

1. Executive Summary

A review of British Columbia's programs to support physicians in rural practice was conducted independently by Harbour Peaks Management Inc. to provide recommendations to the Joint Standing Committee on Rural Issues for consideration in future planning. The purpose of the review was to assess the effectiveness of the Rural Programs and identify opportunities to enhance and streamline the programs. Completed in March 2008, the Rural Review examined the strengths and weaknesses of the programs, evaluated the scope of services, and provided key recommendations for improvement.

The recommendations in this report were developed by Harbour Peaks Management Inc. with input from stakeholders, a review of programs in other provinces and analysis of the data currently available.

Recommendations were developed for each rural program and the major factors influencing recruitment and retention. As the JSC examines the recommendations, cost and financial analysis will be needed to assess the budget requirements and set priorities. The business case, feasibility and implementation strategy will need to be weighed for each and for the Rural Programs as a whole.

The Province of British Columbia and the British Columbia Medical Association continue to respond to the needs of physicians who serve rural communities. The Rural Programs that fall within the mandate of the Joint Standing Committee have been successful in encouraging and supporting physicians to reside in rural communities. The programs also make it possible for many communities to receive services on an outreach basis. In general terms, the suite of Rural Programs is targeted at recruitment, retention, support and continuing education of physicians in rural communities. In 2007/08, approximately 1,600 physicians qualified for support from the Rural Programs, of which 1,200 reside in a rural community.

There is strong support and a great deal of interest by rural physicians to ensure the Rural Programs continue to evolve. While there are opportunities for refinements and enhancements, it is believed the Rural Programs have a solid foundation from which to continue to respond to the needs of rural physicians.

While non-financial factors are now the strongest determinants of rural physician recruitment and retention, financial incentives still play a role in ameliorating the extra burden placed on rural and remote physicians.

Several key observations were made throughout the review:

- There is a need for increased focus on planning, communication and co-ordination of rural programs. In addition to planning and future policy considerations for the current financial incentive programs, non-financial factors need to be considered in the full complement of future rural programs.

- There was a general consensus that the current approach to measuring rurality was adequate but improvements were needed. The current methodology designed to measure the ruralness of a community is robust but not precise. Nonetheless, the outcomes provide a reasonable measure of 'rurality' for communities.
- The Joint Standing Committee (JSC) is familiar with the current A, B, C, and D clustering of communities. It is suggested that, with the addition of two clusters for a total of six, it may be reasonable for the JSC to award the same fee service premiums and flat fees allocated to each cluster to all the communities within it. With the many changes that are occurring in health care, medicine and physician practice patterns, it is becoming more difficult for Health Authorities to ensure the core services of hospital-based emergency room services, community and hospital-based obstetrical services, anaesthesia services and, general surgery. The Rural Programs can be adjusted to support these services.
- It is desirable that the effectiveness of each of the Rural Programs be monitored and measured using objective criteria. At this point in time there are a limited number of performance measures that could be developed and monitored, perhaps on a quarterly basis.
- Stronger performance measurement is required to enable future planning. Determining whether the programs achieve their intended purpose requires a deeper, ongoing performance measurement strategy.
- Ongoing Continuing Medical Education (CME) support for rural physicians is essential to maintaining the level of service required in British Columbia's rural and remote areas. Participants in the Rural Review were consistently positive about the importance of continued medical education.
- The Rural Review identified the need for programs designed to meet the CME needs of rural physicians, delivered locally and jointly designed by CME stakeholders.
- Providing training customized for rural physicians as geographically close to their Health communities as is feasible would strengthen support for rural practice.
- Recruitment incentives are increasingly falling short, particularly in recruitment of specialists.
- It has long been understood that doctors who grew up in rural and remote communities are more likely to practice there. Increasing the number of rural-based students admitted to medical school could enhance successful recruitment to rural practice.

- Younger physicians place a higher priority on work life balance than their more senior colleagues. Workload, working hours, and flexible working arrangements are important to retaining physicians as in many other professions.
- Local communities are becoming active participants in successful recruitment and retention of physicians.

Approach to the Review

The recommendations in this Rural Review were developed through stakeholder consultation, interviews with physicians from across the province who are practicing medicine in rural communities, interviews with mayors, focus groups with medical student residents, a Visioning Day event, and many interviews with knowledgeable experts who are members of the JSC, or staff of the Ministry of Health, the British Columbia Medical Association or a Health Authority. The review and report were completed by Harbour Peaks Management Inc. The project steering committee was appointed by the JSC.

Recommendations were developed for each rural program and the major factors influencing recruitment and retention. As the JSC examines the recommendations, cost and financial analysis will be needed to assess the budget requirements and set priorities. The business case, feasibility and implementation strategy will need to be weighed for each and for the Rural Programs as a whole.

Key Recommendations:

The recommendations in the report are provided to the Joint Standing Committee (JSC) for their review and approval. Key recommendations include:

- That a communications strategy be developed to increase the awareness and understanding of the Rural Programs.
- That structured annual planning and policy development sessions for rural programs be held.
- That a performance measurement strategy be developed for each Rural Program, establishing definitions of success, desired impact, measurement indicators and reporting.
- That the JSC continue to use the opportunities to review individual circumstances as opportunities to consider whether adjustments and/or enhancements are needed to the Rural Programs from a policy, program delivery or program administration perspective.
- That guidelines be provided to the Health Authorities for developing physician supply plans as part of community care plans.

- That the JSC formally request the Ministry of Education to examine ways to increase the number of students who grew up in rural and remote areas of British Columbia enrolled in medical school.
- That the JSC spearhead an RCME strategy for the province to facilitate development of locally based CME designed specifically for rural physicians.
- That the JSC engage the services of an expert geographer to investigate the potential of including an additional variable to the Rural Programs methodology for determining a community's rurality.
- That the eligibility requirements for the Rural Retention Program accommodate up to three physicians who decide to job share a full time position.
- That a Rural Retention Program (RRP) annual payment of \$6,500 be provided to physicians residing for 9 months or more in Rural Subsidiary Agreement (RSA) eligible communities for each of the four (4) designated services: hospital-based emergency room services, community and hospital-based obstetrical services, anaesthesia services and, general surgery.
- That for each community a fluctuation of 10% in the annual calculation of community isolation points is considered as acceptable and small fluctuations up or down not impact on a community's fee premium or flat fee.
- That the JSC consider a step-wise structure for the assignment of fee premiums and flat fees.
- That the Rural General Practice Locum Program guaranteed minimum daily rate for the provision of direct services be adjusted by a RGPLP Daily Rate Premium.
- That the Rural Specialist Locum Program guaranteed minimum daily rate for the provision of direct services be adjusted by a RSLP Daily Rate Premium
- That Psychiatry, Radiology, ENT, Gynaecology and Oncology be added as designated specialities eligible for RSLP support.
- That the Joint Standing Committee JSC develops a strategy to provide physicians in large urban non-RSA centres an awareness of the benefits of being a locum physician in an RSA community and that an 'Adopt a Locum Community' theme is pursued.
- That the JSC explore the feasibility of engaging UBC's Northern Medical Program in administration of selected programs.

Under the guidance of the Joint Standing Committee, the effectiveness of the Rural Programs will be improved and a positive impact on physician retention and recruitment will be achieved through consideration of options developed by the Rural Review and the JSC's vision for the future.

5. List of Recommendations

1. That the JSC consider a step-wise RRP flat fee award.
2. That the JSC increase the \$50,000 income threshold by the increases that have been made to the MSP fee schedule since 2001.
3. That the threshold earning for defining a full time physician be increased in 2009 and in the future to reflect fee rate increases.
4. That a review of new payments available to physicians and benefit payments to physicians be undertaken to inform a discussion by JSC on whether those new payments/benefit payments contribute to a physician's annual income for the purpose of determining eligibility to access Rural Programs
5. That the eligibility requirements for the Rural Programs accommodate up to three physicians who decide to job share a full time position.
6. That a survey of long service physicians residing in RSA communities be completed to seek an understanding of the how to best recognize long service to a community and what incentives may be needed to encourage ongoing service on a part time basis during the retirement process.
7. That the JSC engage the Health Authorities in a dialogue to determine the scope and complexities involved in providing incentives for medical leaders to assume leadership roles.
8. That for RSA communities assigned 20 or more medical isolation points, that a RRP annual payment of \$6,500 be provided to resident physicians for each of the four (4) designated services: hospital-based emergency room services, community and hospital-based obstetrical services, anaesthesia services and surgery.
9. That the JSC explore the merits of using physician billing information generated by physicians who reside in RSA communities to assist in the determination of how many physicians generate incomes greater than the 40th percentile of physicians in the same specialty.
10. That the JSC engage the services of an expert geographer to investigate the potential of including an additional variable to the Rural Programs methodology for determining a community's rurality.
11. That the JSC revisit decisions impacted by 'nearby communities' following a determination of how an additional variable that measures geography and travel time may be included in the methodology for assignment of isolation points.
12. That the JSC continue to review requests where a local circumstance does not fit within the eligibility requirements for a Rural Program or the situation under review does not fit within the policies and procedures for administering the programs.

List of Recommendations (continued)

13. That the JSC continue to use the opportunities to review individual circumstances as opportunities to consider whether adjustments and/or enhancements are needed to the Rural Programs from a policy, program delivery or program administration perspective.
14. That Health Authorities, supported by the Ministry of Health, develop strategies to support communities in crisis due to an acute shortage of physician services, and that the Rural Programs be considered as part of the support needed to recruit and retain physicians in communities in crisis.
15. That for each community a fluctuation of 10% of isolation points in the annual calculation of community isolation points is considered as acceptable and that fluctuations less than 10 % up or down do not impact a community's fee premium or flat fee.
16. That if the annual calculation of a community's isolation points is stabilizing at a new level over two consecutive years, consideration be given on a case by case basis by JSC to the impacts and need to implement the new points level.
17. That the JSC consider a step-wise RRP fee premium structure.
18. That the JSC consider a step-wise Isolation Allowance Fund structure.
19. That the amount of the total payments made out of the Isolation Allowance Fund be monitored and that additional base funding be added to the Isolation Allowance Fund as annual payouts increase.
20. That physicians be eligible for the Isolation Allowance once they have lived and provided service for nine consecutive months in an eligible community.
21. That physicians receive retroactive recognition for the IAF once they reside in a community for 9 months. It is recognized this 9 month period will often straddle two fiscal years and that a prorated payment would be required for a partial year (the first portion of the eligibility).
22. That if a physician is granted a leave of absence of 9 months or less that the physician not be required to re-serve the eligibility period on their return to the same community.
23. That on a quarterly basis each Health Authority provides the Ministry of Health with a listing of IAF eligible physicians and their MOCAP earnings.
24. That the Ministry of Health confirm physician earnings for the prior quarter and that a proportional share of IAF funding be forwarded to the Health Authorities for those physicians whose earnings are \$12,500 or greater.
25. That eligible physicians receive payment of the Isolation Allowance on a quarterly basis.
26. That the following goals are established for the Isolation Allowance Fund:

List of Recommendations (continued)

- The total years of physician service to IAF eligible communities increase each year.
 - The total years of physician service to IAF eligible communities increase each year for each community type.
27. That the Policy for the Isolation Allowance Fund be updated and finalized.
 28. That the current maximums of 24 specialist visits and 48 general practice visits per eligible community be maintained.
 29. That the Health Authority physician supply planning processes include consideration of visits required by specialists and general practitioners.
 30. That the accumulated accrual be allocated proportionately to the Health Authorities and that the Health Authorities be advised they are eligible to receive additional one-time NITAOP funding for 2008/09 upon application to the JSC.
 31. That JSC consider allocating a portion of the new funding available for the Rural Programs to the NITAOP program.
 32. That on an annual basis the JSC receive an updated across Canada summary of locum programs.
 33. That the Joint Standing Committee develops a strategy to provide physicians in large urban non-RSA centres an awareness of the benefits of being a locum physician in an RSA community and that an 'Adopt a Locum Community' theme is pursued.
 34. That the new funding in the amount of \$450,000, for a total of \$2,300,000, be allocated to the RGPLP in anticipation of the future utilization.
 35. That the RGPLP provide up access for up to 60 days of locum support to physicians approved for REAP advanced skills training in emergency department care services, general practice anaesthesia, general practice general surgery, or obstetrics services.
 36. That the daily guaranteed daily income rate for the RGPLP be increased to \$800.
 37. That the RGPLP guaranteed minimum daily rate for the provision of direct services be adjusted by a RGPLP Daily Rate Premium.
 38. That the number of locum days available to resident physicians be increased for physicians whose MSP billings exceed \$100,000.
 39. That an Advanced Skills Premium of 10% be added to the RGPLP daily rate provided to general practice locums who participate in direct service delivery, including on-call in one or more of the following areas: hospital-based emergency room services, community and hospital-based obstetrical services, anaesthesia services and, general surgery
 40. That the RGPLP and budget be re-evaluated on an annual basis.

List of Recommendations (continued)

41. That Psychiatry, Radiology, ENT, Gynaecology and Oncology be added as designated specialities eligible for RSLP support.
42. That Anaesthesia is added as a designated specialty eligible for NITAOP support.
43. That consideration is given to adding additional designated specialities to the Rural Specialist Locum Program, on a community specific basis, on application by Health Authorities who present physician supply plans that call for additional designated specialties.
44. That the RSLP guaranteed minimum of \$1000 per day for the provision of direct services be adjusted by a RSLP Daily Rate Premium.
45. That the maximum number of locum days support available to sole practice specialists residing in RSLP eligible communities be increased from 28 to 35 per annum.
46. That the RSLP and budget be re-evaluated on an annual basis.
47. That Health Authorities provide physicians quarterly statements of their RCME account.
48. That Health Authorities encourage Medical Advisory Committees to appoint 'RCME Coordinators' and that those coordinators be provided with an honorarium funded through available RCME funds.
49. That Health Authorities and Medical Advisory Committees ensure RCME approval guidelines are based on the general parameters and direction of the existing physician agreement as specified by the RSA.
50. That the current policy that unspent RCME funds remain with Health Authorities stays in place.
51. That Health Authorities provide regional and local Medical Advisory Committees with regular reports on RCME activity and balances within the Community Fund.
52. That the JSC spearhead the development of an RCME strategy for the province, taking three steps to facilitate collaboration to develop locally based CME designed specifically for rural physicians.
53. That the JSC collaborate with health authorities and physicians to monitor progress across the province in availability and effective use of technology by rural physicians.
54. That the JSC monitor on an annual basis the utilization of RCME program, the scope of the programs being supported through the community fund and collaborative progress among stakeholders in developing locally based CME designed specifically for rural physicians.
55. That Health Authorities provide input on recruitment trends and strategies to the JSC on an annual basis for planning purposes, for example, monitoring offers made and accepted, # of physician positions not filled, strategies used

List of Recommendations (continued)

- for recruitment, length of time to file vacant positions and, where possible, identifying barriers to successful recruitment in difficult situations.
56. That Health Authorities make recommendations to the JSC on an annual basis for improvements and enhancements to the Recruitment Incentive Fund and Recruitment Contingency Fund.
 57. That the Recruitment Incentive and Recruitment Contingency programs be combined to one recruitment fund for flexibility in allocating funds, maintaining the existing program components and documenting terms of reference.
 58. That the existing \$10,000 Recruitment Incentive be maintained and renamed as relocation benefit available to physicians recruited to fill vacancies or pending vacancies that are part of a Physician Supply Plan in communities listed under the Rural Subsidiary Agreement (RSA).
 59. That the Ministry of Health, the JSC and Health Authorities consider the combined effect of all physician incentive and support programs when implementing new programs in rural communities.
 60. That the JSC formally request the Ministry of Education to examine ways to increase the number of students who grew up in rural and remote areas of British Columbia enrolled in medical school.
 61. That the JSC formally promote the expansion of clinical training for senior medical students in rural sites both with the Ministry of Education and UBC.
 62. That the JSC review with the BC College of Physicians and Surgeons and Health Match ways to promote and support potential training, accreditation and licensure of Canadian citizens graduating from selected international medical schools.
 63. That Health Authorities and communities, in preparing physician supply plans, recognize workload and work hours as increasing factors in recruitment, and consider part time and job sharing where community health needs permit.
 64. That the JSC, Health Authorities and communities, in preparing physician supply plans, recognize professional infrastructure and resources as an increasing factor in physician recruitment.
 65. That Health Authorities assess whether career planning support for physicians is being adequately resourced.
 66. That Health Authority continue to increase involvement of communities in recruitment strategies, including mayors, municipal officials and economic development offices.
 67. That communities actively involved in recruitment be invited to attend the rural conference (recommended in the Communication and Co-ordination section of this report) to share learnings and successes.
 68. That Health Authorities, their Medical Directors, their specialists and communities actively contact and support locums providing service in their

List of Recommendations (continued)

- community to assess their interest in establishing a practice, and increase potential candidates awareness of physician infrastructure, resources and local amenities.
69. That Health Authorities continue to develop their co-ordination role in recruitment efforts, fostering active participation by medical directors, specialists, general practitioners and municipalities.
 70. That the Enhanced Skills Program provide physicians higher stipends, travel and accommodation funds for training approved by REAP in the core services of anaesthesia, emergency, obstetrics and surgery, based on rurality:
 71. That the JSC request annual updates from UBC's Faculty of Medicine on number of medical students accepted who grew up in a rural community.
 72. That the JSC request UBC's Faculty of Medicine to attend a JSC meeting for update on efforts to increase admission of students who grew up in rural communities.
 73. That the JSC review the business case for the proposed rural co-ordination centre by June 30, including objectives, program definitions, target outcomes, performance measures, roles and responsibilities of the multiple organizations involved, and costs.
 74. That the JSC explore engagement of UBC's Northern Medical Program in the future design and delivery of REAP programs.
 75. That the JSC review the administration costs of REAP to determine if there are opportunities for cost savings.
 76. That the JSC explore the feasibility of engaging UBC's Northern Medical Program in administration of the Rural Education Action Plan (REAP), the Rural GP Locum Program, the Rural Specialist Locum Program, and the Ministry of Health's current administrative role for RCME.
 77. That the JSC develop a comprehensive communication strategy, including objectives, target audiences, priority themes and channels such as newsletters, events, displays, printed, electronic and web based systems.
 78. That the JSC sponsor annual presentations, tied to a related seminar or conference event to save costs, inviting rural physicians, Health Authorities and communities to present experiences and successes in rural physician recruitment and retention.
 79. That the JSC provide annual awards in recognition of the contributions of rural physicians.
 80. That the JSC consider ensuring that Northern Health Authority, Interior Health Authority and Vancouver Island Health Authority are all represented in the committee membership.
 81. That structured annual planning and policy development sessions for Rural Programs, hosted by the Ministry and the BCMA, be held with attendance by

List of Recommendations (continued)

- the JSC and at least two representatives from each Health Authority which have RSA communities.
82. That guidelines be provided to the Health Authorities for developing physician supply plans as part of community care plans.
 83. That physician supply plans be developed by Health Authorities as part of overall community care plans for each rural community.
 84. That annual planning sessions and physician supply plans address the multiple dimensions to physician recruitment and retention, including professional issues such as infrastructure and resources.
 85. That Health Authorities, in their development of physician supply plans, engage local communities and physicians to provide input on local needs, trends and community plans.
 86. That MOH and BCMA staff support for the JSC and for planning be increased.
 87. That MOH and BCMA staff work together to provide background information and recommendations on a regular basis on all 'exception' items being presented to the JSC.
 88. That a performance measurement strategy be developed for each Rural Program, establishing definitions of success, desired impact, measurement indicators and reporting.
 89. That data collection and management be improved to support the performance measurement strategy, support JSC decisions and monitor utilization of each of the Rural Programs across rural communities,
 90. That regular performance reports on each Rural Program be provided to the Joint Standing Committee on a quarterly basis.