

RECRUITMENT AND RETENTION OF RURAL DOCTORS IN CANADA

As part of the planning preparations for the second World Rural Health Congress in Durban, a pre-conference workshop on recruitment and retention of rural doctors was held in Banff, Alberta, Canada, in April 1997. This key stakeholders' consensus conference was hosted by the Society of Rural Physicians of Canada with co-chairs and conference organisers Dr Ken Babey and Dr James Rourke.

Canada is a large country in area (9 970 610 km²) with a population of 28 846 761 and a rural population of 8 740 847. The health care system is a provincial responsibility, but there is mixed federal and provincial funding. The overall health care system is governed by the Canada Health Act, which guarantees accessibility, universality and portability.

In fact, the government pays for almost all medical services. There is essentially no private MD billing and no private clinics or hospitals. The health care system is governed by provincial government/medical association agreements, which provide virtual monopolies on negotiations for payment for doctors and physician resources.

There are approximately 50 000 medical doctors in Canada with the GP:specialist ratio of 50:50. The GP's (family doctor's) role is mainly office-based primary care but rural GPs have an extensive hospital role as well. The specialist role is that of consultant/referred care.

In Canada, 30% of the total population is rural, only 11.3% of doctors and 3.8% of specialists and 18.6% of family doctors practise in rural areas, defined as including communities of up to 10 000 people.

The conference goals were to examine the success and failure of various types of initiatives used to recruit and retain doctors in rural areas and to develop a consensus on the elements of a framework, to create a successful program for recruiting and retaining doctors in rural and remote areas.

Conference participants included medical associations, medical schools, the Canadian Association of Interns and Residents, municipalities, provincial governments, federal government and rural medicine leaders.

Report of Pre-Conference Workshop

The conference was one very full day, which included presentations, break-outs and consensus sessions extending well into the evening. In retrospect, it was a little bit much to try to accomplish in one day, but the conference was followed by a three-day rural medicine conference, which allowed further time for discussion and development of the issues and ideas.

a) Key findings

1. Recruitment and retention of rural doctors is a major problem in all provinces and territories, despite a variety of initiatives.
2. The process itself is important. This was the first gathering of the varied stakeholders from across the country. There was a sharing of problems and initiatives tried, with vigorous discussion of what has worked and what has not. This, then, led to consensus building on solution development. There was consensus that both education for rural practice and sustainable rural practice were the keys to recruitment and retention of adequate numbers of appropriately trained rural doctors.

b) Key recommendations

The key recommendations were grouped into two categories:

1. Education for Rural Practice
2. Sustainable Rural Practice

There were ten consensus recommendations for medical school undergraduate education, as follows:

1. An office of rural medicine in every medical school whose role is to develop and co-ordinate medical training for rural doctors;
2. Evaluate regional needs using evidence-based methods;
3. WONCA standards for rural training;
4. Outreach programmes aimed at high school students to encourage and identify students interested in rural practice;
5. The rural background of candidates should be taken into consideration in the selection of students by medical schools;
6. Mandatory exposure to rural medicine early on in undergraduate medical school;
7. Optional additional training in rural medicine;
8. Medical students who have committed themselves to rural practice should have access to bursaries;
9. Recruitment of rural doctors to the faculty — to ensure the quality of rural preceptors in the teaching of rural medicine;
10. The profiles of those rural doctors who train residents in rural medicine should be raised.

There were five consensus recommendations for postgraduate training:

1. A minimum of two months of rural training should be mandatory for all family medicine residents;
2. More rural training streams should be developed;
3. More positions for special skills training should be developed;
4. Physicians in specialty training programs should have greater exposure to rural medicine;
5. More re-entry positions for specialty training should be created. A supplementary salary should be considered.

There were three consensus recommendations for CME:

1. Continuing medical education should be driven by the needs of rural physicians;
2. Continuing education throughout the career of every rural physician should be promoted and supported;
3. Adequate CME should be accessible both individually (including locum support) and as a group, through telemedicine and electronic media.

There was a strong consensus, however, that developing a pipeline of young doctors trained for rural practice is of little good if they land on the rocks of unsustainable rural practice workload and lifestyle.

There were nine consensus recommendations for sustainable practice:

1. Physicians and their communities must interact to discuss the problems and needs of rural doctors;
2. Minimum of five physicians are needed to share call in communities that have 24-hour emergency services;
3. Minimum of three physicians are needed in other areas;
4. Locum relief is needed for all rural communities;
5. Relief contingencies to compensate for any professional or personal disruption related to the practice of rural medicine;
6. Families should be given opportunities to get away for a holiday. A minimum of six weeks per year is recommended. There should be travel subsidies for rural doctors practising in remote areas;
7. Adequate facilities and support staff;
8. "Ready" access to specialists. Electronic consultations and other communication systems. Mechanism for remuneration for these services;
9. Rural physician payment options should recognise:
 - the years they have worked;
 - the amount and type of on-call work they do;
 - the scope of their practices.

c) Implementation

The consensus conference then focused on the implementation process. The rural health field is full of good recommendations that are never implemented. At each of the levels there is a need to identify and gather stakeholders, share problems and initiatives and build consensus on practical, implementable solutions. This conference in South Africa is a good example of bringing together those involved in rural health care from many different perspectives along with key experts.

Successful implementation requires a local/regional/provincial/state/national focus on:

1. Rural health care needs;
2. Education for rural practice;
3. Sustainable rural practice;
4. Funding for rural health care.

Rural reports can provide a solid foundation for discussion and include three basic categories:

1. Rural doctor expert committee reports. A good example of this is *The WONCA Working Party Policy on Training for Rural Practice*, which has been accepted by the World Organisation of Family Doctors and by many organisations around the world.
2. Independent reports. They can be very supportive and sometimes more widely accepted because they lack the appearance of bias that many doctor expert committee reports have. A good example is the *Ontario Fact Finder Report* by Graham Scott.
3. Government reports and policies are most influential in affecting implementation. Rural health strategies as government policies can make rural health care a priority. It is important that physicians be involved and be aware of this political process. For physicians it tends to be a high-stakes exercise but with less control than in other processes that physicians are more used to, particularly as with MD expert committee reports.

Rural health strategies as government policy

Rural health strategies as government policies should address:

1. Rural health care needs (both accessibility and quality);
2. Education for rural practice;
3. Rural practice support;
4. Funding for rural health care.

In both developed and developing countries, health care is undergoing massive restructuring at this point in time. This chaotic process also provides the opportunity for significant and potential

positive changes in direction to support rural health care. The development of rural health care strategies as government policy can be very instrumental in the implementation of such change. It is essential that government policy makers understand the unique needs and characteristics of rural health care.

As an example, in Ontario we are currently involved in a huge hospital restructuring process that has led to a new 1997 Rural Health Framework Strategy as government policy. The restructuring commission came to the realisation: "Often the rural hospital is the only game in town: and therefore must be considered in a different way." Even the title of the new policy framework — *Access to Quality Care in Rural and Northern Ontario* — emphasises a direction that this government is prepared to make.

This policy recognises "the need for a comprehensive framework and clear direction for rural health care that will ensure equitable 24-hour access to appropriate health care services while continuing to support health care restructuring".

This government policy contains four key recommendations:

1. Establish networks with hospitals as focal point;
2. Define and support a changing role for small hospitals;
3. Enhance emergency services/designate levels of care/clarify back-up services required for different levels; and
4. Enhance support for recruitment/retention of rural health care providers.

The policy framework identifies rural health research as a priority and states requirements for educating, recruiting and retaining an adequate number of rural physicians.

Conclusion

An adequate number of appropriately trained rural doctors is an important component in providing accessible quality rural health care. Appropriate education and training for rural doctors, along with rural practice support with adequate facilities and support staff, and sustainable working conditions in rural practice, are the important keys for recruitment and retention of rural doctors.

Implementation requires government rural health strategies and support. Equitable funding for rural health care is required at all levels in order to provide accessible quality rural health care.

There is a shortage of rural doctors in both developed and developing countries and it is at conferences like this that we can share initiatives and approaches that then can be tailored to each country's or region's needs.

For further information, a report on the pre-conference workshop in Banff (and other rural reports mentioned in this lecture) is available at the following website:

<http://ahsn.lhsc.on.ca/sworm.ruralrep.html> ●

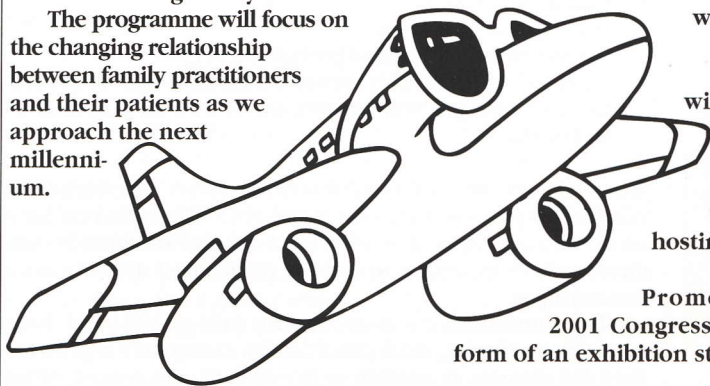
15th World Congress of Family Doctors

Dublin

4-18 June 1998

The 15th World Congress of Family Doctors in Dublin has as its theme *People and their family doctors — Partners in care*, and an interesting programme is on offer that would capture the attention of the most discerning family doctor.

The programme will focus on the changing relationship between family practitioners and their patients as we approach the next millennium.



ably a hospitality suite. It is important that a large delegation of family doctors from South Africa attend the Congress so as to assist the Academy in the promotion of the 2001 Congress.

We are hoping to have at least 60 South African delegates attend the Congress, and Bafenyi Leisure Corporation will be handling all the travel arrangements, including registration and accommodation, for those wishing to attend the Congress. The registration fee is IR£350 (approx US\$550) and IR£75 (approx US\$75) for accompanying delegates.

Please contact Linda Benwell, of Bafenyi, telephone (021) 21-1620 or alternatively Mary Otte, telephone (011) 807-6605, should you wish to register.

The Academy will have a major presence at the Congress, as it will be promoting the 16th World Congress of Family Doctors which it will be hosting in Durban in March 2001.

Promotion of the 2001 Congress will be in the form of an exhibition stand, and possi-