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 has been told 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. Our objective is to ensure rural contracts meet 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). Some of rural communities are closer to 600 patients on a panel – e.g. those with hospital. Creston has written a paper on their panel sizes – avg. 600-700. Communities without a hospital can often be larger – avg. 1000 (e.g. Kimberley)

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		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. Physicians with larger panels (1250+) should not be disadvantaged in the contract or incentivized to release patients. There needs to be a means to recognize their larger panel and workload. The Ministry needs a way to recognize out of province patients who live part time in rural border communities, and are not recognized in panels at the moment. For communities with hospitals, panel sizes that consider the number of physicians required to be fully staffed without undue call burden. 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). The contract needs a flexible range of services. We recommend the ability to develop an a la carte selection of services provided in the contract. E.g. clinic primary care, obstetrics, in patients, ER, anesthesia, etc. Rural FPs provide a

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		range of services, and it can vary between providers and 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. Loss of one or two providers can result in a complete disruption of care for a community. Housing is not available in many rural and remote communities, making a full-time commitment next to impossible. 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. Allow for group contracts for communities with fewer than 3 physicians. 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. A mechanism for existing providers with unreasonably high panel sizes to lighten their load.
Support to explore non-traditional practice models including but	While it depends on the preference of the physician, business ownership and the operational/managerial responsibilities require	Consider including overhead direct and indirect costs (time to administer and manage and direct costs like staff) in the contracts or a mechanism

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not limited to Community Health Centers and Health Authority owned clinics	considerable time and capacity for already stretched rural primary care providers. 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.	to support physicians with overhead burden during physician shortages or vacancies. Include seed funding to support physicians to explore this concept (distinct from the GPSC stream to merge practices)
Clearly defined contract minimums and specify which proportion of hours are suitable, ensure a mechanism for physicians to be remunerated for hours outside their contract.	The current contract does not offer complete clarify on the proportion of administrative time that can be attributed to the contract hours nor does it confirm whether travel time is to be included. It is also does not speak to the mechanism used when a physician utilizes their hours prior to yearend.	Clarify the types of hours that qualify and consider travel given the frequent demands placed on rural physicians. Provide an 'overtime' pay structure or a top up for relief coverage similar to the Rural Locum program for physicians who have exhausted all their hours prior to yearend.
Recognize that the acute care and primary care is inextricably linked in rural communities and include low volume ER shifts as part of the contract.	Almost without exception, rural providers work in ER or urgent treatment centres. Scheduling clinic hours and ER shifts can be challenging. To make do, some physicians rapidly travel back to clinic during ER shifts which reduces the quality of the critical care being delivered. In addition, due to low volume, some physicians may make less than $35 per hour. Providing optimal care should be the main priority.	Consider including low volume ER shifts (for example weekdays between 9am and 6pm) as part of the contract and compensating physicians appropriately when they provide this coverage.
A mechanism to harmonize special programs and incentive programs to promote equity among rural communities.	Depending on the community, rural physicians are compensated differently through programs like REAP, REEF, NITAOP. As each community is approved for different program, this leads to inequality for physicians. For example, physicians on Gabriola Island cannot access REAP or REEF because they have no ER yet they perform	Create a contract that is customizable based on community and providers to fill gaps left by other programs that often create inequality among rural communities.

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	procedures in their urgent treatment room identical to what occurs in ERs elsewhere. Physicians in Pemberton access NITAOP funding for their outreach to Indigenous communities but physicians in Clearwater cannot. Physicians in Whistler receive $176 per hour for ER shifts and a physician in Pemberton may be lucky to earn $35 for that same hour.	
Ability to negotiate based on unique service delivery models for rural communities	Rural communities vary in size and service delivery model. Some have ERs, others have urgent treatment rooms. There are different models that have evolved historically that form a patchwork.	While consistency is important, including options to adapt for communities ineligible for programs like REEF or who are not fully covered by MOCAP would level the playing field
Incentivize medical students	FFS physicians are in some cases paid up to $2600 to supervise medical students. Under the existing contracts physicians are no longer eligible for these payments disincentivizing rural physicians to take students. The more students have a positive rural experience, the more likely it is they will practice in a rural setting.	Allow physicians under rural contract to collect payments related to training students.
Recognize the unique burden of after hours call	The current contract does not distinguish between 9-5 clinic hours and an after hours airlift at 2:00am. The impact to a physician's personal and professional life responding to these emergencies deserves consideration. The current model disincentivizes providers from taking call thereby decreasing the number of physicians who bear the burden which contributes to burnout.	Consider recognizing after hours call as double time or other additional compensation to ensure that physicians are treated fairly.
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.