

**RURAL AND REMOTE HEALTH IN
CANADA**

**PRESENTATION TO THE STANDING
SENATE COMMITTEE ON SOCIAL AFFAIRS,
SCIENCE AND TECHNOLOGY**

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**WILLIAM (BILL) G. THOLL
SECRETARY GENERAL AND CHIEF EXECUTIVE OFFICER**

*Leadership for Physicians... Health for Canadians
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The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, CMA's mission is to provide leadership for physicians and to promote the highest standard of health and health care for Canadians.

On behalf of its members and the Canadian public, CMA performs a wide variety of functions, such as advocating health promotion and disease/accident prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and 43 affiliated medical organizations.

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Mr. Chairman and Honourable Senators:

As Secretary General and Chief Executive Officer of the Canadian Medical Association (CMA), I am here today representing our members, more than 50,000 physicians from across Canada. The Association has a two-fold mission, namely to provide leadership for physicians and to promote the highest standards of health and health care for Canadians.

The CMA wants to expand significantly on part of its May 16th presentation to this Committee on health human resources. The issue of rural and remote health is of concern to the CMA and we commend the Committee for tackling this complex and very important aspect of Canada's health care system.

Our presentation will focus primarily on physician workforce issues in rural and remote practice locations. Most would agree that the health care infrastructure and level of professional support in rural and remote areas of Canada are insufficient to provide appropriate care, and contribute significantly to the difficulty in recruiting and retaining qualified physicians in sufficient numbers (relative to community needs).

I will address the following elements:

1. the distribution of physicians practising in rural and remote Canada;
2. their practice profile;
3. what rural physicians are telling us;
4. the CMA *Policy on Rural and Remote Practice Issues*; and
5. the role for the Federal Government in ensuring reasonable access to health care in these parts of the country.

1. Distribution of physicians practising in rural and remote Canada

As you know, Statistics Canada informs us that approximately 25% of Canadians live in rural areas. This number varies from 15% in British Columbia and Ontario to 45% in Atlantic Canada and as high as 60% in the territories.

The distribution of physicians is somewhat different. The following data are derived from the CMA physician resources database:

- Approximately 10% of Canadian physicians practise outside census metropolitan areas or census agglomerations. This roughly translates to communities of 10,000 or less and for research purposes we consider this cohort to be rural physicians.
- There are about 5,700 rural physicians, 87% of which are family physicians. The male/female split is similar to the overall physician pool in Canada but, among those under 35 years of age, half are female. This reflects the current breakdown of the postgraduate output and implies that females are just as likely to seek out rural practice as males.
- While Quebec and Ontario are home to almost half of all rural physicians in Canada, Newfoundland has the highest proportion of rural doctors (31%) followed by New Brunswick at 23% and Nova Scotia at 21%. The territories are considered separately since one could argue that even those physicians living in northern cities would be considered to be practising in a remote area.
- The majority of rural physicians are graduates of Canadian medical schools (72%) but it varies greatly by region. In Newfoundland, one in three rural physicians is a Canadian graduate; in Saskatchewan, it is only one in five. In contrast, 95% of Quebec rural physicians were trained in this country.

2. Practice profile

The CMA routinely surveys the Canadian physician population. Response rates for the surveys mentioned in this brief are shown in Table 1. The following data from CMA's 2000 Physician Resource Questionnaire will be of interest to the Committee:

- rural physicians are more likely to be in group practice than urban physicians (68% vs. 58%);
- 78% of rural physicians take call (compared to 75% of urban physicians);
- excluding their on-call time commitments, rural physicians report spending the same number of hours on direct patient care as urban physicians;
- however, rural physicians are on-call for more hours in a month than their urban colleagues; not only do they see more patients while on-call but they also spend more hours providing services;
- rural physicians are more likely to be compensated for being on-call, whether it is for carrying a phone or pager (37% are compensated vs 10% of urban physicians) or being available on-site (60% are compensated vs 31% of urban physicians);
- while more than half of rural physicians are paid primarily on a fee-for-service basis, proportionately fewer physicians are remunerated this way (53%) compared with 63% of urban physicians. Rural physicians are more likely than their city colleagues to be paid with a salary or some type of blended arrangement. When asked how they would prefer to be paid, 40% selected blended compared to 30% of urban doctors. Less than a third (31%) preferred fee-for-service.

Please see Table 2 for an overview of these results.

3. What rural physicians are telling us

In the last ten years, in addition to CMA's annual general physician resource questionnaire, two surveys (in 1991 and 1999) were specifically designed to address issues pertaining to physicians practising in rural and remote areas of Canada. I would like to highlight some results from both these surveys.

1991 Survey

- Over half of the survey respondents selected desire for rural practice as a very important factor in the decision to locate in a rural area (Figure 1). Only 11% reported financial incentives as being very important.
- The physicians who moved from a rural to an urban area were asked about the importance of selected *professional* considerations (Figure 2). Hours of work was by far the most frequently cited as very important (39%), followed by the need for professional backup (28%) and access to specialty services (24%).
- The physicians who moved from a rural to an urban area were asked about the importance of selected *personal* considerations (Figure 3). Children's educational opportunities was the most frequently cited (by 36%) as very important among the personal considerations, followed by career opportunities for their spouse.
- The physicians who moved from a rural to an urban area indicated that there were a number of *professional* factors that might have influenced them to stay (Figure 4). These factors include additional colleagues (56%), locum tenens (48%), opportunity for group practice (41%) and specialist services (36%).

1999 Survey

- In a tracking question from the survey conducted eight years previously, the 1999 survey found that, while rural physicians' level of *personal* satisfaction with their choice to practise and live in rural communities has remained constant, their level of *professional* satisfaction – i.e., how they are able to meet the health care needs of their patients – fell significantly since the early 1990s. In a striking example, only 17% reported being very satisfied with the availability of hospital services in 1999 compared to 40% in 1991.
- Rural physicians identified the following five factors as being most important in defining their practice community as rural: (1) a high level of on-call duty; (2) the long distance to a community health centre or hospital; (3) lack of services from medical specialists; (4) an insufficient number of family physicians or general practitioners; and (5) the long distance to a teaching hospital (tertiary health care centre).

CMA's findings were supported by the 1999 report from Barer and colleagues¹ that identified the following barriers to recruiting and retaining physicians in underserved communities in Canada: (1) lack of adequate training for the unique circumstances associated with practising medicine in rural environments; (2) remuneration issues; (3) onerous on-call duties and, more generally, heavy workload leading to burnout; (4) professional isolation; (5) lack of spousal employment opportunities; (6) children's education and extracurricular opportunities; (7) climate, recreational and cultural opportunities; and (8) distance from family and friends.

CMA 2001 Physician Resource Questionnaire

To illustrate some of these findings and highlight some of the positive events, the following quotes are taken from CMA's most recent survey of physicians (the response rate is unavailable for this survey which is still in the field):

I know one of the biggest problems my rural colleagues suffer from is lack of locums and difficulty replacing doctors in the community leading to heavier patient loads and responsibilities. This has particularly become worse since medical students have had to choose earlier about specialties with less options to return later. Somehow students and residents should be exposed to more rural medicine.

Rural surgical specialists have onerous responsibilities placed upon them with little backup, expectations for 24/7 call coverage and no financial compensation or recognition for their unwavering devotion to their communities and their profession. My colleagues and I are a dying breed and do not expect that we will be replaced. There is little incentive to practise in a rural environment yet the need continues to grow.

Although Fort Frances is rural/remote, we have managed to recruit and retain excellent physicians. We service a catchment area of 22,000 and have 10 MD's on the call rotation. We are an example of how you can live rural/remote, practise interesting medicine and have great quality of life.

Most people would think we are over-doctored here but it is the only way we can sustain a healthy lifestyle. Nonetheless the lifestyle of on-call, long irregular hours, and a physician spouse has been hard on the family and relationship. I dream of having regular hours and never having to answer the phone in the middle of the night.

¹ Barer M. et al. Toward Improved Access to Medical Services for Relatively Underserved Populations: Canadian Approaches, Foreign Lessons. Centre for Health Services and Policy Research, University of British Columbia, May 1999.

4. CMA Policy on Rural and Remote Practice Issues

In October of last year, the CMA released its *Policy on Rural and Remote Practice Issues*. A copy of this policy is appended to this presentation. The policy contains 28 specific recommendations in the three key areas of training requirements for physicians practising (or wanting to practise) in rural and remote Canada, compensation, and work and lifestyle support issues.

The policy illustrates the breadth of issues that need to be addressed before we can hope to alleviate the shortage of the rural physician workforce. The CMA believes that strategies developed to recruit and retain physicians to rural and remote Canada must be comprehensive, flexible and varied to meet and respond to local needs and interests; they must also include, from the outset, community and physician input.

The CMA also believes that, as a general rule, these strategies should not be coercive in nature, for example mandatory return-in-service contracts with new medical students. However, this is not to say that strong, positive incentive programs would not work. The Nova Scotia Department of Health, for example, developed a successful incentive program for physicians (including a guaranteed minimum income, a signing bonus and moving expenses, among others) and, importantly, hired a full-time recruiter to implement it. Under this program, 52 physicians were recruited in 1999, 50 in 2000 and 15 so far in 2001; none of these physicians were actively recruited from other Atlantic Canada provinces.

There are also examples from the international scene. In Australia, the National Rural Health Strategy involved funding a rural incentives program and the creation of the Australian Rural Health Research Institute (a consortium of five universities with rural campuses). The Australian Journal of Rural Health was also funded through this strategy. The incentive program included relocation grants, grants for continuing medical education and funding for temporary replacements (locums). While this strategy has been well received, there are still many problems of reasonable access to primary care in many parts of rural Australia.

In the United States, a financial incentive program, with its roots in the HMO act of 1973, uses an index of medical underservice to determine which areas receive the most funding. The CMA developed an index of rurality in 1999 which could be used in a similar fashion should the federal government decide to become involved in a similar program.

5. Role for the Federal Government

The CMA and others have identified a number of issues that need to be addressed to increase physician recruitment and retention in rural and remote Canada. While our presentation appropriately focuses on the physician workforce issue, this situation applies to other health care professions as well. On this note, the CMA has recently embarked on a study, in collaboration with the Society of Rural Physicians of Canada and the Canadian Nurses Association, that will examine the rural workforce of a number of health care professions.

We understand that, constitutionally, it is the role and responsibility of the provincial and territorial governments to oversee the provision of health care within their respective jurisdictions. Nonetheless, the CMA has identified five major leadership opportunities for the Federal Government in ensuring that Canadians who live in rural and remote areas have access to appropriate health care. These opportunities are in delivery, evaluation, immigration, planning and funding. Allow me to expand on each of these:

- i) *Delivery*: the Federal Government already has a health care delivery role in rural and remote Canada through the Indian and Northern Health Services Directorate of Health Canada. It would be important and valuable to identify lessons learned from this role and share this knowledge with all jurisdictions and players (for example, how physicians can best work with out-post nurses).
- ii) *Evaluation*: the CMA applauds the creation of the federal Office of Rural Health within Health Canada. We encourage the Federal Government to expand the role of this office so it can carry out an ongoing evaluation and roll-up of rural health and workforce status; this would become a reliable source of information for researchers, planners and decision-makers.
- iii) *Immigration*: in order to meet the short-term health care needs of Canadians, the CMA encourages the Federal Government, through Bill C-11, to develop an immigration policy that is friendly towards *qualified* international medical graduates. At the same time, any such policy must recognize the need for Canada to strive for reasonable self-sufficiency in the production of physicians.
- iv) *Planning*: we need a national planning approach for the short, medium and long term. Again, the CMA encourages the Federal Government to expand the role of its Office of Rural Health, with adequate support and funding, to carry out a comprehensive workforce needs assessment in rural and remote Canada. This information is critical to a successful planning process.
- v) *Funding*: finally, there is a role for the Federal Government in funding a mechanism whereby physicians and other health care professionals who want to prepare for practice in rural and remote Canada can obtain the appropriate training and experience. This is one of the main identified barriers to recruitment and retention in rural and remote areas. There is a precedent for the Federal Government in providing one time only funding to create capacity: this was in the 1966 Health Resources Fund Act, whereby the Federal Government funded the creation of new medical schools and the expansion of existing ones. The Federal Government could do the same thing now for the rural and remote workforce capacity. As you know, the Government of Ontario has recently announced the creation of its Northern Ontario Rural Medical School. This begs the question about the rest of the country and opens the door to the Federal Government to work with the Association of Canadian Medical Colleges, the CMA and other relevant medical education organizations to address this issue on a national scale.

I want to thank the Committee for inviting us to appear today and we trust that we will have further opportunities to appear before this Committee and work with you during the course of this study.

Table 1 – Response Rates of CMA Surveys to Rural Physicians

Year	Response rate	Sample size of respondents	Accuracy level (19 times out of 20)
1991 CMA survey Rural cohort	55%	n = 1320	+/- 2.7%
Rural to urban cohort	49%	n = 196	+/- 7.0%
1999 CMA Rural survey	31%	n = 1658	+/- 2.5%
2000 CMA Physician Resource Questionnaire	40% (rural respondents)	n = 253 rural respondents	+/- 6.2%

Table 2 – Results of the CMA 2000 Physician Resource Questionnaire

	Rural	Urban
Take call	78.3%	75.4%
Hours of shared call per month	175 hrs/month	139 hrs/month
Patients attended while on call	73 per month	41 per month
Hours spent providing service while on call	56 hrs/month	34 hrs/month
Group Practice	68.4%	58.2%
Remuneration		
90%+ professional income from fee-for-service	52.6%	63.0%
Preference for fee-for-service mode	30.8%	38.1%
Preference for blended mode	40.3%	29.7%