



TORC Comments On:

Ontario Ministry of Health and Long-term Care
UNDERSERVICED AREA PROGRAM (UAP) REVIEW

AUGUST, 2009



Introduction

The Ontario Rural Council Rural (TORC), through its TORC Rural Health Working Group, is pleased to have the opportunity to provide input into the current review of the Ministry's **Underserviced Area Program (UAP)**. TORC strongly supports this review and values the opportunity to contribute observations, thoughts and recommendations regarding much-needed **UAP** changes.

TORC is a member-driven, multi-sector provincial rural organization with a mandate to act as a catalyst for the dialogue, collaboration, action and advocacy on a wide range of rural issues for the purpose of helping to inform and influence rural policy, program and research development. TORC has had a long-standing active interest in rural health issues.

The TORC Rural Health Working Group is composed of organizations and individuals with an expertise and interest in rural health. Our past initiatives have focused on providing a 'grassroots' rural perspective on rural health and the Local Health Integration Networks, as well as health and learning in rural and remote areas.

Background to the Crisis in Rural Health

The Canadian Institute for Health Information Report, *"How Healthy Are Rural Canadians? An Assessment of Their Health Status and Health Determinants"* (September 2006), reports on the disadvantages and disparities in health status between rural residents and their urban counterparts. This report clearly indicates the health status of residents in rural and remote communities is generally below the average compared with that of other Canadians. It reinforces the point that good health does not solely depend on an individual's behaviour but, rather, where people live can also have a significant impact on their health.

The Roy Romanow Commission Report, *"Future of Health Care"* (November 2002), chronicles how Canadians living in rural and remote communities spoke of the need for good health care and access "not only because it is essential to sustain their own quality of life, but also the quality of life in their communities".

These reports confirm the existence of an inverse care law, whereby rural residents have higher health care needs and less access to care, especially high quality comprehensive primary care. Other national and provincial reports have also confirmed that one of the key challenges facing rural communities is chronic shortages of health care professionals. While the current **UAP** review is more narrowly focused on physician recruitment, our observations are certainly influenced by this larger reality of access to primary care for rural residents.

Several national reports and studies dealing with rural health have identified the critical health issues affecting rural residents. Actions must be taken to improve the access and services provided to rural and northern Ontario residents. It is, then, with these realities and observations in mind that TORC provides its comments related to the **UAP** review.

Underserved Area Program Review

This TORC submission will provide observations related to the current and proposed **UAP**, as well as specific responses to the questions as noted in the Consultation Guide document.

It is noted that the proposed redesign of the **UAP** is intended to:

- a) meet the unique requirements of northern and rural communities facing chronic physician shortages; *and*
- b) help all Ontario communities experiencing physician shortages

In order to meet these goals, the redesigned **UAP** is proposing:

- a) a northern / rural Rurality Index of Ontario (RIO) of 40+ as the basis for providing financial incentives; *and*
- b) a province-wide Return Of Service (ROS) program

General Observations

The Ministry of Health and Long-Term Care shall be commended for its action to review and revise the current **UAP**. We do believe this review is long overdue. There has been a long-standing desire to see the **UAP** revised to more adequately address the real rural health needs of rural and northern communities as related to physician recruitment and retention. **The current practices under the UAP no longer meet the original objectives of the Program.**

We are in agreement with the Consultation Paper statement: *"Within a matter of just a few years, the number of designated underserved areas in the south began to overwhelm the number in the north. By 2008, almost 3 out of every 4 underserved areas were in southern Ontario. Although the UAP was created to help rural and northern communities, currently only \$1 of every \$5 spent in the program on physician recruitment goes to the most northern and rural Ontario communities."* **The current implementation of the UAP is clearly not responding to the need for physicians in rural and northern communities.**

1. Rurality Index of Ontario (RIO)

It is noted the proposal intends to utilize the revised (2008) RIO scores as the means of identifying rural and northern communities requiring special incentives and assistance. Communities with a RIO of 40+ would qualify for special financial incentives to attract physicians. **Based on our experience and understanding of rural and northern communities, the RIO cut-off of 40+ is too high and does not adequately reflect the rural and northern communities requiring assistance.** There are a significant number of rural and northern Ontario communities falling below this cut-off that are clearly rural and should be included as communities requiring physician incentive assistance. In order to address this issue, we recommend the RIO index and the 40+ cut-off be reviewed.

TORC recommends the following:

- An Advisory Committee composed of individuals representing rural health organizations and rural and northern municipalities/communities be established to 'ground truth' the appropriateness of the RIO index and the 40+ criteria as the basis for excluding or including communities from physician attraction and retention assistance
- A broader range of criteria be introduced to identify "rural and northern communities in need". Factors such as lack of transportation, age, weather, etc. must be considered in defining 'rurality'. Many of these variables were part of the original RIO index, so there is significant concern that the current Rurality Index oversimplifies the definition of what is 'rural'.

TORC strongly suggests consideration be given to establishing a graduated RIO index with appropriate incentive support for each category. Our proposed graduated scale would appear as:

RIO index	Program Assistance
40+	100%
30-39	75%
20-29	50%
0-19	0

What is the proposed program support for those communities losing their underserved designation as a result of the RIO implementation? Some rural communities, particularly in southern Ontario, will be disadvantaged by this new definition of underserved areas in the revised UAP.

The grouping of "rural" and "remote" communities under one definition of rurality is seen to be simplistic and inappropriate. Remote communities clearly have very unique challenges, as do some very rural communities. Not all of rural southern Ontario is adequately serviced with physicians. This reality must be adequately addressed.

2. UAP Review and the Rural and Northern Health Care Panel

There appears to be a disconnect between the potential outcome from the Rural and Northern Health Care Panel regarding the definition of 'rurality' and related program support, and that of the **UAP** Review. It is recommended the input received through the **UAP** Review be considered in conjunction with those of the Panel. These two consultation processes and the recommendations should support each other.

3. Physician and Specialist Needs and the "Underserviced" Designation

There is a significant issue in rural Ontario related to the need for both family physicians and specialists. A community may be well-served by family physicians and, as a result, not part of a designated underserviced area, yet that same family is still underserviced as related to specialists. In that the community is not a designated underserviced area for family physicians, it will not qualify for assistance for the much-needed specialists. This situation must be corrected in the new **UAP**.

4. Fundamentals of Rural Health Care

Adequate health care in rural Ontario is about more than just physicians. A comprehensive and integrated health care approach must be taken to serve the needs of rural Ontario residents. The **UAP** only deals with physician shortages. The Program must take an integrated health care approach and should address shortages related to other health practitioner categories i.e. nurses, chiropractors etc.

Rural communities value a comprehensive and integrated approach to health care. The new **UAP** must be developed to ensure this approach is supported and funded.

There is a need for flexibility in the implementation of the Program. This flexibility is critical to respond to unique local circumstances i.e. the loss of a doctor due to family circumstances or illness etc.

5. UAP Program Implementation

There exists the need for an appeal process to address decisions being made under the **UAP**. Local communities falling outside of the 40+ RIO need recourse to this initial decision.

There is a need to understand how other recruitment and incentive programs are affected by the changes to the **UAP** and the RIO scores. Programs must continue and be flexible in order to meet the health requirements of rural residents.

The funding and administration of the **UAP** program should be delegated to the Local Health Integration Networks (LHINs). The LHINs are "closer to the ground" and are more aware of the needs of local communities and the supply of health care professionals.

- The allocation of physician recruitment incentives and benefits to each LHIN should be based on a population-based formula that recognizes the size of each LHIN's rural population. This might take the form of a modified HBAM methodology, as long as the size of urban populations do not have an undue influence on the allocation of dollars to more rural areas within the LHINs.
- The LHINs do not have adequate human resources to provide the physician attraction and recruitment needs of the vast LHIN area. At present, there is only one Health Force Ontario recruiter working in each LHIN office. It is recommended that additional tools and resources be allocated to the LHINs for recruitment purposes – both for physicians and other health care professionals.

6. Return of Service Program

The Return of Service program should remain in place. This is an effective means of a community's ability to retain physicians who have initially been in the community through the Return of Service Program (ROS).



CONSULTATION QUESTIONS:

1. Is the government's plan for improving and strengthening physician recruitment and retention programs in Ontario clear?
 - There is a lack of clarity, transparency and rationale for the RIO cut-off of 40+. Many rural communities in need of financial incentives for the recruiting of physicians will be marginalized and have greater difficulty recruiting desperately needed physicians.
 - It appears as if the Ministry of Health and Long-Term Care and the Ontario Medical Association have pre-determined the solution for a revised **UAP**. In view of this fact, there is concern it will be difficult to secure "buy-in" for the new **UAP** from rural stakeholders.
2. In your experience, what kinds of physician recruitment and retention initiatives have been a) effective and b) ineffective?
 - a) **Effective recruitment programs**
 - Comprehensive physician recruitment and retention initiatives have generally been seen to be most effective. These programs not only provide financial incentives but also address spousal employment, the availability of quality community services and amenities, availability of high speed broadband etc.
 - The Family Health Team (FHT) and Community Health Centre models have been extremely successful in rural communities. In FHT models, doctors are able to connect with a group of physicians, share administrative and infrastructure

overhead costs, participate in a turnkey operation and have access to other colleagues and specialist resources.

- In the CHC model, family physicians are part of a supportive interdisciplinary team and do not have to bear any administrative or infrastructure/overhead costs. Currently, the number of physicians per CHC is 'capped' through the Ministry budgeting process. Additional physician positions should be allocated to CHCs so that new physicians have recruitment options and choices in terms of a preferred practice model.
- Programs that provide opportunities for teaching, research and professional development have aided in the recruitment of physicians.

b) Ineffective recruitment programs

- Programs and initiatives that *only* provide financial incentives have generally been less effective. In these instances, physicians will leave the community as soon as another community offers them more money to relocate.
- The general, inflexibility faced by non-fee-for-service models (e.g., CHCs, FHTs, FHOs, etc.) in accommodating return-of-service candidates in underserved areas presents a significant barrier to both physicians and communities in addressing access needs. For example, in a designated underserved rural municipality where no fee-for-service practice is in place but a CHC has been established, there is no opportunity for a new physician to join the existing primary health care practice of the CHC. This restriction arises from the fact that CHC funding and physician FTE levels in particular, are set by the LHINs and the MOHLTC. If the CHC is fully staffed for physicians, and yet the community is underserved and needs more physicians, there actually exists no opportunity for a new physician to join the CHC to fill the UA vacancy and/or exercise a ROS requirement.

3. What recommendations would you make to ensure the new programs are coordinated with other access-to-care initiatives like Health Care Connect and Family Health Teams, so that, together, they support a) northern and rural communities and b) communities throughout the province?

- TORC strongly supports the coordination of all health care programs.
- As mentioned previously, TORC recommends the LHINs be given the responsibility for delivering the **UAP**. The LHINs are aware of local circumstances and would therefore be better positioned to meet local needs.
- A comprehensive and integrated health care approach should be taken when dealing with rural and northern communities.
- Community Health Centres need to be included in any access-to-care initiatives for primary health care/physician services.

4. What recommendations would you make to ensure disruption is minimized during the transition to the new programs?

- The recommendations of the **UAP** review should be incorporated and integrated into those of the Rural and Northern Health Care Panel.
- A process featuring special program provisions needs to be developed for those communities that stand in a position to lose **UAP** benefits as a result of these changes. Some rural communities will definitely see themselves as losers in this exercise.

TORC recommends:

- ⇒ a “phasing-in” of the new program
- ⇒ a graduated RIO system with accompanying incentive provisions
- ⇒ an appeal process for those rural communities being disadvantaged as a result of this new UAP