Addendum

October 28, 2021

President's Letter: Is the Minister of Health Opposed to existing family practices participating in team-based primary care?

Last week the government sent signals that it is opposed to existing community-based family doctors participating in teams-based primary care. As amazing as this sounds, it seems this is true.

Team-based primary care for all citizens of our province is a widely shared goal and we are pleased the Health Accord is supporting it. If this goal is to be achieved, we must create opportunities for all family doctors to be part of these teams. A complex part of this transition is that family doctors currently work in different kinds of organizations and under different payment models, with some in the public sector organizations and others in small private practices. Therefore, for a successful transition to teams, the diversity of providers, payment models and practice organizations must be built into the plan.

Most family doctors practice in private community-based offices and receive fee-for-service payments, mainly through MCP, but also for non-insured services. They are small businesses that pay for their own staff and operating expenses. A minority of family doctors are salaried employees of regional health authorities (RHAs) in which the RHAs pay for the related staff and operating expenses. A smaller group of family doctors have professional services contracts with RHAs and operate in a similar fashion to salaried employees. How do we ensure that all these doctors have the opportunity to transition into integrated primary health care teams, allowing citizens no matter where they live to receive consistent and high-quality services while maintaining their relationships with their current family physicians?

Unfortunately, Minister Haggie only conceives of one team model for the future. In this model, physicians work as employees for the RHA, along with other team members such as nurse practitioners and registered nurses. This team model excludes the hundreds of fee-for-service physicians who provide care to 325,000 attached patients. Many of these practices can also expand under a team model to absorb some of the 99,000 unattached patients.

Team-based models are a positive step, whether they occur inside RHAs, in the community, or a hybrid model. We applaud RHAs that are creating collaborative care teams (though we have considerable concern at the moment, while there is a physician shortage, as new RHA clinics will draw family doctors away from other important roles in the health system).

However, the massive "elephant in the room" is how we create the opportunity to transition the hundreds of fee-for-service physicians and their 325,000 patients to team-based care? Last week we did not hear anything from the Minister of Health on this question. Most family physicians want to work in teams but they also want to maintain their practices outside RHAs. In 2020 the NLMA surveyed family physicians and asked about their interest in team models and relationship with RHAs. The largest group, 70% preferred team practices outside RHAs, 12% preferred team models where they are employed by a RHA, and 18% are not interested in working in teams. The vast majority of physicians therefore want to maintain practices where they can innovate and serve patient needs without being controlled by a large scale RHA or government management system.

The government has suggested that new-to-practice doctors do not enjoy the business side of private practices and would prefer to work within RHAs where administrative staff and management take care of the overhead issues. Frankly, there are few physicians who enjoy the business side of medicine, but as the above survey shows, this does not mean they wish to work for RHAs. The longstanding under-funding of fee-for-service practice has made it difficult for physicians to afford their overhead expenses, so naturally some doctors would prefer a job where these overhead expenses do not exist.

The RHA-based model with salaried employees is not the only path to team-based care, yet it is the only one in the Minister's plans. The NLMA supports the RHA-based model where it makes sense, but has also tabled proposals inside negotiations and with the Health Accord on how to create pathways for family practices to participate in team-based care. Essentially there are two additional pathways, and both are consistent with the goal of having family doctors, nurse practitioners and registered nurses working together in restructured community-based practices. On one path, the practices would be funded with a new

payment model called “blended capitation”. On the other path, the fee-for-service schedule would be adjusted to ensure sufficient revenue in the practices to hire additional providers. We believe the blended capitation model is the best payment system for transitioning to team-based care, and we have been pursuing it through negotiations. However, we must recognize that some physicians will remain with the fee-for-service system, at least for a period of time. These practices and their patients should not be denied the benefits of team-based care. Therefore, plans must be made to include all the above practice types in the vision for team-based care in our province.

When we heard the Minister announce four new collaborative clinics last week to provide more access for patients, we wondered why the only path was the RHA-based salaried model. (We are not even mentioning the interim rotas of family physicians, because these are simply not an acceptable way to staff a clinic to provide continuity of care. We presume these interim measures will quickly be set aside.) An equally viable, rapidly deployable model for expanding access to teams is to ask existing community--based practices if they can incorporate a nurse practitioner or registered nurse into their practice right away, to help more patients have access to primary care. Not every practice can do this, but many can. Proposals for this model are already on the Minister’s desk. The NLMA proposed it as part of negotiations, and this idea could easily be implemented outside negotiations as well. It is a cost-effective approach, less costly per patient than setting up new clinics inside RHAs. A similar model was also recommended in a study jointly commissioned by the Department and the NLMA through the Family Practice Renewal Program.[1]

The Minister, however, sees only barriers to this approach. He was asked by reporters about the idea of adding other providers to existing clinics and he responded as follows:

> *Well, I mean, we’re perfectly ready to entertain that suggestion. I think the challenges are around who the employer would be, they are as much labour relations issues as anything else. From our point of view, the turnkey operation at Mundy Pond or at Topsail Road would seem to be the most attractive solution, judging by the fact that I’m told that there is no difficulty from Eastern Health’s point of view in finding physicians prepared to do the sessional work. I think, um, that would be probably my first response. I think we have made it quite plain with our actions around scopes of practice that other health care professionals are autonomous, they need to work in a team environment, but it’s a team of equals and so I think there are all sorts of considerations like that that really need to be addressed, rather than simply, you know, just dispatching someone to a clinic up the road. It’s a team. We shouldn’t have people working in isolation, but we need to get the team right. And that’s what Eastern Health has been doing over the last little while.*

Despite viable proposals on his desk that contain answers to his questions, the Minister has not moved to a broader vision of team-based care. RHAs are not the only place where nurse practitioners and registered nurses can work with professional autonomy and to their full scope of practice. A team in a community-based practice does not work in isolation, especially when it is net networked with primary care practitioners such as social workers and pharmacists within the RHA. This approach is consistent with the vision of the Health Accord. These issues are all perfectly manageable, and the Minister should know this.

So, why does he throw barriers to the idea rather than say he will work with the NLMA to solve the issues? We fear that the Minister is actually opposed to allowing community-based physician practices to transition into multi-disciplinary teams. Other statements from the Minister last week reinforced our concerns:

- Regarding “…*the business side of a practice for family medicine not being appealing to new grads and current trainees, those are things that the RHAs, for example, do very well. They organize clinics, they staff facilities*.”
- Regarding the proposed human resource plan: “*the number of practitioners and the skill mix will depend on kind of the model that you have. And at the moment we’re using the collaborative team approach to determine that model, and so the numbers will shake out of that….”*
- Regarding the role of family physicians within a team: “*we would reserve then, if you like, the unique skillset of family physicians to deal with those more complicated patients where there are several competing clinical priorities.”*
- Regarding triage in a collaborative clinic: “*So, if you’re in need of care, you might not know whether it was your mum who was going to look after you or your grannie, but you’ll get the same level of care.”*

These statements reveal several things: a bias in favour of RHAs assuming responsibility for all teams; conceiving the future human resource plan based on the RHA-based collaborative clinics; and directing family physicians on the role they will play within teams. In fact, on this latter point, the language used by the Minister presumes that patients will be attached to a whole team without ever developing a continuous long-term relationship with their own family doctor or nurse practitioner. This is simply not the way primary care should work. Team-based care will allow patients to receive care from different providers at different times, but the continuous relationship with a family doctor or nurse practitioner is fundamental. An Eastern Health official clarified this point in a subsequent media interview, stating that continuity of care with family doctors and nurse practitioners will be a central feature of the Eastern Health collaborative clinics. However, we cannot understand why the Minister is on a different page.

The Minister also poured cold water on the most important innovation that will enable family practices to transition to team-based care: blended capitation. He said:

> "*There is no jurisdiction in Canada that has implemented universally a blended capitation for primary care. None of them have been able to get their pilot schemes or demonstration schemes to work the way everybody wants it. So we want to make sure with our approach to the NLMA that we get that right because it is the way to go but it's not an easy road to go down*."

This statement is all about delaying this important goal, and the statement is also misleading. The NLMA has never suggested that blended capitation should be universal. We have proposed adding blended capitation as an additional payment model to the existing salaried and fee-for-service models. We need to design it in our current negotiations and agree on a transition plan to bring it into service. We need to move carefully, avoid the mistakes of other provinces (Ontario has been using it for 15 years), and adjust as we go. But it must start now.

It has been puzzling to the NLMA why our proposals for blended capitation and team-based care have been moving so slowly in negotiations. The fact that the Minister has no vision for how to incorporate the hundreds of community-based practices into team-based care may be the explanation.

It is ironic that while the Minister seems to be blocking the path for community family doctors to participate in teams, he is asking these same doctors to help the RHAs design their collaborative care teams. It may be time for family physicians to stop facilitating a model of team-based care that is different than the one they wish to work in, especially while the RHAs have no choice but to poach physicians from other important roles in the community. These doctors want to grow team-based care in the community; not just in RHAs.

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