Rural and Remote
Division of Family Practice
A GPSC initiative

**Rural Group Service Contracts – Discussion Paper**

**Purpose**

The Rural and Remote Division of Family Practice understands that the Ministry of Health is developing a rural adaptation to the Group Service Contract in recognition that the current contract is more suitable to an urban setting. As many of our members have expressed interest in the existing group contracts, the Chapter Support Team wishes to engage broadly with members to provide some recommendations to the Ministry of Health and Doctors of BC on some of the ideal attributes of a future rural group service contract. The objective is to ensure it meets the needs of our dedicated rural primary care providers and enhances the sustainability of rural primary care.

**Background**

In an effort to provide a plurality of funding options, the Ministry of Health, in consultation with Doctors of BC, released a new Group Service Contract in fall of 2020. Key attributes of the existing group contract include:

- minimum of 3 physicians at a minimum of .5 FTE
- physicians responsible for overhead and management of practice
- payment between $269,644 and $329,664 plus limited FFS
- panel size of 1250 of patients of average complexity.

For more information on the existing group contracts, click here.

**Desirable Attributes of a Rural Group Service Contract**

| Attribute | **Rationale** | Tactics for Consideration |
|---|---|---|
| Rural contracts should incentivize physicians for the broader scope of rural practice | Rural physicians are more likely to provide obstetrical, newborn, pediatric, occupational, palliative, and mental health care than urban family physicians, and are more likely to see patients in the hospitals or long-term care facilities and to conduct home visits. This broader scope of practice is necessary in rural areas where there are fewer options to access more specialized medical services. | Panel sizes designed to deliver primary, acute and community care for a given population, while ensuring a work-life balance (e.g., panel of 800 patients of average complexity). For physicians travel to communities to provide services or those with panels that include indigenous patients and/or those with complex co-morbidities, a smaller number may be more appropriate. |

| Attribute | **Rationale** | Tactics for Consideration |
|---|---|---|
| | | For communities with hospitals, panel sizes that consider the number of physicians required to be fully staffed without undue call burden.<br><br>Compensation must be adequate to reflect full scope of rural practice and must consider the unique practice circumstances of some rural communities (i.e. helicopter travel to remote Indigenous communities). |
| Encourage longer term service to minimize the disruption of primary care services in rural communities by creating more flexible working arrangements to reflect rural reality and rural GP interests. | Rural communities struggle to recruit and retain physicians.<br><br>Loss of one or two providers can result in a complete disruption of care for a community.<br><br>Housing is not available in many rural and remote communities, making a full-time commitment next to impossible.<br><br>Some rural physicians choose to live outside community to balance the educational and financial needs of children and partners and part time/quarter time models make this sustainable. | Lower required FTE commitment (e.g., .2) to allow providers to work one week a month in community. Many physicians committed to their communities' desire these working arrangements to allow them to fulfil other responsibilities including leadership with the Division or JCCs or to offer balance for their family responsibilities.<br><br>Allow for group contracts for communities with fewer than 3 physicians.<br><br>Adequate supports for physicians to access parental leave. Within the current system, there is no support above and beyond existing funding streams like the Rural Locum Program. This is a barrier for many physicians that disproportionally affects women and discourages rural practice.<br><br>A mechanism for existing providers with unreasonably high panel sizes to lighten their load. |

| Attribute | **Rationale** | Tactics for Consideration |
|---|---|---|
| Support to explore non-traditional practice models including but not limited to Community Health Centers and Health Authority owned clinics | While it depends on the preference of the physician, business ownership and the operational/managerial responsibilities require considerable time and capacity for already stretched rural primary care providers.<br>Additionally, research demonstrates that new to practice physicians prefer to work in team-based care environments where business management and ownership are not an expectation. | Consider including overhead direct and indirect costs (time to administer and manage and direct costs like staff) in the contracts or a mechanism to support physicians with overhead burden during physician shortages or vacancies.<br><br>Include seed funding to support physicians to explore this concept (distinct from the GPSC stream to merge practices) |
| Prioritize future wave PCN Communities | Rural communities are often behind with the PCN planning due to capacity and group contracts may increase capacity. | Allow for a rolling intake so rural communities can benefit regardless of PCN status. |

**Questions**

- Do you agree with the desirable attributes suggested above? If not, why not?
- Does the panel size make sense to you? If not, what would you suggest as a mechanism for calculating an appropriate panel based on the community?
- If the compensation is not competitive to your earnings FFS, what amount do you think is fair?
- What attributes are missing for the ideal rural group service contract?
- Is there anything else the Division should advocate for in a rural group service contract?