



The College of
Family Physicians
of Canada

Le Collège des
médecins de famille
du Canada



PRIMARY CARE and FAMILY MEDICINE IN CANADA A PRESCRIPTION FOR RENEWAL

A Position Paper

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THE COLLEGE OF FAMILY PHYSICIANS OF CANADA (CFPC) STRIVES TO IMPROVE THE HEALTH OF CANADIANS BY:

- **ENSURING THE HIGHEST STANDARDS OF TRAINING, CERTIFICATION, AND MAINTENANCE OF PROFICIENCY FOR FAMILY PHYSICIANS;**
- **EDUCATING AND INFORMING THE PUBLIC ABOUT HEALTHFUL LIVING;**
- **SUPPORTING RESEARCH AND DISSEMINATING KNOWLEDGE; AND**
- **CHAMPIONING THE RIGHTS OF EVERY CANADIAN TO HIGH-QUALITY HEALTH CARE.**

REPRESENTING 15 000 FAMILY DOCTORS ACROSS THE COUNTRY, THE CFPC IS THE COLLECTIVE VOICE OF FAMILY MEDICINE IN CANADA. ITS MEMBERS ARE COMMITTED TO THE FOUR PRINCIPLES OF FAMILY MEDICINE:

- **THE PATIENT-DOCTOR RELATIONSHIP IS CENTRAL TO ALL WE DO**
- **FAMILY PHYSICIANS MUST BE SKILLED CLINICIANS**
- **FAMILY PHYSICIANS SHOULD BE A RESOURCE TO A PATIENT POPULATION**
- **FAMILY MEDICINE IS A COMMUNITY-BASED DISCIPLINE**

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-INTRODUCTION-

This *Prescription for Renewal* is presented as a ‘living document’. It is part of an evolutionary process that has grown from years of policy work in the area of primary care reform by the College of Family Physicians of Canada (CFPC) and its Chapters.

In 1995, the CFPC’s green paper: *Managing Change: The Family Medicine Group Practice Model* was the first response by any medical organization to the Federal/Provincial/Territorial proposal for reforming primary care in Canada. Subsequently, the CFPC was an active participant in the *National Consultation on Primary Care*, which was part of the Prime Minister’s consultation with Canadians on primary health care. Between 1996 and the present, the CFPC has produced annually updated discussion papers on primary care renewal.

In May 2000, a major summit on the future of family medicine and primary care in Canada was hosted by the CFPC. This conference was attended by more than 70 representatives of national and international health care and medical organizations, family physicians and medical and surgical specialists, the public, nurses, representatives of medical schools, students, residents, licensing authorities, and the federal government. The consensus reached by summit participants contributed substantially to this ‘*Prescription for Renewal*.’

In addition to involvement at the national level, the CFPC has also participated, through the work of its Chapters, in primary care deliberations within the provinces. Of particular note has been the work of the Ontario College of Family Physicians (OCFP), which has taken a leadership role in primary care renewal discussions in Ontario and has developed a series of important position papers on this subject (see Appendix 1).

At their meeting in September 2000, the First Ministers agreed to collaborate on several priorities for health system renewal. Their communiqué identified many of the goals that the CFPC itself has long advocated and endorsed.

In this document, *Primary Care and Family Medicine in Canada: A Prescription for Renewal*, the CFPC presents a model for delivery of primary care services by family doctors, nurses, and other health care providers and offers strategies and recommendations to both create and sustain this model. We hope that this document will stimulate a response from governments and our health care partners across Canada that will result in the realization of the vision we all share.

- BACKGROUND -

When governments and planners from around the world look for a health care model to emulate, they are invariably drawn to what we have in Canada. Canadians, too, value their health care system. Historically, Canadian medicare has enjoyed one of the highest user satisfaction ratings of any nation.

One of the main reasons for this Canadian success has been the work of front-line health care professionals, including family physicians. Primary care services provided by family doctors and nurses contribute substantially to the quality and cost-effectiveness of the system. Canada has long recognized this relationship, and Canadians have benefited because family medicine has been nurtured and promoted as a vital component of health care.

Today, almost every country with a successful public health system has a strong primary care component led by family doctors. This is true of the United Kingdom, France, the Netherlands, Finland, Australia, New Zealand, and other nations. Even in the United States, where specialists have traditionally far outnumbered primary care physicians, there is now great interest in recruiting family doctors, particularly from Canada.

Why are family physicians playing an increasingly important role in the health systems of these countries? Because, like Canada, other nations have recognized that primary medical care is one of the best investments in health care that can be made, and that the key to the success of a primary care system is having a strong cadre of well trained family physicians.

Countless studies have shown that family physicians deliver the kind of health care that planners and decision makers want and people need. Centred on patients and committed to comprehensive continuing care, the discipline of family medicine espouses the same principles so valued by health care systems around the world.

In Canada, family physicians provide diagnosis and medical treatment; health protection, and promotion; coordination of care; advocacy on behalf of patients; and office-based care, as well as care in hospitals, homes, nursing homes, and community facilities. They provide not only first-line medical services, but also a substantial amount of secondary and tertiary care in all communities, particularly in rural and remote settings.

In spite of this, and even though the Canadian family medicine model is envied throughout the world, governments here in recent years have lost sight of the many benefits and strengths that family doctors bring to Canada's health system.

Unfortunately, over the past decade, many public policies throughout Canada have had the effect of undermining the important role of family physicians and other primary care providers, demoralizing this vital health care workforce.

For example, the decision to downsize the hospital sector has, in many cases, been implemented without a corresponding increase in support for the activities of community-based family doctors and nurses. This has resulted in growing numbers of patients in communities with more complex and higher acuity needs.

To meet this increasing demand, what we needed were more family doctors. . Instead, since 1993, decreases in medical school enrolments and postgraduate training positions have resulted in our producing 285 *fewer* family physicians per year – a cumulative loss of more than 1900 family doctors for our system (Thurber, Busing, *Canadian Family Physician*, September, 1999).

Further compounding these resource problems have been the large number of family physicians throughout the 1990s who chose to establish or move their practices into the United States and the increasing numbers of family doctors who retired from practice. The rate of retirements is actually expected to increase even faster as the physicians who joined the work force in the 1960s enter the final stages of their careers.

The cumulative result of all these trends, policies, and government decisions has been steady erosion in the number of family doctors in this country.

Doctor shortages are now a reality being felt in communities in every part of Canada, especially in rural areas. But shortages are not only a rural problem. Today, many people living in the most populated areas are also experiencing difficulty accessing a family doctor.

These shortages are putting enormous pressure on the existing workforce. According to the CFPC's 1997 National Family Physician Survey, family doctors are working an average of more than 70 hours a week, including scheduled office visits, hospital responsibilities, and after hours on-call services.

In spite of the hours they are working, many physicians find themselves at the limit of their capacity to care for patients, causing them to either close their practices to new patients or to limit the scope of services they offer- e.g. no longer caring for hospitalised patients, not including palliative care services, not delivering babies, etc.

Some family physicians, particularly in urban communities are confining their practices to specific areas like sports medicine, occupational health or psychotherapy. In rural or remote communities, family doctors facing similar pressures usually cannot close or limit the scopes of their practices. Unfortunately, they often see leaving the community as being their only option.

As noted above, many family doctors have moved to the United States or other countries. Some have left medicine altogether. The 1997 CFPC National Family Physician Survey reported 31% of family physicians planning to leave or substantially alter their present practices within 2 years, and the Angus Reid/Alberta Medical Association 1998 Survey identified 51% of physicians in Alberta as dissatisfied with their medical careers and 29% considering leaving the province.

How have these changes affected patient care? Patients in one community after another across Canada have been speaking out about the difficulty they are having finding family doctors. More than half the family physicians in the 1997 CFPC survey reported that patients were having difficulty accessing medical care. With physician shortages already causing problems, many family doctors overworked, and the supply of new family doctors insufficient to fill the growing gaps, patients' access to services could be even further compromised in the future. There are simply not enough family doctors, and the numbers we do have are inadequate to ensure equitable distribution around the country.

Patients today are more worried than ever that the system will fail them. They are confronted with delays, waiting times, and crowded emergency departments. In ever-increasing numbers, they are heading to United States centres for diagnosis and treatment. They see more and more medical services being privatized.

"There is a perception among providers and the public that access to core services is deteriorating." (National Forum on Health. *Canada Health Action: Building on the Legacy*, Volume 2. Ottawa, 1997.)

To further complicate matters, recent medical school graduates concerned about the lack of support for family doctors in our system are no longer choosing careers in family medicine as they once did. Between 1995 and 2000 the percentage of graduates selecting family medicine as their first choice careers fell from 40% to 29%. Our nation's goal of having family doctors make up 50% of all practicing physicians in the country could be seriously jeopardized if this trend continues.

In response to these many pressing problems and challenges, the CFPC has developed this *Prescription for Renewal*. It is a new vision for primary care and family medicine in Canada, and it offers innovative strategies and recommendations for revitalizing our health care system. Our model proposes roles and relationships for family doctors, nurses, and other health care professionals, which would result in appropriate and improved access to primary care services for all Canadians.

The CFPC urges 'renewal' rather than reform. Our current system, though in need of repair, is still the envy of the world. We need to build on our strengths, not tear down what has served Canadians so well for so long.

As providers and coordinators of care and patient and population health advocates, family physicians are valuable assets to the Canadian medicare system. The success of health system renewal in Canada will rest with a strengthened rather than a diminished role for Canada's family doctors.

As stated by Dr. Carolyn Bennett in her book *Kill or Cure – How Canadians Can Remake their Health Care System* (Harper Canada, 2000) – “At the present time there are 15,000 members of the College of Family Physicians of Canada... they are a firm foundation on which to build the reformed system. They are part of the solution.”

It is with this in mind that we have applied ourselves in formulating *Primary Care and Family Medicine in Canada: A Prescription for Renewal*.

- STRATEGIES AND RECOMMENDATIONS -

The CFPC's *Prescription for Renewal* proposes strategies and makes recommendations on two fronts: (A) **Creating a Model for the Future Delivery of Primary Care: The Family Practice Network (FPN)**; and (B) **Sustaining the Model: The Resources Needed**.

(A) CREATING THE MODEL: THE FAMILY PRACTICE NETWORK (FPN)

1. FAMILY PRACTICE NETWORKS (FPNs)

One of the keys to the success of primary care renewal will be the ability of family doctors to work together more effectively in providing services to their patients.

Some have suggested that an expansion of Community Health Centres (CHCs)—staffed by family doctors and other health professionals would accomplish this objective.

While the CFPC believes that CHCs will continue to be a model of choice for some physicians and patients, there are too many variables from one community to the next (e.g. geography, physician and nurse resources, patient/population demographics, special needs) to presume that a single model will be appropriate for all. We therefore oppose any attempt to force or conscript family doctors into CHC practices. The reality is that in Canada, most family physicians still favour some form of independent private practice and should be supported to carry on in this way.

At their meeting in September 2000, the First Ministers stated that one of their goals for the health system is to ensure that Canadians have timely access to an appropriate, integrated, and effective range of health services. A particular objective they highlighted is to decrease overuse of hospital emergency departments to prevent overcrowding and to avoid the expensive and inappropriate use of this limited resource.

The CFPC is proposing a model of primary care delivery that would meet the goals and objectives described by the Ministers. It is calling for the establishment of **Family Practice Networks (FPNs)** throughout Canada.

With this model, family doctors throughout Canada would be encouraged to form real or virtual groups, practising either in the same office setting or in different locations, but linked with one another to facilitate transfer of information and to share clinical responsibilities. Wherever possible, this linkage should be supported through the implementation of electronic information and communications technology.

FPNs would facilitate provision of **comprehensive and continuing** care by family physicians and other health care professionals. Some family physicians would offer a broad range of services while others would provide expertise in areas of special interest. Patients would benefit by having family doctors within an FPN refer to one another when necessary to ensure access for them to the entire range of services.

The number of physicians and other health care professionals to be included in each FPN would be determined by factors such as its geographic location and the demographics of the patient population to be served.

With family doctors and other health care professionals working together as integrated teams, FPNs would be able to respond to the needs of patients with respect to a defined scope of primary care services 24 hours a day, 7 days a week, 365 days a year – with the after-hours on-call responsibilities shared by the doctors and nurses of each FPN.

While more work needs to be done to define the scope of services to be included, a good starting point might be the ‘set of mandatory functions for primary care’ presented in 1996 by the Ontario Provincial Coordinating Committee on Community and Academic Health Science Centre Relations (PCCCAR) (see Appendix 2).

Family physicians working in FPNs would continue to be the entry point to the medical care system, ensuring patients access to and coordination of all medical services required, including care in office, hospital, home, and other community settings. The role and responsibilities of nurses in FPNs would be substantial and would recognize their knowledge and skills as defined by the scope of nursing practice.

Patients should be encouraged to receive all their non-emergency primary medical care from their FPN. If they access care elsewhere, no financial penalties for patients, family doctors, or FPNs should be imposed. Freestanding walk-in clinics, unaffiliated with comprehensive continuing care office practices, should not be encouraged as part of our health care system.

It is important that there be a centralized record for each patient. This record should be owned by the patient and maintained by his or her family physician and FPN. It should follow the patient through the health care system.

FPNs should not be mandated, but should be introduced and allowed to expand and grow as a result of patient and physician choice. With more than half of all family physicians already practising in groups of three or more, we believe that with the appropriate encouragement and support, FPNs could become the organizational model of choice for all family physicians in Canada.

2. INTERDISCIPLINARY TEAMS AND COLLABORATIVE PRACTICE

Under the FPN model, family physicians, nurse practitioners, nurses, midwives and other health care professionals would work in interdisciplinary, integrated teams.

While this is already the case in a number of family practices across Canada, the CFPC recommends that this approach be more strongly encouraged and supported to help foster the kind of comprehensive, integrated care that our patients will increasingly require in the future. Teamwork involving a broad spectrum of health care professionals, with patients at the centre, is essential to the provision of high-quality care.

The spectrum of care required by patients will be provided for them by their family physicians working together with nurse practitioners, nurses and other health care professional members of FPN teams. The number of family doctors, nurse practitioners, nurses, and others required to participate as part of an FPN will vary from practice to practice depending on geographic location and patient demographics. Besides nurse practitioners, nurses and midwives, other professions, which could also be part of integrated teams, include dietitians, social workers, psychologists, physiotherapists, occupational therapists, and pharmacists.

While the specific roles of each provider may vary from one FPN to the next, generally, family physicians would be responsible for taking the lead role in providing and coordinating medical care, and nurses would provide and coordinate a range of nursing services.

A collaborative practice approach based on mutually supportive roles for doctors and nurses would facilitate the delivery of a comprehensive scope of primary care services for patients within FPNs. As described by Way, Jones, and Busing in their paper *Collaboration in Primary Care – Family Doctors and Nurse Practitioners Delivering Shared Care* (May, 2000) “Collaborative practice involves working relationships and ways of working that fully utilizes and respects the contributions of all providers involved”. Their article also states that in a collaborative practice, “Nurses practice nursing, physicians practice medicine.”

While it is recognized that in some parts of Canada, nurses with advanced training i.e. nurse practitioners or extended-practice nurses, may now perform some acts previously restricted to physicians, generally, nurses are not licensed to carry out independent medical practice. The CFPC supports expanded roles for nurses with advanced training but maintains that all licensed providers of medical diagnosis and treatment in Canada should be required to meet the same high standards of education and training.

It will be important for governments to provide appropriate funding to support interdisciplinary teams. Currently, remuneration for office nurses is usually provided by family physicians from their own earnings. This has resulted in many private practices finding it difficult to include nurses as part of their professional staffs. Continuation of this approach will likely rule out the appropriate inclusion of nurses as key players in FPNs. The CFPC therefore supports government funding being offered as an option for remuneration of nurses, nurse practitioners, and other health care professionals working within FPNs.

To encourage maintenance of competence, governments should also support continuing professional development for family physicians and other members of the FPN team.

The CFPC also recommends that each provider on an FPN team be accountable for his or her own professional practice and be responsible for securing his or her own liability coverage.

3. PATIENT CHOICE

Every Canadian should be encouraged to have a family doctor of his or her choice, preferably within an FPN. Patients should have the right to change family physicians, FPNs. When patients transfer their care to other family physicians or FPNs, their health records should follow them.

Programs should be developed to help patients understand their responsibility to seek primary care services from only their own family physicians and FPNs whenever possible. There should, however, be no financial penalties for patients, family doctors, or FPNs if patients access care outside their own FPN.

The issue of patient registration or rostering has been the focus of debate for some time. The CFPC recognizes that, while patient registration might provide some organizational and health outcome benefits, it will only work if it is strongly endorsed by both patients and physicians. We therefore believe that formal patient registration or rostering should not be mandated but rather should be left as an option which could be adopted by any practice.

4. HEALTH INFORMATION AND COMMUNICATIONS TECHNOLOGY

The Canadian health care system has been slow to realize the potential benefits and power of new information and communications technologies.

Hopefully the focus on e-health technologies emphasized in this fall's meetings of our First Ministers and Health Ministers will mark the beginning of greatly increased support for the introduction and expansion of this important resource.

To stimulate the use of information technology in medical practice, the CFPC, The Royal College of Physicians and Surgeons, Scotiabank, and WebMD Canada have recently launched *The Canadian Doctors Network* (CDN). This initiative will provide family doctors, medical and surgical specialists, and patients with secure access to on-line medical and health information, including the e-based tools needed to communicate, transfer data, carry out continuing education, and share expertise with one another. Ultimately, we expect that CDN will facilitate creation and management of electronic health records for all Canadians.

One of the most advanced web-based portals in the health care field, CDN will offer Canada the opportunity to accelerate the formation and support the functioning of FPNs and would open the door for other patient and health care system benefits in the future, including:

- * Enhanced physician-to-physician communications and consultations including distance consultations;
- * Links between physicians and other health care providers, pharmacies, hospitals, laboratories and other diagnostic services;
- * Immediate secure access to patients' health records (including information regarding medications) in clinical settings such as emergency departments;
- * Patient access to information regarding their FP/FPNs (i.e. through practice websites) as well as to other health information and educational materials;
- * Shortened waiting times for appointments.

The CFPC recognizes much work still needs to be done to achieve this e-health vision including development of standards to ensure compatibility of health information networks and resolution of issues related to consent, privacy, security, and confidentiality of personal health information.

We invite government and all health and medical care organizations in Canada to join us and our partners in further development of the Canadian Doctors' Network.

(A) CREATING THE MODEL: THE FAMILY PRACTICE NETWORK (FPN)

SUMMARY OF BENEFITS

I. BUILDS ON STRENGTHS

The FPN model expands on current practice structures, builds on existing patient-doctor relationships, offers continuing comprehensive care to patients through a network of family doctors and other health care professionals, avoids disruption for patients and upheaval in the system, and, if introduced as part of a well-supported, voluntary strategy, capitalizes on the power of motivation of those choosing to participate.

II. IMPROVES PATIENT ACCESS

Teams of health care professionals working in FPNs will be better able to respond to the needs of patients with respect to a defined scope of primary care services 24 hours a day, 7 days a week, 365 days a year.

III. ENSURES COMPREHENSIVENESS AND CONTINUITY OF CARE

Drawing on the skills and knowledge of teams of family physicians and other health care professionals, FPNs can offer comprehensive, continuing, primary care services to patients throughout their lives.

IV. PROVIDES COST-EFFICIENCIES

FPNs will help reduce health service duplication and inefficiencies, including the costly overuse of hospital emergency departments.

FPNs will facilitate coordination of care.

V. ENHANCES QUALITY OF CARE AND FACILITATES INTEGRATION OF HEALTH CARE PROFESSIONALS

FPNs ensure delivery and coordination of a defined scope of needed services for patients by highly skilled health care professionals working together as integrated teams.

FPNs ensure access for patients to services provided by their family doctors and other health care professionals in offices, homes, hospitals, and other community settings.

FPNs support and facilitate integrating the care of physicians, nurses, and other health professionals, recognizing and respecting each for the knowledge and skills related to their disciplines.

VI. ENABLES OPTIMAL USE OF HEALTH INFORMATION AND COMMUNICATIONS TECHNOLOGY

The FPN model facilitates rapid adoption and ongoing evaluation of new technology.

VII. SUPPORTS RURAL AND REMOTE COMMUNITIES

The availability of teams of health care professionals who share primary care responsibilities will enhance recruitment and retention of family physicians and other health care providers in underserved areas.

The introduction of health information and communications technology will greatly enhance patient care and help meet the continuing professional development needs of rural family doctors and other health care professionals.

VIII. MEETS BOTH THE PROFESSIONAL AND PERSONAL NEEDS OF FAMILY PHYSICIANS AND OTHER HEALTH CARE PROVIDERS

FPNs offer more flexible working arrangements, which could lead to improved personal and family health for family physicians and other members of the team.

FPNs can accommodate family doctors with more specialized scopes of practice, allowing them to pursue their areas of interest while still being part of a team that provides patients with comprehensive, continuing care.

(A) CREATING THE MODEL: THE FAMILY PRACTICE NETWORK (FPN)

RECOMMENDATIONS

- A1** Every Canadian should have a family physician of his or her choice, preferably one who is part of an FPN.
- A2** Family physicians, nurses, and other health care professionals in Canada should be encouraged and supported to join FPNs.
- A3** Interdisciplinary integrated care teams should be established within each FPN.
- A4** FPNs should serve all Canadians as the point of entry for primary care family practice services.
- A5** FPNs should provide comprehensive continuing care for patients throughout their lives.
- A6** FPNs should be prepared to respond to the needs of patients with respect to a defined scope of primary care services 24 hours a day, 7 days a week, 365 days a year. After hours, the family physicians and nurses who are part of the FPN team should share on-call responsibilities.
- A7** There should be no financial penalties for patients, family doctors, or FPNs if patients access care outside their own FPNs.
- A8** Freestanding walk-in clinics, unaffiliated with comprehensive continuing care office practices, should be discouraged.
- A9** Direct funding from government should be available as an option for remunerating nurses, nurse practitioners, midwives, and other health care professionals working in FPNs.

- A10** Government funding should support FPNs in the acquisition and maintenance of computerized information and communications systems.
- A11** Patients should own their health records; family doctors should be custodians of the records. If patients move from one family doctor or FPN to another, their health records must move with them.
- A12** Formal patient registration or rostering should not be mandated but rather should be left as an option which could be adopted by any practice.

(B) SUSTAINING THE MODEL: THE RESOURCES NEEDED

As a society, Canadians must be assured of access to high quality primary care both today and in the future.

To sustain the model will require a commitment to:

- The human resources needed to provide the services;
- The training of future providers;
- The research required to evaluate outcomes;
- The remuneration and funding strategies needed to support all parts of the system and,
- The collaboration and communications amongst all key players which will be required.

1. HEALTH HUMAN RESOURCES

There is an urgent need for a substantial increase in the number of trained family physicians in Canada. As described earlier, doctor shortages are now a pressing problem in many communities. Yet Canada is presently producing approximately 285 *fewer* family doctors a year than it was in the early 1990s.

While the CFPC is pleased that some provinces have introduced modest increases in medical school enrolment, we believe more must be done. In keeping with the recommendations of the Canadian Medical Forum (CMF), we support an immediate expansion of medical school entry positions to at least 2000 per year (up from 1500 as of September 1999).

As well, we propose that family medicine residency positions be increased to 50% of the total of all first year postgraduate residency positions available across Canada (from the present 38%).

While increasing opportunities for young Canadians to enter and complete their medical training in Canada must be a priority, we recognize that the benefits of this strategy will not be felt for at least 6 to 10 years.

The CFPC therefore also supports implementation of programs to identify and help train physicians from other countries in order to help them to become Certified (CCFP) and fully licensed family physicians in Canada able to help us meet the immediate problems patients are experiencing accessing family doctors.

While we welcome those who have been educated and trained in other countries as valuable colleagues in the Canadian health care system, we believe that all physicians must be expected to meet the same high standards before they are awarded Certification or granted licenses to practice.

We will also continue to encourage provincial and territorial governments and licensing authorities to work toward standardizing their policies and protocols for the awarding of licenses to new physicians and locum tenens physicians in order to diminish the complicated process and the confusion that presently exists from one jurisdiction to another across Canada.

The CFPC is also concerned about the serious shortages of other health care professionals, especially nurses. Of note, in 1999, the Canadian Nurses Association projected a shortage of more than 50 000 registered nurses by 2010. We encourage and support an immediate increase in nursing school entry positions as an essential component of the renewal of primary care in Canada.

In September 2000, the First Ministers promised to "coordinate efforts on the supply of doctors, nurses, and other health care personnel so that Canadians, wherever they live, enjoy reasonably timely access to appropriate health care services." We applaud their words and hope they will be translated into action.

2. TRAINING FOR TOMORROW

Core training

To ensure a sustainable supply of practising family physicians, nurses, and other health care professionals, Canada must provide opportunities to educate and train adequate numbers of young Canadians to meet the present and future health care needs of our society. This will require not only an increase in the number of training positions but also an ongoing commitment to ensure that the training provided is meeting these needs.

The 16 Canadian University Departments of Family Medicine and the CFPC have long been committed to this goal and will continue to work together to help further clarify and define the core knowledge and skills that should be included as mandatory components of all family medicine residency-training programs. The PCCCAR set of mandatory primary care services can serve as one of the models for the further development of the core curriculum objectives for family medicine residency training (see appendix 2).

The CFPC's accreditation standards for family medicine residency training programs should include the requirement for programs to have provided residents with the opportunity to develop their competence in a defined set of core knowledge and skills.

As well, the CFPC must remain committed to ensuring that the awarding of Certification in Family Medicine (CCFP) includes the requirement for physicians to have demonstrated their competence in a defined set of core family practice knowledge and skills.

Following completion of residency training, family physicians usually decide which services they will provide (or not provide) based on their own competencies, interests and needs as well as the needs of the patient population they are serving. While each family doctor should be encouraged and supported to provide as broad a scope of services as possible, gaps may exist in an individual physician's practice. To fill these gaps and to ensure patients have access to the most comprehensive scope of primary care services possible, family doctors should practice in collaboration with others, i.e., in FPNs.

Added skills training

While core family practice competencies must be included in all 2-year family medicine residency programs, each trainee should also have the opportunity to acquire extra skills to meet the needs of specific communities or populations (e.g., rural, inner city, aboriginal). These extra skills could be acquired as elective experiences during the 2 years of family medicine training or during optional third year (R3) programs.

At present, while at least 40% of those in two-year family medicine programs indicate their interest in acquiring further training, R3 positions are available for only 10% of them. The CFPC is therefore calling for an immediate fourfold increase in the total number of R3 positions to meet the needs of both the graduating physicians and the populations they will be serving.

There should also be an increased number of added skills training positions to accommodate both international medical graduates and family physicians in practice seeking to return for further training. These positions could be offered for varying lengths of time based on the past experience and competency of each individual.

The positions for family medicine residents moving directly from R-2 to R-3 slots should be protected (separate from those for international medical graduates [IMGs] and re-entry candidates).

Training for rural practice

Over the past several years, the CFPC has clearly stated its position supporting the need for more exposure to rural and remote community practices for all undergraduate medical students and family practice residents. Medical school admission criteria need to be modified to encourage and welcome more applicants from rural, remote, and other special-needs communities. Family physicians, including rural physicians, should have larger roles as lecturers, supervisors, and mentors for undergraduate medical students.

Better role modelling and positive messages about family practice, including rural practice, at both undergraduate and postgraduate levels, must be encouraged. All programs should offer rural-based training experiences following the recommendations in the May 1999 CFPC position paper, *Postgraduate Education for Rural Family Practice: Vision and Recommendations for the New Millennium*.

Integrated training

The CFPC supports integrated models of education and training for all health care professionals (family physicians, specialists, registered nurses, etc). We believe providing shared experiences during both undergraduate and postgraduate training will enable those preparing for different health care professions to learn to work together and enhance their understanding of one another's roles.

Funding and support

Enhanced training of increased numbers of medical and nursing students, postgraduate residents, IMGs, re-entry physicians, and others will only be possible if adequate funding and other support resources are provided for university departments, hospitals, and physician and nurse teachers and researchers.

Overlooking or denying this support will severely compromise the likelihood that Canada will resolve its present and future health human resource problems.

3. RESEARCH

Primary care and family practice research is one of the most important components of the discipline of family medicine.

Ensuring sustainability of a high-quality primary health care system will require a commitment to ongoing research. Studies should be carried out to measure the impact of FPNs and physicians' different patterns of practice on patient care and health system outcomes.

Family medicine as an academic discipline and as a community-based resource with family doctors practising across the country is ideally placed to lead these research initiatives. Establishment of information and communications technology systems in FPNs would facilitate research activities.

The CFPC and the 16 University Departments of Family Medicine are committed to playing a leadership role in the future of primary care and family medicine research in Canada.

4. FAMILY PHYSICIAN REMUNERATION

One of the effects of the changes taking place in the health care system (hospital downsizing, regionalization, health human resource shortages, aging population, increasing complexities of care, etc) has been that family physicians are increasingly being called upon to 'fill the gaps' and provide a growing number of services, including some with greatly increased complexity.

At the same time, however, there have been no incentives for family doctors to take up this additional workload. In fact, many governments over the past decade have provided disincentives, such as caps or 'claw backs' on physician incomes.

We hope that the September 2000 federal/provincial/territorial agreement will mark an end to these approaches and the beginning of an era that will identify more appropriate recognition of the needs of patients and the role of family doctors. This must include appropriate remuneration for their services as well as programs that address the need for them to have a balance between practice commitments and their personal lives.

If we are to ensure Canadians of an adequate supply of family physicians in the future, it is imperative that family doctors be appropriately compensated for the many roles they play and services they deliver. This must include incentives for providing care in hospitals, homes, and community-based facilities; obstetrical care; palliative care; anaesthesia; emergency room work; and other more demanding services. In addition, family physicians must be supported in their critical role in health promotion and prevention, in teaching, and in research.

With respect to the model of remuneration, the CFPC urges flexibility and choice. In February 2000, this point was made in an open letter to the Federal Minister of Health, the Honourable Allan Rock, in which we strongly opposed the suggestion that all family physicians in Canada might be placed on salaries and emphasized our support for each physician and community retaining the right to choose the payment strategy best suited to them.

Patients and their needs vary widely, and this diversity must be reflected in how doctors are compensated. Several years ago, the CFPC put forward a blended funding formula that supports this flexibility. This mechanism offers a range of remuneration options (e.g., fee-for-service, salaries, sessional fees, and/or capitation) that can be implemented either alone or in combination.

Whatever the payment mechanism, the goal is to ensure that patients receive the highest-quality health care possible. This will require a motivated workforce of health care professionals. We must ensure that family doctors, nurses, and other members of the primary care team are well remunerated with appropriate incentives to support the broad range of services they offer.

5. PUBLIC / PRIVATE FUNDING

The CFPC supports a single-payer, publicly funded system for all medically necessary services. We also support medically necessary home care services and essential medications being publicly funded as part of our nation's medicare program.

We recognize, however, that public funding must be maintained at appropriate levels if Canadians are to be protected from the need to pay privately for such services.

Patients must also be assured that they will not have to pay directly for medically necessary services even if such services are delivered by the private sector. When the private sector is involved in delivering services, providers and facilities should be required to meet the same standards as are expected of those in the public sector. Governments working with professional colleges and associations have a responsibility to establish a monitoring and disciplinary process applicable to the private sector.

The roles and relationships of the private and public sectors in the delivery of health and medical care services require ongoing study. The effects of private-sector delivery of services on patients, providers, governments, and other players must be part of this research.

As a society, we have important challenges ahead of us. One challenge is to try to agree on which services are to be defined as 'medically necessary.'

6. ONGOING COMMUNICATION AND COLLABORATION:

Many of the concepts forwarded in the FPN model will require further deliberation, communication, and study as they are being addressed and implemented, including:

- The supports needed to establish and sustain the model;
- The roles and relationships of nurses and other health care professionals within FPNs;
- Studies to be carried out to measure the pros and cons of formal patient registration;
- Studies to measure the impact of FPNs on patient care and health system outcomes;
- Strategies to ensure accountability of providers, patients, and governments;

Collaboration, which includes all key players – physicians, nurses, patients, other health care providers, and governments – will be critical to the ultimate success of this vision.

(B) SUSTAINING THE MODEL: RESOURCES NEEDED

RECOMMENDATIONS

- B1** There should be immediate expansion of medical school enrolment across Canada to address the critical shortage of practising physicians.
- B2** There should be immediate increases in family medicine residency positions to address critical shortages of practising family physicians.
- B3** There should be immediate increases in other appropriate training programs across Canada to address critical shortages of medical and surgical specialists, nurses, and other health care professionals.
- B4** The CFPC and the University Departments of Family Medicine should maintain their commitment to ensuring that a clearly defined set of core knowledge and skills are a mandatory part of the curriculum of the two-year family medicine residency-training program for all residents.
- B5** The CFPC's accreditation standards for family medicine residency training programs should include the requirement for programs to have provided residents with the opportunity to develop their competence in a defined set of core knowledge and skills.
- B6** The CFPC must remain committed to ensuring that the awarding of Certification in Family Medicine (CCFP) includes the requirement for physicians to have demonstrated their competence in a defined set of core knowledge and skills.
- B7** There should be expanded training opportunities for 'added skills' in family practice for family medicine residents, IMGs, and physicians in practice seeking further training.

- B8** All university undergraduate and residency programs should offer rural-based training experiences consistent with the CFPC's May 1999 position paper: *Postgraduate Education for Rural Family Practice: Vision and Recommendations for the New Millennium*.
- B9** Integrated education and training programs for health and medical professionals should be introduced and supported to provide shared experiences among various disciplines.
- B10** There must be a commitment to ongoing research in primary care and family practice in order to sustain the system.
- B11** There must be adequate funding and other support resources for university departments, hospitals, and physician and nurse teachers involved in the training of family physicians, nurses and other health care professionals.
- B12** Family physicians must be appropriately compensated for the increasing numbers and complexity of services they provide, including incentives for carrying out specific services needed by patients across the country. Such services include emergency care, in-hospital care, palliative care, obstetric deliveries, services for rural and remote communities and other special-needs populations, house calls, and achieving preventive health goals.
- B13** Family physicians should be remunerated by the payment mechanism that best responds to their professional, practice, and patient needs.
- B14** Nurses and other members of the health care team must be appropriately remunerated.
- B15** As a nation, we must try to define 'medically necessary services' and ensure that public funding is always able to support provision of these services to all Canadians.

- B16** Where private-sector providers exist, governments must ensure that all medically necessary services are publicly funded and that governments, professional Colleges, and Associations establish monitoring and disciplinary processes to guarantee that private providers and facilities will meet quality and standards of care.
- B17** Studies should be carried out to measure the impact of the FPNs and physicians' patterns of practice on patient care and health system outcomes.
- B18** Strategies must be developed to ensure accountability of providers, patients and governments.
- B19** Ongoing collaboration, including representatives of family medicine, medical and surgical specialties, nursing, other health care professions, patients and governments, must be carried out regarding the FPN model: (a) to address questions still to be answered related to its creation and sustainability, and (b) to evaluate its ongoing impact.

- CONCLUSION -

As the voice of family medicine in Canada, the CFPC, its 10 provincial Chapters, and its 15 000 practising family doctor members across the country are dedicated to enhancing the health and health care of all Canadians. This commitment is brought to life by what family doctors do every day—in medical schools, through research, and on the front lines in their practices.

Canada's family doctors are proud of our nation's health care system and believe we should build on its strengths. While there are challenges to improve and renew it, we are ready to work with governments and all other stakeholders in this renewal process.

We believe that *Primary Care and Family Medicine in Canada: A Prescription for Renewal* presents strategies and recommendations for creating and sustaining a model of care that will meet the needs of all Canadians.

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Le Collège des médecins de famille du Canada
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APPENDIX 1

The following is a list of some of the papers on primary care reform/renewal produced by the Ontario College of Family Physicians (OCFP)

Bringing the Pieces Together: Planning for the Future -March, 1995

Bringing the Pieces Together: Beginning the Process -March, 1995

Family Medicine in the 21st Century – A Prescription for Excellence in Health Care – Visioning the Future, Listening to Reality -November, 1999

Family Medicine in the 21st Century – A Prescription for Excellence in Health Care - June, 1999

Where Have Our Family Doctors Gone: #1 A Brief History of the Family Physicians Shortage in Ontario - 1999

Where Have Our Family Doctors Gone: #2 Reversing the Trend -1999

Where Have Our Family Doctors Gone: #3 Hospitals without Family Physicians -1999

Where Have Our Family Doctors Gone: #4 The Future is Now! -September, 1999

Family Medicine in the 21st Century – Implementation Strategies -March, 2000

Mental Health Reform Initiatives – Implementation Strategies for the New Millennium -March, 2000

Implementation Strategies: “Collaboration in Primary Care – Family Doctors & Nurse Practitioners Delivering Shared Care” -May, 2000

Implementation Strategies: Protecting Trust in the Patient-Physician Relationship -June, 2000

Implementation Strategies: “Too Many Hours, Too Much Stress, Too Little Respect” -July, 2000

APPENDIX 2

PROVINCIAL COORDINATING COMMITTEE ON COMMUNITY AND ACADEMIC HEALTH SCIENCE CENTRE RELATIONS (PCCCAR), 1996

Common Set of Mandatory Functions

1. Health Assessment
2. Clinical evidence-based illness prevention and health promotion
3. Appropriate interventions for episodic illness and injury
4. Primary Reproductive Care
5. Early Detection, Initial and Ongoing Treatment of Chronic Illnesses
6. Care for the majority of illnesses (in conjunction with specialists as needed)
7. Education and Support for self-care
8. Support for In-Home Long Term Care Facility and Hospital Care
9. Arrangements for 24-hour/7-day a week response
10. Service Coordination and Referral
11. Maintenance of a comprehensive client health record for each rostered consumer in the primary health care agency
12. Advocacy
13. Primary Mental Health Care including psycho-social Counseling
14. Coordination and Access to Rehabilitation
15. Support for People with a Terminal Illness