Politics of rural health care: recruitment and retention of physicians

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Une mauvaise répartition importante des médecins canadiens contribue directement aux problèmes liés à la prestation des soins de santé en région rurale. Les facteurs de recrutement et de rétention liés à cette question ont été identifiés. Les facteurs principaux pouvant être modifiés — la formation, les conditions de travail et les incitations financières — doivent être pris en considération par l'action coopérative des médecins, des collectivités, des facultés de médecine, des associations médicales et des gouvernements.

Despite Canada's well-developed health care system, the provision of health care in underserviced areas remains a major challenge. Barer and Stoddart[1] and the CMA[2] have identified a significant maldistribution of physicians that contributes directly to the problems of providing health care in rural areas.

The problems can be defined, causative factors determined and modifiable factors identified. The daunting questions of how to resolve the problems, who should do it and who makes these decisions need to be addressed.

Definition of the problems

Even though 23.5% of Canadians live in rural areas, including communities with populations of up to 10 000, only 17% of family physicians and 4% of specialists practise in those areas.[2] General surgeons are the predominant specialists, followed by general internists, a few radiologists and psychiatrists, and a scattering of others.[3] Compared with their urban counterparts, many rural family physicians are heavily involved in hospital work such as emergency medicine, obstetric deliveries and the general care of inpatients and have less time for office work, which magnifies the seriousness of the problem.

Each setting is unique and has its own problems. In general, family physicians practise in three kinds of rural settings:[3] small communities with no hospital, communities with a small "cottage" hospital and larger rural communities with a small, active hospital.[4] Family physicians in the last setting provide emergency medicine,[5] obstetric[6] and anesthesia services.[7] The comprehensive general surgeon,[8] who performs common general, plastic, gynecologic and orthopedic surgical procedures and cesarean sections, provides the fourth "leg in the table." These four legs are interdependent. For example, without anesthesia, general surgery is impossible and obstetrics is difficult. Currently many general surgeons are approaching retirement, and the new general surgeons are being trained mainly to do abdominal and breast surgery; they are unprepared to meet the needs of small community hospitals.[8]

Causative factors

Why do physicians enter or leave rural practice? The CMA,[2] in its study involving 2400 physicians in rural areas and 400 who moved from rural to urban areas, identified important recruitment and retention factors for rural practice. The desire for a rural practice, attractiveness of a rural location to the spouse, considerations of children, recreational opportunities, experience in training, community size and financial incentives were given as important

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factors in the decision to locate in a rural area.

Important professional factors in the decision to move from a rural to an urban area included work hours, professional backup, specialty services, additional training, hospital services, continuing medical education and earning potential. Family and personal reasons were children's education, spousal job opportunities, recreation, cultural opportunities and retirement. Factors that might have influenced physicians to stay in rural practice were, in order, additional colleagues, locum tenens, an opportunity for group practice, specialist services, alternative compensation, continuing medical education, improved facilities and emergency transportation.

Physicians closest to urban centres (within 60 km) reported the greatest satisfaction with their job, hours of work, professional backup, availability of specialists, continuing medical education, spousal job opportunities, cultural opportunities and children's education. As expected, the physicians in the most distant (more than 160 km from an urban centre) and smallest (population less than 5000) rural areas reported the least satisfaction.

Modifiable factors

The key modifiable factors are education, group practice opportunities, improved hospital facilities, reasonable working conditions and financial incentives. Small, isolated communities have additional problems imposed because of increased distance and isolation. As well, spousal factors need to be addressed.

Education

Education begins with fostering an interest in higher education, particularly medicine, among rural students. Several medical associations and medical schools actively promote medicine in high schools as a possible career goal. The selection of medical students could be altered to facilitate the entrance of those from rural areas, who are more likely than other students to choose rural practice.

Exposure to rural practice during undergraduate medical education can help to develop the desire to practise in rural areas — the most important determining factor in choosing a rural practice. Most medical schools now provide this opportunity.

Postgraduate training can provide important exposure to the joys and challenges of rural practice. Appropriate training in rural practice helps physicians prepare for such a career. Considerable progress has been made in this area, at least for family practice, through the cooperation of medical schools and ministries of health. More attention needs to be paid to these factors in postgraduate training, particularly for residents in psychiatry, general surgery and internal medicine. As well, rural communities that have medical students or residents are more likely to be able to attract their needed complement of physicians.

Appropriate continuing medical education remains a concern for many rural physicians and is complicated by the cost and time away from practice. Rural family physicians face difficulties in maintaining their knowledge and skills in all the varied aspects of their practice. Increased support for continuing medical education (travel, accommodation, tuition fees and locum tenens replacement) would help. Medical schools could provide professional support and outreach programs to try to address this need.

Group practice opportunities

Graduating physicians are much more likely to locate in a community where there is an opportunity for group practice than in one where they have to take the financial risk and make the commitment to set up an office. Small rural communities are more likely to be able to attract physicians by building and subsidizing group practice clinics.

Improved hospital facilities

Practising in a small hospital is difficult enough without being hampered by outdated and inadequate equipment. Many small hospitals do have adequate capital funds from community donations. Not every small hospital needs to provide every service. Part of the answer to improved facilities is to regionalize and rationalize services. Small hospitals in close proximity to each other or to larger hospitals should re-examine their roles: it may be appropriate for some to close or to limit their services; others may need to strengthen their services. By pooling resources, including physicians, hospitals could provide more effective care. They can also fund and staff outpatient clinic facilities to attract and support local and visiting specialists.

Reasonable working conditions

A heavy workload, including long "on-call" hours, is a major difficulty that causes physicians to leave rural practice. For rural family physicians, being on call often means providing hospital emergency, inpatient, obstetric and, sometimes, anesthesia services. A rural general surgeon often has no one to share on-call coverage with. These on-call demands often far exceed reasonable expectations in other areas of society. An Ontario Medical Association/Ontario Hospital Association task force recently

addressed this issue and published guidelines to set reasonable on-call limits and strategies to address the demand for services.[9]

Reasonable working conditions include the need for locum tenens. One of the greatest difficulties in rural practice is securing uninterrupted free time, often available only when the physician goes away for vacation or study leave. It is difficult for physicians in rural practice to compete for locum tenens with physicians in urban practices and walk-in clinics. The provincial medical associations, in cooperation with the ministries of health, could set up subsidized locum tenens services for rural areas.

Financial incentives

Programs to provide bursaries in return for rural practice service have had varied success. Incentive grants such as those from the Ontario Underserviced Area Program[10] have been beneficial in recruiting physicians, but these physicians often leave after the grant is used up.

Premiums for isolated rural practice are more likely to be beneficial in retaining physicians. The CMA study found that the more isolated the rural practice the lower the level of satisfaction physicians have with many aspects of their practice and lifestyle.[2] This can be partially offset by a premium based on distance from an urban centre. Only a small proportion (1.7%) of Ontario's physicians practise in a centre with less than 10 000 people located more than 80 km from a centre with more than 50 000 people (Ontario Medical Association: unpublished data). A significant premium for this group would have a negligible effect on the overall health care budget and would encourage the retention of physicians in more isolated communities.

Funding is also required to maintain physicians' involvement in necessary activities in their rural practices. For example, funding alternatives are needed for small-volume emergency departments that would reflect the management of difficult cases with little back-up and for social and sleep disruption with long hours of on-call service.[9] Some of this funding may need to be provided by the local hospital in the form of a guaranteed-minimum fee or an on-call stipend. Medical associations, in cooperation with the provincial ministries of health, need to address these financial issues more effectively.

Small, isolated communities

These communities have the greatest difficulty in recruiting and retaining physicians. Health care may best be provided by community health clinics that offer a range of services such as pharmacy, radiology, nursing and physiotherapy. Such clinics can provide an office and staff for two to four family physicians. Physicians can have a 1-year renewable contract that would include payment for holiday and education leave, travel expenses for regular trips to urban centres and bonuses for on-call service. The physician would not have the difficulty and commitment of setting up an office and staff and the desperation of trying to find a locum tenens in order to get away for a break. A regular schedule and an assured income rather than the standard fee-for-service remuneration are more likely to attract needed physicians to these communities. Preliminary experience in Ontario suggests that this model may be more expensive than traditional fee-for-service per-capita costs, but its success may be well worth its cost to communities and provincial governments.

Spousal factors

This factor is the most difficult to modify in small communities that are far from urban areas with more opportunities for the career and personal needs of spouses. Small communities need to consider spousal factors and modify their recruitment and retention planning to address individual circumstances and needs. Unmarried physicians may be reluctant to come to or stay in isolated rural areas because of the small pool of potential mates.

Other variables

Graduates of foreign medical schools have helped fill the needs of some rural communities. This represents a failure to address the modifiable factors to make rural practice more attractive to Canadian medical school graduates. Similarly, restrictions on geographic billing numbers, to force rather than attract physicians to work where they are needed, have been unsuccessful.

Summary

The shortage of physicians in underserviced areas has been defined, and the causative recruitment and retention factors have been identified. The CMA report[2] provides a framework for understanding these factors. Many can be modified, but this requires cooperation between physicians, communities, hospitals, medical schools, medical associations and governments. The development of a rural-practice master plan[11] in each province would facilitate this process.

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Conferences

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May 19, 1993: Balancing Physician Accountabilities — Dr. Jekyll and Mr. Hyde? (cosponsored by the Ontario Medical Association and the Centre for Health Economics and Policy Analysis [CHEPA] and in conjunction with CHEPA's 6th Annual Health Policy Conference)
Hamilton
Ms. Lynda Marsh, conference administrator, CHEPA, McMaster University, Rm. 3H26, 1200 Main St. W, Hamilton, ON L8N 3Z5; tel (416) 525-9140, ext. 2135, fax (416) 546-5211

May 19-21, 1993: CHEPA's 6th Annual Health Policy Conference — the Buck Stops Where? Accountabilities in Health and Health Care (preceded by the seminar "Balancing Physician Accountabilities: Dr. Jekyll and Mr. Hyde?")
Hamilton
Ms. Lynda Marsh, conference administrator, Centre for Health Economics and Policy Analysis, McMaster University, Rm. 3H26, 1200 Main St. W, Hamilton, ON L8N 3Z5; tel (416) 525-9140, ext. 2135, fax (416) 546-5211

May 19-22, 1993: American Back Society — the Industrial Back
Buffalo, NY
Dr. Aubrey A. Swartz, executive director, St. Joseph's Professional Center, Ste. 401, 2647 E 14th St., Oakland, CA 94610; tel (510) 536-9929, fax (510)536-1812

May 20-23, 1993: Second World Conference on Injury Control
Atlanta
Second World Conference on Injury Control, c/o Division of Injury Control NCEHIC (F36), Centers for Disease Control, Atlanta, GA 30333; tel (404) 488-4360, fax (404) 488-4349

May 27-29, 1993: Genetics and Society
Montreal
Lynda O'Donnell, communications coordinator, Royal Society of Canada, PO Box 9734, Ottawa, ON K1G 5J4; tel (613) 991-9000

Du 27 au 29 mai 1993 : Génétique et Société
Montréal
Lynda O'Donnell, coordonnatrice des communications, Société royale du Canada, CP 9734, Ottawa, ON K1G 5J4; tél (613) 991-9000

Du 30 mai au 3 juin 1993 : XVIIe Congrès de l'Association internationale pour la prévention du suicide (Congrès conjoint de l'Association canadienne pour la prévention du suicide et de l'Association québécoise de suicidologie organisé avec la collaboration de Suicide-Action Montréal)
Montréal
Les langues officielles : le français et l'anglais
Congrès I.A.S.P., a/s Professeur Brian L. Mishara, LAREHS, Université du Québec à Montréal, CP 8888, Succ. A, Montréal, QC H3C 3P8; tél (514) 987-4832, fax (514) 987-8408

May 30-June 3, 1993: 17th Congress of the International Association for Suicide Prevention (combined meeting with the Canadian Association for Suicide Prevention and l'Association québécoise de suicidologie organized in collaboration with Suicide-Action Montréal)
Montreal
Official languages: English and French
I.A.S.P. Congress, c/o Professor Brian L. Mishara, LAREHS, University of Quebec at Montreal, PO Box 8888, Stn. A, Montreal, PQ H3C 3P8; tel (514) 987-4832, fax (514) 987-8408

May 31, 1993: 6th World No-Tobacco Day (coordinated by the World Health Organization and promoted by the Canadian Council on Smoking and Health and the Canadian Society for International Health)
Mary Bridgeo, communications officer, Canadian Society for International Health, 902-170 Laurier Ave. W, Ottawa, ON K1P 5V5; tel (613) 230-2654, fax (613) 230-8401

June 2-4, 1993: Medical and Scientific Writing Dynamics
Toronto
McLuhan and Davies Communications, Inc., 167 Carlton St., Toronto, ON M5A 2K3; tel (416) 967-7481, fax (416) 967-0646

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