From Education to Sustainability: A Blueprint for Addressing Physician Recruitment and Retention in Rural and Remote Ontario

Part 2

Were you looking for Part 1?

B. RURAL PRACTICE ISSUES

13. Referral/Support Network

One of the most intimidating features of Rural and Northern medicine practice for new clinicians is obtaining willing and useful specialist backup. It has often been said that the most useful survival skill is sound training in telephone aggression.

Present referral patterns are informal and place onerous and often unremunerated demands on regional consultants. The current Rural and Northern Health: Parameters and Benchmarks Report39 may clarify linkages and, to some degree, support. However, larger issues of specialist remuneration and availability of beds in the receiving institution will require a higher level of co-ordination.

Recommendations:

1. A user friendly specialist referral network with appropriate remuneration for consultants needs to be established and reliably available. This should exist in two tiers: a “corridor consultation”, with a 24 hour turn around of information and a real time teleconsultation for more urgent issues.

2. The network should be co-ordinated through regionally based hospitals. However, for subspecialty consultations, the support infrastructure may necessarily cross regional and even provincial boundaries.

3. Referral/support networks should be integrated with development of user friendly medical information technology (see section 14), including flexible access via phone, fax and the internet.

4. The referral/support network should be reviewed by an external body (potentially linked to hospital accreditation), with the power to recommend and make changes.

5. A commitment to developing local centres of excellence, with sufficient critical mass for integrated service provision and teaching, would reduce the need for specialist referral and support.

14. Medical Informatics

The development of Telemedicine is plagued everywhere with three basic problems:

a. Unclear remuneration/liability for consultants rendering opinions

b. Unsatisfactory infrastructure for reliable transmission of suitable imagery

c. A “top down planning” error of attempting to compensate for inadequate training of rural physicians by providing “hand holding” Telemedicine links.

An effective Telemedicine system needs to be built in the field, and then linked to appropriate supports. The focus of medical informatics must always be on supplementing and enriching rural practitioners, and

neither replacing them nor the consultant services their patients need. For this reason, medical informatics should be regionally based, reflecting the rural referral/support networks (as recommended in Section 13), since this builds a stronger team and supportive network. In short, current referral patterns should be supported, not thwarted, by medical informatics.40

Equally important, the development of Telemedicine must not take precedence over the need for a critical mass of physicians in each community, i.e. as one participant noted, “fancy toys do not help on-call coverage”. Medical informatics can enhance rural practice, but in itself cannot solve underserviced problems.

Medical informatics goes far beyond Telemedicine, to include computerized patient record systems and computer/internet access to medical informatics for physicians, other health care workers and patients. Medical informatics has a great potential to improve patient care and physician connectivity in a rural area.

Unfortunately, it is very difficult for rural physicians to buy, develop and effectively use medical informatics because of lack of local resources and support. Significant financial and medical informatics support is required to make it possible for rural physicians to harness the potential advancement in medical practice that medical informatics can make. Local hospitals can play an important role in medical informatics system development, integration and support. Patient confidentiality, security and systems compatibility are important considerations.

Recommendations:

1. The development of Telemedicine must not take precedence over the need to provide adequate training in skills like radiology and EKG interpretation for rural physicians.

2. Telediagnostic imaging transmission is the highest priority in terms of development of medical informatics, but there is a need to ensure broad compatibility standards.

3. Substantial investment in infrastructure, training and support is needed when medical informatics programs are initiated.

4. Wide consultation among workers in the field, both provincially and nationally, should precede development.

5. Consideration should be given to encouraging Web Site “virtual” hallway consultations which are national in scope, with costs shared among provinces.

6. Communications technology should be developed to promote networking and communications among rural physicians, as well as with their urban counterparts.

7. Direct medical informatics grants should be provided to rural physicians for:

i) physicians and staff medical informatics training and support; and

ii) purchase or lease of computerized patient record systems and medical information sources and systems.

15. Telephone Triage

Telephone triage is an important component of the primary care reform process currently being considered in Ontario. The potential for easing the workload of rural physicians, particularly during after-

office hours is real and should be further explored. However, there is a concern that the province-wide “1-800 numbers” might offer solutions primarily directed towards urban areas with their easy access to fully staffed emergency departments and walk-in clinics. Historically, telephone triage in rural areas has usually been provided by RNs in local hospitals, who often have the important advantage of previous knowledge of the caller’s medical and social history which will influence the advice provided. These RNs also have an in-depth knowledge of exactly what services the local hospital and physicians are able to provide, and the hours during which these services are best provided.

Recommendations:

1. Telephone triage in rural areas should be provided by experienced RNs, expanded role nurses and physicians working through the local or nearest hospital.

2. Province-wide triage systems should be avoided in rural areas. If such a system is implemented, information about each rural area should be built into the design, and advice should be based on these characteristics. Except in life-threatening situations, patients should be advised to call the local hospital before going there.

16. Physician Licensing

The elimination of licensure after one year of residency training, and restriction on licensure and certification of international medical graduates (IMGs) have had a significant adverse impact on medical service provision to rural communities. As a result of these changes to licensure and certification, the role of foreign-trained physicians in serving rural and isolated communities has been substantially diminished. Furthermore, the removal of the one year interneship licensure stream has eliminated the opportunity for new general practitioners, to practise in rural and isolated communities before proceeding to further training, or to provide locum support while continuing their specialty training.

Recommendation:

1. Governments and licensing bodies should consider providing forms of licensure to:

i) enable qualified trainees to provide locum and hospital call coverage, and

ii) permit rural physicians to cross provincial borders in order to provide locum services as well as teach rural CME (an initiative already started by SRPC).41

17. Allied Health Professionals

Ontario has developed training routes intended to prepare nurse practitioners and midwives for expanded diagnostic and therapeutic roles. However, in the rural context, it is particularly important to give sufficient attention to the different roles that these practitioners may play in rural communities, and the training required for those roles.

While the scope of practice of a rural family physician, spanning the ER/ICU/in-patient/delivery room/nursing home/office, cannot be replaced by allied health professionals, there is scope for a supportive and collaborative relationship among all of these practitioners. Essential to developing such complementary relationships is the development of funding models which prevent duplication and competition. It must be stressed, however, that the expanded nursing role does not remove the need for a critical mass of physicians to ensure access to medical care for the community.

At the recent SRPC Annual Policy Conference in May, 1998, the participants adopted the following five resolutions:

i. There should be a national process to develop guidelines for the scope of practice of nurse practitioners.

ii. There is an enhanced skill set and education required by nurse practitioners.

iii. The activities within the role of nurse practitioners are location specific.

iv. Funding models must be developed to enhance cooperative and collaborative care.

v. Innovative education is needed to provide core competency and an enhanced skill set.

Rural communities also require significantly more support and funding for physiotherapists, occupational therapists, speech therapists and audiologists and other similar allied health professionals. There should also be funding for continuing education and support to enhance the roles and skills of these allied health professionals.

Recommendations:

1. Improved dialogue must be established between rural physicians and rural nurse practitioners/midwives. It is essential that these groups establish a cooperative working relationship that will be complementary and lead to quality outcomes for all rural communities.

2. Urgent attention should be given to issues of training and role development, especially for nurse practitioners establishing rural practice. In this regard, government, medical organizations and other stakeholders should consider the SRPC resolutions in developing further policy in this area.

3. Development of community mental health models with wider use of allied health professionals would make the work of rural psychiatrists much more manageable and sustainable.

18. Rural Physician Clinical Support Program

Rural communities have traditionally had their medical care provided by independent physicians working from their own private offices, either solo or in small groups of two or three. This has become a barrier both to recruiting new physicians and retaining existing physicians. Many longstanding, independent rural physicians are becoming desperate to escape the onerous management and fiscal burden that independent office ownership requires. Moreover, small private practices have become almost worthless as new graduates generally do not wish to assume the responsibilities of office management and ownership in addition to their professional roles. Most graduating physicians are more likely to be attracted to communities where, regardless of the payment mechanism, there is a group clinic facility, with staffing and information system and administrative support provided.

As part of reforming the physician remuneration system, separate government funding for the provision of excellent group clinic facilities, clinical support staff and administrative information system support would have an enormous positive effect in facilitating group practice arrangements that provide better patient care availability, at the same time relieving physicians of day to day management and administrative responsibilities, enabling them to concentrate on delivering medical care, and providing more opportunity for a sustainable lifestyle.

These facilities and supports would singlehandedly provide more attractive group practice working conditions as well as an indirect and long overdue financial benefit for rural practice. They would also provide increased opportunities and space needed to integrate allied health professionals, including nurses and nurse practitioners, and promote a more effective and efficient integrated rural health care

system. For any such program to succeed, however, it is critical that it be designed and implemented in a manner which is sensitive to the need to respect and protect physician autonomy and independence.

Recommendation:

1. Government should provide special funding and support for rural practice clinics, including group clinic facilities, clinical support staff and administrative information system support.

19. Remuneration for Family Physicians

Many physicians in rural and remote communities have concluded that the current fee-for-service system is inadequate to meet the unique skills and demands of their medical practices. Moreover, for many new physicians, alternate payment plans are a more attractive method of remuneration for practising medicine, and their availability in underserviced communities would serve as an incentive for them setting up practice.

To some extent, both the Government and the OMA have recognized this, but in practise little has been done to offer workable alternate payment plans that would truly serve the needs of rural and remote communities and their physicians. However, this lack of progress does not diminish the critical importance of alternate payment plans for sustainable physician recruitment and retention.

One successful application of alternate payment plans has been the Community Sponsored Contract (CSC), which provides for a reasonable annual payment, together with paid overhead and expenses. Unfortunately, CSCs have only been offered in the smallest and most remote of Northern communities, and despite their significant success, the government has been unwilling to expand the eligibility for CSCs to communities with an Underserviced Area Program (UAP) complement of three or more, or to rural communities in the near-North and South.

Instead, the government has insisted that communities with a UAP complement between three and seven physicians can only access Alternate Payment Plans [variously described as Globally Funded Group Practice Agreements (GFGPAs), Rural Alternative Payment Plans (RAPPs), or Northern Group Funding Plans (NGFPs)]. However, the funding for these Alternate Payment Plans (APPs) continues to be based on the bare minimum numbers under the UAP program, rather than the critical mass needed for sustainable physician recruitment and retention. Furthermore, the funding offered per physician still fails to recognize the unique skills and responsibilities of rural and remote physicians.

In this respect, the document Toward a New Vision for Globally Funded Group Practice Agreements produced in January, 1998 by the Northwest Ontario Physicians, has outlined what would be required to make GFGPAs work. The Executive summary of that document is attached as Appendix 19 to this Blueprint.

At the same time, other payment systems, including fee-for-service, remain the payment system of choice for many established rural physicians, and should be supported as viable options in rural areas. No one payment system will solve the needs of all rural practice, particularly when attempting to address the many diverse lifecycle and lifestyle needs and choices of rural physicians.

Recommendations:

1. Different communities have different capabilities and different needs, so that there can be no single rigid alternate payment plan model imposed by government. Rather, any alternate payment plan needs to be flexibly available to any underserviced community, if they are to act as incentives and not disincentives.

2. For those rural physicians choosing to remain on fee-for-service, medical associations and government should incorporate specific fee codes and/or rural modifiers which properly reimburse rural physicians for the unique services which they provide. In addition, other payment systems including salary and capitation models should be supported where requested by rural physicians.

3. The principles of sustainability, critical mass and remuneration commensurate with the unique skills and responsibilities of rural and remote physicians, as contained in Toward a New Vision for Globally Funded Group Practice Agreements should be incorporated in future efforts to develop alternate payment programs. This includes the need to fully address the issue of funding for an adequate physician complement (critical mass) in rural areas in various proposed systems for physician reimbursement in these areas. While there are significant difficulties with relying on crude doctor/population ratios, if they are to be used then a distinct rural doctor/population FTE (full time equivalent) benchmark, (perhaps set at no less than 75% of the provincial doctor/population average of 1:1150, i.e. at 1:862) should be the starting point. However, this must be subject to further adjustment based on individual community and physician needs.

4. Any funding formula adopted for an alternate payment plan must reflect the unique nature of work provided by rural practitioners and compensate them fairly by providing a significant premium for their work. This will require an adequate baseline formula supplemented by additional incentive fees to recognize clinical work requiring both generalist and advanced skills. These skills include GP anaesthesia, in-patient care, obstetrics, night call, GP surgery, administrative responsibilities, CME/teaching roles, and supervision of programs such as dialysis, chemotherapy, emergency departments and mini-ICUs.

5. Sessional funding should be extended beyond the current hourly “Scott sessional fee” for on-call emergency coverage, to apply at least to GP anaesthesia and obstetrics. As well, the current sessional fee for emergency coverage should be revised to reflect market realities.

6. The remuneration for individual physicians or groups of physicians should incorporate an isolation support payment, based on the degree on “rurality” or “remoteness”, including distance from referral centres, the size and demographics of the community, and the complexity of the services provided (see Section 27 for additional discussion of this concept).

7. Alternate payment plans should include additional leave/time off in recognition of longer service, as a retention bonus. This should include credit for up to ten years of prior rural practice service.

8. Sabbatical programs should also be offered both as a retention incentive and as a method of allowing a periodic break from the stresses of rural practice while at the same time offering an opportunity for professional development.42

9. Consistent with the recommended Rural Physician Clinical Support Program (see Section 18), hospitals should offer to provide clinic/office space, as well as nursing information and administrative support, to physicians. This would create a central, sustainable practice environment drawing on the administrative and other resources of the hospital, help offset overhead costs, and provide attractive and sustainable rural practice conditions. Overhead assistance is an important recruitment and retention incentive for rural physicians. For those who choose to practise in their own offices, this would take the form of direct financial support.

10. An effort should be made to minimize the administrative and legal obligations inherent within any rural alternate payment plan. In particular, formal legal partnerships should not be mandatory and the obligations of shadow billing, timesheets, and patient satisfaction surveys should be either eliminated or supported with additional funding.

11. Rural and remote physicians, and their communities, should not suffer because of ongoing disputes between the Government and the OMA over who is responsible for providing the necessary funding for effective and sustainable alternate payment plans.

12. Fee disincentives and other restrictive measures aimed at new physicians form no part of a sustainable solution to the underlying challenges of Rural and Northern practice, fail to remove longstanding barriers to physician recruitment, do nothing to improve the conditions and supports necessary for physician retention, and only end up “ghettoizing” rural medicine by making it appear less attractive.

20. Physician Payment/Specialists

Although there has been considerable debate and discussion of alternate payment plans for rural primary care providers, the equivalent has not been the case for rural specialists.

This has largely been a function of the smaller number of rural specialists. However, rural specialists share many of the same problems as their rural FP/GP counterparts, including isolation and high call frequency with low volume.

Recommendations:

1. More attention must be devoted to alternate payment plans, and/or sessional payments, for specialists in rural and remote areas.

2. Core specialties in rural medicine (i.e. comprehensive general surgery, paediatrics, obstetrics/gynaecology, internal medicine, psychiatry, anaesthesia and orthopaedics) should be eligible for some form of “block” remuneration for call (such as hourly remuneration for night time and weekend call and/or special premiums for the fee for service services they perform while on-call during evenings and on weekends).

3. Special, urgent consideration needs to be given to alternate payment plans for psychiatry, in view of the failure of the fee-for-service system to compensate them for their various activities and services, including co-ordinating with social services and families.

4. Hospitals should provide office and clinical support for specialists.

5. Specialists in regional hospitals must be compensated for telephone advice/consultations.

6. Visiting specialists should be given access to clinic space and support staff, reimbursed for traveling expenses and travel time, and provided with a stipend for teaching and educational activities.

21. Natural Limits, Including Retirement and Burnout

Exit incentives are attractive to both physicians and governments for a variety of reasons. The idea of a retirement payment or incentive for a long-serving physician is both reasonable and justified. Historically, physicians have not shown expertise in the area of retirement planning, and this situation is worsened by the absence of formal pension plans. For some physicians, retirement is not financially feasible due to poor financial planning, and the option of working harder under fee-for-service is often taken. Finally, medical associations and governments recognize that exit incentives could be helpful in addressing the issues of physician distribution and utilization, given the current “hard-cap” provincial funding system.

It will be necessary to proceed with caution in encouraging retirement among our valuable senior rural physicians, at least until they can be properly replaced. At the same time, we want to create incentives for

retention of rural physicians, by offering recognition for their valuable service, and encouraging future physicians to establish rural practice, perhaps by a facilitated retirement plan. Hopefully, with appropriate physician recruitment and retention measures in place, long term planning should be possible including provision of planned physician retirement.

Recommendations:

1. Payment plans for rural physicians should include retirement packages that are flexible enough to meet the varying and different needs of rural physicians.

2. It is not acceptable for exit incentive plans to be offered only in over-supplied urban areas.

3. Any retirement incentive must reconcile the need to ensure that rural and remote communities are not deprived of critical and needed medical services, while recognizing the importance of rewarding and not penalizing long-service rural physicians for their valuable services over the years. Possible options to consider include offering rural physicians the option of accepting a partial retirement payment in return for a reduced billing number or adjusted APP, thereby allowing part-time practice, or even in some cases providing physicians with the full retirement amount but allowing them to continue to practise without penalty until a replacement physician is recruited.

4. Consideration should be given to the introduction of physician retirement packages to help existing rural physicians, who have worked a fixed combination of years of practice and age, to retire. In this respect, the Newfoundland PRAG Report proposed a point system which not only takes into account years of practice and age but also isolation and time on-call.43 As well, a blended sabbatical/retirement system as proposed in Alberta should be examined as a retention tool (see also Section 19, recommendation 8).

5. Retirement planning needs to happen in conjunction with improved recruitment and retention measures.

6. The “back before burnout” concept, which creates viable options for time

off after a certain number of years of rural practice, as promoted by the New Zealand Government, should be examined.44 This would provide opportunities for teaching, administration, further training or sabbatical after a certain number of years of rural service.

7. There must be improved education with respect to retirement planning, to avoid physicians perceiving that they are not able to afford to retire.

8. After 20 to 25 years of practice, rural/remote physicians should not be required to take overnight call. This is only workable if funding is sufficient to ensure that there is a sufficient complement of remaining physicians to permit for a reasonable call schedule.

22. Physician “Turf” Issues

An important disincentive to new physicians moving to a small rural community can occur when the established physician (or physicians) resists the perceived “encroachment” on their territory. This occurs in various ways, both overt and covert, including simply not sharing patients, or insisting that new physicians join an existing group and then make the working conditions and remuneration less than tolerable. There are numerous possible motivations for this behavior, but the fee-for-service payment system and the potential loss of income for physicians with significant debt loads or who are financially ill prepared to retire has certainly been a significant contributing factor.

It is possible that, with the introduction of alternate payment plans for physicians in rural and remote communities, this will be less of an issue in the future. However, it must also be recognized that alternate payment plans can become disincentives in their own right if absolute limits placed on overall remuneration lead the existing physicians to resist new physicians being added to the plan. As a result, alternate payment plans should be designed so as to avoid this disincentive against new physicians establishing practice in a community.

It is important to address these issues honestly and openly and ensure that community needs are met. In this respect, external mentoring from physicians outside the community45 has been useful in helping to resolve such problems in the past.

Recommendations:

1. Effective and attractive alternate payment plans for rural physicians need to be offered in order to minimize the competition often arising in the fee-for-service payment system.

2. The Rural and Remote Areas Program (as proposed in Section 26) needs to incorporate mechanisms to respond to community or physician concerns, especially where they obstruct qualified new physicians from coming to a community where they are needed. Community Development Officers should also be aware of such problem areas and facilitate their resolution.

3. The Society of Rural Physicians Initiative of Community to Community Support is a sensitive and workable option for responding to this issue, but should be integrated with the efforts of Community Development Officers in identifying problem areas and facilitating their resolution.

4. A voluntary retirement program with buyout package may be the least expensive and most effective method of resolving these issues if other efforts fail to do so.

23. Spousal and Family Concerns

The difficulties faced by spouses and families of rural physicians are well documented and known to be a significant factor affecting both recruitment and retention. The realities of life in small rural communities, their limited resources, population and economic base can limit spousal employment opportunities as well as family education and social opportunities.

The inordinate demands on both male and female physicians, especially with regards to onerous on-call time and administrative responsibilities, limit family time, increase spousal isolation and generally impose an excessive toll on their non-working lives, ultimately leading to physician burnout.

Zero tolerance legislation for physicians having relationships with patients can also significantly increase the isolation of single physicians, especially in more isolated communities where a physician is potentially the care giver for the entire population.

Recommendations:

1. No physician should be required to provide on-call services more frequently than one night in five, as consistently recognized and recommended by the CMA, the Scott Report, and other expert bodies and reports. These limitations on excessive call reflect not only the needs of the physician, but the very real needs of her/his spouse and family.

2. CDOs should foster relationships with municipal boards and community leaders to facilitate integration of physicians, spouses and families into the community.

3. To the extent possible, spouses and family members should be included in medical school and residency placements,46 since the evidence suggests that early involvement creates spousal and family expectations more favourable to rural life.

4. A rural medical family network has proven successful in other jurisdictions, including Australia, in providing support to and nurturing of spouses and family members, through personal contacts, mentoring, newsletters, help pamphlets, and conferences.47 A similar network should be established and funded in Ontario.

5. The Rural and Remote Areas Program (as discussed in Section 26), in conjunction with CDOs, communities and other physicians, needs to place priority focus on identifying and accommodating spousal requirements wherever possible, including at the initial recruitment stage.

24. Locum Programs

The lack of a functional, accessible locum program continues to be one of the most significant disincentives to physicians locating and staying in rural areas. It is also an important hurdle to physicians seeking holiday time and CME. The problem is most acute in smaller communities with one to six physicians. Unfortunately, existing programs often operate at cross purposes, with little coordination, and an inadequate or unpredictable funding base.

Recommendations:

1. A provincial locum program must have independent, responsive administration that can update and fill physician need in rural areas rapidly from a roster of “registered” physicians.

2. The locum program should operate in conjunction with an expanded physician and community registry, either building on the PAIRO Registry or a specialized locum registry.

3. University faculty involved in training physicians destined for rural practice or providing CME to rural physicians should be recognized as an important source of locum service to rural areas.

4. Consultants in regional and tertiary referral centres should be encouraged to serve as locums as part of their commitment to a rural service network.

5. The SRPC CME/Locum Service should continue to be developed and work towards generating local centres of excellence (as detailed in Section 12).

6. Provision of time limited interprovincial licenses would allow physicians to cross provincial boundaries to provide locum service. This would both broaden the interest and expand the pool of available locums.

7. Similar reciprocal arrangements should be developed for international exchanges, particularly since Canadian physicians are already encouraged and licensed to serve as locums for fixed periods of time (i.e. on an annual basis) in other countries, such as Australia.

8. “In place” regional locums should be added to the critical mass required for local communities so that communities within a region can better provide self-sufficient locum coverage on a regional basis. This regional structure could also be more closely integrated with existing or new training programs.

9. Disincentives to newly trained physicians serving as locums should be eliminated, including the imposition of restrictive measures, the threat of such restrictive measures, licensure rules which have eliminated the ability of residents to provide locum services during their residency training programs, and the failure to provide timely provision of OHIP billing numbers to residents completing their training.

10. Locum programs must be sufficiently flexible to allow physicians to sign up as locums for varying periods of time (i.e. ranging from a weekend, to a week or month, to a longer period) without rigid, fixed requirements or minimums.

11. Payment plans for locums should be generous, in recognition of the historical difficulty in recruiting physicians for this role, the challenge of providing service in a series of varying practice settings, and the inevitable gaps in scheduling. Assistance for travel, accommodation and CME (especially advanced life support courses) along with a guaranteed minimum income, should be included.

12. Recruiting communities and physicians should be provided with a checklist of practical, proven suggestions for attracting locums, and providing a positive working experience.

C. INFRASTRUCTURE

25. Community Development Officers

The momentum created by early success of the Community Development Officer in Northwestern Ontario has been somewhat stalled by inertia in expanding the CDO program to include other rural regions. Important issues, including the development of the CDO role, accountability and reporting structure, need to be further clarified.

Recommendations:

1. Six Community Development Officers should be in place with appropriate program support and funding, to serve defined regions within the province: Northwest, Northeast, Southwest, Southeast, Central, as well as underserviced urban domains of practice within the province.

2. CDOs should function as local operatives of the Rural and Remote Areas Program (as discussed in Section 26), responsible to communities rather than the Ministry. They must be in constant communication with their communities and responsive to needs as they arise. They should work towards meeting short and long term physician needs in the communities, and work in close co-operation with university-based Regional Director of Rural Training (see also Section 9, recommendation 1).

3. CDOs would have the primary responsibility for facilitating and improving physician recruitment, with an intimate knowledge of the communities and physicians they serve. However, the role of the CDO must also include matters such as physician retention, participation in the co-ordination of locum tenens arrangements, and the integration of recruitment and medical education activities.

26. Rural and Remote Areas Program (RRAP)

The current “Underserviced Area Program” has come to be perceived as distant from and unresponsive to the needs of rural and remote communities. A clear consensus has evolved that the current UAP approach results, at best, in an inadequate estimate of the true levels of medical need within rural areas, providing an unco-ordinated and ad-hoc array of different programs. The effectiveness and transparency of the program must be increased and the program’s directions and actions must be realized to meet the changing needs of rural and remote communities.

Recommendations:

1. Renaming and restructuring of the current UAP program to the “Rural and Remote Areas Program” would help to refocus the core objective of ensuring that communities are no longer underserviced, and would be a positive step in refocusing the government’s direction, responsiveness and renewed commitment.

2. The mandate of RRAP should include developing, funding and implementing programs and support to recruit and retain an adequate and equitable number of appropriately trained and skilled rural physicians to provide accessible, quality medical care in all rural areas of the province. The ultimate goal of RRAP should be to remove the notion of “underservice” from Rural and Northern planning.

3. RRAP should receive government funding needed to support the initiatives required in order to recruit, retain and support the necessary number of rural physicians. This should include funding for the Rural Physician Clinical Support (as detailed in section 18), locum programs and the negotiations of alternate payment plans to meet the needs of each community.

4. RRAP should be responsible to an Assistant Deputy Minister for Rural and Northern Health, but administered by a small and responsive Board, which includes membership from the community, rural health providers and rural and health care organizations.

5. The Board would be responsible for selecting the Director of the Program. The Director would be responsible for the day to day operation of the Program.

6. RRAP should have a clear line of communication with the newly created Executive Director of Rural Health at Health Canada.

7. RRAP’s structure and mandate should include funding and staff to conduct and review relevant research and ideas from other jurisdictions working on similar rural and remote access problems.

8. One of the first responsibilities of RRAP would be to work with communities, physicians and other stakeholders to develop more workable and effective criteria for defining rural and underserviced designations, as well as proactively developing permanent community recruitment committees.

9. RRAP would work in an integrated and co-ordinated fashion with university medical schools on education and training activities, through the University Offices of Rural Medicine (as proposed in Section 4, recommendation 1).

10. CDOs would be co-ordinated through RRAP, providing integrated planning of recruitment, retention and locum activities and services.

27. Rurality Index

Rural is a perspective, dependent on person, place and context. As such, the definition and meaning of rural practice will vary considerably, depending on whether the person is a rural patient trying to access care, a rural doctor or other rural health care worker, a researcher or a government planner.

In general terms, rural practice can be defined as practice in non-urban areas, where most medical care is provided by a small number of general practitioners with limited or distant access to specialist resources and high technology health care facilities.48 In Canada, communities of up to 10,000 are often classified as rural.

An agreement between the Ontario Ministry of Health and the Ontario Medical Association identifies communities of fewer than 10,000, greater than 80 km from a regional centre of more than 50,000 people as “specified” or “isolated” communities. The Rural Committee of the Canadian Association of Emergency Physicians defines “rural remote” as “rural communities about 80-400 km or about one to four hours transport in good weather from a major regional hospital” and “rural isolated” as “rural communities greater than about 400 km or about four hours transport in good weather from a major regional hospital”.

Definitions such as these, however, fail to include or measure the depth and variety of rural practice and the many factors important to recruitment and retention of rural physicians. The practice of medicine becomes more challenging as distances from urban areas and isolation increase, while local resources decrease. Rural physicians in many settings may be called upon to have a much broader scope of practice than physicians in urban practice. In fact, a practical definition of rural practice used by the Royal Australian College of General Practitioners, Faculty of Rural Medicine, is “medical practice outside of urban areas where the location of practice obliges some general/family practitioners to have or acquire procedural or other skills not usually required in urban practice”. Physicians in the smallest, most remote settings have to cope with the difficulties of help being a long time and distance away. In larger rural communities with a small, active hospital many rural physicians have an extremely active hospital role that may include emergency medicine, obstetrics and sometimes GP anaesthesia. Acquiring and maintaining the necessary knowledge and skills is a daunting challenge.

In the smaller, more distant communities, educational facilities, job opportunities, religious/cultural access and potential mate pool for unmarried physicians are all less available. Transportation for these activities are both time-consuming and expensive.

Given the broad diversity of rural settings, it is important to offer payment plans and other incentive programs in these varied settings in a graduated fashion. Sometimes measures adopted to address the problems in one rural area will cause unexpected adverse consequences in other rural areas. For example, incentive plans offered in one rural locale might result in a movement of physicians away from another rural area, simply shifting the undersupply problem from one area to another. Tailoring programs based on a measure of rurality would reduce the likelihood of such unintended consequences.

In the case of some recruitment and retention programs, it may be possible to utilize a rather simple rural index, but other programs will likely require a more detailed index which incorporates a wide variety of parameters. A valid rural index would also be of value to researchers and to those engaged in other aspects of health care planning in rural areas.

General practice rurality indexes need to be developed and assessed by how well they reflect where physicians practise (community and lifestyle factors), what these physicians do (scope of practice and on-call burden), what professional isolation and support they experience and how these three main considerations are weighted.

Recommendations:

1. That an ad-hoc committee with adequate resources be immediately struck to:

i) examine current rural index proposals;

ii) propose a model which utilizes the best features of the various current proposals;

iii) initiate a detailed assessment/validation of the model;

iv) formulate final adjustments to create a usable, reliable rurality index.

2. In the interim, as a temporary measure only, the current accepted Ontario Ministry of Health/Ontario Medical Association definition of “practising in communities with fewer than 10,000 people, greater than 80 km from a regional centre with more than 50,000 people” should be used as a base definition for rural practice incentive programs. The most generous incentives and other positive measures and supports would be available for the smallest and most remote communities (for example, communities with less than 3,000 people and most distant communities, i.e. more than 160 or 200 km from a regional centre

with more than 50,000 people). Varying levels of incentives and supports would be available, as the size of the community increases and/or the community is closer to a larger regional centre.

IV FUTURE DIRECTIONS

A. THE NEED FOR OTHER HEALTH CARE REFORMS

The practice of medicine in the rural setting depends on ensuring that rural physicians are properly prepared for the challenge, competitively remunerated, and provided with a sustainable work and living environment. This Blueprint document represents an outline toward achieving these goals.

Nevertheless, because of its focus on training, remuneration, and retention initiatives for rural physicians, it is beyond the scope of this paper to discuss in detail a number of other issues that are of critical importance in achieving the greater goal of full and sustainable health care as a whole for the people of rural Ontario. This final section of the document enumerates some of these key issues that must also be dealt with to ensure that the working milieu of rural physicians, and other health care workers, will be equal to the tasks ahead.

Rural hospitals are different than those in urban areas. Important as they are in cities, hospitals are perceived in rural areas as being among the most important local institutions. They provide a different, and in some respects a broader, range of services than in cities because they are often the only resource available to rural physicians. For example, many rural towns do not have a shelter for battered women and sometimes the hospital might be the only safe place immediately available. Few small towns have “half-way” houses. Services such as physiotherapy, radiology, and laboratory are usually located in the rural hospital, in contrast to urban areas where private facilities outnumber public ones. As well, rural hospitals can be one of the major employers in rural towns. The presence or absence of a rural hospital may also determine which industries (including tourism) can survive in a rural area.

It should go without saying that rural physicians absolutely require hospitals in order to provide the wide range of services needed in rural areas, from emergency care to in-patient admissions, from obstetrics to surgery, from diagnostic studies to dialysis, from chemotherapy to palliative care. From the perspective of the rural patient, the value of care “as close to home as possible” must not be overlooked. Outcomes in the care of emergencies frequently depend on the provision of care within the “golden hour”. A properly supported local rural hospital can provide a critical personal touch, particularly for the elderly, the young, and the palliative care patient. It can also provide the opportunity for frequent supportive visits from family and friends, and a significant reduction in travel costs for both the ambulance system and for the patients themselves. Some important preventative health care opportunities, such as mammography and cardiac rehabilitation, will not be taken advantage of if not provided locally. Finally, an integrated system of pre-operative evaluation provided to rural patients in local hospitals can eliminate duplication of tests and save both time and money for rural residents.

The true value to the patient of the rural hospital seems apparent, but it is our contention that these hospitals are also cost efficient when all factors (including ambulance costs, travel costs for families, and the greater per diem and other costs incurred in tertiary care centres) are included. Research into this proposition is urgently needed.

For all these and many other reasons, the rural hospital occupies an extremely important niche in rural Ontario both for physicians and the general public. Any restructuring initiatives such as those found in proposals for regionalization, and in recent recommendations by the HSRC (Health Services Restructuring Commission),49 will likely be met with stiff community and physician opposition. While the special consideration given rural hospitals through the “Framework”50 and “Benchmark”51 documents is appreciated, the implementation of the recommendations remains open to interpretation of the various District Health Councils, DHCs, (which are now urban-based, with limited representation from rural areas), and it is not at all clear that the thresholds which have been established will ensure the continued

thriving of rural hospitals, let alone the expansion and repatriation of services in rural areas that are needed for the times ahead. (It must be born in mind that demographic shifts from urban to rural, accelerated by the demographic shift of “boomers” into rural settings, plus the advances in information technology allowing ever-increasing numbers of at-home workers, mean that the demand for health care services in rural areas will probably outpace the growth rate in urban areas).

It is of the greatest importance that clear plans to sustain and nurture rural hospitals be developed now and implemented as soon as possible and that there be firm opposition to the shift toward centralization of services inherent in the trend to regionalization.

Along similar lines, concern must be directed toward the “downloading” of many services from Provincial to Local Governments. Public health and ambulance services are complex and expensive but essential services for rural areas. Particularly with the closure or reduced capacity for rural hospitals expected to come from DHCs, based on directions established by the HSRC, the importance of ambulance services grows ever larger. The economies and efficiencies of scale enjoyed by running such programs on a province-wide scale have now been sacrificed. Of great concern as well is the limited revenue base that many Rural health care is limited not only by chronic shortages of physicians but of other health care professionals as well. Virtually all areas, including nursing, laboratory services, occupational therapy, physiotherapy, respiratory therapy, nutrition services, mental health services, and pharmacy services, to name but a few, are chronically understaffed. What is not generally appreciated is the ongoing shortage of skilled administrators, financial officers, and other key management personnel.

A particular concern in these days of cutbacks is the rural home care nurse. More and more, patients are sent home “quicker and sicker” and reliance on this essential service is growing. However, in rural areas, while this service may be even more important than in urban areas, sustaining and enhancing this service does not seem to be a government priority at present. One of the problems is that patients are scattered over large, sometimes vast distances, and travel time can consume a significant amount of a nurse’s day. It is key that formulas for determination of provision of home-care nursing hours be based on the amount of time nurses actually spend with patients, not the total number of hours on the job per day, to account for “down time” incurred during travel between patients. (In this context, the relative economic value of rural hospitals might be enhanced, as the true cost of nursing at home for a widely scattered, low-density population is probably not being fully calculated at present.)

There are similar concerns about long-term care in rural areas. Due to insufficient family and home-care support, there is generally a greater need for long-term care beds in rural areas. Furthermore, because of the relative lack of such beds in rural areas, acute-care beds are frequently blocked by patients for whom placement in a nursing home far away from family and friends would be inappropriate and potentially deleterious to their health. Such situations arise, for example, when a person is placed in a setting where her or his mother tongue is not spoken. Elderly residents of Thunder Bay are not routinely placed in nursing homes in Ottawa, distant from their life-long support networks. Rural residents deserve the same.

Other elements of infrastructure within rural society also affect the recruitment and retention of rural physicians. Anything making rural areas better places to live, be they excellent schools, police and fire services, or cultural and social outlets, improves the chances of retaining rural physicians and other health care professionals. Unfortunately, many recent changes in Ontario have been felt by many in rural Ontario to be working in just the opposite direction. Downloading of other services such as highways, reduced snow-plowing operations, threat to funding for education and the loss of local control for rural schools, deregulation of bus services, ever-worsening postal services, and so on, contribute to making rural practice less attractive, particularly to those born and raised in urban settings. Both Federal and Provincial Governments must re-examine this situation and institute measures to reverse this trend.

A program to sustain rural physicians must include measures to sustain the infra-structure required to deliver health-care services. While beyond the scope of this paper, it is necessary to address these issues as part of a larger integrated plan for rural health care. It is suggested that this ought to be the work of a new task force, perhaps one involving a range of “stakeholders”.

Recommendation:

1. That the government strike a commission (perhaps similar in scope and powers to the HSRC) dedicated to the issues involved in providing health care to rural areas; its mandate should include the co-ordination of the efforts of the many organizations and committees currently working on rural health care.

B. A CALL TO ACTION

Much work needs to be done to improve physician recruitment and retention in remote and rural Ontario. It is our hope that the process of renewal can be assisted by the discussion and recommendations contained within this Blueprint. Now is the time to put a comprehensive and integrated plan into action - to use this Blueprint and the work of other stakeholders to collectively build the health care structure that rural Ontarians need and deserve.

V appendices

APPENDIX 1

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