



Society of Rural Physicians of Canada Document

Comment on “Improving Access to Needed Medical Services in Rural and Remote Canadian Communities: Recruitment and Retention Revisited” by Morris L. Barer and Greg L Stoddart (June 1999)

EXECUTIVE SUMMARY

The Barer/Stoddart document, “Improving Access to Needed Medical Services in Rural and Remote Canadian Communities: Recruitment and Retention Revisited” gives a clear analysis of the current situation with a good rendition of the challenges. However, the SRPC feels the suggestions in the report would be counter-productive without reinforcing the principles of 1) the distinctiveness of rural practice, 2) two way accountability, and 3) alternatives to the usual “primary/secondary/tertiary” division of duties.

Beyond this wider context, the SRPC has much to offer specifically about the three “levers” suggested in the report (nurse practitioners, regionalization of health budgets, and enhanced role of the Academic Health Centres). If these levers are to be used, they can only be successful with strong “field” input.

Fortunately there is now an opportunity to build on the cumulating expertise from planners, governments and the medical system. The concept of a National Rural Health Strategy is building momentum politically, not just at the community level, but within the political parties. The medical system appears ready to accept new funding directed at rural health care. This opens the door for the new funding to create a system of health care incorporating the above three principles, a system which would ultimately be more suited for Canada’s needs and which would guide the way to creative federal-provincial collaboration.

Comment on *“Improving Access to Needed Medical Services in Rural and Remote Canadian Communities: Recruitment and Retention Revisited”* by Morris L. Barer and Greg L Stoddart (June 1999)

The Society of Rural Physicians of Canada (SRPC) commends the authors for a cogent and trenchant analysis of the issues facing recruitment and retention of physicians to adequately serve the health needs of rural Canadians. We agree with the analysis, and indeed could not have said it with such clarity. The following comment is advanced in the spirit of benign criticism, hoping that input from “the field” will enhance the context, usefulness and eventual implementation of the recommendations. Rather than getting entangled with all the specifics of the document at this stage, we would prefer to paint with a larger brush, all the while emphasizing those “at the coal face” have much to contribute about the “details” (if indeed such things as regionalization of health care budgets, or roles of nurse practitioners can be considered “details”).

Our comment will be divided into: 1) Content and, 2) Implementation. We will finish with some point form suggestions. We understand that the Barer/Stoddart document was not intended to be a complete research report, nor was implementation a mandate of the authors.

CONTENT:

- 1) **“Primary/secondary/tertiary” division of health care responsibilities which the report seems to use as an analytical tool does not work readily in rural areas and is often an impediment to rural populations getting proper care.** In many places the document mentions the gap in standards of care between rural and urban areas, but it does not go far enough to emphasize how rapidly that gap is growing, nor why it is growing. As specialists and their clinical standards increasingly sub-differentiate, and as generalists are seen to be “primary care providers”, there are few left to care for the severe but common illnesses (myocardial infarctions, stroke, the ill child, the acute abdomen, the woman in obstetrical distress, etc) that present with inexorable and predictable rates in rural areas. This convenient but artificially rigid division of duties, so common in health policy analysis, is also a major reason why rural women are having an increasingly more difficult time having babies in their own communities, since obstetrics is treated as ‘secondary’ care by many in the medical profession, particularly if practiced without immediate specialist backup. This static three level framework works well for densely populated countries with easy transport, but has always been bypassed, usually in an underground, officially ignored manner in such places as rural Canada (or, for that matter, in much of the Third World). Until there is a change in national clinical standards (which also implies a change in national training standards), the rural-urban gap will continue to be only partially plugged with the current practice of under the table, ad hoc importing of International Medical Graduates combined with informal unsupported

Canadian added skills programs. Modification of standards and improved access to specialized care for rural populations will be unlikely to happen, we believe, unless the “primary/secondary/tertiary” analysis is adjusted to reflect rural realities, where most providers function at a fluctuating combination of these levels all the time.

The same considerations hold when speaking of nurse-practitioners. In 1998 the SRPC held a well attended conference in St. John’s on nurse practitioners. We tried to give voice both to the field rural doctors, many of whom already work closely with nurse practitioners, and to the existing nurse practitioners deployed in rural Canada. One unanimous recommendation, agreed to by the delegates of government, professional associations and Faculties, was that a national process be started to define the scope of nurse practitioners. The difficulty of “Who does what?” and adapting that to local needs will be compounded by a rigid “primary/secondary/tertiary” framework. The full scale implementation of nurse practitioners is a goal the SRPC would welcome if done well, but it would be unrealistically costly as a means of bringing limited urban styled “primary care’ to rural areas.

- 2) **The SRPC strongly supports the principle of accountability.** We would like to see this concept brought out clearly in the report for reasons cited below. To oversimplify, the governments are accountable to assure health care to the population and the bureaucrats are accountable for the implementation, but there has been difficulty making the medical profession accountable to society’s needs. This has led to fractious, counter-productive disputes with mutual distrust between physicians and governments. Indeed, many say that governments appear to have lost much of their accountability to the medical profession and to patients.

At the risk of sounding too bold, we believe new ways to address the mutual accountability issue could be pioneered in rural Canada. The SRPC was one of the few medical organizations to support in principle the Kilshaw report on capitation. The rationale was (and is) that rural health care providers are extremely cost efficient. Their presence in rural Canada also testifies to their responding to one of the largely unmet health needs of this country. A system that actually rewarded accountability, quality and efficiency would make rural practice more attractive. Implicit here is the understanding that governments and administrators would overcome the entrenched distrust to work accountably with the providers – no small condition according to some. We nevertheless feel it is time to bring the concept of accountability forward, using it as a new paradigm for improving health care in rural areas. We feel that the problem is not only numbers of health providers in the entire Canadian health system, but also what these providers actually do. **Health providers in rural Canada have been offering a broad range of services, often against the prevailing winds of our centralist medical system, and at a lower cost.** There is a great need for outcome analysis, but what there is of this type of research documents results that meet national standards. This in itself makes rural medicine more “accountable”. This principle needs to be clearly identified and reinforced.

- 3) **The report was not asked to address the lack of ancillary services available to rural Canadians.** Access to care that urban dwellers consider routine, such as mental health services, counseling, care of handicapped children, speech therapy, physiotherapy, occupational and work therapy, support groups and so on, is either rarely found in rural areas or is improvised by the very practitioners who are in such short supply. This added burden on rural physicians, nurses and administrators contributes to the problem of recruitment and retention. Matters will simply get worse without a concerted, coordinated national plan.

IMPLEMENTATION:

An important obstacle for implementation of any effective national approach to improving rural health care is the lack of coordinated Federal funding, or even the possibility of funding. This has been compounded by unfamiliarity with the concept of rural health care delivery being a distinct entity, with its own set of challenges and solutions, solutions that can have positive effects on the rest of the health system.

The SRPC feels the time is now ripe to bring together funding with some of the imaginative but pragmatic policy suggestions coming from a variety of sources, including the recent Barer/Stoddart report.

The SRPC has been working at the community, provincial and federal levels to promote the concept of a **National Rural Health Strategy**. Briefly, the message has been that there is a strong role for the Federal Government to play in evaluating and facilitating recommendations for improving rural health care, including those found in the Barer/Stoddart document. A description of how this can be made to work is found at the end of this comment, but we underline it cannot be done without effective “field” input.

There has been considerable interest in the concept of a National Rural Health Strategy. Many community organizations, such as the Federation of Canadian Municipalities, the Canadian Rural Restructuring Foundation, and the Canadian Community Newspaper Association have wholeheartedly endorsed the concept. The Liberal rural caucus has issued a powerful document entitled “Towards Development of A National Rural Health Strategy”. The Reform and Progressive Conservative Parties have created a joint task force to look at rural health care.

Three questions are frequently raised. The first concerns existing provincial rural health care delivery programs and whether there is the political will within the provinces and between governmental jurisdictions to collaborate on generic rural health policies. Our answer is that the existing provincial programs are not working, for reasons eloquently outlined by Barer and Stoddart. A cooperative Federal role, even within strict federal jurisdictional limits, could be of substantial benefit to the

provinces. New models of federal-provincial cooperation would follow. Furthermore, we believe there is great potential for rural health care to pioneer new ways to deliver all levels of care, both in cities and in the country, by altering the accountability rules, expanding, supporting and legitimizing the roles of front line health providers.

Another question concerns the level of support within the medical profession itself. The SRPC feels the support is there.

- The College of Family Physicians of Canada (CFPC):
 - a) Has already sent a letter to Health Canada endorsing a National Rural Health Strategy.
 - b) Has developed a curriculum for training generalists for rural practice, with the formal input of the SRPC.
 - c) Is working with the SRPC on accords with some specialist societies to help provide rural populations with certain essential specialized services. One example is the recent understanding with the Society of Obstetricians and Gynecologists of Canada for training generalists for advanced obstetrical skills, including caesarian sections. Discussions on access to specialized services in rural areas are underway with the Canadian Anesthesiologists Society and the Canadian Association of General Surgeons.
 - d) Has also been working with its sister accrediting body, the Royal College of Physicians and Surgeons of Canada (RCPSC), to develop suitable accrediting schemes for this type of training so essential to rural Canadians.

- The Canadian Medical Association General Council passed a unanimous motion in 1998 supporting the development of a “national action plan for rural health”. In 1999 the CMA Board agreed to facilitate the discussion of a National Rural Health Strategy.

- The Association of Canadian Medical Colleges (ACMC) has expressed informal support. Universities are likely to be prime beneficiaries of National Rural Health Strategy funding.

- The Federation of Medical Licensing Authorities (FMLAC) is also interested. Provincial licensing bodies are feeling a great deal of pressure about rural health and need national guidance and funding to enact programs of examination, licensure and standards of practice.

The SRPC believes the seeds for national cooperation among medical bodies are planted. We have learned, however, that the spirit of gradualism (some would say statism) within the medical-political system moves only to the solid possibility of long term funding, at least for rural health care changes.

A further question frequently raised, but this time from the “field” itself, is whether the Academic Health Centres are actually able to rise to the challenge of helping rural health care delivery. There is concern that in the past, even with sufficient funding,

Academic Health Centres have not been able to transcend their internal structural and essentially urban limitations to give truly practical results in rural Canada. Time and time again, many rural providers feel, money given to the Faculties of Medicine for rural projects has been frittered away with more benefit to the University than to rural health, usually with little “field” input at all. Again, the principle of accountability needs to be emphasized, this time from the Academic Health Centres to the field. The SRPC has firm views on how this could be done.

Summary

Before listing some specific point form suggestions for implementing a National Rural Health Strategy, the SRPC would like to summarize our general argument. We believe that, when attempting to address the challenges of rural health care delivery, one can treat the issue as an anomaly, any tinkering of which will be both limited in scope and restricted to rural areas. On the other hand, one can postulate the challenges in rural health care delivery to such a sprawling country as Canada are to a great degree compounded by mimicking “primary health care” models more clinically and fiscally suited to densely populated countries such as the UK.

If one takes the latter view, then the opportunities become quite exciting for tailoring a “primary health care” system to suit not only rural Canada’s geographic, demographic, and health needs, but also for alleviating the health delivery pressures in all parts of the country. The key, we think, lies in accountability (providers, administrators and government) and in looking at what generalists actually do. There is now an unparalleled opportunity to fund new approaches to the restrictive, ill-suited “primary/secondary/tertiary” model which never really did operate in rural Canada. To do this we need to examine and use the ailing but nevertheless trustworthy and time proven rural models of generalists that have been cobbled together over the decades on the basis of practical need. This new look at old approaches, backed by a strong National Rural Health Strategy, could provide fresh approaches to generic “primary care”.

The rural system is contained and defined, the system is large (30% of the population) and national, the system serves a politically powerful part of Canada, and it is now open to help and change. Using the strengths of this system seems to be a far more pragmatic way of bringing about “primary care” change in all of Canada than the current small alternate payments pilot projects in urban areas. There is the added bonus of truly improving the health care of rural Canadians. This wider dimension will also help avoid some difficulties Australian and other international rural health programs encounter when treating rural health care as an aberration or an exception.

We look to the open mindedness of health policy planners, and to the vision and courage of politicians to take these matters into consideration.

Implementation Suggestions

- **Immediately establish an Federal/Provincial/Territorial Advisory Council on a NRHS to provide input to the F/P/T Ministers of Health**
- **Immediately establish a multidisciplinary Working Group to advise the F/T/P Advisory Council on designing a NRHS**
- **This Working Group could then divide tasks according to function, with the formation of Medical, Nursing, and Administrative Forums**
- **The Forums would formulate policy options for implementation by the appropriate responsible authority**
- **Both the Working Group and the Forums would be guided by the principle of accountability, with strong provincial participation**
- **Establish a series of well designed “Town Hall” local public consultations to give rural areas significant input to the process of establishing a NRHS**
- **Create an autonomous, stand alone rural branch in the new Canadian Institute of Health Research to contribute directed research and data collection for the NRHS**
- **Large (\$150 million/year) recurrent budget for a National Rural Health Strategy to be announced and phased in over the next two years**