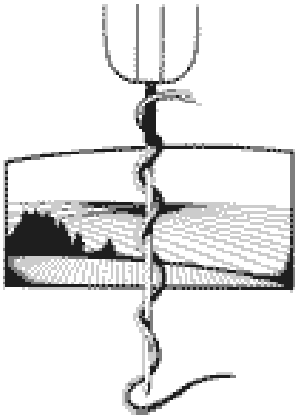
RURAL HEALTHCARE

- THE CHASM NOT CROSSED

PRESENTATION TO
THE COMMISSION ON THE FUTURE OF HEALTH CARE IN CANADA

APRIL 11, 2002 Sudbury, Ontario



PETER HUTTEN-CZAPSKI, MD PRESIDENT
SOCIETY OF RURAL PHYSICIANS OF CANADA
RR #5 SHAWVILLE QC, Y0X 2Y0 phc@srpc.ca

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Society of Rural Physicians of Canada
Société de la médecine rurale du Canada
www.srpc.ca

About the Society of Rural Physicians of Canada

The Society of Rural Physicians of Canada (SRPC) is the national voice of Canadian rural physicians. Founded in 1992, the SRPC's mission is to provide leadership for rural physicians and to promote sustainable conditions and equitable health care for rural communities.

On behalf of its members and the Canadian public, SRPC performs a wide variety of functions, such as developing and advocating health delivery mechanisms, supporting rural doctors and communities in crisis, promoting and delivering continuing rural medical education, encouraging and facilitating research into rural health issues, and fostering communication among rural physicians and other groups with an interest in rural health care.

The SRPC is a voluntary professional organization representing over 1,300 of Canada's rural physicians and comprising 5 regional divisions spanning the country.

"Nous soignons les régions- We care for the country"

"Every citizen in Canada should have equal access to health care regardless of where they live."
- Mr. Justice Emmet Hall

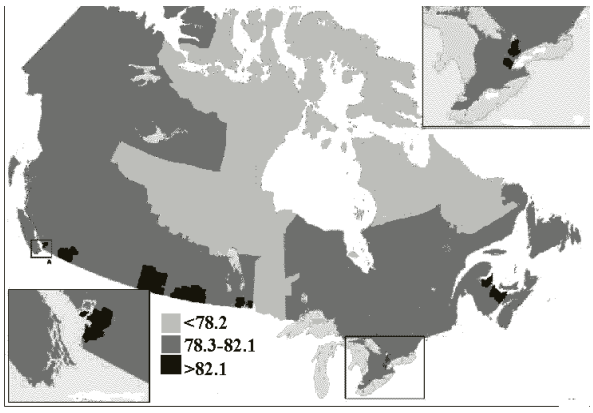
Observing these sessions it is clear and gratifying that there is a lot of interest and concern over the Health Care System. Many say we need more doctors, more nurses, more money, and they are correct, but health already is the single largest budget line and few are saying where these extra resources should and must come from. Others say that the system needs reform, and they are correct, but the current system, however flawed, works and few are saying which parts should and must continue.

As president of the Society of Rural Physicians of Canada, representing over 1,300 members[1], I will try to speak of things rarely spoken, to concentrate on bridging a few of the gaps. Rural is one of those gaps, a chasm that is rarely crossed. So you rarely hear rural voices in meetings such as this, and it is not surprising that you only have three paragraphs on the issues that affect 6 million rural Canadians in your interim report[2]. Thank you for accommodating our presentation and taking a step to cross the gap.

Rural is a Canadian Value

Rural Canada is huge, over 98% of our land mass, 22% of our people[3], producing a large proportion of the food that we all eat, providing the areas in which we vacation, and the exports on which our economy depends. The fact that even a Toronto schoolboy will recognize the call of the loon emphasizes the fact that Rural is a part of the Canadian identity, indeed Rural is a Canadian Value and yet Rural is a chasm that is rarely crossed.

In rural Canada, large numbers of first nations peoples live, our tractors overturn, mineshafts collapse, fishers get swept to sea, smoking rates are higher, poverty is more common and the litany goes on with mortality rates higher for most causes of death. In the end our most isolated rural Canadians live three years shorter lives than our urban counterparts.[4] This difference is the same as what would happen if we had a cure for Cancers but you could only get it if you lived in the cities. For all these complex social, cultural and economic reasons, and more, geography is a determinant of health and yet Rural is a chasm that is rarely crossed.



Life Expectancy Female in Years

Despite the health status of the 22% of Canadians who live in towns under 10,000 population[5] only 10% of Canada's physicians[6] live there. Furthermore the services that were once there are being dismantled. One Alberta study showed that before centralisation under a fifth of rural patients had to travel for health care. Now it's a third[7].

Geography is a Determinant of Health

Not only are there less services available locally, accessing services in the city is harder and rural residents are getting lost in the cracks[89]. The Calgary Regional Health authority has instituted a policy that discriminates against rural citizens by refusing them access in order to keep beds open just in case city residents need them[10]. Not only is Rural a chasm that is rarely crossed, the Chasm is getting deeper.

As Allan Rock has stated "The real threat of two tiered health care in Canada is not rich and poor, nor have and have nots, its rural and urban." I agree, rural Canada needs more, much more, indeed we need a fair share. And yet Rural is a chasm rarely crossed.

Barer and Stoddard told the health ministers in 1999 that "It seems important to reinforce the idea that such a restructuring would need to be pan-Canadian if it is to be expected to provide an effective remedy to the problems of rural and remote communities. Absent such cross-country agreement, provinces and territories would likely be faced with whipsawing and increased migration between jurisdictions."[11] We do not solve the need of the rural population for physicians by taking doctors from Happy Valley Goose Bay and moving them to Fort St John.

Is dealing with this determinant of health, sustaining this Canadian value, is this enough to motivate the Federal provincial and territorial leaders to move past historic grievances to forming such an approach, a National Rural Health Strategy? The good news is that this doesn't require much money and so there is little to fight over. Perhaps the bad news is that this doesn't require much money and so there is little to fight over. However it is an approach that is worth attempting and one that would be a worthy recommendation if the commissioner so chooses.

A national rural health strategy would involve the various players in the medical system to look at the systemic barriers to meeting the needs of rural Canadians and provide strategic program funding to catalyse change.

To start in Canada 22% of the population are rural but only 10.8% of medical students are of rural origin[12]. About half of the rural medical students will choose careers in rural medicine while only about one in twenty urban students do so[13,14,15,16]. Why are we picking medical students in a way that

22% of the population are rural but only 10.8% of medical students

doesn't meet societies needs? We need to work with universities in increasing representation of rural students. We need more, we need our fair share.

In 1996 the same situation existed in Australia. However In Australia health careers are now promoted to rural students and bursaries and national scholarships made available to aboriginal, rural and urban students to enable further studies in nursing, pharmacy and medicine. In Australia Medical schools have targets of 25% rural students and they are starting to reach these targets.

Then there is the issue of what is taught. Most medical students in Canada don't even see what life, much less medicine, is like outside a high tech and specialist centred teaching hospital. Specialists in general surgery graduate without training in simple surgeries such as caesarean section or setting bones, skills that are practised daily by surgeons in smaller centres.

In 1996 the same situation existed in Australia. However in Australia now the activities of rural student interest clubs are supported so that students get to experience life and medicine outside the city context. Medical curriculums have become rural relevant and friendly and training is available for training in the skills that generalists and specialists need outside the cities.

Currently in Canada there are more and more vacancies for rural and even urban doctors. The needed changes to ensure equitable distribution of health professionals across the country have been well documented in previous government reports and commissions, but have been untried.

In 1996 the same situation existed in Australia. However in Australia in 1996 they formed a Regional Health Strategy to organise all the players into groups capable of dealing with the reforms needed and were able to enact policy measures that were in their governmental reports. They increased the number of doctors practising in rural Australia from under 7,500 in 1996 to almost 8,300 in 2001[17]. This hasn't been by huge incentives encouraging doctors to go where they don't want to, but because their system now produces doctors ready for the challenge and who want to practice in country Australia.

Isn't it time, commissioner, for us to get our house in order. Don't we need to ensure that rural gets more, that it gets its fair share. Isn't it time to cross the chasm?

References

1 See srpc.ca

2 Roy J. Romanow, Q.C. Commissioner "Shape the Future of Health Care Commission on the Future of Health Care in Canada" Interim Report February 2002 p31

3 1996 Census data, Statistics Canada on line table "Population counts, showing distribution inside and outside Census Metropolitan Areas(CMA) and Census Agglomerations(CA) for Canada Provinces and Territories" Cat No. 93-357-XPB

4 Statistics Canada "Life Expectancy" Health Reports, Winter 1999, Vol. 11, No. 3 Statistics Canada, Catalogue 82-003 http://www.statcan.ca/english/indepth/82-003/feature/hr1999_v11n3_win_a01.pdf

5In 1996, 31.4 percent of Canada's population lived in predominantly rural regions http://www.statcan.ca/Daily/English/010116/b010116a.htm and 22% lived in towns under 10,000 population 1996 Census data, Statistics Canada "Population counts, showing distribution inside and outside Census Metropolitan Areas(CMA) and Census Agglomerations(CA) for Canada Provinces and Territories" Cat No. 93-357-XPB

62000 CMA, physician resources data base. As of Jan 1st 5740 physicians were working outside CMA/CA's. An additional 1391 work in towns betwen 10,000 and 25,000 pop

7Konkin J "Travel for Medical Services in Rural Alberta" personal communication

8Rural patients in Manitoba see specialists for 14% of their ambulatory visits while urban patients see specialists for 29% of their visits (this is based on the location of the patient's home regardless of the location of the specialist or gp). http://www.umanitoba.ca/centres/mchpe/reports/pdfs/rha.pdf

9Urban residents had18.4% higher health expenditures per capita than rural in Ontario Finkelstein MM Do factors other than need determine utilization of physicians' services in Ontario? CMAJ 2001;165(5):565-70 http://www.cma.ca/cmaj/VOL-165/ISSUE-5/0565.asp

10Many other hospitals defend themselves from referrals however CRHA has advertised the policy in their newsletter "Vital Signs" Feb 2002 http://www.crha-health.ab.ca/nav/VS7.pdf

11 Barer and Stoddart Sept 16th 1999, Improving Access to Needed Medical Services in Rural and Remote Canadian Communities: Recruitment and Retention Revisited. http://www.srpc.ca/librarydocs/BarSto99.htm

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14Rabinowitz HK, Paynter NP The role of the medical school in rural graduate medical education: pipeline or control valve? J Rural Health 2000 Summer;16(3):249-53

15 Pathman DE, Steiner BD, Jones BD, Konrad TR Preparing and retaining rural physicians through medical education. Acad Med1999 Jul;74(7):810-20

16Rolfe IE; Pearson SA; O'Connell DL; Dickinson JA Finding solutions to the rural doctor shortage: the roles of selection versus undergraduate medical education at Newcastle. Aust N Z J Med 1995 Oct;25(5):512-7

17More Doctors Better Services Australian Ministry of Health http://www.health.gov.au/budget2000/ruralcov.htm