payments for widely dispersed populations in rural areas.

Incentive. Incentive payments would recognize successful delivery of various kinds of services, mostly preventive services. For example, family physicians who managed to deliver Papanicolaou smears, blood pressure screening, and breast screening to 90% of their practice populations would receive either a straight bonus or an increase in the capitation fee. Falling below a target level of, say, 70% would negate any such payments.

The Society of Rural Physicians have suggested that incentive bonuses be provided to those on call and to those who staff emergency rooms in small hospitals.

Fee for service. A basic fee for service for other needed services in the region would cover, for example, obstetric and anesthesia services in small communities, palliative care services, and home visits. The fee-for-service model currently in place does not compensate telephone advice. Many physicians prefer a patient visit to ensure that the service will be adequately paid for.

Integration of different methods of payment into a blended funding system would provide incentives and increase the level of accountability of family physicians in the provision of services to which society attaches importance. It should improve the quality of care provided to individual patients.

services that the population needs and an assurance of being adequately paid for them. Consumers would have access to high-quality services from family practices that are accountable for what they provide. Government, acting as purchaser, at provincial, regional, or local levels, would have a controllable, predictable budget for the health care for its citizens.

Table 1. **Problems in the primary health care system and potential solutions**

PROBLEM	NINE-POINT PLAN'S SOLUTION
Clarifying accountability	Accountability to local authority, managed system
Lack of population orientation	Patient registration, use of health targets
Identifying determinants of health	Patient registration, use of health targets
Lack of intersectoral collaboration	Blended funding, collaboration among health professionals, use of multidisciplinary agencies
Health promotion	Patient registration, blended funding, accountability to local authority, computerized database, balance among services
Disease prevention	Patient registration, blended funding, accountability to local authority, computerized database
Access, long-term care, community service development	Patient registration, blended funding
Equality of opportunity	Regional authority
Drug use, drug interactions	Patient registration, central health records, computerized database
Quality control	Patient registration, regional authority, managed system
Disseminating practice guidelines	Patient registration, balance among services, computerized database

Local authority coordinating care. We propose the establishment of Regional Primary Health Care Authorities set up under the auspices of district health councils. We propose that in an urban environment they service up to 75 000 people.

Local authorities, composed of health professionals and others and selected through an appropriate non-political mechanism, would be responsible to regional health authorities or district health councils for providing a range of services for each citizen. They would also control and authorize medical and other health-related services within their districts. From a funding envelope they would allocate funding to facilities and providers according to how the community's needs were being met.

Municipalities, through their district health councils, could articulate the primary health care needs of the people within their borders. They would set priorities based upon economic and other circumstances within their regions. They would obtain their authority directly from the provincial Ministry of Health and in turn delegate that authority to the Regional Primary Health Care Authorities in their districts.

The main advantage of such a local authority is that *family practice services would be linked to the health care needs of the community in which the family practice organization exists. Services would be set up with a clear accountability to the community agency. Fiscal control within provincial guidelines would make the system both responsive and accountable.*

All primary medical care organizations would be accountable to a local authority for the type and quality of the services provided. Each would be required to report annually. Each would be responsible for the creation of service targets for their registered practice populations. Such targets would relate to the needs of their communities and would reflect local, provincial, and national expectations.

Primary health care through multidisciplinary agencies. We propose that family practice services be provided by teams of professionals working in a coordinated way. Family physicians, nurses, and other health professionals and support staff would

work together to provide care for the community. Community-based professionals, such as public health nurses, social workers, and psychologists, could be administratively attached to specific practice organizations for regular consulting visits. Nurse practitioners would play an important role in providing services.

Mandatory use of health targets. Most Canadian family physicians have difficulty accurately defining their patient populations. Patients are free to have as many doctors as they wish and, apart from fees for successfully encouraging annual health examinations and routine screening maneuvers, physicians have no incentive to reach out to their practice populations. Indeed, under the fee-for-service system, such outreach can be technically unethical. Thus, it is difficult for a practice to determine current immunization rates, smoking rates, suicide rates, the level of hypertension, and so on within its community. Determining measurable improvements in them is similarly difficult.

With practice registration each practice organization would be expected to set and meet health targets for its patient population. Such health targets would be based upon epidemiologic studies of needs for the district or region in which the practice operates. Provincial agencies, such as the Premier's Health Council, would then have a mechanism for implementing their objectives and targets at a practice level. Providing local authorities with decentralized fiscal control will greatly increase providers' accountability and responsiveness to local needs.

Central health records. Our current system of health records is provider based. Most individuals have as many health records as they have seen doctors in their lifetimes. Very little attempt is made to coordinate and centralize the health records of any one individual.

We propose that each Canadian have a standardized and central health record maintained by the practice with which he or she is registered. The record would be the property of the province and be portable from one practice organization to another if and when the patient changed physicians or organizations. All records pertaining to that patient would be in one place. If a patient required hospitalization or specialist consultation, records of those visits would be sent to the primary care physician or organization with which the patient was registered.

Computerized database. Good population and individual health care requires good data. All health-related data should be stored on computer databases. Data would be available to determine accurately the health status of individuals and populations registered with a practice. Appropriate standards would be developed for data management.

Managed system. The resources to provide good health care are limited. We as a society have made the important decision that the cost of health care is a responsibility we hold collectively. We have rejected user fees for medical services. It is, therefore, necessary to act responsibly in managing our limited resources. Professional and accountable management must be employed at all levels of the health care system.

Balance between preventive, curative, and palliative service. We do not have the means to prevent all illness. Nor, unfortunately, can we cure illness much of the time. We must strive to devise effective strategies for prevention as we attempt to cure illness. Similarly we must recognize the limitations of modern medicine but acknowledge that our mission is to care for and comfort the sick even when cure is impossible.

Conclusion

We have proposed in this document an overview of a nine-point plan of primary medical care through a new model of family practice service. It is radically different from the existing system and yet retains the essence of our national system of medicare. We have addressed the essential elements of our health care system that require attention and incorporated them into the new model. The effect of reforms on each of the existing problems is shown in *Table 1*. We do not underestimate the difficulties inherent in changing our health care system. However, change is needed, and there has never been a time when it was more possible. ■

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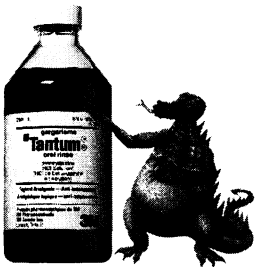

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(Benzydamine HCl Solution)

Relief only you can prescribe.

Summary of prescribing information

THERAPEUTIC CLASSIFICATION
Topical Analgesic — Anti-Inflammatory

Action
Animal studies using the parenteral route have shown that "Tantum" Oral Rinse possesses properties of an analgesic—anti-inflammatory agent. This effect is not mediated through the pituitary-adrenal axis. Studies using the topical route have demonstrated the local anesthetic properties of benzydamine hydrochloride. In controlled studies in humans with oro-pharyngeal mucosity due to radiation therapy, "Tantum" Oral Rinse provides relief through reduction of pain and edema. Similar studies in patients with acute sore throat demonstrated relief from pain.

Indications
"Tantum" Oral Rinse is indicated for relief of pain in acute sore throat and for the symptomatic relief of oro-pharyngeal mucositis caused by radiation therapy.

Contraindications
"Tantum" Oral Rinse is contraindicated in subjects with a history of hypersensitivity to any of its components.

Precautions
The use of undiluted "Tantum" Oral Rinse may produce local irritation manifested by burning sensation in patients with mucosal defects. If necessary, it may be diluted (1:1) with lukewarm water. Since "Tantum" Oral Rinse is absorbed from the oral mucosa and excreted mostly unchanged in the urine, a possibility of its systemic action has to be considered in patients with renal impairment.

Use In Pregnancy
The safety of benzydamine HCl has not been established in pregnant patients. Risk to benefit ratio should be established if "Tantum" is to be used in these patients.

Use in Children
Safety and dose directions have not been established for children five years of age and younger.

Adverse Reactions
The most frequent adverse reactions reported are: local numbness (9.7%), local burning or stinging sensation (8.2%), nausea and/or vomiting (2.1%). The least frequent were reports of throat irritation, cough, dryness of the mouth associated with thirst, drowsiness and headache.

Treatment of Overdosage
There are no known cases of overdosage with benzydamine HCl gargle. Since no specific antidote for benzydamine is available, cases of excessive ingestion of the liquid should receive supportive symptomatic treatment aimed at rapid elimination of the drug.

Dosage and Administration
Acute sore throat: Gargle with 15 ml every 1 1/2 to 3 hours keeping in contact with the inflamed mucosa for at least 30 seconds. Expel from the mouth after use.

Radiation Mucositis: Use 15 ml as a gargle or rinse repeated 3-4 times a day, keeping in contact with the inflamed mucosa for at least 30 seconds and then expel from the mouth. Begin "Tantum" Oral Rinse the day prior to initial radiation therapy; continue daily during the treatment and after cessation of radiation until the desired improvement is obtained.

Availability
Tantum Oral Rinse is available in 100 and 250 ml bottles. "Tantum" Oral Rinse is a clear yellow-green liquid containing 0.15% benzydamine hydrochloride in a pleasant-tasting aqueous vehicle with 10% ethanol.

Product monograph is available on request.

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