

THE STATE OF RURAL HEALTHCARE

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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 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 1,100 of Canada's rural physicians and comprising 5 regional divisions spanning the country

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"Every citizen in Canada should have equal access to health care regardless of where they live."

- Mr. Justice Emmet Hall

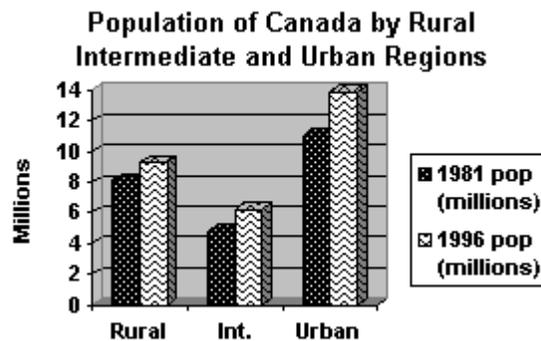
There are many health care challenges for Canadians, but none are any greater than the challenge of providing care for those who live in remote and sparsely populated regions of this country. The Society of Rural Physicians of Canada has extensive experience in rural health care analysis.⁽¹⁾⁽²⁾⁽³⁾⁽⁴⁾⁽⁵⁾ The following will explore some rural trends and offer suggestions on how we can deal with the issues. In a way, the challenges of Rural Health are an opportunity as by building a system that can address rural needs in a fair and equitable manner we will build a system that can address the needs of all Canadians.

Rural Health Current Status and Trends

Rural Canada has about 20 percent of the employed Canadian workforce, 31.4 percent of the Canadian population and over 99.8 percent of the nation's territory.⁽⁶⁾

It is a highly diverse economy and society, from its coastal regions to its agrarian heartland. Canada's rural natural resources provide employment, forest products, minerals, oil and gas, food, tax revenue and much of our foreign exchange. Rural and remote Canada provides an intense cultural identity for the country as celebrated by our artists.

Rural Canada is growing in population at a half percent annually ⁽⁶⁾, and this will accelerate as baby boomers retire to the country where many of them have their roots.



There are major challenges in rural health care delivery. The chronic and often critical shortages of physicians, nurses, rehabilitation therapists and other health care providers are well-known. For instance, while 31 percent of Canadians live in rural areas, only about 17 percent of family physicians and about four percent of specialists practise there.⁽⁷⁾

Increasing Urban Rural Gap

A 1999 study funded by Health Canada projected that our overall supply of doctors will reduce from 56,775 in 1999 to 52,438 in 2021. Relative to the population, this means the ratio will fall from 1.82 physicians per 1000 people in 1999 to 1.39 in 2021 (a 24% decrease).⁽⁸⁾

It will be worse in rural Canada. Statistical modelling predicted a decrease of rural physicians from 5,531 in 1998 to 4,529 in 2021. The ratio of physicians per 1000 population will decrease from an already low 0.79 physicians per 1000 population in 1999 to 0.53 by 2021 (a 33% decrease).

And so the gap between urban and rural grows.

Our existing health system trends will cause accelerated rural attrition and increasing disparity between rural and urban Canada in terms of access to physicians.

The Urban Centric Educational Paradigm

"An important attitudinal problem is that of 'learned helplessness'. The highest that many new medical graduates aspire to in dealing with medical problems is being able to assess to which specialist to refer the patient. Consequently, it is a frightening prospect for them to contemplate rural practice."

-WONCA Policy on Training for Rural Practice 1995⁽⁹⁾

Education is the entry point into the national health human resource pool. Research shows that training experience in rural medicine is important and that rural origin applicants are the most likely to practice in rural settings⁽¹⁰⁾⁽¹¹⁾⁽¹²⁾⁽¹³⁾. The current system of training physicians generally does not take advantage of that information.

Medical schools preferentially select people from urban neighbourhoods with an average income of over \$80,000⁽¹⁴⁾, train them in an urban environment that promotes and emphasises subspecialisation, research and academia, separate from the larger community. Graduates of the educational system are thus increasingly interested in subspecialisation and urban practice. Family medicine training positions are increasingly unfilled⁽¹⁵⁾, and even those that fill do not train to the skills needed for rural practice. Only eleven percent of current medical school graduates choose to practice in rural areas⁽¹⁶⁾.

Universities have appeared reluctant to take on responsibility for serving the rural community, however they have a societal obligation to meet the needs of the population as a whole. This some medical schools do better than others.

Increasing Centralization

Rural hospital closures and centralisation of many health services in larger cities mean that rural residents have more difficulties accessing services. The lack of community

services in many smaller centres means that patients discharged early from hospitals often lack community-based care. Not to minimise urban difficulties, but residents in rural areas, small towns and remote locations face many more obstacles to care and those obstacles tend to be much more formidable.

The fact that a metropolitan hospital offers health care of the highest standard to its city citizens does not mean that a rural population who has to travel to it will have the same results. In fact the need to travel will always produce worse outcomes on a population basis because some will not travel and others, especially for emergent conditions, will suffer negative health outcomes due to the inherent risks of travel and the time it takes.

By example Walter Rosser has pointed out that

"The geographical context in which health care is delivered in a country such as Canada, with widely scattered small communities far from major medical centres, creates unique problems for the application of medical evidence. Although there may be good evidence that the quality of life of elderly people can be improved by palliative radiotherapy, the practicality of a frail 85-year-old travelling several hundred kilometres to the nearest radiotherapy centre must also be considered.... Thus, the geographical context of the situation affects decisions about treatment, even though good quality evidence may be available to support a specific course of action."⁽¹⁷⁾

Centralization and Women's Health

The ability to become pregnant is distributed throughout the population but providers of maternity care are not. Rural physicians, in the absence of volume to attract specialist midwives or obstetricians have developed mechanisms that transcend urban classifications of primary and secondary care. An obstetrically trained GP ⁽¹⁸⁾, with a GP anaesthetist and a trained nursing staff will be able to care locally for over 98% of women with results equal to that of the city.⁽¹⁹⁾

The ability to deliver in your community, however, even if it still has a hospital, is becoming much less for rural women. Access to maternity services in southern Ontario is decreasing.⁽²⁰⁾

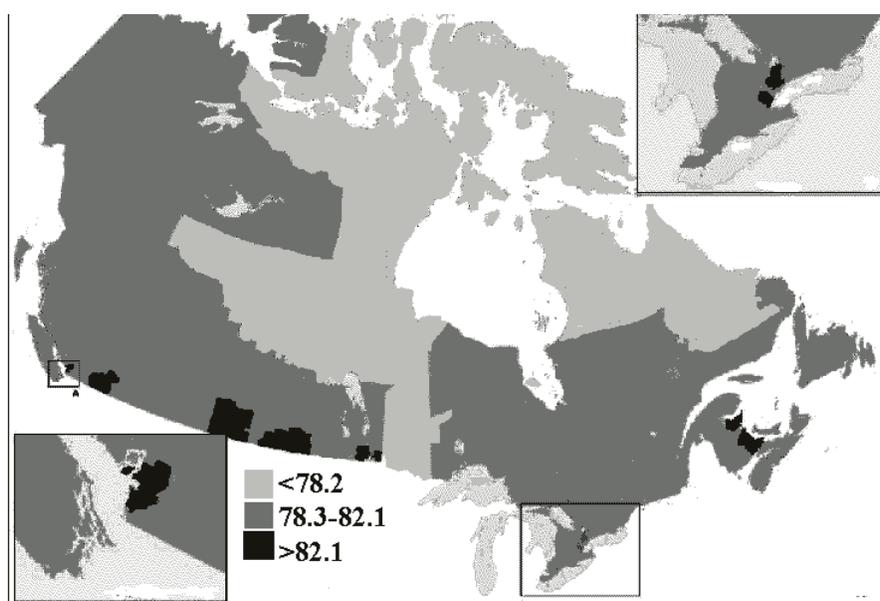
In Northern Ontario the reported number of community hospitals that have closed their maternity ward has increased 5 fold since 1981. The distances that women have to travel are increasing.⁽²¹⁾

Studies in the United States ⁽²²⁾⁽²³⁾⁽²⁴⁾ and Norway ⁽²⁵⁾ consistently document significantly poorer outcomes for communities that lack maternity services, even when the referral centre is of an excellent calibre. Children of women who are forced to travel have greater rates of perinatal death and prematurity and incur higher health care costs.

Health Status

"There is a trend towards a progressive deterioration in health as one moves from that area bordering urban centres into the very remote hinterland"-The Quebec health survey⁽²⁶⁾

Health status decreases as one travels to more rural and remote regions. As an example heart disease is common in northern Ontario. Certain types of cancer are found among miners and farmers. There are substantially higher rates of diabetes, respiratory and infectious diseases, as well as violence-related deaths, in some aboriginal communities. Combined, there is an increase in mortality in rural regions as evidenced by life span.



1996 Female Life Expectancy at birth by Health Region

The lower life expectancies are not associated with just a few specific causes; rather, the mortality rates in these regions are higher for most causes of death. Consistent with other measures of the health of the population, there is an association with socio-economic factors: life expectancy decreases as the rate of unemployment increases and the level of education decreases.

The differences between low life expectancy regions and the Canadian average is over 3 years of life.⁽²⁷⁾

This is a striking difference as this is equivalent to the effect of having a cure for cancer in all regions of Canada except for the rural ones.

Overall life expectancy is still increasing. It is not clear how much credit the health care system can take for this or if the rural gap is closing or widening. It is clear that these rural regions with the most ill health, and higher rates of long-term disability and chronic

illness, as well as increased mortality have the least access to health services to alleviate this suffering.

Telehealth

"Telehealth is the delivery of health services at a distance. It has considerable potential to have either positive or negative impacts on access to and delivery of rural health services."

-WONCA Using Information Technology to Improve Rural Health Care [\(28\)](#)

While the technology of telehealth changes rapidly, the principles remain unchanged from the time the first doctor picked up Graham Bell's invention to talk to another doctor. The potential of telehealth lies in supplementing the skills and abilities of existing rural health workers to deal with problems that would otherwise require patients to travel out of the community to access care. The risk lies in diverting resources so that there is no local expertise and that now the only way to access needed care is from outside.

The most common problem with telehealth, however is that fascination with the technology becomes the focus and the process is made irrelevant. How much TeleVideo conference equipment sits in rural hospital administrator offices unused? The first priority with telehealth must be to acknowledge and respond to local needs and expectations of the rural community and health care workers. Without this the money is wasted.

Provincial Rural Incentive Plans

While the existing array of strategies is better than doing nothing, it has not prevented the sharpening of rural/remote access as a policy issue. Something different and additional will have to be done in future if rural/remote access is to be improved.

-Barer and Stoddart 1999

The vast majority of medical graduates are of urban origin, have been trained to city standards in metropolitan hospitals, and can make a good living not far from where they were trained. In Ontario over 90% of the graduating classes choose to enter urban practice. [\(29\)](#)

The provinces have monetary incentives for physicians to move to rural and remote areas. Most provinces rely on recruitment incentive programs. The success of these programs is under debate. Proponents will point to how many new doctors have been attracted. Detractors will point out how the number of vacancies keeps increasing every year despite rapid escalation in funding and number of rural incentive programs. [\(30\)](#)

In a way both groups are correct.

These programs have been very successful in attracting physicians, annual recruitment to rural regions in Quebec has been 12.5% and in BC between 17% and 25%. Few of the doctors stay. BC data shows that attrition in the smallest BC communities (under 7000 pop) was twice that of communities over 7,000 and under 30 000 population.⁽³¹⁾

In these communities, most cancer patients outlive the tenure of their physician (4 years).

And so the gap between urban and rural grows.

Recent attempts in BC, Quebec, Alberta and Ontario have focussed on structuring and increasing retention payments and/or contract positions to reduce attrition rates. Although some programs (eg replacement physician or locum programs) do focus on working conditions, most rely on direct financial incentive and fail to provide adequate infrastructure support.

Table 1: Year of Introduction Provincial Rural Incentive Schemes

	Standby funding for on Call	Locum Support for	Incentive Remote	Rural Signing Bonus	Reentry Training for Rural MDs	Rural Contract Positions
BC	1998	1995	yes			Some
Alberta	1998	1992		1996	1996	
Saskatchewan	1998	yes		1979	1995	1984
Manitoba	1997	yes	yes	yes	2000	1996
Ontario	1995	1998	1996	1969	1997	1996
Quebec	1996	some	1982	1982	yes	
New Brunswick	1999		yes	yes	yes	
PEI				2000	2000	
Nova Scotia	1996			1995	2000	1995
Newfoundland			2000		yes	many

Notes: The date, when available, refers to the first introduction of a provincial program in that category

Program details are summarized at <http://srpc.ca/regions.html>

Improving Rural Health

With all this suffering and few providers, rural areas by virtue of necessity have found efficient and effective mechanisms to provide care. Rural areas have supported collaborative models of health involving patient self care, nurse practitioners, midwives, and mental health workers. GP's in these settings work in the hospital and everywhere

else, and local or distant specialists act as consultants and do not provide ongoing primary care. All this happens for the lowest per capita cost in the system.

These systems are so small that they are subject to attrition of key personnel. This vulnerability makes the systems fragile. Rural areas need support for maintenance and expansion of these models where services are faltering or at risk.

A Role for the Federal Government

There is a constantly changing landscape in health professional education systems, hospitals, clinical standards and incentives that occur just outside the jurisdiction of any given province. Thus it is not surprising that all provinces have been unable to equitably distribute health human resources across their own geography. Many have called for a pan Canadian solution. The rationale for a national approach to physician distribution was argued in 1999 by consultants to the federal and provincial health ministers, Barer and Stoddart :

"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."⁽³²⁾

Indeed solving one province's problem by attracting physicians from another is a zero sum game. This is an opportunity for a novel non-coercive federal provincial approach whose co-operative synergy will be to every province's benefit. Before a national approach to the challenges of rural health care delivery can be implemented, there are national systemic structural changes required. Three groups, councils, or committees need to be established:

1) A Federal/Provincial "Advisory Committee on Rural Health". This would be similar to the current Advisory Committee on Health Human Resources supported by Health Canada. It would be made up of Federal and Provincial public servants who would report to the combined Federal / Provincial / Territorial ministers and Deputy Minister's of Health and would be responsible for co-ordinating and initiating co-operative government solutions to rural health care.

2) A "Ministerial Council on Rural Health" - This has been announced but seems stalled. It would be made up of community and health care groups and would directly advise the Federal Minister of Health on rural health concerns. The Office of Rural Health of Health Canada would serve as secretariat.

3) A "Rural Medical Forum" made up of the national medical organisations involved in training, licensing, accreditation and standards. It would be patterned on the current "Canadian Medical Forum" but would focus only on rural health care.

All three are essential. One or two is not sufficient nor is simple modification of existing multifunction structures.

A National Rural Health Strategy could then be implemented, supported by the three groups mentioned above, funded by a significant recurrent federal budget and backed by dedicated research and data collection from CIHR. A NRHS with the structural backup outlined above, besides improving rural health care, would also be of enormous benefit to the whole system in such areas as Primary Care Reform

Recommendations

1. That the federal government, in co-operation with the provinces, reduces the structural barriers to national rural health policy advancement and form a National Rural Health Strategy that can be implemented

2. That the NRHS initial priorities include

- Aiding the provinces in accelerating expansion of existing successful rural collaborative models including those that rely on non-physician health professionals to provide care.
- Supporting initiatives to promote retention of health professionals.
- Ensuring educational of an adequate workforce for rural health care.
- Funding to let universities develop plans to become more rural orientated in admissions policy and to develop empowering rural health professional training curriculae, and incentive funding for the universities as they implement them.
- Facilitating Canadian medical licensing, standards and training bodies to develop and implement rural friendly policies

3. That federal funding for telehealth becomes contingent on tailoring programs by local rural analysis of health care needs amenable to telehealth support.

4. That rural health delivery research is adequately funded.

Conclusion

Making do and the status quo are not options. This is an opportunity for the Federal government to assist the provinces to develop a National Rural Health Strategy and make a difference.

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