NEGOTIATING FOR ONTARIO'S WELL BEING (NOW)
RURAL HEALTH ACTION PLAN

The Rural Health Action Plan is a 12 point plan recognising previous Government/OMA initiatives and setting forth concrete solutions to address the physician shortage challenge in underserviced Ontario.

The NOW Alliance is comprised of Ontario stakeholders including Ontario's municipalities, chambers of commerce, rural educators and both rural and new physicians.

1. New Earmarked, Committed Government Funding

Build on concept of earmarked, committed funding begun in the 1997 agreement. For the 2000 agreement, increase the amount of earmarked, committed funding for communities with physician shortages by an amount equal to the proportionate increase in the number of physicians currently needed in underserviced communities, relative to the approximately $45 million committed to the 65 physician vacancies covered by the 1997 agreement.

2. Continue Existing Funding

Continue funding for programs implemented under 1996 agreement, recapture funding that should have been but was not spent under the 1997 agreement, and continue existing CME funding.

3. Non-coercive Supply and Distribution Measures

Any physician recruitment and retention measures must be non-coercive

4. Complement/Critical Mass

Incentives must be redesigned and funded to facilitate the necessary critical mass of physicians (at levels beyond historical UAP minimum numbers) needed for sustainable recruitment and retention, including taking into account:

- •on-call coverage;
- •hospital services and work including in-patient care, special skills and committee/administrative work;
- •medical educational activities for medical students, residents and others;
- •reasonable working conditions and quality of life considerations;
- •relative degree of 'rurality'

5. Conversion

Re-institute conversion of fee for service dollars when physicians switch to APPs. (Necessary top-up funding for APPs to come from additional new provincial government funding)

6. APP improvement and expansion

a) for any APPs

_ improve funding to adequately compensate for special skills and circumstances of rural practice

_ guaranteed stable base funding for physicians in APP regardless of variation in numbers of physicians

b) Extend funding for APPs for family physicians to mid-sized communities with Full Time Equivalent complement of 8 to 20;

c) Extend funding for APPs to specialist networks (beginning with general surgery and psychiatry). This could be modelled after the success of the N.W.Ont. Regional Surgical Network, and as proposed in SRPC Millennium document;

d) Extend existing funding for APPs for 1 to 7 doctor communities in Northern Ontario to rural communities in the rest of Ontario;

7. Government funding for SRPC Millennium Document
http://www.srpc.ca/librarydocs/proposal.htm

Incentive funding (APP, FFS top-up, or blended) for family doctors who provide comprehensive community care doing critical hospital services (e.g. anaesthetic, obstetrical, in-patient and surgical services).

8. Government Funding for Physician Support Complex

a) "turn-key" facilities with group practice structure (including funding for equipment, staff, information technology, and support for established practices);

b) support for more integrated group practices through funding of virtual networking of separate physician facilities.

9. Retention Incentives

Physicians in rural communities should, in addition to funding for CME leave, also receive funding for long service paid sabbatical leave and paid maternity/paternity leave.

10. Locums (relief physicians)

Expansion and restructuring of locum programs (including improved flexibility, compensation, delivery, administration and regional support/coverage), to support reasonable vacation time off, sick leave, maternity/paternity leave, CME leave, and long service sabbatical leave.

11. Rurality Index

An accepted rurality index (RI) should be established for the province of Ontario. Most recruitment and retention measures should be designed and funded to reflect the degree of 'rurality' and remoteness, in recognition of the fact that the more remote and rural the community, the more difficult it is to recruit and retain physicians. Institute a regular review of the rurality index (RI) to ensure that the needs of all rural communities are being served.

12. Implementation Implementation of NOW package by group including OMA and Government, but also including representatives with expertise and commitment to

rural/underserviced communities (including AMO, chambers of commerce, FONOM, NOMA, OFA, SRPC, Section on Rural Practice of the OMA, PAIRO and other stakeholders)

Other necessary measures, outside of Government/OMA Negotiations, include:

Expand resident and medical student training and exposure in rural and remote areas

Establish and fund a medical school in a rural/northern setting with a rural/northern mission

Increase the overall supply of physicians, including through increased medical school enrollment

Implement limited licensure for qualified senior residents