What family doctors actually want in a job: a cross-sectional survey of primary care reform priorities

Lindsay Hedden, PhD[1,2], Setareh Banihosseini[4], MD, PhD, Nardia Strydom[3,4,5], Rita McCracken[3,4], MD, PhD

[1]Faculty of Health Sciences
Simon Fraser University

[2] Academic Health Science Network

[3]Department of Family Medicine
Faculty of Medicine
University of British Columbia

[4]Department of Family Medicine
Providence Health Care

[5]Department of Family Medicine
Vancouver Coastal Health Authority

Lindsay Hedden – Lindsay_hedden@sfu.ca
Rita McCracken – rita.mccracken@ubc.ca
Setareh Banihosseini - sbanihosseini@providencehealth.bc.ca
Nardia Strydom - NStrydom@providencehealth.bc.ca

***Address Correspondence (and Request for Reprints) to:**

Dr. Rita McCracken
Rita.mccracken@ubc.ca

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Abstract

Background: Despite consistent increases in primary care physicians per-capita, BC is facing a family physician (FP) shortage. System-level reform to address the shortage is ongoing. We sought to explore FPs' perspectives about priorities reforms, and discuss alignement of those perspecitves with the provincial policy direction.

Methods: All FPs credentialed within Vancouver Coast Health (VCH) Authority in 2018 were invited to participate in a cross-sectional survey (N=1017). Respondents were asked about their current model of practice and other practice characteristsc, demographics, level of burnout, and priorities for system-level reform. We used chi-square tests and multivariable logisitic regression to investigate replationships between personal and practice characateristisc, burnout, and priorities for reform.

Results: We received responses from 541 (53.2%) FPs. 399 (73.8%) respondents indicated a need for fundamental change to how primary care is delivered. 244 (47.6%) reported they would prefer to be an employee of a clinic, rather than a small business owner. Other identified reform priorities included options to practice in a team (reported as very important by 64.7% of respondents), direct funding for team roles (66.7%), direct clinic funding (59.8%), part-time work options (69.6%) and parental leave (81.1%). Priorities for reform were consistent across practice models.

Interpretation: Half of FPs would prefer to be employees of a clinic rather than small business owners, a model that has very limited availability in the province. The lack of availability of this model may push physicians away from community-based family medicine and towards alternative models, contributing to ongoing access issues for patients.

Keywords: Primary health care; family medicine; reform; workforce planning; models of practice

1. Introduction

The British Columbia (BC) Ministry of Health is implementing a suite of structural reforms to primary care (1–3) to address the worsening family physician (FP) shortage and introduce an integrated system of primary and community care. The reforms are centered around interdisciplinary teams working within Patient Medical Homes (4), that are collectively organized into Primary Care Networks (5). Under these reforms, practices will remain FP owned and operated, and fee-for-sevice remuneration will continue to be the primary payment scheme. There is a need to assess whether these reforms are concordant with physician perspectives on what specific strategies are needed to improve access to primary care. This study takes initial steps to address that knowledge gap.

Job satisfaction among FPs is generally high (6–9); however, rates of stress and burnout are also high (10–13), and concerns about poor work-life balance (14–16), burden of administrative work (14,17), long hours (6,7,14,16,18,19), and rate of pay (6–8,14,17,20) are frequently raised. Despite a lack of supported structural change to date, FPs in BC appear to moving towards alternative or blended models of practice, such as working part-time in hospitals, long-term care, clinically-focused practice, or in walk-in clinics (21–24). The reasons for this shift have not yet been directly examined; howver, it's fair to hypothesize that FPs are seeking practice arrangements that will reduce administrative burden, lower stress, reduce burnout, and/or improve work-life balance. This has the net effect of reducing the capacity for longitudinal, community-based family medicine, potentially contributing to ongoing access challenges (25).

Given this ongoing shift away from family medicine and widespread access challenges, it is essential that Ministry reforms are in alignment with both current evidence on best practices in primary care and on physician preferences. Assessing this alignement could facilitate creation of a pragmatic policy shift to address the FP shortage. The objective of this study is therefore to identify new to practice and established PFs' specific priorities for structural health system reform and provide commentary on the alignment of those priorities with BC's slated suite of incoming primary care reforms.

2. Methods

2.1 Setting and Data Collection

Primary care in BC consists primarly of physicians working in solo or small-group practice community clinics under a fee-for-service (FFS) remuneration model. While some other Canadian provinces have moved away from this model, incorporating team-based care, non-physician health professionals and alterative forms of remuneration (26,27), there has been little structural change to primary care organization and delivery in BC.

This study was conducted within Vancouver Coastal Health (VCH) Authority, one of five regional health authorities in BC, which provides services to approximately one quarter of the province's population. Data used in this study were drawn from an annual credentialing survey of physicians seeking to maintain privileges to provide services at VCH facilities. The voluntary survey was designed to capture information on physician practice models and patterns and demographics in order to inform workforce planning for the Health Authority. Questions about priorities for structural reform to the primary health care system in BC were also included. All

family physicians who had clinical privileges within VCH were sent a participation request and reminders (at one and five weeks) via email. The survey was administered online through REDCap, and the research team used de-identified data for analysis. Data were collected between January 30th and April 15th of 2018.

2.2 Variables

Participants were asked whether they felt that any changes needed to be made to how primary care is being delivered in BC. They were also asked about their preferences for a non-fee-for-service remuneration model (such as capitation or salary) and whether or not they would prefer to be an employee of a clinic rather than a small business owner. In addition, participants were asked to consider what it would take for them to provide longitudinal, community-based care to more people by rating a series of specific potential reform priorities. These priorities covered payment structure, work structure and job benefits, and response options were "not important", "somewhat important", or "very important". The specific reform priority options were selected based on the content of the Ministry of Health's policy direction for primary and community care (28) as well as based on an existing survey of practice preferences for newly practicing FPs in BC (29).

We assessed level of burnout using a validated single-item measure: "I feel burned out from my work" (30,31). Responses are measured on a seven-point scale that ranges from "never" to "every day". West and colleagues define a cut-point of four (feeling burnt out once per week or more) as "high levels of burnout" (30).

Our two key independent variables of interest were newness to practice, and model of practice. We identified new to practice physicians as those who completed medical school within the last twelve years (i.e. had a maximum ten years in practice after residency), and established physicians as those who graduated more than twelve years ago. Models of practice included full-time community-based primary care (CBPC) (>37.5 hours per week), mostly CBPC plus other work (20-<37.5 hours per week CBPC), mostly other work but some CPSC (<20 hours per week CBPC), full-time hospital or inpatient care only, or locum only. Demographic data included gender, number of years in practice, location of training (within or outside of Canada), and location of practice (rural or urban). We also collected data on work hours and on-call responsibilities.

2.3 Statistical Analyses

We dichotomized responses to the reform priority questions by grouping "somewhat important", "not important" and "no opinion". We conducted sensitivity analysis by grouping "somewhat" and "very important", compared to "not important" and "no opinion" to determine if this alternative resulted in similar patterns by practice model and newness to practice. The decision to dichotomize was made for ease interpretation of multivariable model results. We compared new to practice physicians to established ones according to model of practice, demographic characteristics, burnout, and reform priorities at the bivariate level using Chi Square tests.

We used multivariable logistic regression to examine the independent relationships between dichotomous burnout and reform priority measures with our two key independent variables of interest: newness to practice, and model of practice. In all cases we adjusted for the potentially

confounding effect of gender, training location, practice location and weekly work hours. We report results as odd ratios and 95% confidence intervals. Individuals with missing values for specific outcome variables were excluded from those models.

3. Results

3.1 Descriptive Results

One thousand and seventeen FPs seeking a renewal of privileges were invited to complete the survey. Among them, 525 (51.6%) responded and completed the core model of practice and demographic questions. The sample included 291 (55.5%) women, 112 (21.1%) international medical graduates and 111 (21.1%) physicians who do at least some of their work in a rural area (Table 1). At the bivariate level, new to practice physicians differed from established physicians on all variables with the exception of the provision of call coverage. New physicians worked more hours on average (47.3 versus 42.9 hours per week for established physicians), had lower odds of reporting that they worked entirely in CBPC (15.9% versus 24.1%), and higher odds of being a locum (22.7 versus 9.5%, $p<0.0001$).

Two hundred twenty-three (42.5%) individuals reported experiencing a high level of burnout (Table 2). Rates of burnout varied significantly by years in practice, with new to practice physicians having higher odds compared to more established ones (51.7% versus 37.8%).

The majority of the sample (77.8%) reported that primary care reform is needed in BC. Almost half (47.5%) reported that they would prefer to be an employee of a clinic rather than a small business ownder. Highest levels of support were reported for vacation and parental leave

(81.1%), option to work part-time (69.6%), option to practice in a team (64.7%) and direct funding for team-roles (66.7%). New to practice physicians had higher odds of reporting all priorities as being very important compared to established physicians, with the exception of vacation and parental leave, transparent evaluation of transformation initiatives, and option to practice in a team.

3.2 Burnout

The relationship between newness to practice and burnout did not persist when we adjusted for demographic and practice variables (Table 3). Rather, women (OR 1.94, 95% CI 1.32-2.85) and individuals who work more than forty hours per week (e.g. 60+ hours per week OR 4.26, 95%CI 2.02-8.98) had higher odds of experiencing high levels of burnout. No other variables had a statistically significant association with rate of burnout in the multivariable model.

3.3 Reform Priorities

New to practice physicians had higher odds of reporting that all reform priorities (with the exception of transparent evaluation of reform initiatives, and vacation and parental leave) were very important, consistent with the bivariate level analyses (Table 4 a and b)). They also had higher odds of reporting they felt a non-fee for service remuneration model would make it easier to provide longitudinal care (OR 3.45, 95% CI 2.22-5.38) and that they'd prefer to work as employee of a clinic rather than a small business owner (OR 2.29, 95% CI 1.48-3.49).

Individuals working in blended models of practice (either mostly CBPC or mostly hospital/facility) also had higher odds of preferring non fee-for-service remuneration and direct

employment rather than an entrepreneurial model. Model of practice also seemed to be related to some specific priorities, with physicians working in blended or hospital-based roles having higher odds of reporting that team-based care, direct funding for team roles, and time-limited commitments to a patient panel were very important.

Physicians in rural practice had lower odds of agreeing that primary care reform is needed (OR 0.57, 95% CI 0.35-0.94). Physicians who trained outside of Canada had higher odds of reporting that options to practice as a team (OR 1.68, 95% CI 1.01-2.82), direct funding for team roles (OR 1.69, 95% CI 1.02-2.79), and a time-limited commitment to a patient panel (OR 2.48, 95%CI 1.48-4.14) were very important. Weekly work hours did not appear to be predictive of reform priority preferences with the exception of the option to work part time and loan forgiveness, with physicians working the most hours having lower odds of reporting that part time options were very important (e.g. OR for >60 hours/week 0.32, 95% CI 0.15-0.69), and higher odds that loan forgiveness was very important (OR 3.44, 95% CI 1.49-7.91).

3.4 Sensitivity Analysis

We conducted sensitivity analysis to examine the robustness of our analytic choices. Grouping reform priority "somewhat important" and "very important" responses to questions about individual reform priorities resulted in only very minor changes to the odds ratios we report in tables 5 a and b, and no changes in directionality.

4. Discussion

Almost 80% of the physicians we surveyed agreed that BC's primary care system is in need of fundamental reform, and 42% met the criteria for suffering a high level of burnout within their current model of practice. We found a high rate of agreement among all physicians for the majority of different possible priorities, and with the exception of vacation and parental leave, and evaluation of reforms, where level of agreement was higher among newer to practice physicians.

Direct employment, rather than being a small business owner was preferred by almost half of respondents. Direct clinic funding and benefits (vacation and parental leave), both of which could be included in a direct employment model, also had high levels of support. These finding are consistent with the American literature on the declining rate of small business ownership among physicians, particularily among newer to practice physicians and women (32). Previous studies of physicians' overall satisfaction with work-life suggests that they are more likely to experience burnout when they spend more time doing work they perceive as being less meaningful, such as administrative and management tasks (33). Furthermore, compared to physician ownership, models of practice in which clinics are owned by hospitals (and physicians are therefore employees) have been associated with lower rates of burnout and more positive perceptions of work environment (34). It follows that models of practice that involve more administrative burden, such as BC's standard physician owned-and-operated FFS practices, may be associated with higher rates of burnout and lower satisfaction.

The proportion of physicians who would prefer to be an employee rather than small business owner is particularly striking because it represents a radical departure from BC's "classic" model

of entrepreneurial practice, and because it is a model that not being supported within the Ministry of Health's suite of reforms.

Interdisciplinary team-based care and direct funding for team roles also had a high degree of support. The Ministry's Integrated System of Primary and Community care introduces opportunities for team-based care in a Patient Medical Home model, and as well as in networks, and funding is provided to support these expanded roles. This new policy also introduces an alternative payment contract specifically for new-to-practice physicians who do not wish to be paid under the standard FFS model. On the surface, this aligns with our findings that family physicians are looking for an alternative model. However, the BC Society of General Practitioners advised their membership not to accept the contracts, stating that they were developed without sufficient physician consultation and that they do not reflect the needs of patients or physicians, undervalueing community-based family doctors relative to those practicing in hosptials or urgent care cenres (35).

4.1 Limitations

This research was conducted as a cross-sectional survey of physicians working in a large, urban health authority in BC. While our survey had a high response rate relative to other similar surveys (36), it is important to note that the perspectives of our respondents may be different from physicians who elected not to participate or who were not eligible (i.e. who did not have privileges in a VCH facility). Futhermore, pysicians working within VCH may structure their practices in ways that are fundamentally different from those working in regional health

authorities with more rural and remote areas. Consequently their priorities for reform my be different from what we report.

While we based our selection of reform priorities on existing literature and on relevance to the local context (given incoming structural reforms), the list was certainly not exhaustive. It is possible that other structural reform options that were not listed may be highly desirable. Additional qualitative work should explore whether there are additional evidence-informed reforms that would encourage more physicians to work in community-based family medicine.

4.2 Conclusions

There is general agreement that BC's primary care system is in need of fundamental reform. While the approach taken by the Ministry of Health does address some physician priorities (the ability to practice in interdisciplinary teams in particular), there are certainly gaps. The lack of availability of a model in which physicians are employees rather than business owners is a striking oversight, and one that may continue to push many physicians away from longitudinal, community-based primary care, and into other models or specialities, exacerbating significant accessibility challenges for patients.

Authors' contributions

LH developed the online survey tool, designed the analytic strategy, cleaned and analyzed all data, drafted the manuscript and incorporated coauthor feedback. RM conceptualized the study, drafted the survey questions, and provided feedback on data analyses and manuscript development at all stages. SB assisted with conceptualization of the study, and contributed to

drafting the manuscript. NS assisted with conceptualizing the study, contributed to drafting the manuscript and interpretation of results. All authors read and approved the final manuscript.

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Table 1: Study sample

Characteristic, N(%)	New to Practice Physicians N=176 (33.5%)	Established Physicians N=349 (66.5%)	Total N=525	Test Statistic
Demographics				
Gender (women)[1]	109 (61.9)	182 (52.3)	291 (55.5)	X^2=4.4*
International medical graduates	85 (24.4)	27 (15.3)	112 (21.1)	X^2=5.7*
Any rural practice	46 (26.1)	65 (18.6)	111 (21.1)	X^2=4.0*
Work Hours (SD)	46.3 (15.0)	43.0 (15.2)	44.1 (15.2)	F=5.6*
Practice model				
Full-time CBPC	28 (15.9)	84 (24.1)	112 (21.3)	X^2=22.8***
Mostly CBPC	42 (23.9)	99 (28.4)	141 (26.9)	
Mostly other work	40 (22.7)	62 (17.8)	102 (19.4)	
Hospital/facility only	26 (14.8)	71 (20.3)	97 (18.5)	
Locum only	40 (22.7)	33 (9.5)	73 (13.9)	
Provides call coverage	148 (84.1)	269 (77.1)	417 (79.4)	X^2=3.5
Weekly work hours				
<30	12 (6.8)	57 (16.3)	69 (13.1)	X^2=12.1*
30-<40	85 (16.2)	61 (17.5)	85 (16.2)	
40-<50	157 (29.9)	98 (28.1)	157 (29.9)	
50-<60	112 (21.3	70 (20.1)	112 (21.3)	
60+	102 (19.4)	63 (18.1)	102 (19.4)	

*p<0.05
**p<0.01
***p<0.001
[1]missing N=1
Weekly hours average 42.9 (SD 15.2) for established physicians and 46.3 (SD 15.0) for new grads, F=5.55, p=0.018

Table 2: Burnout frequency and priorities for reform

Reform Priorities	New to Practice Physicians N=172 (33.5%)	Established Physicians N=341 (66.5%)	Total N=513[1]	Test Statistic
High level of burnout[1]	91 (51.7)	132 (37.8)	223 (42.5)	X^2=9.2**
Reforms (Y/N)				
Primary care reform is needed	146 (84.9)	253 (74.1)	399 (77.8)	X^2=7.6*
An APP model would make it easier to provide longitudinal care	117 (68.0)	136 (39.9)	253 (49.4)	X^2=39.5***
I would prefer to be an employee of a clinic (not a small business owner)	101 (58.7)	143 (41.9)	244 (47.5)	X^2=28.5***
Specific reform prioritie[2]				
Payment Structure				
Alternative forms of physician payment	109 (63.4)	136 (39.9)	245 (47.8)	X^2=25.3***
Direct funding for team roles	133 (77.3)	209 (61.3)	342 (66.7)	X^2=13.2***
Direct clinic funding	124 (72.1)	183 (53.7)	307 (59.8)	X^2=16.2***
Work Structure				
Option to practice in a team	118 (68.6)	214 (62.7)	332 (64.7)	X^2=1.7
Time-limited commitment to patient panel	51 (29.7)	69 (20.2)	120 (23.4)	X^2=12.9***
Transparent evaluation of transformation initiatives	101 (58.7)	210 (61.6)	311 (60.6)	X^2=0.4
Option to work part-time	144 (83.7)	213 (62.5)	357 (69.6)	X^2=24.4***
Job Benefits				
Vacation and parental leave	143 (83.1)	273 (80.1)	416 (81.1)	X^2=0.7
Loan forgiveness	69 (40.1)	69 (20.2)	138 (26.9)	X^2=23.0***

[1]Defined as feeling burned out at a frequency of once per week or more.(31)
[2]Missing N=12 for all questions; proportion who reported each priority very important.
*p<0.05
**p<0.01
***p<0.001

Table 3: Multivariable model results: burnout

	High Rate of Burnout
New grad (ref=established)	1.41 (0.92, 2.15)
Female (ref=male)	**1.94 (1.32, 2.85)**
Model of practice (ref = full-time CBPC)	
Mostly CBPC	1.55 (0.89, 2.68)
Mostly other work	1.59 (0.87, 2.93)
Hospital/facility only	0.93 (0.50, 1.73)
Locum	0.76 (0.37, 1.54)
Any Rural Practice (ref = Urban)	1.31 (0.83, 2.08)
International training (ref = Canadian trained)	0.92 (0.58, 1.46)
Weekly work hours (ref=<30)	
30-<40	1.15 (0.55, 2.42)
40-<50	**2.60 (1.33, 5.08)**
50-<60	**2.42 (1.19, 4.91)**
60+	**4.26 (2.02, 8.98)**

Table 4 (a and b): Multivariable model results: reform priorities

	Primary care reform is needed	An APP model would make it easier for me to provide longitudinal care	I would prefer to be an employee of a clinic (not a small business owner)	**Payment Structure[1]**		
				Alternative Forms of Physician Payment	Direct funding for team roles	Direct Clinic funding
New grad (ref= established)	1.56 (0.94, 2.59)	**3.45 (2.22, 5.38)**	**2.28 (1.48, 3.49)**	**2.89 (1.85, 4.52)**	**2.40 (1.47, 3.90)**	**2.27 (1.44, 3.58)**
Female (ref=male)	0.88 (0.58, 1.35)	1.25 (0.86, 1.83)	1.35 (0.93, 1.97)	1.38 (0.94, 2.02)	1.41 (0.95, 2.09)	**1.47 (1.00, 2.14)**
Model of practice (ref = full-time CBPC)						
Mostly CBPC	1.42 (0.75, 2.67)	**1.95 (1.10, 3.42**	**2.01 (1.13, 3.56)**	**1.76 (1.00, 3.10)**	**1.83 (1.03, 3.23)**	1.10 (0.63, 1.91)
Mostly other work	1.11 (0.56, 2.20)	**2.87 (1.54, 5.36)**	**2.73 (1.46, 5.09)**	**3.51 (1.84, 6.69)**	**2.67 (1.37, 5.21)**	1.17 (0.63, 2.18)
Hospital/facility only	1.11 (0.56, 2.21)	1.34 (0.72, 2.51)	**2.12 (1.13, 3.99)**	**2.34 (1.25, 4.39)**	**2.16 (1.14, 4.10)**	1.53 (0.82, 2.84)
Locum	1.38 (0.62, 3.10)	1.51 (0.75, 3.06)	1.39 (0.69, 2.80)	1.37 (0.67, 2.81)	1.15 (0.56, 2.36)	0.66 (0.32, 1.32)
Any Rural Practice (ref = Urban)	**0.57 (0.35, 0.94)**	0.73 (0.46, 1.16)	0.71 (0.45, 1.12)	0.67 (0.42, 1.07)	0.76 (0.47, 1.23)	1.13 (0.71, 1.81)
International training (ref = Canadian trained)	1.08 (0.64, 1.81)	0.88 0.67, 1.40)	0.63 (0.39, 1.00)	0.99 (0.62, 1.57)	**1.69 (1.02, 2.79)**	1.15 (0.72, 1.82)
Weekly work hours (ref=<30)						
30-<40	1.41 (0.68, 2.91)	1.40 (0.72, 2.75)	0.83 (0.42, 1.61)	1.42 (0.71, 2.82)	0.95 (0.46, 1.95)	1.22 (0.62, 2.41)
40-<50	1.83 (0.93, 3.60)	1.39 (0.74, 2.59)	0.73 (0.39, 1.35)	1.80 (0.95, 3.40)	0.94 (0.49, 1.81)	1.57 (0.84, 2.93)
50-<60	1.67 (0.81, 3.44)	1.18 (0.61, 2.30)	0.58 (0.30, 1.12)	1.23 (0.63, 2.39)	1.12 (0.56, 2.26)	1.31 (0.68, 2.52)
60+	1.37 (0.64, 2.89)	1.00 (0.49, 2.03)	0.64 (0.32, 1.29)	1.01 (0.49, 2.09)	1.44 (0.68, 3.07)	1.65 (0.81, 3.34)

[1]Odds of reporting each reform priority as very important.

	Work Structure[1]					Job Benefits[1]
	Option to practice in a team	Time-limited commitment to patient panel	Transparent evaluation of transformation initiatives	Option to work part-time	Vacation and parental leave	Loan forgiveness
New grad (ref= established)	**4.29 (2.45, 7.52)**	**1.81 (1.13, 2.91)**	0.93 (0.61, 1.43)	**1.37 (0.87, 2.17)**	1.34 (0.77, 2.33)	**2.15 (1.37, 3.36)**
Female (ref=male)	1.14 (0.75, 1.71)	1.21 (0.78, 1.88)	1.17 (0.81, 1.71)	1.27 (0.85, 1.88)	1.37 (0.86, 2.18)	1.24 (0.82, 1.90)
Model of practice (ref = full-time CBPC)						
Mostly CBPC	**1.98 (1.10, 3.56)**	1.27 (0.65, 2.51)	1.49 (0.86, 2.58)	**1.88 (1.07, 3.31)**	0.98 (0.50, 1.92)	1.30 (0.70, 2.42)
Mostly other work	**2.61 (1.31, 5.19)**	**2.41 (1.17, 4.98)**	**2.20 (1.16, 4.17)**	1.43 (0.76, 2.70)	0.95 (0.44, 2.04)	1.68 (0.84, 3.35)
Hospital/facility only	**2.34 (1.20, 4.54)**	**2.14 (1.03, 4.44)**	1.28 (0.70, 2.35)	1.20 (0.64, 2.22)	0.57 (0.28, 1.17)	1.52 (0.76, 3.03)
Locum	1.16 (0.55, 2.48)	**2.35 (1.05, 5.24)**	1.07 (0.54, 2.13)	1.77 (0.85, 3.72)	1.20 (0.48, 3.03)	1.49 (0.69, 3.21)
Any Rural Practice (ref = Urban)	0.64 (0.39, 1.06)	0.67 (0.39, 1.17)	0.68 (0.43, 1.07)	1.16 (0.71, 1.91)	1.21 (0.66, 2.21)	0.87 (0.52, 1.45)
International training (ref = Canadian trained)	**1.68 (1.01, 2.82)**	**2.48 (1.48, 4.14)**	0.90 (0.57, 1.42)	0.83 (0.51, 1.34)	0.97 (0.55, 1.71)	1.59 (0.97, 2.63)
Weekly work hours (ref=<30)						
30-<40	0.71 (0.34, 1.51)	0.85 (0.37, 1.96)	0.90 (0.45, 1.79)	0.99 (0.44, 2.22)	0.91 (0.36, 2.28)	1.50 (0.65, 3.46)
40-<50	0.93 (0.46, 1.86)	1.26 (0.60, 2.65)	0.77 (0.41, 1.44)	0.61 (0.30, 1.26)	0.65 (0.28, 1.48)	1.68 (0.77, 3.65)
50-<60	0.82 (0.39, 1.70)	1.07 (0.48, 2.36)	1.22 (0.62, 2.40)	**0.29 (0.14, 0.60)**	0.71 (0.30, 1.68)	1.74 (0.77, 3.92)
60+	0.80 (0.37, 1.74)	2.13 (0.94, 4.79)	1.30 (0.63, 2.67)	**0.32 (0.15, 0.69)**	0.53 (0.22, 1.31)	**3.44 (1.49, 7.91)**

[1]Odds of reporting each reform priority as very important.