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FEATURE ARTICLE

Interview with Khati Hendry MD by Tom Bodenheimer, March 2008

Primary care in British Columbia, Canada

Khati Hendry is a family doctor in Summerland, British Columbia, Canada. Summerland is a semi-rural town of about 11,000, one of a ring of communities around Lake Okanagan, 5 hours east of Vancouver. A dozen family doctors provide medical care in town, and admit patients to the Penticton Regional Hospital 10 miles away. Penticton has a population of 33,000, and hosts a wide range of specialty services. More complex procedures are done in Kelowna, a city of 120,000 an hour to the north, and the highest complexity referrals go to Vancouver.

Tom: You recently moved from primary care practice in the US to Canada. What is the most striking difference?

Khati: Not having the worry of uninsured patients as an overriding feature of your medical life. Virtually everyone here has a "Care Card", which authorizes insurance coverage through the Province of British Columbia. The focus becomes providing care, not worrying about how to bill for it. This has really brought home to me the fact that access is number one. In the US, even though there is great expertise and technological capacity, measures such as life expectancy and population health lag compared to other developed countries because of all the patients who can't even get in the door. I was quite astonished to meet so many patients in their 50's who were retiring, cutting back, or changing careers without a thought to health insurance consequences—how liberating!. In fact, people tend to make life choices based on all the other things that matter—interests, career opportunities, family issues. In the office I'm back to the model of the doctor and the patient, with no insurance companies looking over my shoulder and with far less paperwork. The Province has a relatively hands-off approach to meddling in what remain mostly private family physician practices. We bill, they pay. Of course if you are a specialist working in a hospital, there are constraints based on hospital budgets and policies I won't go into here

I find things are more relaxed generally. There is not the constant pressure from insurers to get patients out of the hospital. There is definitely concern about overcrowding and moving patients to the appropriate level of care in a timely fashion, but it is addressed on many levels by the Province and each regional health agency. It's not just a question of getting people out, but of increasing nursing home beds, chronic care services, home care services, primary care coverage, and generally improving the population health status. Since the health care organization is not so fragmented it is possible to manage issues from a more holistic perspective. There is some waste and bureaucracy, and the regional health authorities have their challenges managing a complex budget. What is interesting is the degree of engagement everyone has in the issues.

Health care is big press, constantly in the public eye, with problems widely publicized. Because health budget decisions affect people across the spectrum, politicians are under constant pressure to address deficiencies. It is frustrating to people of means that they can't easily buy themselves into a different tier of care, and that is both a strength and source of complaint about the system.

Tom: do you have a pretty average primary care practice?

Khati: Our practice is fairly large, with 7 family doctors who share space. We see our patients in the office and rotate hospital rounds. We have a part-time billing person (the single payer system makes this really easy), an office manager, 2 medical assistants, and 2 part-time RNs. We routinely do minor procedures in office. It is a bit unusual for family doctors to have RNs in their practice.

Tom: what is your day like?

Khati: I see 20-25 patients per day. Some days I work the walk-in clinic, which is run out of the office on evenings and weekends. It was started when the small GP-run Summerland Hospital was closed down a few years ago and patients had no place to go in town for urgent matters. Doctors in the community take turns staffing it; it is open to anyone. During regular office hours, doctors set their own schedule, usually seeing patients every 10 or 15 minutes. I use a basic 15 minute visit, 4 per hour, though physical exams are 30 minutes. I tend to run a bit behind, and have always been the "turtle" style. When I worked in a community health center in the US, we always claimed our patients were "harder" than the norm, and now I believe it even more--it is in fact much easier to see patients here because they have more resources in their lives generally. The Province pays us fee-for-service, which means we create our own demon – more patients per day means more money but a harder day. There are limits -- you are paid half price for any patients above 50 per day, and get no money for any more than 65. I haven't even come close!.

Tom: Are family doctors in British Columbia gatekeepers? Do patients need to see their family doctor in order to access a specialist?

Khati: In theory patients can go directly to a specialist. However specialists get paid more if the patient is referred by a family doctor, which causes most specialists to require a referral before seeing the patient. One thing that is different from the US is that general internists and general pediatricians are specialists, not primary care physicians; they see complex patients referred by family doctors. The concept of having a family doctor is still alive and well in Canada—people just wish there were more of them.

Tom: Is there a standard panel size for primary care physicians?

Khati: It varies. The concept of "panel size" isn't prevalent—people see as many as they want to or have to (especially in rural areas) People aren't paid by panel size, and most practices don't know exactly how many patients are "theirs". People come and go. Certainly some family doctors serve at least 2000 patients. With the advent of patient registries for chronic disease, it will be easier to keep track of active patients with those health concerns.

Tom: is primary care respected and valued in Canada?

Khati: Patients certainly appreciate and respect family doctors, but as with primary care everywhere, we complain that we don't get adequate respect from academia, adequate payment for cognitive services, or institutional appreciation for the hard work we do. Moreover, medical schools tend to push specialization as in the US. However, maintaining primary care is a big concern, and things are changing. In British Columbia there is a strong movement for *primary care renewal.*

Tom: What is primary care renewal?

Khati: In this province, the British Columbia Medical Association (BCMA) negotiates with the provincial government to determine how much we get paid and how we work together providing health care to the population. Five years ago the BCMA and Ministry of Health formed the joint General Practice Services Committee (GPSC) to address the renewal of primary health care in BC, to encourage more people to choose family medicine as a career and to stay in practice. They heard the message from province-wide meetings with family doctors—value us, pay us, train us, and support us. There is a financial incentive program for recently graduated family physicians to help them establish practices in areas of need throughout BC. They have developed a broad menu of programs, with changes in the billing structure, to better recognize primary care services. We used to be paid a flat rate for patients of a given age regardless of complexity. Now we get a yearly bonus payment of over $300 -- in addition to the visit-based fees -- for certain complex patients. If we maintain a registry and flow sheets for patients with chronic diseases, we can also bill yearly bonus fees for each patient. That makes a huge difference in practice income. Thus far, most practices don't have a registry but that will change soon with the EMR project. There is a fee for coordination of care with specialists, home care nurses, or other community providers. This year there is a new code for mental health care patients who take more time and need more counseling and care coordination. There are also special bonuses for family doctors providing obstetric care, which has helped stem the loss of maternity services. These billing changes are designed for full-service family doctors who are caring for the patients requiring more time and effort, and it is already making a big difference in income. There have been some conflicts in the province over how to allocate money between specialists and primary care, but the primary care renewal program is happening and the commitment seems real.

Tom: We could use that kind of primary care renewal in the US. So what is the EMR project?

Khati: The British Columbia Medical Association and the BC Ministry of Health developed what they call "PITO" (Physician Information Technology Office for British Columbia), set up as part of the 2006 Agreement. They selected 6 EMR vendors that meet certain requirements such as population registry capability, decision support with embedded guidelines and flow sheets, ability to take lab, x-ray and other data feeds from hospitals, servicing support, and privacy/security. For practices that pick one of those approved EMR vendors, the Ministry of Health pays 70% of the qualifying hardware, software, and related costs. There is also assistance with training and redesign of office workflow required by a digital office. In our community, 122 physicians – primary care and specialists – came together to pick one EMR. This will allow the best possible coordination of care with e-referrals, reliable service from the vendor, and the ability to form user groups for training. We can input templates and lists of medications on the provincial formulary. Our practice will be rolling out the EMR soon.

Tom: I'm getting jealous. Why can't we do those things in the US? Are other primary care innovations taking place in British Columbia?

Khati: The primary care renewal GPSC is also responsible for promoting a series of programs to generally improve patient care, all part of the Practice Support Program. There are four main modules—advanced access to same-day appointments, group visits, managing chronic disease, and patient self management. These are highly adapted versions of the IHI (Institute for Healthcare Improvement) programs, tailored to small practices. Doctors and staff are paid to attend local learning sessions on how to implement these reforms. If practices implement disease registries providing basic and summarized data to the province (no individual patient data), they receive over $1000 per doctor; that money can be used to have someone in the practice use the registry for population management. Our local health authority is also on the verge of starting to outstation its own staff in physician offices if the doctors want help managing registries or other chronic conditions. I would love it if we can get a mental health worker on site.

Tom: Is there a major primary care-specialty income gap in British Columbia?

Khati: Not as great as in the US. The big income disparity is between Canadian and US specialists, which does create some flight of specialists to the US. There is less disparity between time spent in cognitive services vs. in procedural services here than in the US. But the fees are low – currently $27.90 for a standard primary care visit. If the patient is over 60 years, the amount rises somewhat, and more if over 70 and over 80, and we do have a pay raise pending. The good thing is that it is easy to get paid. We bill the provincial government and 2 weeks later we are paid, with few denials or partial payments. While payment is low, practice expenses are much lower than in the US. For example, we don't need the big billing departments of US practices; we have one insurer and the billing is quick and easy. Moreover, my malpractice insurance costs $107 per month. Yes, $107. In fact, the rates were reduced last year. And most of that is covered from rebates from BCMA dues. Malpractice suits are not as common in British Columbia.

Tom: Do you have pay for performance in British Columbia?

Khati: Not yet, though there is talk. To some extent, the billing incentives already discussed offer more pay in return for care, which is a first step in that direction, but it is not closely monitored at this point. Physicians are concerned that pay for performance will require more paperwork, data will be inaccurate, and it will lead to the government inappropriately micromanaging patient treatment, which is not happening now. Ultimately the EMR will allow everyone to get better data on patients, and the Ministry of Health would certainly want to have information on health status of the population. These are all issues for the future.

Tom: As you know, primary care physicians in the US seldom go into a hospital any more since the advent of hospitalists. Is that true in British Columbia also?

Khati: Many family doctors still go into the hospital to care for their patients. In our local hospital that is the standard, and all admitted patients have an identified (assigned if needed) family doctor. We bill for hospital visits. Generally the emergency department physician does admissions and care at night so that we don't get called. However, this is an issue in flux; in Vancouver and some of the larger areas they do use hospitalists, so there may be a trend in that direction. It believe that its future depends in part on the primary care renewal program, since hospital care generally takes up time and doesn't pay very well so is tempting to stop if finances are otherwise tight.

One problem that is surfacing in British Columbia is the tendency for family doctors to work in walk-in clinics Walk-in clinics can create a nice work life and pay better in a fee-for-service system, as you can see a lot of urgent problems in a shift. This choice does not involve a commitment to be the personal physician who provides long-term continuity of care for a panel of patients, including hospital, nursing home, or maternity care. This development reduces the number of family doctors available to provide more comprehensive care. This is part of the reason for the primary care renewal/GPSC efforts previously described.

In summary, family doctors in British Columbia are under pressure, but they are wanted by the community and there is recognition that steps must be taken to strengthen this resource. The work may be difficult and the work life challenging, but the primary care renewal process with its various incentives and programs is starting to make family doctors feel that their voices are being heard. I'm looking forward to seeing how the changes proceed. I want to continue to enjoy being a family physician, and I want everyone to have their own family doctor who enjoys the work and does a great job.

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British Columbia Primary Care Charter