HARBOUR PEAKS
MANAGEMENT INC.

BRITISH COLUMBIA RURAL PHYSICIAN PROGRAMS REVIEW

HARBOUR PEAKS MANAGEMENT INC.
FINAL REPORT

March 31, 2008

Harbour Peaks Management Inc.
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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.

This report was developed independently by Harbour Peaks Management Inc. with input from stakeholders, a review of programs in other provinces and analysis of the data currently available. Not all recommendations will be undertaken in the future, and any implemented may be modified. This is to be expected. As the Joint Standing Committee 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.

Report prepared by Harbour Peaks Management Inc. March 2008-03-31
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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.

2. Introduction

In today's environment of limited resources and rising expectations in health care, British Columbia has continuously strived to improve recruitment and retention of physicians in rural and remote communities. Over time, programs to promote recruitment and retention have been developed and refined, with the aim to support physician services in these communities and ensure effective services are sustainable.

The Joint Standing Committee on Rural Issues (JSC) was established in 2002 to enhance the delivery of rural medical care. It is a joint committee of five members appointed by the Ministry of Health (MOH) and five by the British Columbia Medical Association (BCMA). The JSC's mandate is to advise the government and the BCMA on matters pertaining to rural medical services practice.

A suite of programs was developed to enhance the availability and stability of physician service in rural and remote areas of British Columbia by addressing some of the unique, demanding and difficult circumstances attendant upon these physicians, and by enhancing the quality of practice of rural medicine. The programs are targeted at recruitment, retention, support and continuing education.

Each community is assessed a number of points defining their degree of rurality or remoteness. The point system is used to categorize and group communities in order to determine their eligibility for programs covered by the Rural Subsidiary Agreement (RSA). Programs to support and retain physician services in RSA communities are considered crucial.

In 2007/08, about 1600 physicians qualified for at least one of the Rural Programs, of which 1200 resided in a Rural Subsidiary Agreement (RSA) community. There is strong support for continuation of the Rural Programs as a tool to support the retention and recruitment of general practice and specialist physicians to rural communities.

The Joint Standing Committee on Rural Issues (JSC) requested Harbour Peaks Management Inc. to conduct an independent review of the Rural Programs to assess their effectiveness and identify opportunities to enhance and streamline the programs. Completed in early 2008, the Rural Review examined the strengths and weaknesses of the suite of Rural Programs, evaluated the scope of services, and provided key recommendations for improvement.

This report summarizes the findings and recommendations of the 2008 Rural Review. The review was conducted independently by Harbour Peaks Management Inc., utilizing a qualitative methodology including interviews, focus groups, a facilitated stakeholder consultation and a review of programs in other provinces. The Rural Review also included analysis of limited data available on program utilization, budgets and expenditures.

The recommendations were developed by Harbour Peaks Management Inc., for consideration by the Joint Standing Committee in future planning.

Introduction (continued)

In 2006, a survey to assess the awareness and use of rural programs and influential factors in recruiting and retaining rural physicians was conducted by the British Columbia Medical Association (BCMA 2006). Physicians practicing in rural BC were surveyed to assess the programs offered under the Rural Subsidiary Agreement (RSA) for awareness, use, effectiveness in recruitment and retention, and satisfaction with the programs and their administration. Physicians were asked how the programs could be improved, and were offered a checklist, including an "other" option for added comment.

The survey and its accompanying review of the literature identified five major themes that have an impact on physicians' recruitment and retention. Below is an excerpt of the description of these themes (BCMA 2006):

- *"**Physician background**, i.e. growing up in a rural community, residency experience or locum experience in a rural community, has been shown to be the number one factor in practice location decisions for rural physicians."*

- *"**Professional issues** such as infrastructure, access to resources, Internet access, on-call schedule and specialist backup are all important to rural physicians."*

- *"**Lifestyle** and the sense of balance is an essential component for today's rural physicians. Considerations made for spouses, children, recreation and leisure opportunities, cultural environment, resources and ultimately the quality of life have also been found to be valuable and may influence a physician's decision to practice in a rural community."*

- *"**Attitudes toward rural and general practice** are often negative. Schools of medicine are urban-oriented, and this orientation produces biases towards urban practice. The best way to offset the bias is to provide longer durations of residencies in a rural area. Longer residencies allow time for bonding with the community and an understanding of the social, political and economic forces behind rural health."*

- *"**Community involvement** in recruiting new physicians, and support in retaining them, may also be effective. A community that is understanding and sensitive to a physician's on-call schedule and need for continuing education or professional development will encourage retention. Appreciation and support will give the physician a sense of accomplishment which complements the reasons why they initially chose to practice in a rural community. "*

It is recommended that readers of this report also read the BCMA document Rural BC Programs: How are We Doing? (BCMA 2006).

The 2008 Rural Review drew input from stakeholders, a review of programs in other provinces and analysis of the data currently available. Key recommendations identified by Harbour Peaks Management Inc. in the Rural Review for enhancing the suite of nine programs for rural physicians are outlined in this report for consideration by the Joint Standing Committee. The report also addresses the need for increased focus on planning, communication and administration of Rural Programs.

3. Findings and Recommendations

British Columbia's suite of programs is a mature, sustained program for the education, recruitment and retention of physicians in rural and remote areas of British Columbia. The recommendations in this report are refinements and enhancements to further strengthen the support for rural physician services.

The current programs have fundamental strengths that address their mandate:

- The suite of programs addresses all three areas key to enhancing rural physician services: recruitment, retention and education.
- The programs are intended to span several stages in the lifecycle of rural physicians - high school students, medical students, international medical graduates and practising physicians.
- Eligible communities with established practising physicians and those without physicians are supported by the Rural Programs.
- When compared to other provinces, British Columbia's programs are reasonably well positioned to compete in attracting physicians.
- The point system used to categorize and group communities in order to determine their eligibility for programs is a mature methodology which can be adjusted and improved as conditions change. Incremental improvements are recommended in this report.
- The Ministry of Health and the British Columbia Medical Association are active participants in the Joint Standing Committee, advising the government and the BCMA on matters pertaining to rural medical services practice. Their joint collaboration has been important to the success in supporting rural physicians.

Overall, British Columbia's Rural Programs are viewed to have a positive impact and are reasonably well established. The suite of nine programs primarily addresses financial incentives and compensation. Five provide financial benefits and four have both financial and non-financial benefits. The findings of the Rural Review identify opportunities to enhance both types of benefits and address current trends among physicians and their communities.

The five current programs with principally financial benefits are:

- The Rural Retention Program which provides fee premiums and flat fee financial benefits.
- The Isolation Allowance Fund which provides stipend benefit for physician residing in small communities.
- The Northern and Isolation Travel Assistance Outreach Program which provides funding to assist Health Authorities in providing outreach services.
- The Recruitment Incentive Program which provides financial incentive for new physicians

- The Recruitment Contingency Fund which assists RSA communities with recruiting expenses where the difficulty in recruiting is severe.

The four other programs impact both financial and non-financial factors.

- The Rural Continuing Medical Education which provides financial support for educational opportunities, to support the broad base of clinical skills required from rural physicians, improving career satisfaction and quality of care.
- The Rural Education Action Plan which supports advanced skills training for physicians in rural practice, provides undergrad medical students with rural practice experience, and increases rural physician participation into the medical school selection process.
- The Rural GP and Rural Specialist Locum programs which help GPs and specialists secure subsidized periods of leave from practice, positively impacting work life balance, lifestyle and family priorities.

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While there are opportunities for some refinements and enhancements, the base of programs already provided is a sound framework. With this foundation, enhancements to make the suite of programs more robust can be successful.

The report begins with an overview of current trends in the physician workforce, followed by findings and recommendations to enhance each of the nine existing Rural Programs.

There are also recommendations to address two broad areas that are central to overall program success: communication and co-ordination of Rural Programs, and policy development and planning.

The findings of the Rural Review include ways to enhance the financial incentives and also to address the professional, community, family and lifestyle issues that are becoming increasingly important in recruiting and retaining physicians.

The BCMA survey (BMCA 2006) stated that physicians' desire for non-financial incentives far outweighs the desire for financial incentives. In literature reviewed by the BCMA and in recent studies (Ko et. al. 2007), career, personal interests, family and community factors rate higher than financial considerations.

Too often, once a physician is recruited to a rural community, the length of stay depends on the personal initiatives of the individual physician to achieve career satisfaction and access needed resources such as diagnostic support. The BCMA, the Ministry of Health, Health Authorities, communities and universities could have stronger roles. Improved collaboration to support each rural physician is needed. Policy development and planning for Rural Programs requires more focus by these stakeholders. Collaborative planning is needed, with staff resources assigned to capitalize on shared initiatives.

Further detail on the recommendations is provided in the sections of the report that follow. 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.

3.1. Current Trends in the Physician Workforce

As the JSC considers strategies to enhance and improve its programs, trends in the physician workforce that impact choice of practice and career satisfaction offer context for planning.

Work and life balance figure prominently across all demographics in the workforce. As in other professions throughout Canada, younger physicians place more priority on personal, family and lifestyle factors, and tends to work less hours. As the physician workforce ages, there is a growing trend to retire at an earlier age or to reduce working hours.

If present trends continue, 40% of the physician workforce is projected to be women by 2015 (Task Force Two, 2005). The new cohort of younger doctors, both male and female, is anticipated to work fewer hours in general, with their renewed commitment to work life balance. Female physicians are more inclined to practice part time at some periods of their careers.

Similar to other professions, workload and flexible working arrangements are now important to retaining physicians. Career choice and satisfaction is influenced by scope of practice and time required on call.

Spouses and partners are more likely to seek employment. Family considerations, such as children's school, or lessons in interests such as music, art or sports can affect choices.

The availability of locums affects time away, vacation time with families and opportunity for continuing medical education.

While the wide scope of practice in rural and remote communities has sometimes been considered a deterrent to new graduates, the focus group participants in the Rural Review identified it as a positive reason to choose rural practice. Opportunity to practice a broad set of skills and provide full service care was singled out as appealing.

Changes in new technologies and new knowledge impact rural and remote physicians the most because of their broad scope of practice. Keeping abreast can be especially challenging in smaller communities, with isolation from professional colleagues augmented by barriers to accessing continued medical education.

Specialist and administrative support, availability of diagnostic tools, local surgical services and technology are elements of infrastructure and resources that new physicians may consider when assessing a community for their practice.

Where in the past, recruitment of new candidates was borne by existing local physicians, municipalities are increasingly playing a role. Municipalities may have felt 'at arm's length' in the past, but now an increasing number are proactive partners in the search.

Regional Health Authorities have taken on principal roles in recruitment, adding staff to assist with recruitment and collaborating with municipalities to host candidates. Stronger physician supply plans are needed in community health care plans, to support Rural Program administration and planning.

As in other parts of Canada, the regionalization of medical schools has improved exposure of medical students to rural practice. UBC's Northern Medical Program's goal is to train physicians in the north for rural and northern practice.

Overall, gender and generational differences are introducing a range of changes in the medical workforce that impact rural physician supply, require ongoing monitoring and demand collaborative planning by all stakeholders.

3.2. Overview of Cross Country Review

In order to benchmark British Columbia's programs within the Canadian context, a high-level review of the programs offered by other provinces and territories within Canada was undertaken. At completion of this report, information on Quebec programs was being gathered and was provided separately.

Program Scope

Overall, the breadth of programs offered in British Columbia meets or exceeds that found by other provinces. There is strength in the overall balance between a focus on supporting education (both of new physicians and practicing physicians), along with improving the work life and financial remuneration to those who are consistently providing patient care in rural and remote areas.

The following chart (next page) summarizes the types of programs offered by each of the provinces and territories within Canada to recruit and retain rural physicians. (Please note that a full summary of program offerings, province by province is found within the full Cross-Country Review report in Appendix A.)

Some areas of strength in terms of breadth of programs include:

- A comprehensive approach to supporting undergraduate and postgraduate rural placements: BC's programs clearly create a strong base of exposure to rural practice. The focus of providing benefits to both the preceptor and the student is a good balance which is not found in other provinces.

- While not formally within the set of programs covered by the Rural Subsidiary Agreement, the Family Practitioners for BC (FPs4BC) program ensures that BC is staying competitive against other recruitment incentives offered to new graduates.

- Programs such as NITAOP, which target the provision of service to remote communities through physician visits, are not very common in other provinces. Ontario has a similar program, as does Manitoba with its "fly in" program.

- BC's continuing education, re-training and re-entry programs are comparable in size and scope to those offered in other provinces.

Overview of Cross Country Review (continued)

Summary Table: Scope of Benefits

	Type of Program	BC	AB	SK	MB	ON	NS	NB	PEI	NF	YK	NWT
Training (Undergrad/Postgrad)	Tuition Reimbursement	●	●	●	●	●	●	●	●		●	●
	Undergraduate Placement Support	●	●	●		●		●	●	●	●	●
	Postgraduate Placement Support	●	●	●	●	●		●	●	●	●	●
	Housing Services/Reimbursement		●			●					●	
	Student Conference/Education Grants					●		●				
	Honorariums for Undergraduate Teaching	●										
	Student Summer Programs/Experience		●			●	●	●	●	●		
Recruitment	Recruitment Bonuses	●	●	●		●		●	●		●	●
	Visit Programs		●			●			●			
	Relocation Funds (*separate from other recruitment programs)*			●			●		●		●	
	Incentives targeted to first-year or early years of practice	●	●	●	●		●	●	●		●	
Retention Initiatives/ Bonuses	Rural/Remote Top-Ups/Premiums	●	●			●	●			●		●
	Premiums tied to ER or other services					●		●				●
	Retention Bonuses *(based on years of service)*		●		●	●				●	●	
	Vacation Leave											●
	Paid Parental/Maternity Leave	●	●		●	●		●				●
	Sick Leave											●
Locums/Coverage	Locums - GP	●	●	●	●	●	●				●	●
	Locums - Specialist	●	●			●						
	Visiting Specialist Clinics	●		●		●						
	Visiting GP/Primary Care Clinics	●				●						
CME	Financial Reimbursement for CME	●	●	●	●	●	●				●	
	Skills Enhancement opportunities for practising MDs	●	●	●	●	●			●		●	
	Training programs targeted at early career MDs	●		●								
	Urban/Rural Cross-Training	●										
	Allowance for Textbooks/Journals											●
Other	Awards		●									
	Pension/Retirement Plan											●
		BC	AB	SK	MB	ON	NS	NB	PEI	NF	YK	NWT

Note: Information about Quebec's programs was not available at completion of this report and was provided separately.

Given that each province's set of programs reflects a current negotiated agreement which is in place for several years, one must recognize that there may be time delays before a province is able to address an emerging issue or trend in its next negotiation. For this reason, some provinces have added new foci to their programs or enhanced benefits to certain target groups. While a discussion of nuances or competitive issues within comparable programs can be found in the following section, there are a couple of key gaps which are of particular note:

Retention of Older Physicians
As the physician supply challenge continues to increase, the continued participation of older physicians in the system will be an important source of teaching expertise and service. Alberta has a *Seniors' Weekend Locum Program* which is open to physicians over age 54 who have practiced in Alberta for over 9 years, and are in a community with less than 16 physicians. This program offers additional locum coverage to further reduce or eliminate their weekend call.

Retention Bonuses
While BC has flat fee bonus payable within the Rural Retention Program, variations on this theme have emerged in various provinces. Alberta has launched a new Retention Benefit program which is based on the number of years of service, with four categories (ex. 1-5 years, 6-15, 16-25, and 26+ years). This type of program is also in effect in the Northwest Territories, Newfoundland and Yukon, but with an earlier maxing out of the scale of benefits (either at 3 or 4 years). Ontario's Physician Retention Initiative also presents with a similar benefit which is based on a minimum number of 4 years of continuous service. What differentiates these retention bonuses from the RRP is that the bonus is a generally predictable amount, and creates an incentive for continuous service.

BC Programs' Competitiveness in the Canadian market

In situations where there are comparable programs within other Canadian provinces, some of the key eligibility criteria and benefits have been evaluated against those offered elsewhere to assess BC's competitiveness within the Canadian market for physicians. While this is not meant to act as an exhaustive comparison of all aspects of the program, it does highlight certain areas which may merit further consideration as BC continues to shape its programs.

Throughout the course of completing the cross-country review, a number of different ideas were noted as "food for thought" for the JSC as it considers which types of investments it wishes to make in future programs. These are nested within this thematic discussion.

1. Tuition/Debt Relief Programs

Most large provinces offer a tuition reimbursement program. There are variations in the amount per year, but most are approximately $10,000 per year for medical school, and $15,000 per year of residency. BC's Family Practitioners for BC (FPs4BC) program does not fall within the scope of this review, however, it is

important to note a few findings when reviewing these programs and their impact on recruitment to rural areas.

A Return of Service agreement is almost universal in these programs. Most require one year of service for each of tuition paid. Feedback from focus groups of family practice residents in this review was that the return of service commitment can be deterrent because it forces an early choice in community. BC has been strategic in the use of 3 years return of service for the $40,000 portion of the FPs4BC grants – which will give BC competitive edge in this area.

Flexibility of Return of Service Options
It is of interest that Saskatchewan has developed alternatives for completion of return of service to create options for the candidate. Those who receive grants in Saskatchewan can return their service in one of the following ways: (for each year of tuition received)

- 8/12 months in a rural community, OR
- 16/24 months in a regional centre, OR
- 6 months in the Rural Relief Program (locum)

This type of approach may address some of the concerns of residents and young practicing physicians who wish to maintain some flexibility early in their career.

Increased focus on recruiting rural students for medical school admission
Alberta appears more aggressive than other provinces in specifically targeting rural students for coverage of their medical school tuition through their two awards – the RPAP Medical Student Bursary, and the RPAP Medical School Award. It has been demonstrated that there is a relationship between the origin (rural or urban) of medical students, and where they decide to set up practice.

2. Recruitment Benefits

Prior to the launch of the FPs4BC program, BC's rural recruitment bonuses ($10,000 offered under Recruitment Incentive Fund) did not fare well compared to other provinces. With this program now in place, some of the following observations may be moot. However, FPs4BC is currently a one-time funding initiative, and therefore it may be wise to be fully aware of the impact of its discontinuation, should it occur. Other provinces are more competitive in the following ways:

- Ontario's Incentive Program provides payment of $40,000 over 4 years, which provides some longevity to the benefit. New Brunswick offers $50,000 per GP with only a 3 year return of service agreement.
- The Northwest Territories offers differential benefits depending on the length of service, which creates an incentive for a longer commitment
- Some provinces provide a cushion in the first year in terms of guaranteed earnings (ex. New Brunswick), or exempt certain physicians from billing caps in their first year of practice (Ontario).

Some services or trends noted from other provinces include:

Candidate and Spouse Visit Programs:
Programs which encourage visits by clinicians to a potential employer community. Ontario's *Community Assessment Visit Program* (administered by UAP) reimburses health care professionals and their spouses for travel and accommodation expenses within Ontario to visit a designated underserviced community to assess practice opportunities. Air travel from the point of entry into Ontario (Winnipeg or Montreal) or Toronto is covered, as well as standard accommodation costs. Alberta has a similar program which pays up to $3,000 for an interview visit.

Programs to support skills assessment and licensing:
In Alberta, there is a program where honorariums are paid for both Candidates and Assessors in situations where the candidate has been asked by the College to undergo assessment for licensure or approval of additional skills/privileges. The payment is $1,500/week up to a maximum of $6,000 per candidate for new recruits, and $500/week up to a maximum of $2,000 for currently practicing rural physicians. This program encourages candidates to take time out of practice to upgrade skills.

Moving Costs/Relocation Grants:
Some provinces offer grants which are dedicated to addressing relocation costs (NWT, Saskatchewan). Should the FPs4BC program be made a permanent program, some consideration could be given by the JSC to refocus the "Recruitment Incentive Fund" as a Relocation Fund.

Strong supporting internet sites and technology:
Nova Scotia's Maritime Physician Recruitment Initiative (www.mpri.ca) and Alberta's Physician Link (www.ruralphysicianlink.ab.ca) are examples of well-integrated recruitment interface for those seeking and posting positions, both locum and permanent opportunities. All opportunities to increase the transparency of the recruitment process, provide community information and ease the process will increase BC's competitiveness for reaching the newly-graduated physician who is accustomed to the internet as a primary search tool.

3. Undergraduate/Post-Graduate Medical Education

As discussed previously, the breadth and benefits of BC's medical school and residency programs are very strong, and there is little variation from province-to-province in terms of overall stipends or cost reimbursement for rotations and residency, although some are "marketed" as stipends, and some "marketed" as travel and accommodation cost reimbursement.

However, while the components are strong, it seems that other provinces have models of organization and administration for these programs which improve the clarity of communication, transparency of application processes, and student knowledge of the programs. Alberta's RPAP (Rural Physician Action Plan) and Ontario's ROMP (Rural Ontario Medical Program) are examples of organizations that establish early and constant communication with the students in the province. It

is important to note that having a focal point such as RPAP or ROMP is also important for students external to the province who may be considering electives or seeking CaRMS matches in other provinces.

Some of the supporting services or trends noted in other provinces include:

Provide housing to Support Rotations, Residencies
RPAP has a housing service in which up to 42 properties are managed by RPAP in placement communities. Similarly, the Rural Ontario Medical Program provides a coordinating function which allows for individuals in the communities to list their rental property with ROMP, and pay them directly for the rent to minimize administration. In addition, some free properties are available for placements for which there is no reimbursement available (ex. pre-clerkship placements). A service such as this breaks down barriers to the short-term move for potential recruits and will provide a favourable impression of the community and the province.

Increase exposure to rural practice in medical school
Rural placements are mandatory within Alberta. This is also supported by other types of short-term, low-commitment opportunities to gain exposure to rural settings through tours and skills days organized by the 2 universities. Students can also sign up to shadow a rural clinician for a weekend.

4. GP & Specialist Locum Programs

All provinces have some form of GP locum program, but the scope of the program may range from simply providing some funding to offset annual locum costs (ex. Yukon), through to fully developed locum programs which provide the recruitment and administration for locums. The comparable large scale programs are in Alberta, Saskatchewan, Manitoba, Ontario, and the Northwest Territories. Specialty locum programs are less well-developed in Canada, with fewer provinces providing the service.

The locum programs' benefits to ***host physicians*** are competitive in the following areas:

- BC's GP Locum program compares favourably with respect to its eligibility criteria for the program (7 or fewer physicians). Many other provinces impose stricter criteria which render the program inaccessible unless you have less than 3-5 physicians in a community.
- Similarly, BC's Specialist locum program has a lower threshold for enabling specialists to obtain locum coverage. This compares favourably to Ontario, for example, where if a community has more than 3 specialists, the locum program only offers travel costs and minimal accommodation costs to the locum physician. Therefore BC specialists have a competitive edge in attracting specialist locums.
- The overhead percentage allocation to the host physician to cover overhead costs exceeds that of other provinces. (With the caveat that this is negotiated individually in Ontario).

However, there are issues with respect to the competitiveness of the benefits in the following areas.

- The number of days available annually through the plan (28) is comparable to Alberta, but falls short of the much higher allowances of Manitoba (40) and Ontario (37). Based on consultation with key BC stakeholders, this is a key issue for host physicians.

The locum programs' benefits to ***locum physicians*** are less competitive in the following areas:

- The GP Locum per diem rate offered by BC ($750) is lower than its immediate neighbours of Alberta ($800), Northwest Territories ($900-$1,200) and Ontario ($800).
- The gap is larger in the Specialist locum program with BC's rate of $1,000 per day being dwarfed by rates of $1,500 in Alberta, and $1,550 in Northwest Territories.
- The degree to which the locum physician must take on the work of sourcing the placement, completion of licensing, obtaining hospital privileges and sourcing accommodation varies from province to province. Services such as Alberta's locum program provide an integrated service to its locum physicians which eases the administrative burden on that individual.

It is not only the benefits which are important. The administrative systems must also support easy access to the locum program from both a host and locum physician perspective. The following trends and best practices from other provinces may guide the JSC in its ongoing development of the locum programs:

Explore synergies between locum services and other programs:
Currently, BC's locum service is not integrated with other services. Other provinces have capitalized on synergies with two key areas.

Recruitment: In Alberta, RPAP has both management of locums and physician recruitment within its mandate. Therefore, there are economies of scale in the investments made in creating community profiles, etc. It also allows for encouraging connection between short-term locum placement and opportunities for longer-term practice. In Ontario, the Ontario Medical Association's (OMA) locum registry and physician job registry are linked on their website. Health Match BC's listing of locums on its website is helpful, but it is not the organizing body for rural locums. Online access to this process is not intuitive.

Continuing Medical Education: In Saskatchewan there is overlap in mandate between the arrangement of locums and the administration of continuing medical education. Locums are viewed as a key enabling tool for the success of the CME program, and therefore the knowledge of both sides of the equation assists the office in trying to successfully meet the host physician's needs and schedule.

Strong customer service orientation of the locum organizing body
The overall objective is to try to bring together as many pieces of the administrative puzzle (e.g. posting, community profiles, application, matching of candidates, screening, licensing, privileges, contracts, accommodation, payment, evaluation) under one roof to provide a clear focal point for both the host and locum physician. Good examples of success in this area include: AMA Physician Locum Services.

Utilize template for locum contracts:
The Ontario Medical Association has a standard form contract which can be used between the host and locum physician to clarify the roles and financial arrangements of the locum. This is particularly important in Ontario given that the percentage of the fee-for-service billings retained as overhead by the host physician is subject to negotiation.

Evaluation processes
Several provinces have online tools or forms for the evaluation of the locum process. In the case of Ontario, completion of the form is a pre-requisite for completion of payment of the locum. This gives immediate feedback to the locum service about the quality of service provided by the locum. These types of tools are also in place from a locum physician's perspective to give feedback on the program and how it could be improved.

5. Continuing Medical Education

BC is competitive in its Rural Continuing Medical Education program benefits. The maximum allowance of $5,300 is exceeded only by $5,500 in Ontario (max). BC's approach to determining total compensation (defined by years of service + rurality) is similar to Ontario which also employs the rurality index. Other such as Saskatchewan or Northwest Territories only employ years of service as a criterion.

One of the defining features of the Rural CME benefit is its flexibility for a physician to accumulate benefits over time. This is also permitted in other provinces (such as Alberta) and is mirrored in the Educational Leave program in Newfoundland which allows for a greater continuous period of time off if all leave time is accumulated and taken as one leave every 3 years.

Explore options for coordinated planning for Rural CME
BC has variations between its health authorities and communities regarding the frequency and type of CME programming available. One organizational structure for consideration is the Continuing Medical Education in Manitoba seems strong – the Rural and Northern Physicians Committee which brings together a rep from each of the 2 universities which 7 physicians representing "communities" for the purposes of planning and administering CME. An annual learning needs assessment of members is undertaken every year. The programs delivered include the Friday@Noon videoconference, the monthly on-site speakers series, and the annual Winter Conference.

Bringing Learning Opportunities to the Physician:
Alberta's *General Emergency Medicine Skills Program (GEMS)* is a self-study program which enables physicians to build upon their emergency skills. This is an excellent example of a remote learning program which uses technology such as simulators and multi-media to address key skill development. There is interest from BC stakeholders in emergency medicine learning opportunities, and this program seems like an excellent candidate for a potential shared educational resource between the two provinces.

Ontario's *Visiting Speakers Program* allows communities of physicians to bring forward their own proposal for speakers in their own community. The Ontario Medical Association then pays the speaker directly for the trip. In Manitoba, a monthly on-site speaker's series brings education to the communities. Both of these are similar to the concept behind the "pooled" resources for Rural CME in BC, but are funded at the outset as group learning.

Manitoba's "Friday@Noon" videoconference series brings weekly learning opportunities to the desktop of the rural physician.

3.3. Rural Retention Program

The Rural Retention Program (RRP) was implemented January 1, 2003. The purpose of the RRP is to provide a provincial rural incentive program that enhances the supply and stability of physician services in eligible RSA communities. Communities are assessed annually for RRP eligibility and community eligibility may change from one year to the next. RRP eligibility is determined through the application of 7 variables, each of which allocates 'medical isolation points to a community'. Overall, the medical isolation points are quite well distributed among RSA eligible communities with very remote communities receiving the highest points and hence have the highest economic incentives to reside/practice in those communities (see Appendix C1). The medical isolation points are allocated to communities through the application of the following 7 variables:

Factor 1. Number of Designated Specialties within 70 km

Factor 2. Number of General Practitioners within 35 km

Factor 3. Distance from a Major Medical Community

Factor 4. RSA Specialist Centre

Factor 5. Community Size

Factor 6. Degree of Latitude

Factor 7. Location Arc

A detailed description of the methodology to calculate the medical isolation points is provided in Appendix C2.

Rural Retention Fee for Service Premiums are based on the Medical Isolation Point Assessment and are set annually by the JSC. A physician in an eligible community who is funded by an alternative payment arrangement will receive a retention payment, equivalent to the fee-for-service premium.

The total medical isolation points result must be at least 6.0 for a community to be eligible for a fee premium and/or flat fee allowance. If the annual review by the Joint Standing Committee results in a community falling below the minimum isolation points required, the community will be deleted from the RRP list. Eligible physicians in that community are entitled to receive 50 percent of the previous year's retention allowance (fee and flat fee premiums – if received previously) for a one-year period.

Medical Isolation Points

It is interesting to note the overall number of medical isolation points allocated to communities has increased by 5.4% from January 2003 to 2006/07.

Medical Isolation Points Gain/Loss Over Four Years			
Community	**Isolation Points 2006/07**	**Isolation Points January 2003**	**Difference in RRP Points**
Total Medical Isolation Points	3973.70	3769.25	204.45

The increase in points is largely accounted for through the addition of communities (see table below) as designated RSA communities. With the exceptions of Tatla Lake and Teppella, the other six communities were added as designated communities for 2006/07.

Community	Isolation Points 2006/07	Isolation Points 2003
Lower Post	51.25	0.00
Klemtu	39.00	0.00
Blueberry River	35.75	0.00
Doig River	35.75	0.00
Halfway River	34.25	0.00
Tatla Lake	34.20	0.00
Seton Portage	23.55	0.00
Teppella	15.90	0.00
Total	269.65	

Although the number of assigned medical isolation points varies from year to year for many communities, the overall points assigned to all communities is quite stable after accounting for the new communities listed above.

Year	2003	2004/05	2005/06	2006/07
Assigned Points - Total	3769.25	3752.85	3749.85	3973.70

Number of Physicians Benefiting from the RRP

RSA communities have seen a 20% increase from 2004/05 through to 2007/08 in the number of physicians benefiting from the RRP and providing service in RSA communities.

Count of Practitioners[1]				
Community Type	**FISCAL YEAR**			
	2004/05	**2005/06**	**2006/07**	**2007/08[2]**
A	446	448	466	502
B	364	400	395	399
C	452	488	531	537
D	34	11	118	129
N/A	15	15	19	19
Provincial Total	**1,309**	**1,357**	**1,512**	**1,568**

Seventy percent (70%) of physicians benefiting from the RRP are providing services to RSA communities assigned less than 20 isolation points. Conversely, thirty percent (30%) of physicians benefiting from the RRP provide services to RSA communities assigned 20 or more isolation points.

Count of Practitioners by Community Isolation Points					
ISOLATION Points	**Fiscal Year**				**% Distribution for 2007/08 (rounded)**
	2004/05	**2005/06**	**2006/07**	**2007/08**	
00	27	21	29	19	1
0.01 TO 9.999	306	313	447	448	29
10 TO 19.999	533	580	594	634	40
20 TO 29.999	230	218	240	271	17
30 TO 39.999	203	212	217	208	13
40 TO 49.999	9	8	7	11	1
50 TO 59.999	11	15	15	16	1
Provincial Total	**1,309**	**1,357**	**1,512**	**1,568**	

[1] Note that the count of physicians for each community type is not additive as there are physicians who provide services in more than one community, each of which may not be designated as the same community type (A, B, C, D). Accordingly, the annual totals for each fiscal year does not equal to the sum of the number of unique practitioners providing service within each community type.
[2] Partial year

Number of Physicians Who Reside in an RSA Community

Physicians who meet a residency requirement are eligible to receive the flat fee component of the RRP. It is interesting to note the overall number of physicians residing in an RSA community has been stable at approximately 1200 practitioners from 2004/05 to the present time.

Count of Practitioners Qualifying for the RRP Flat Fee					
	Community Type	Fiscal Year			
		2004/05	2005/06	2006/07	2007/08[3]
Provincial Total	**A, B, C, D**	**1184**	**1224**	**1184**	**1190**

A review of the distribution of physicians among the various areas of practice is of interest. The overall number of General Practitioners in RSA communities has been stable from 2004 to the present time. It is also worthy to note that over the same timeframe

- The number of Anaesthetists in RSA communities has increased by 6 (30%)
- The number of General Surgeons has remained fairly stable at 41.
- The number of Nuclear Medicine specialists has decreased by 2 (67%)
- The number of Radiologists has increased by 4 (14%)

[3] Partial year

Count of Practitioners Qualifying for the RRP Flat Fee by Specialty				
Most Recent Specialty	**Fiscal Year**			
	2004/05	**2005/06**	**2006/07**	**2007/08[4]**
ANAESTHESIA	20	21	24	26
CARDIOLOGY	1	1	-	1
DERMATOLOGY	2	2	2	2
EMERGENCY MEDICINE	1	1	2	3
GASTROENTEROLOGY	-	-	-	1
GENERAL PRACTICE	889	924	886	884
GENERAL SURGERY	41	38	36	41
HEMATOLOGY ONCOLOGY	-	-	-	1
INFECTIOUS DISEASES	-	-	-	2
INTERNAL MEDICINE	44	41	42	36
LABORATORY MEDICINE	13	13	13	7
MEDICAL GENETICS	-	-	1	1
NEPHROLOGY	1	2	1	3
NEUROLOGY	3	4	2	2
NUCLEAR MEDICINE	3	3	3	1
OBSTETRICS & GYNAECOLOGY	22	24	23	25
OPHTHALMOLOGY	13	13	13	14
ORTHOPAEDIC SURGERY	21	22	22	24
OTOLARYNGOLOGY	6	4	4	6
PAEDIATRICS	16	16	17	16
PHYSICAL MEDICINE AND REHABILITATION	1	1	1	1
PLASTIC SURGERY	5	4	4	5
PSYCHIATRY	37	43	40	38
PUBLIC HEALTH (COMMUNITY MEDICINE)	3	4	2	3
RADIOLOGY	29	29	33	33
RESPIROLOGY	-	3	3	3
UNKNOWN SPECIALTY	2	-	-	-
UROLOGY	9	9	8	9
VASCULAR SURGERY	2	2	2	2
Provincial Total	**1,184**	**1,224**	**1,184**	**1,190**

Flat Fees

Physicians are entitled to the flat fee sum upon successful completion of the annual residency requirement in an eligible RSA community. Before a flat fee is determined, 70% of the total medical isolation points (to a maximum of 30 points) designated for a community is allocated as a fee premium. If a physician lives and practices in an eligible RSA community for at least nine months of the year and bills $50,000 or greater in MSP billings for the previous calendar year, s/he also receives the full flat fee sum. If s/he bills < $50,000, s/he receives no flat fee premium.

The amount of the flat fee available to eligible physicians is determined by the overall number of medical isolation points remaining after the 70% allocation is made as a fee premium. To determine the value of the flat fee, the remaining points available are multiplied by the value of each remaining medical isolation point. The

[4] Partial year

value of a flat fee point has been $2,040 since 2003 when the program was first established. A listing of the flat fees assigned to communities is provided in Appendix C3. The range of flat fees provided to physicians varies significantly with the most rural resident physicians receiving the largest flat fees.

There are two variables in determining the flat fee: the overall number of medical isolation points assigned to a community and the financial value of the medical isolation points available for the flat fee. Both of these variables are subject to change. This can cause a lack of certainty among physicians regarding the amount of the flat fee they are entitled to on a yearly basis. This also provides uncertainty to the JSC and the Ministry regarding the overall cost of the RRP flat fee. An alternate model whereby the flat fee amounts are established at set amounts for different ranges of community medical isolation points would introduce greater certainty for everyone. The current distribution of medical isolation points would suggest the following step-wise structure for the allocation of the flat fee merits further consideration:

Medical Isolation Points	Number of Communities Affected	Potential Flat Fee Payment
> 40	**21**	**$30,000**
> 30 to 40	**48**	**$25,000**
> 20 to 30	**32**	**$20,000**
> 10 to 20	**31**	**$10,000**
> 6 to 10	**12**	**$6,000**
< 6	**10**	**$0**

Recommendation 1:
That the JSC consider a step-wise RRP flat fee award.

Full Time Physician

A theme throughout the Rural Programs Review was the need to better define what a full-time physician is. A universally agreed upon method of determining a full-time physician is elusive.

Within the realm of the Rural Programs, the $50,000 threshold is felt to be easily achieved in most communities where there are fee-for-service physicians. As a result, it is possible that a physician may choose to work just enough to qualify for

the flat fee. When this occurs a physician who earns just over $50,000 and a truly full-time fee for service physician in the same community receive the same flat fee sum.

The $50,000 income threshold has not been adjusted since 2001. From 2001 to the present time there have been increases to the overall MSP fee schedule. It would be reasonable to increase the income threshold defining a full time physician by the same overall increase reflected in the fee schedule. It would also be reasonable that future adjustments to this threshold be made to reflect future adjustments to the fee schedule.

The Province of British Columbia has been responding to the changing needs within the health care system. Included have been a number of new payments available to physicians to encourage an increased emphasis on primary health care. As well, physicians are eligible to receive benefit payments from the Province for leaves such as Maternity/Parental Leave. Throughout this Rural Review there was interest in whether or not these new fees and benefit payments should be included as earnings for the purpose of defining a full time physician. This is an important factor for physicians whose annual MSC billings are below the threshold amount. Including additional sources of income from Government may assist a physician meet the threshold and thereby be eligible for the RRP Flat Fee, if the residency requirement is also met. The RRP policy states:

> *'6.1.3 If a physician lives and practices in an eligible RSA community for at least nine months of the year and bills $50,000 or greater in MSP billings for the previous calendar year, s/he receives the full flat fee sum. If s/he bills < $50,000 s/he receives no flat fee premium'.*

Further review is needed to determine the impacts of the new payments available to physicians and the impacts of benefits payments on physician incomes. The suggested review would need to carefully consider which payments to physicians are 'billed' to the Medical Services Plan by a physician and which payments are the result of an application for payment of a benefit. This will be helpful in answering questions such as 'Does a physician bill the MSP or apply to the MSP for a disability payment?" and 'Should Full Service Family Practice payments be included in annual income calculations to determine eligibility for Rural Programs support?' It is anticipated a review would layout areas where there are differences in approaches in how program payments and benefits payments impact eligibility for various MOH and BCMA programs and benefits. There may be opportunities to streamline eligibility requirements across selected programs/benefits.

Recommendation 2:
That the JSC increase the $50,000 income threshold by the increases that have been made to the MSP fee schedule since 2001.

Recommendation 3:
That the threshold earning for defining a full time physician be increased in 2009 and in the future to reflect fee rate increases.

Recommendation 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.

Physicians Who Job Share

A number of British Columbia's rural communities are supported by physicians who job share. To job share, physicians who do not wish to work full-time work with one or two other physicians to share a full time position within a community. Physicians who wish to job share full time positions should be accommodated as this meets the needs of our changing physician work force. Job sharing works well for communities as the residents do become familiar with the two or three physicians who are job sharing and develop long term relationships with a community. It is important that the eligibility requirements of the Rural Programs accommodate physicians who are job sharing a full time position. In these circumstances it is reasonable that the benefits (such as the flat fee) be determined on the basis of the full time position and that the payment be prorated among the two or three physicians sharing the position.

It is desirable that a community's needs for full time physicians be included in the physician supply plan developed for community.

Recommendation 5:
That the eligibility requirements for the Rural Programs accommodate up to three physicians who decide to job share a full time position.

Supporting Long Service

There are significant benefits to a community when a physician resides in and provides services to the community on a long term basis. There is an interest in acknowledging and rewarding long service to a community.

With the aging demographics within the physician workforce it is anticipated many physicians in rural communities will be looking to adjust their work/life balance over the next several years. It would be prudent for the JSC to be proactive by enhancing the Rural Programs to encourage long service physicians to continue to provide services on a part-time basis. It is suggested that an age and length of service profile be developed of physicians residing in rural communities. As well, it would be beneficial to survey long service physicians who reside in rural communities to seek an understanding of the opportunities and what may encourage and support to continue to provide services as they move into retirement.

Recommendation 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.

Recognizing the Need to Recruit and Retain Medical Administrators

Physicians living in eligible communities and receiving a majority of their income from their medical administrative roles (for example as a Medical Director) may not earn a sufficient income from MSP billings to qualify for the flat fee. There is a recognized need to support and encourage physicians to assume leadership roles. Not being eligible for the flat fee is a disincentive to physicians wishing to contribute to the betterment of health services via an administrative role.

Like other physicians who fulfill medical leadership roles, Medical Health Officers provide a key service within the healthcare system. In December 2003 the JSC agreed Medical Health Officers would be eligible to receive benefits available through the Rural Programs including a fee premium equivalent and flat fee sums if they met income and residency requirements.

Recommendation 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.

The RRP and Physician Recruitment

Some concern was shown that the fee premium aspect of the RRP may, in some circumstances, be a disincentive for some physicians to recruit additional needed physicians to a particular community. It is possible this may be the case in a small number of circumstances where physicians are attempting to maximize their income. This potential anomaly is best addressed through the development of community by community physician supply plans and where accompanying recruitment plans are developed. Most physicians do attempt to create work situations where there is a healthy balance between their medical practice, the income they earn and lifestyles. As a result, in most communities where there is a need for additional physicians, existing physicians are often very welcoming of potential recruits to their community.

Recognition of Enhanced Skills

It is desirable that there be recognition of physicians with enhanced skills that support emergency services in hospital settings. From the interviews conducted for this review it is clear there is general support that the RRP be amended to recognize physicians who regularly participate in service rotations (including on-call) for the following services: hospital-based emergency room services, community and hospital-based obstetrical services, anaesthesia services and general surgery. This is of particular concern to smaller communities where there are hospitals and only a small number of physicians to support these services.

> **Recommendation 8:**
> That for RSA communities assigned 20 or more medical isolation points, an 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.

This recommended premium should be prorated on an annual basis (calendar year) to reflect the number of months a physician is resident in a community and was participating equally in a scheduled service rotation, including on-call. As an example, if a physician participated equally with other physicians in providing on-site coverage of a hospital-based Emergency Room and was also participating equally with other physicians to provide community and hospital-based obstetrical coverage, that physician would receive a lump sum payment of $13,500 (= $6,500 x 2).

A Review of the RRP Medical Isolation Point Rating System

The fee premium is 70 percent of the total isolation points to a maximum of 30 percent for communities with a minimum of one resident physician or a vacant position, as per Health Authority Physician Supply Plans. The flat fee allocation is based on the remaining 30 percent of the total isolation points multiplied by a per point dollar figure determined annually by the JSC. For communities without a resident physician the total isolation points are applied as a fee premium, to a maximum 30 percent.

Physicians *practicing* in eligible rural communities will receive a fee premium on claims paid by the Medical Services Plan. This approach rewards physicians who provide more service. The more fee-for-service (FFS) work a physician performs results not only in more basic FFS income but will also generate a greater fee premium earnings.

A physician *living and practicing* in a qualifying rural community for at least 9 months of the year and earning greater than $50,000 in MSP billings also receive a flat sum premium allocated to the community. Having a flat fee is seen to be a positive feature of the RRP as this recognizes all full time physicians and most part time physicians who reside and provide services in RSA communities. The earnings threshold is seen to be an incentive to provide a minimum level of service.

A physician in an eligible community who is funded by an alternative payment arrangement will receive a retention payment, equivalent to the Fee-For-Service (FFS) premium.

For the purpose of determining isolation points, Health Authorities report physician numbers and vacancies on an annual basis. That information is integral to the development of the Health Authority regional Physician Supply Plans. Annually the Ministry of Health asks the Health Authorities to complete a 'Physician Count' form by the first week of January based on the physician complement as of Dec 31 of each year. The physician count information is needed to determine:

- The number of Specialties available within 70 kilometres of each community
- The number of General Practitioners within 35 kilometres of each community.

For each general practice physician included in the December 31 count, the Ministry confirms whether their MSP billings income during the calendar year is greater than the 40th percentile of MSP billings income for general practice physicians in the Province. Each person with an annual MSP billing of over the 40th percentile is counted as 1 Full Time Equivalent (FTE) physician. The incomes of physicians below the 40th percentile are added together to form additional FTE physician positions for the purpose of counting the number of General Practitioners within 35 kilometers of a community.

For each of the eight designated specialties (General Surgery, Orthopaedics, Paediatrics, Internal Medicine, Obstetrics/Gynecology, Anaesthesia, Psychiatry, and Radiology) included in the December 31st count, the Ministry confirms whether at least one of the specialists in each designated area of specialty has a MSP billing income greater than the 40th percentile of MSP billing income for physicians in the same specialty in the Province.

> **Recommendation 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.

The Ministry assigns the number of medical isolation points to each RSA community based on seven factors:

Factor 1. Number of Designated Specialties within 70 km

All designated specialties within 70 km (by road or ferry) of the community where the specialist(s) meet the FTE income figure are counted.

The 'Number of Designated Specialties within 70 km' factor supports recruitment and retention in rural and remote areas. The communities benefiting from this factor are communities primarily supported by general practitioners. Most general practitioners prefer to work where there is a nearby a network of specialist support services. The further a general practitioner is from specialist support services requires a general practitioner to have a wide range of experience and skills to be able to support a community's medical needs. A higher point allocation to communities further from specialist supports is seen to be appropriate as it recognizes and rewards physicians for working in communities with reduced access to specialist services.

Factor 2. Number of General Practitioners within 35 km

General Practitioners practicing within 35 km (by road) of the community and who meet the FTE income figure are counted. General Practitioners practicing in a community within 35 km of the community by ferry are not counted.

This factor recognizes the desirability of working in a network of nearby general practitioners. In communities where there are greater numbers of general practitioners, there is often a number of general practitioners who have advanced skills and an interest in providing specialized services such emergency room care, obstetrical care, and anaesthesia. Where there are clusters of general practitioners, they often work in shared practices and develop rotations to be able to cover each other's patients while on call or while one or more physicians is away.

In communities where there are reduced numbers of general practitioners, each general practitioner is often required to have an increased range of experience and

skill to be able to collectively support the community's medical needs. Most general practitioners prefer to work in or very near communities where there is an adequate number of general practitioners to support each other. A higher point allocation to communities with a reduced number of general practitioners is seen to be appropriate as it recognizes and rewards physicians for working in smaller communities.

Factor 3. Distance from a Major Medical Community

The designated Major Medical Communities are Kamloops, Kelowna, Nanaimo, Vancouver, Victoria, Abbotsford and Prince George. A Major Medical Community is defined as those communities with at least 3 specialists in each of the Designated Specialties.

This factor recognizes the desirability of working in a nearby network of specialist support services. The further a general practitioner is from specialist support services often requires a general practitioner to have a wide range of experience and skills to be able to support a community's medical needs. Most general practitioners prefer to work in or very near communities where there is a range of specialist skills available. A higher point allocation to communities further from specialist supports is seen to be appropriate as it recognizes and rewards physicians for working in communities with reduced access to specialist services.

Factor 4. RSA Specialist Centre

Points are assigned to a community where the regional Physician Supply Plan requires designated specialists to provide services for a community. A community must be included in Appendix A of the RSA in order to be considered an RSA Specialist Centre.

This factor recognizes the desirability of there being centres throughout the Province where there is a wide range specialists working together and in close co-operation with general practitioners residing in the RSA Specialist Centre and throughout a geographic region. The RSA Specialist Centre factor awards a greater number of medical isolation points to centres with larger numbers of designated specialties as a way to support specialist recruitment and retention to those regional RSA centres. It is noted that that being a RSA Specialist Centre also supports the recruitment of general practitioners to those centres as general practitioners tend to favour working in communities with excellent specialist support.

The communities that benefit from this factor and have a final 2006/07 total medical isolation point assessment of 6 or greater are listed in Appendix C3. On average, this application supports communities with 5 designated specialties and communities with an average population of approximately 16,400. Note, the application of this factor allows for two nearby communities (e.g. Sparwood and Fernie) to work together to attract specialists.

Factor 5. Community Size

Where a community is within 35 km by road of a larger community, the points are based on the population of the larger community. Where a community is within 35 km of a larger community by ferry, the population of the larger community is not counted. When two communities are combined in this Agreement, the populations are amalgamated.

Community populations are established annually using the most recent National Census-based estimate for the preceding calendar year.

This factor recognizes the difficulty in recruiting physicians to smaller communities.

Factor 6. Degree of Latitude

Points are allocated for those communities in British Columbia located at and above the 52nd degree of latitude. No concerns were raised during the review regarding this factor. This factor is reasonably successful at contributing to the notion of 'rurality'.

Factor 7. Location Arc

Four differential multipliers have been established for the purpose of determining the final point total for determination of retention allowances. Arcs based on air distance from Vancouver are used to assign an applicable multiplication factor to determine the community's final point total.

No concerns were raised during the review regarding this factor. This factor is reasonably successful at contributing to the notion of 'rurality'.

The Need to Adjust the RRP Isolation Points Methodology

During the course of this Rural Review there was considerable interest in continuing to adjust the method of assigning isolation points to RSA communities. The following topics reflect the significant themes.

- **Current methodology is adequate:** There was a general consensus that from a broad perspective the current approach to measuring rurality was adequate but improvements were needed.

- **Impact of geography and travel time**: The most significant area of concern is the need to include a measure of travel time into the equation. Many comments were made that geography, climate, ferry schedules and closures, highway conditions and closures often contributed to a resident's ability to access physician services in a reasonable time. With the significant progress made in the area of climatology, geographical mapping and geographical information systems software, there is an interest in investigating whether or not those advancements would permit the introduction of a new variable that could measure the amount of time to access health care services. That new time

variable may be able to take into account geography, travel time, climatology, ferry schedules, highway conditions and perhaps other variables.

Recommendation 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.

- **Impact of 'nearby communities'**: Another significant area of concern is the need to consider the impact of nearby communities on the number of isolation points allocated to individual communities. A cited example is the comparison of Enderby and Lumby. The assignment of isolation points is impacted by nearby larger communities. The impact of Enderby being 1 km. outside the 35 km. radius of Vernon and within the 35 km. radius of Salmon Arm has a material positive impact on Enderby. The impact of Lumby being slightly within the 35 km. radius of Vernon has a material negative impact on Lumby. That review would be an opportunity to review whether the 35 km. and 70 km. distance parameters used in other factors should be adjusted.

Recommendation 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.

The Need for Flexibility

The overall goal of the Rural Programs is to support the recruitment and retention of physicians in RSA communities. With there being 154 RSA communities, approximately 1,600 physicians who benefit from the Rural Programs (of which approximately 1,200 reside in an RSA community) and 6 Health Authorities that benefit from the Rural Programs, it is important that there be standard approaches to determining eligibility to access each Rural Program and in the administration of each Rural Programs.

Much of the work of the JSC involves the review of requests where the circumstances do not fit within the eligibility requirements for a Rural Program or the situation under review does not fit within the policies/procedures for administering the programs. Many times the circumstances under review are 'at the margin' and are just outside of being within the scope of eligibility requirements or a policy/procedure. It is the dialogue by JSC on these issues that creates opportunities to continually improve on the effectiveness of the Rural Programs.

Feedback from the major stakeholder consultation (Visioning Day) included a request that the JSC be flexible in its decision making and that where it makes sense, the JSC should find ways make decisions that demonstrate a willingness to be flexible and support the ability of a community to recruit and retain physicians.

Recommendation 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.

Recommendation 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.

Communities in Crisis

Communities will from time to time face expected and unexpected crises in being able to maintain a sufficient number of physicians to provide stable medical services. When a crisis occurs it is important that the appropriate Health Authority, with support from the Ministry of Health develop plans to address the immediate and intermediate needs of the community. The Ministry has a small source of funding it can access to support short term initiatives. At the same time as the immediate issues are being addressed, it is necessary to establish plans that will lead to a sustainable medical service. The plan for a sustainable medical service often weaves together a number of initiatives and supports available through the Health Authority programs and the Ministry of Health Programs. It is perhaps most

appropriate for the appropriate Health Authority to have the prime responsibility to develop the plans for a community in crisis. The Rural Programs should be considered by the Health Authorities as part of the solution to support rural physicians. In being part of the solution, the JSC has the opportunity to determine if there are trends that require the JSC to assess whether any adjustments need to be made to any of the Rural Programs to better support communities in an ongoing way.

Recommendation 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.

The Need to Recognize Impreciseness

A key feature of the Rural Retention Program is the determination of isolation points on a community by community basis. The current methodology is considered by many to be adequate but requires adjustments to reflect current and emerging needs and circumstances.

It is intended that the assignment of isolation points be recalculated each year and that any changes to point assignments would be implemented on an annual basis. The recalculation has been made each year but the changes to point assignments have only been implemented once (in 2007 based on the 2006/07 points) since the original points determination was implemented in January 2003. There has been reluctance to introduce new points assignments due the negative impact on communities that were assigned a reduced number of isolation points.

The current methodology provides an outcome that approximates the degree of rurality of each RSA community. The individual variables included in the methodology attempt to measure different aspects. Each variable is not precise and therefore includes a margin of error. There are two products of the methodology:

- a fee for service premium for each RSA community
- a flat fee for each community. See the above discussion on Flat Fees.

Despite the impreciseness of the methodology the current community determinations reflect a presumed accuracy to two decimal points for the fee premium and to .01 dollars for the flat fee. It important to note there are cumulative impacts in the methodology that contribute to the need for recognition that although the overall methodology may be adequate it is not precise.

How precise is the current methodology? There is no correct answer as there is no recognized way of measuring the rurality of a community.

How should the JSC respond to the observation that the methodology for determining isolation points is not precise? It is suggested that within the current methodology that a fluctuation of 10% be considered as acceptable and that small fluctuations up or down not impact on a community's fee premium or flat fee.

Recommendation 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.

Recommendation 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.

It is also suggested the JSC consider a strategy that clusters communities into groups that have a similar number of assigned isolation points. An approach that places each community in a cluster would permit the JSC to award the same fee service premium and flat fee to a cluster of communities. The 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) that it may be reasonable for the JSC to award the same fee service premium to each community within each of the six clusters.

The proposed model whereby the fee premium amounts are established at set amounts for different ranges of community medical isolation points would recognize that the methodology is imprecise and simplify the communications on the fee premium. This approach would reduce the number of communities looking to understand why other communities in similar circumstances are provided a greater fee premium and flat fees. There will always be communities on the margin who will be requesting that JSC review their unique conditions and adjust their community to the next higher cluster. Given there is an impreciseness in the methodology, in some cases it may be reasonable to move a community to a higher cluster on an exception basis.

In those circumstances where the annual calculation of isolation points would move a community to a lower cluster, it is suggested the JSC consider 'red circling' the community at their rate prior to the recalculation. This is a reasonable solution given that the nature of the overall methodology lends itself to a fluctuation of isolation points awarded to individual communities. As in Recommendation 16, if the annual calculation of a community's isolation points is stabilizing at a new level over two consecutive years, consideration can be given to the impacts and need to implement the new points level.

An approach that clusters communities into a series of step-wise clusters that recognizes the value of assigning larger fee premiums based on rurality would support the recruitment and retention of physicians to British Columbia's most vulnerable communities.

A difficulty lies in the reality that no community will readily accept a reduction to their current fee premium or flat fee amount. This can be solved through a considered implementation either of two processes that involve 'feathering' the implementation process. One approach would involve determining the most appropriate fee premium for each cluster (perhaps the mid-point) and awarding incremental fee premiums to the communities below the fee premium for the cluster. This allows each such community to reach the chosen fee premium through upward adjustments. Also, as part of this first approach, a 'feathering' would occur for the communities that exceed the chosen fee premium. Those communities could reach the fee premium for their cluster through small downward adjustments over three years. An alternate approach would be to choose a fee premium for each cluster equal to the current highest fee premium in the cluster and adjust the fee premium for each remaining community through small upward adjustments over the course of three years until each community was equalized. In this second approach, no community would be adjusted downward.

The current distribution of medical isolation points would suggest the following step-wise structure for the allocation of the fee premium merits further consideration by JSC.

Medical Isolation Points	Number of Communities	Current Range of Fee Premiums %	Potential Fee Premium %
> 40	21	Each community is at 30	30
> 30 to 40	48	21.14 - 30.00	26
> 20 to 30	32	14.42 - 26.25	20
> 10 to 20	31	7.14 - 14.00	12
> 6 to 10	12	4.20 - 11.10	7
< 6	10	0.00 - 2.1	0

Recommendation 17:
That the JSC consider a step-wise RRP fee premium structure.

3.4. Isolation Allowance Fund

The Isolation Allowance Fund (IAF) provides an allowance to physicians providing necessary medical services in eligible RSA communities with fewer than four (4) physicians. Eligible communities must not have a hospital and physicians must not be receiving Medical On Call Availability Program MOCAP, Call Back, or Doctor of the Day payments. Payments are shared by the physicians providing coverage.

The funding for the IAF program has remained at $600,000 for the three fiscal years 2004/05, 2005/06 and 2006/07.

Methodology to Allocate the IAF

The amount of funding provided to individual physicians is dependant on the number of IAF eligible communities and the number of physicians residing in those communities. There is variation from year to year in the number of communities and the number of eligible physicians. The methodology to allocate the set annual budget of $600,000 results in:

- A lack of certainty of funding to individual physicians in IAF eligible communities.
- Different levels of funding to physicians in similarly designated A, B and C, communities.

To determine how much of the overall Isolation Allowance Fund is allocated to an eligible community and physician, the total isolation points for the community is first multiplied by the number of eligible physicians residing in the community. The higher the points thereby assigned to a community translates into more funding for a community. Once the weighted point values are determined for each community they are added together to provide a grand total of RRP points for all IAF eligible communities. The budget of $600,000 is then allocated on a proportional basis among the eligible communities. The funding provided to each community is then shared equally among the physicians in a particular community. The following table shows how the allocation of the Isolation Allowance Fund was made for 2006/07

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ISOLATION ALLOWANCE FUND Funds allocation for 2006/07						
Community	**A/B/C /D**	**Number of GP's 06/07**	**RRP Points April 1/07 multiplied by # physicians**	**% of Total Points**	**IAF Allocation to the Community for 2006/07**	**IAF Payment to Individual Physicians**
1. Atlin	A	1	51.25	9.09	$54,516.44	$54,516.16
2. Hudson's Hope	A	2	97.5	17.29	$103,714.21	$51,856.84
3. Houston	A	3	114.6	20.32	$121,904.09	$40,634.49
4. Greenwood / Midway / Rock Cre	A	2	61.2	10.85	$65,100.61	$32,550.14
5. Cortes Island	A	1	24.15	4.28	$25,689.21	$25,689.08
6. Sayward	A	1	23.55	4.18	$25,050.97	$25,050.84
7. Hornby Island	A	1	22.65	4.02	$24,093.61	$24,093.48
8. Barriere	B	2	34	6.03	$36,167.01	$18,083.41
9. Big White	B	1	17	3.01	$18,083.50	$18,083.41
10. Texada Island	B	1	16.65	2.95	$17,711.20	$17,711.10
11. Slocan Park	B	1	16.6	2.94	$17,658.01	$17,657.92
12. Quadra Island	C	1	14.25	2.53	$15,158.23	$15,158.15
13. Denman Island	C	2	27.3	4.84	$29,039.98	$14,519.91
14. Sorrento	C	1	12.8	2.27	$13,615.81	$13,615.74
15. Logan Lake	C	1	12.75	2.26	$13,562.63	$13,562.56
16. Bowen Island	C	2	17.8	3.16	$18,934.49	$9,467.20
Total		**23**	**564.05**	**100.00**	**$600,000.00**	**26,086.95**

As noted earlier, the amount of funding provided to individual physicians is dependant on the number of IAF eligible communities and the number of physicians residing in those communities. The following table illustrates the year to year variation of the average payment to all IAF eligible physicians and shows that the average payment to physicians has decreased over the last three years.

ISOLATION ALLOWANCE FUND Average Payment to a Physician				
Community	**Number of GP's 20004/05**	**Number of GP's 2005/06**	**Number of GP's 2006/07**	**Average Payments over three fiscal years**
Average Payment each year to a physician:	**$28,571.46**	**$25,270.91**	**$26,086.95**	**$26,516.91**

The following table illustrates the significance of the variation of the payment to IAF eligible physicians on a community by community basis over three fiscal years.

ISOLATION ALLOWANCE FUND Physician Payments						
Community	**$$ per Physician 04/05**	**$$ per Physician 05/06**	**$$ per Physician 06/07**	**% Change from 04/05 to 05/06**	**% Change from 05/06 to 06/07**	**% Change from 04/05 to 06/07**
Atlin			$54,516.16			
Hudson's Hope	$61,948.29	$57,770.83	$51,856.84	-6.74%	-10.24%	-19.46%
Houston	$49,597.43	$46,523.24	$40,634.49	-6.20%	-12.66%	-22.06%
Greenwood/Midway /Rock Creek	$41,865.39	$37,360.76	$32,550.14	-10.76%	-12.88%	-28.62%
Cortes Island	$32,630.37	$29,119.42	$25,689.08	-10.76%	-11.78%	-27.02%
Sayward	$32,219.93	$28,753.14	$25,050.84	-10.76%	-12.88%	-28.62%
Hornby Island	$7,744.30	$26,654.29	$24,093.48	244.18%	-9.61%	67.86%
Barriere	$23,258.55	$20,755.98	$18,083.41	-10.76%	-12.88%	-28.62%
Big White	$23,258.89	$20,755.98	$18,083.41	-10.76%	-12.88%	-28.62%
Texada Island	$25,242.37	$22,526.34	$17,711.10	-10.76%	-21.38%	-42.52%
Slocan Park	$28,183.89	$25,151.36	$17,657.92	-10.76%	-29.79%	-59.61%
Quadra Island	$19,085.69	$17,032.11	$15,158.15	-10.76%	-11.00%	-25.91%
Denman Island	$9,515.07	$16,049.55	$14,519.91	68.68%	-9.53%	34.47%
Sorrento	$22,985.26	$20,511.79	$13,615.74	-10.76%	-33.62%	-68.81%
Logan Lake	$17,443.91	$15,566.99	$13,562.56	-10.76%	-12.88%	-28.62%
Bowen Island	$11,629.28	$10,377.99	$9,467.20	-10.76%	-8.78%	-22.84%
Gabriola Island	$11,629.45	$10,377.99		-10.76%		

The year to year variation in Isolation Allowance causes confusion and a lack of certainty for individual physicians, for the Ministry of Health and the Health Authorities. For the most part the payments to individual physicians decreased from 2004/05 to 2006/07. This is due to the annual budget for the Isolation Allowance fund being set at $600,000. With there being a slight increase in the number of eligible physicians over the three years and with the calculation including a weighting factor to reflect a higher payment for more rural communities, most physicians have received a lesser payment in each of the last two years. It is important that the payments made within this program be stable and predictable.

It is desirable that the methodology for the allocation of the Isolation Allowance Fund be simplified. An alternate model whereby the allocations are established at set amounts for different ranges of community medical isolation points would introduce greater certainty. The current distribution of medical isolation points would suggest the following step-wise structure merits further consideration:

Isolation Allowance Fund (continued)

Medical Isolation Points	IAF Allocation
> 40	$55,000
> 30 to 40	$35,000
> 20 to 30	$25,000
> 10 to 20	$18,000
> 6 to 10	$10,000
<6	0

Recommendation 18:

That the JSC consider a step-wise Isolation Allowance Fund structure.

Using the above recommended Isolation Allowance Fund payment schedule the total payments to eligible physicians for 2006/07 would have been $615,000 as illustrated in the table below.

ISOLATION ALLOWANCE FUND Estimate of funds needed if the funding per physician was changed			
Community	**Proposed $ per physician**	**# of GP's 06/07**	**Allocation of IAF by Community**
Atlin	$55,000	1	$55,000
Hudson's Hope	55,000	2	110,000
Houston	35,000	3	105,000
Greenwood/Midway/Rock Creek	35,000	2	70,000
Cortes Island	25,000	1	25,000
Sayward	25,000	1	25,000
Hornby Island	25,000	1	25,000
Barriere	18,000	2	36,000
Big White	18,000	1	18,000
Texada Island	18,000	1	18,000
Slocan Park	18,000	1	18,000
Quadra Island	18,000	1	18,000
Denman Island	18,000	2	36,000
Sorrento	18,000	1	18,000
Logan Lake	18,000	1	18,000
Bowen Island	10,000	2	20,000
Totals		**23**	**$615,000**

Recommendation 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.

Number of Physicians in Eligible IAF Communities

Seventeen communities from across British Columbia have benefited from the Isolation Allowance Fund over the previous three years. The seventeen IAF communities and the cumulative amount provided to physicians in those communities are listed below. Community eligibility for any given year is determined based on the number of physicians who reside and practice for nine months (as well as the other eligibility criteria). For example, communities that do not have resident

physicians are not eligible as they do not meet the criteria or having a physician residing and practicing for nine months. An example of a community that would be eligible, but the physicians are not is Salmo. There are two physicians who practice there, but neither of them resides there. There are also examples of some physicians within a community receiving the IAF, while others do not as they do not meet the eligibility criteria. Residents of IAF eligible communities would benefit from having a stable physician workforce residing in their communities. Strategies to recruit in these communities would be part of a physician supply plan which is recommended as part of overall community care plans later in the report.

ISOLATION ALLOWANCE Allocating $600,000 Each Year					
Community	**A/B/C/D**	**# of GP's 06/07**	**# of GP's 05/06**	**# of GP's 04/05**	**Payments to physicians over three fiscal years**
1. Atlin	A	1	n/a	n/a	$54,516.16
2. Hudson's Hope	A	2	1	1	$223,432.79
3. Houston	A	3	3	3	$410,265.46
4. Greenwood/Midway/Rock Creek	A	2	2	2	$223,552.58
5. Cortes Island	A	1	1	1	$87,438.87
6. Sayward	A	1	1	1	$86,023.91
7. Hornby Island	A	1	1	1	$58,492.08
8. Barriere	B	2	2	2	$124,195.88
9. Big White	B	1	1	1	$62,098.28
10. Texada Island	B	1	1	1	$65,479.82
11. Slocan Park	B	1	1	1	$70,993.17
12. Quadra Island	C	1	1	1	$51,275.96
13. Denman Island	C	2	1	1	$54,604.45
14. Sorrento	C	1	1	1	$57,112.79
15. Logan Lake	C	1	2	2	$79,584.35
16. Bowen Island	C	2	2	1	$51,319.65
17. Gabriola Island	C	n/a	3	1	$42,763.42
Total funding over three years:					**$1,803,149.60**
Number of Participating Physicians each year:		**23**	**24**	**21**	
Average Payment per Community:					**$100,174.98**

Cash Flow of Payments to Physicians

On December 31st of each year Health Authorities report the number of eligible physicians in each eligible community to the Ministry of Health as part of the annual RRP confirmation process. Based upon this information, the Ministry then calculates the amounts of to be paid to eligible physicians working in eligible communities. The funds are released by the Ministry of Health to the Health Authorities who will disburse the applicable amounts to physicians who have resided and practiced in an eligible community for at least nine months of the calendar year. The funding is to be released to the Health Authorities annually in the last quarter of the fiscal year and be paid to the physicians in a single lump sum payment at or near the end of the fiscal year (ending March 31).

As a result, whenever a physician relocates to an eligible community after March 31st in any given year, they will not have resided in the community for a full nine months *within the calendar year* and will therefore not be eligible until the next calendar year, at which time the funding is provided to the Health Authorities in the last quarter of the following fiscal year and then it is forwarded to the physician. For example:

- April 2006 – a physician moves to an eligible community.
- December 31, 2006 – because the physician has resided in the community less than 9 months the Health Authority does not include the physician's name on the list of eligible physicians being provided to the Ministry of Health.
- December 31, 2007 – the Health Authority does include the physician's name on the list of eligible physicians being provided to the Ministry of Health.
- Between January 1, 2008 and March 31, 2008 – the Health Authority receives funding from the Ministry
- At or near March 31, 2008 – The Health Authority forwards the Isolation Allowance Fund payment to the eligible physicians. Although the policy indicates the funding is to be released to the Health Authorities annually in the last quarter of the fiscal year it may be that the Health Authorities are not receiving this IAF monies from the Ministry until two or three months after the end of the fiscal year, as Health Authorities must report on MOCAP payments that have been made to the physician prior to the funding being released by the Ministry.

A physician does not receive any credit toward the Isolation Allowance for any partial calendar years less than nine months. In the example above the physician does not receive any Isolation Allowance for the time spent in the community April 2006 to December 2006 (8 months).

Recommendation 20:
That physicians be eligible for the Isolation Allowance once they have lived and provided service for nine consecutive months in an eligible community.

Recommendation 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).

Recommendation 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.

Recommendation 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.

Recommendation 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.

A physician currently receives one annual payment if they are eligible for the Isolation Allowance.

Recommendation 25:
That eligible physicians receive payment of the Isolation Allowance on a quarterly basis.

Other Area of Potential Improvement within the IAF

The effectiveness of the Isolation Allowance Fund is not assessed on a regular basis. Nor are there established measurable goals for the fund. Performance measurement for all the Rural Programs is recommended later in the report.

Recommendation 26:
That the following goals are established for the Isolation Allowance Fund:

- 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.

The 'total years of physician services' would be calculated by determining the number of calendar years each physician in an IAF eligible community has resided and served in a community (partial calendar years of nine months or more would be included as one year). The sum of 'years of service' could then be determined as a total for all IAF eligible communities and separately for each cluster of communities.

The Interim Policy for the Isolation Allowance Fund was established in November 2005 and continues to be posted on the Ministry of Health website. That policy statement should be reviewed, updated and finalized.

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Recommendation 27:
That the Interim Policy for the Isolation Allowance Fund be updated and finalized.

3.5. Northern and Isolation Travel Assistance Outreach Program

The Northern and Isolation Travel Assistance Outreach Program (NITAOP) provides funding for approved physicians who visit rural and isolated communities to provide medical services. The program also provides a travel time honorarium for approved visiting specialists and family medicine physicians.

When physicians make visits to communities under the NITAOP they are providing needed services where they are needed and when they are needed. An important aspect of this program is that it promotes the provision of services close to people's homes. As a result patients do not have to travel for services that would otherwise not be available in their community. The NITAOP program includes two sub-programs:

- The Northern Isolation Travel Assistance (NIITA) component covers specialist travel expenses
- The Physician Outreach Program (POP) component covers travel expenses for General Practitioners and General Practitioner and Specialist travel time honorariums.

NITAOP is recognized as a very positive and important program by physicians, Health Authorities, patients and other key stakeholders.

Annual Visits

The total annual visits to RSA eligible communities have grown significantly over the five years from 2002/03 to 2006/07. Information was not available to demonstrate how many clients were seen during those visits nor is there information to available to indicate the number of days of service provided. Nonetheless it is clear residents in rural communities benefit significantly from not having to travel for the physician services supported by the NITAOP program.

Year	Total NITAOP Visits
2006/07	2076
2005/06	2047
2004/05	1572
2003/04	2774
2002/03	1063

Although Health Authorities have historically applied for more visits than physicians are able to use, it appears this may no longer be less the case than in earlier years with there being a significant decrease in the number of unused visits from a level of approximately 1700 unused visits for 2004/05 and 2005/06 as compared to 963 unused visits for 2006/07.

Utilization of the program has been increasing such that it would be wise to maintain the maximum number of community visits as they currently exist for the next two years. Currently a Health Authority may apply for up to 24 specialty visits per community and up to 48 for family medicine per eligible community. The JSC is able to approved exceptions to where the need to exceed these limits has been justified.

It is desirable that that the number of community visits by specialists and general practitioners be determined through a community needs and physician supply planning process.

Recommendation 28:
That the current maximums if 24 specialist visits and 48 general practice visits per eligible community be maintained.

Recommendation 29:
That the Health Authority physician supply planning processes include consideration of visits required by specialists and general practitioners.

Annual Planning

In September of each year the Ministry of Health holds information and planning session with the Health Authorities to discuss the NITAOP planning process for the following fiscal year. It is an opportunity to discuss issues, problems and potential policy changes. Following that initial planning session, the Health Authorities develop a NITAOP funding application to request NITAOP funding. The Health Authority applications are submitted to the Ministry of Health by November 1 of each year. The application is specific in that the NITAOP request must include the RSA community for which funding is being requested, the number of visits being requested for each community and the names of the physicians who will be making the visits to the RSA community.

An overall summary of the NITAOP funding requests for the upcoming fiscal year are presented to the JSC at the beginning of the calendar year, usually in February. The review by the JSC focuses on the requested changes from the previous year. The Health Authorities are then notified of the approvals for the upcoming fiscal year. The Health Authorities then inform the physicians and the appropriate Managers of the approved visits. The physicians are then able to submit an Application for Expenses for reimbursement of travel expenses and for their travel time. Each physician submits their fee-for-service work as they would normally do. Visiting physicians must ensure the Rural Retention Program Service Clarification Code (SCC) is indicated on all Fee-For-Service (FFS) billings to receive the FFS premium.

The Health Authorities can make changes to the approved NITAOP visits by working in close cooperation with the Ministry. All approved changes are to be within the approved total number of annual visits and must meet the eligibility criteria for the program.

Eligibility for Family Medicine Physicians
Family medicine physicians are eligible for funding to visit eligible RSA communities where a general practitioner is not available in the community (within 105 km). A maximum of 48 visits per community per year may be approved.

Eligibility for Visiting Specialists
Eligibility for each specialty service sought is assessed individually, applicable to rural communities where the specialty requested is not available within a 1.5 hour drive (distance of 105 km). The maximum number of visits per specialty for each community per year is 24. Specialty services eligible for funding (when not supported by Outreach Programs) include:

ENT	*Urology*	*Cardiology*	*Ophthalmology*
Paediatrics	*General Surgery*	*Oncology*	*Radiology*
Dermatology	*Psychiatry*	*Neurology*	*Plastic Surgery*
Orthopaedic Surgery	*Methadone Program*	*Internal Medicine (including subspecialty services)*	*Obstetrics &Gynaecology*

Travel Reimbursement
Reimbursement is paid directly to approved family medicine physicians or visiting specialists by MSP upon receipt of their travel expense form and applicable original receipts for each visit. Travel expense forms and receipts must be submitted before June 30 for the previous fiscal year

Travel Time
Approved Family Medicine Physicians and Specialists are entitled to a travel time honorarium. Travel time is calculated from the time the physician leaves his or her residence/office to the time of arrival in the community, and from the time the physician leaves the community to the time of arrival in their residence/office. Travel time is reimbursed per return trip as follows:

- *less than 4 hours = $500*
- *over 4 hours = $1,000*
- *greater than 10 hours = $1,500*

Health Insurance BC
The listing of approved NITAOP visits by community is sent to Health Insurance BC (HIBC) (the current government payment agency). When the Ministry receives an Application for Expenses they ensure original receipts are attached. The Ministry approved Application for Expenses is then forwarded to HIBC for payment. HIBC sends a biweekly payment report to the Ministry for review and sign-off as the 'spending authority'. The Ministry notifies Health Insurance BC of all changes made to the distribution of NITAOP visits.

The Ministry receives regular reports from HIBC on the overall payments by Rural Program, including NITAOP. Within some limitations, HIBC is able to provide ad hoc reports to the Ministry for a fee. HIBC is able to provide payment reports by physician or by community. HIBC is unable to run a report 'by community and by physician.

Annual Funding

	2005/06		2006/07		2007/08	
Program	**Budget**	**Actual**	**Budget**	**Actual**	**Budget**	**Projected Actual**
Physician Outreach Program (POP)	1,946,000.00	2,131,706.86	2,051,000.00	2,051,000.00	2,701,000.00	2,745,024.00

Expenditures for the POP have increased almost 30% over the last three years. Given the strong interest in this program as a very viable and successful program it is likely there will continue to be continued growth in this program. NITAOP makes it possible to provide a significant level of service closer to home for many rural residents thus avoiding financial hardship and inconvenience for many residents. As well, visiting specialist services add to the range of available local services needed to support the work of resident general practitioners. NITAOP funding also supports a significant number of general practitioner visits to communities that would otherwise not have that service.

The POP funding available for the program has an accumulated accrual of $283,713.77.

Recommendation 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.

Recommendation 31:
That JSC consider allocating a portion of the new funding available for the Rural Programs to the NITAOP program.

The 2006 report by the BCMA Rural Issues Committee on the Rural Programs (BCMA 2006) notes 60.9% of respondents were aware of NITAOP. Awareness was generally more likely as the years practicing medicine in physicians' current community increased. NITAOP was reported to be effective in recruiting physicians to visit their communities by fewer than 50% of respondents. Specialists responded significantly differently than GPs; they were more likely to have a neutral opinion. This may be due to the fact that specialists have less opportunity to provide services to highly remote areas.

Of those who were aware of NITAOP, 62.5% had used the program in their communities in the 12 months previous to the review by the BCMA Rural Issues Committee. Nearly 80% of these physicians indicated that the program met their expectations well or very well. Over three quarters of respondents who had used NITAOP believed that it was important or very important in maintaining their own satisfaction with rural practice.

Physicians were asked how NITAOP could be improved. The most popular answer, indicated by 42.9% of respondents, was to increase the number of eligible visits per year.

3.6. Rural GP Locum Program

The Rural GP Locum Program assists rural general practitioners in taking reasonable periods of leave from their practices. The program provides locum physicians with opportunities to practice in rural British Columbia, and enables rural general practitioners to secure subsidized relief for Continuing Medical Education (CME), vacation, and health needs.

Participants in the Rural Review viewed the RGPLP as essential to the retention and recruitment of physicians in eligible RSA communities.

RGLP Overview

To qualify for the RGPLP a physician must be living and practicing medicine in an eligible RSA community with seven or fewer full-time general practitioners. The RGPLP is very popular with rural physicians and seen as a significant contributor to making rural practice in BC attractive.

Each rural physician who meets the criteria may request up to 28 days of locum services per year, with each request lasting a minimum of five days (see below for weekend locum coverage). These days may be used at the discretion of the physician and are dependent on available coverage. Locum general practitioners receive a travel time honorarium of $600 and a guaranteed daily rate of $750 when providing coverage in eligible RSA Communities. Host physicians retain 40% of the MSP paid claims to cover overhead. Locums are eligible to receive payment for on-call and the Rural Retention Program (RRP) fee-for service premium. They may request consideration by the JSC for the flat fee sum if they live and practice 9 months of the year in eligible RSA communities. Normally locums are not eligible for the flat fee if providing short term locum assignments.

Weekend Locums

Weekend Locum coverage provides 3 days of short-term relief for rural physicians. A weekend commences on Friday at 18:00 and concludes at 08:00 on Monday or 08:00 Tuesday if a statutory holiday is part of the weekend. Payment for weekend coverage is a minimum of $2,000 Fri–Mon. Accommodation while on assignment is pre-arranged by the community or the host physician for both weekend and 5 days or more locum assignments.

Locum Pool

The locum pool is maintained by the Rural GP Locum Program. In 2006/07 there were 103 physicians who provided general practice locum services.

2006 BCMA Rural Survey Results – Highlights: Rural GP Locum Program (RGPLP)

The 2006 survey of rural physicians (BCMA 2006) showed that nearly 83% of GP respondents were aware of the RGPLP, but only 23.1% had used the program in the past 12 months. Awareness was affected by number of years practicing in their current community, with the highest instance of awareness in the 21-30 years category. However, there are no evident trends. (BCMA 2006)

Of those respondents who had used the program, 64.2% believe the program was effective in recruiting and retaining physicians to their practice community. When asked how important the RGPLP is in their decision to remain in their community, 82.7% of those who had used the program said that it was important (16.0%) or very important (66.7%). (BCMA 2006)

The RGPLP administration was reported satisfactory by 59.3% of respondents who had used the program (Table 6, Figure A19). This statistic depended on the respondent's number of years practicing medicine. Until 30 years of practicing medicine, satisfaction increases with the number of years. Past 30 years of practice, however, the responses become more neutral. This may be because this group is practicing less by this point in their career. (BCMA 2006)

Of those who used the RGPLP, 53.0% believed that the program could be improved by expanding the days of coverage and 44.6% agreed that more locums should be encouraged to join the program. (BCMA 2006)

National

Each Province and Territory has a program in place to attract and support physicians to work as locum physicians. The participants in this Rural Review tended to be aware that several other jurisdictions have enhanced benefits for locum physicians as compared to British Columbia. The following table provides a summary of current GP locum programs across Canada.

2007/08 Canadian Rural GP Locum Programs by Geographic Location									
	BC	AB	SK	MN	ONT	NS	NFL	Yukon	NWT
Budget	1.86 million	Unknown	Unknown	$819,526.00	No specific budget	$1,000,000	NA	$200,000	No budget
Locum maximum request (days) per year	28	28	No maximum	40	37/21	28	None	Undefined	Undefined
Minimum days requested	5	5	4 to 12 days	None	5	0.5	1	Undefined	No minimum
Daily rate guaranteed	$750	$800	No daily rate	$825 max.	Up to $800/day	$510	$662	$1979/fiscal	$900 - $1200
Travel honorarium maximum per trip	$600	Yes	No	$200 max.	Up to $500/day	$.3987/km	None	$250/day	Yes
Host Physician retain for overhead	40% FFS	30% FFS	30%	$150/day FFS	Negotiated	$160/day FFS	NA	Undefined	NA
Travel expenses paid	Yes	.48/km	Mileage only	Yes	$.44/km	Mileage only	Yes	Yes	Yes
Accommodation provided	Yes	Yes	Yes	Yes	Yes	None	Yes	Yes	Yes
Certificates needed	Fully Licensed	Fully Licensed	Fully Licensed	Fully Licensed	Fully Licensed	Fully Licensed	NA	Fully Licensed	Fully licensed

Recommendation 32:

That on an annual basis the JSC receive an updated across Canada summary of locum programs.

For the three fiscal years 2004/05 to 2006/07 a total of 9139.5 days of locum service was provided throughout British Columbia. The Interior Health, Vancouver Island and Northern Health Authorities benefited from most of the days of locum services.

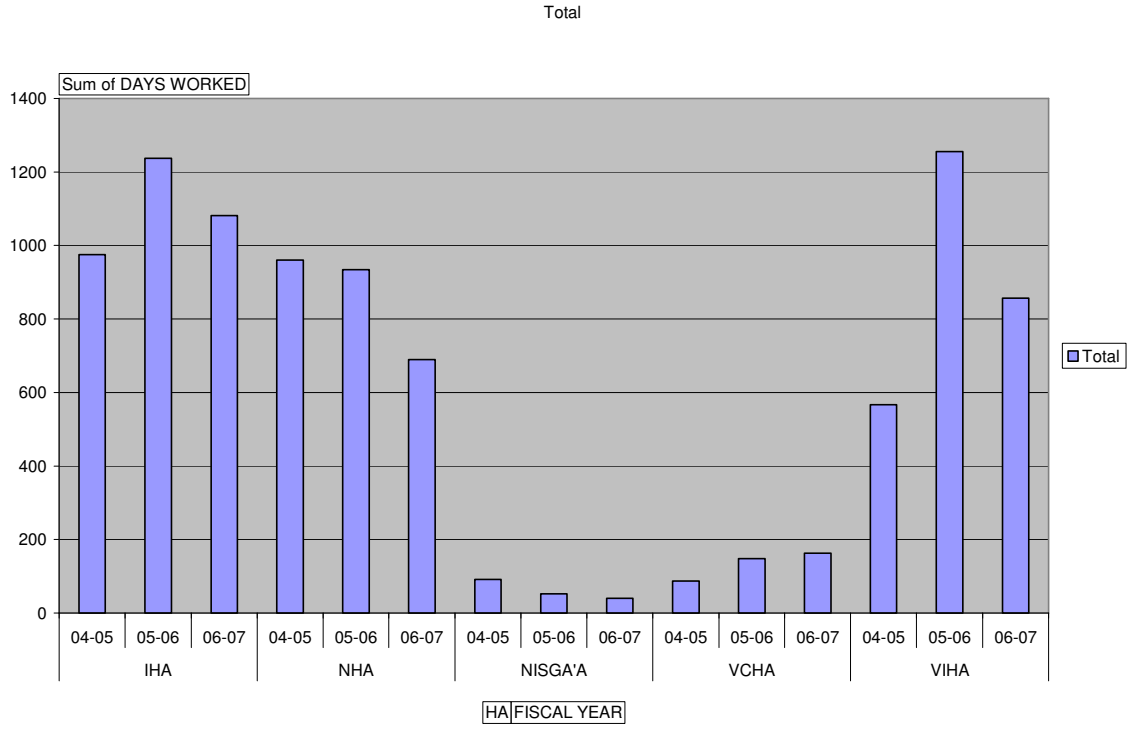
Health Authority	Locum Days Worked
Interior Health	3293
Northern Health	2584
Nisga'a Health	184
Vancouver Coastal	398.5
Vancouver Island	2680
Grand Total	**9139.5**

It is interesting to note there was a 22% decrease in the number of locum days worked from 2005/06 to 2006/07. An attachment provides a community by community breakdown of the Locum Days Worked.

Fiscal Year	Locum Days Worked
2004/05	2681
2005/06	3627
2006/07	2831.5
Grand Total	**9139.5**

The decrease in locum days worked between 2004/05 and 2006/07was most noticeable for the Northern Health Authority with a decrease of 244 days of locum service.

Sum of Days Worked per Fiscal Year in each Health Authority



Rural GP Locum Program (continued)

Health Authority	Fiscal Year	Locum Days Worked
Interior Health	2004/05	975
	2005/06	1237
	2006/07	1081
IHA Total		**3293**
Northern Health	2004/05	960
	2005/06	934
	2006/07	690
NHA Total		**2584**
Nisga'a Health	2004/05	92
	2005/06	52
	2006/07	40
Nisga'a Total		**184**
Vancouver Coastal	2004/05	87
	2005/06	148
	2006/07	163.5
VCHA Total		**398.5**
Vancouver Island	2004/05	567
	2005/06	1256
	2006/07	857
VIHA Total		**2680**
Grand Total		**9139.5**

From 2004/05 to 2006/07 the number of locum physicians providing locum services to the RSA communities increased by 32%. The number of locum visits to RSA communities also increased by 19%. In 2004/05 each participating physician made an average of 3.6 visits to an RSA community. By 2006/07 the average number of visits to an RSA community by each participating physician dropped to 3.3.

SUMMARY OF GP LOCUM PRACTITIONER AND LOCUM VISITS BY HEALTH AUTHORITY

		Fiscal Year		
Health Authority	**Data Elements**	**2004/05**	**2005/06**	**2006/07**
Interior Health	Count of Unique Locum Practitioners	40	47	42
	Number of Locum Visits	103	125	117
Fraser Health	Count of Unique Locum Practitioners	1	0	0
	Number of Locum Visits	1	0	0
Vancouver Coastal	Count of Unique Locum Practitioners	12	20	17
	Number of Locum Visits	12	26	27
Vancouver Island	Count of Unique Locum Practitioners	30	56	50
	Number of Locum Visits	66	144	108
Northern Health	Count of Unique Locum Practitioners	40	38	41
	Number of Locum Visits	91	91	80
Nisga'a Health	Count of Unique Locum Practitioners	3	3	3
	Number of Locum Visits	8	5	4
Unique Locum Practitioners		**78**	**106**	**103**
Sum of Locum Visits		**281**	**391**	**336**

1. Number of Locum Practitioners is the unique count of locum practitioners

2. Sum of Locum Visits does not include the number of days for each locum visit.

There is a general consensus that the pool of general practice physician locums needs to be increased. It is also observed that over time a number of general practice locums have developed an affiliation with the communities they have provided locum services to. There are many practicing physicians who are nearing the end of the career and do not want the burden of managing a busy office practice. Some of those physicians are turning to the opportunity of providing locum services as a way to manage their time (as they can work as locums when they choose) and avoid the burden of managing an office practice.

Communities benefit from the consistency provided by locum physicians who provide regular locum services to a community. Host physicians also benefit from the familiarity and confidence in regular visits from locums they know.

It is suggested that the Joint Standing Committee develop 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, including the satisfaction of supporting a chosen community in which to provide locum services. A name that has been suggested for this initiative is 'Adopt a Locum Community' initiative.

Recommendation 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.

Funding for the RGPLP

	2005/06		2006/07		2007/08	
Program	**Budget**	**Actual**	**Budget**	**Actual**	**Budget**	**Projected Actual**
GP Locum Program	$1,850,000.00	$2,309,881.26	$1,850,000.00	$1,850,000.00	$1,850,000.00	$1,702,441.00

The funding for the RGPLP has been a negotiated amount between the Ministry of Health and the British Columbia Medical Association. As a result the funding provided to the RGPLP has remained constant as shown above. However, the utilization of the program has varied from year to year. There is general support that growth in the RGPLP be supported. It is reasonable to expect 2006 levels of RGPLP activity will once again be achieved in the future. The Joint Standing Committee had been allocated a total amount of $2.5 to expand, support and improve existing Rural Programs.

Recommendation 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 the future utilization.

Role of Physician Supply Plans and the RGPLP

Ideally, each RSA community will have an adequate number of physicians who can provide a range of services and support to each other, including practice coverage while a physician is away for CME, vacation or other reasons. It is also a reality that in the smaller communities, circumstances will arise where the services of a locum physician are needed. It is desirable that Health Authorities work toward the ideal goal of having a planned number and mix of physicians working in each RSA community. Having an adequate number and mix of physicians providing a stable service to an RSA community will reduce the demand for locum physicians. To this end, the current Provincial initiative to develop Physician Supply Plans on a community by community basis needs to continue to be supported by the Joint Standing Committee.

Services in Small Rural Hospitals

In communities where there are small numbers of physicians, the service burden to the community resting with each physician is often significant. It is not unusual for physicians to withdraw from providing certain services as a means to cope with the overall workload burden. As well, the skill sets of community physicians may make it difficult to fully participate in selected critical care services such as obstetrical care, emergency room services, surgery and anaesthesia. When physicians withdraw from hospital based services or do not have the skills to provide selected critical care services there can be serious and significant impacts on service delivery. This often results in increased stress among the remaining physicians providing the hospital based services and an increase in the frequency of transportation of patients to larger centres.

There is a need to support local physicians through the RGPLP to better enable them to pursue skills training to support selected critical hospital based services. Providing access to enhanced locum services for community physicians will better support physicians to acquire and maintain selected critical hospital based services. A combination of enhanced locum support and coverage by peer physicians in the community could support a physician who pursues long training programs. The RGPLP could provide enhanced locum support services and the physician could also access REAP funding to support the training opportunity.

Recommendation 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.

RGPLP Daily Rate Guarantee

Daily Rate: GP locums earn more in other provincial/territorial jurisdictions. British Columbia monitors rates/benefits provided to locums across the country. The two Territories pay higher locum rates than the Provinces. In general terms it is reasonable that British Columbia compare its locum rates/benefits most often with those provided in Alberta and Ontario. Alberta and Ontario currently pay its general practice locums a guaranteed daily rate of $800, while British Columbia's guaranteed daily rate is $750.

Recommendation 36:
That the daily guaranteed daily income rate for the RGPLP be increased to $800.

Locum Services in Remote Communities

The RGPLP makes no distinction between difficult to access remote communities and communities that have a relative ease of access to larger referral centres. There is a misconception that locum physicians tend to provide services to communities where travel in/out is neither difficult nor time consuming. The following table supports the observation that the RSA communities in the most rural settings tend to have the largest number of locum physicians providing service.

Number of General Practice Locums Providing Locum Services to RSA Communities			
	FISCAL YEAR		
	2004/05	2005/06	2006/07
A Communities: Number of Unique Practitioners	73	90	89
B Communities: Number of Unique Practitioners	21	27	23
C Communities: Number of Unique Practitioners	8	18	12
D Communities: Number of Unique Practitioners	0	14	17

Locum general practitioners receive a travel honorarium of $600 and a guaranteed daily rate of $750 when providing coverage in eligible RSA Communities whether they provide services in easy to access communities or a remote community. There is no distinction made in payments made to locums who provide services in RSA communities based on the 'rurality' of the community. Preference for locum support through the RGPLP should be given to the most isolated/vulnerable communities. It is desirable that there be a fee incentive to provide service in British Columbia's most rural communities as defined by the assignment of RSA isolation points. The following RGPLP Daily Rate Premium is suggested:

Medical Isolation Points	Number of Communities Affected	Proposed RGPLP Daily Rate Premium	Daily Rate with Proposed Premium
> 40	21	30%	$1040
> 30 to 40	48	25%	$1000
> 20 to 30	32	20%	$960
> 10 to 20	31	10%	$880
6 to 10	12	No Daily Rate Premium	$800
< 6	10	No Daily Rate Premium	$800

Recommendation 37:

That the RGPLP guaranteed minimum daily rate for the provision of direct services be adjusted by a RGPLP Daily Rate Premium.

Full Time and Part Time Physicians

The RGPLP currently makes no distinction on extent of locum coverage provided to part time and full time physicians. It is reasonable to assume that physicians working full time require more time away for Continuing Medical Education (CME), vacation, and health needs. There is also support for the notion that the RGPLP should give preference to the most isolated/vulnerable communities. The following table outlines two options to address these observations:

Medical Isolation Points	Number of Communities Affected	Current Number of Available General Practice Locum Days to Part-time and Full-Time General Practitioners	Option A Reduce the Proposed Number of Locum Days Available to Resident Physicians Whose MSP Billings do not exceed $50,000	Option B Increase the Number of Locum Days Available to Resident Physicians Whose MSP Billings exceed $100,000
> 40	21	28	14	55
> 30 to 40	48	28	14	50
> 20 to 30	32	28	14	45
> 10 to 20	31	28	14	40
6 to 10	12	28	14	35
< 6	10	28	14	30

The JSC can anticipate resistance and negative feedback should current access to locum days be reduced as outlined in Option A. A preferred approach is to provide additional general practice locum days to physicians who are clearly working full time.

Recommendation 38:
That the number of locum days available to resident physicians be increased for physicians whose MSP billings exceed $100,000.

Supporting Rural Hospitals through the RGPLP

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. It is often difficult to recruit locum physicians with advanced skills in these four areas. To attract these skilled physicians to the RSA communities it is suggested that a higher guaranteed daily rate be provided to recognize locum physicians who participate in direct service delivery, including on-call. This higher guaranteed daily rate is intended to be added to the adjusted daily rate premium based on rurality as presented above.

> **Recommendation 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

Performance Measurement

It is desirable that the effectiveness of the RGPLP 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. Potential performance measures include:

- Number of RGPLP locum days provided to eligible RSA communities. This would assist in observations on whether British Columbia's most vulnerable rural communities continue to benefit most from the RGPLP.

- Number of RGPLP locum days provided within each of the Health Authority regions. This measure would assist in observations on which Health Authority communities are benefiting most from the RGPLP and whether additional support is needed by any one Health Authority to recruit additional locum physicians.

- Number of unique practitioners providing locum services to RSA communities. This measure would permit the JSC to monitor the whether the overall number of locum physicians is increasing.

Later in the report, a performance measurement program is recommended for all the Rural Programs, including the RGPLP.

Annual Evaluation of RGPLP

Participants in the Rural Review viewed the RGPLP as essential to the retention and recruitment of physicians in eligible RSA communities. It is desirable that this Rural Program and budget be re-evaluated on an annual basis.

Recommendation 40:

That the RGPLP and budget be re-evaluated on an annual basis.

3.7. Rural Specialist Locum Program

The Rural Specialist Locum Program (RSLP) supports specialists living and working in rural areas to secure subsidized periods of leave from their practices for purposes such as Continuing Medical Education (CME), vacation and to assist in the provision of continuous specialist coverage as designated by the Health Authority (HA). The RSLP can also be accessed in cases where an HA is experiencing difficulty recruiting the number of specialists needed to provide sustainable on-call services.

Eligible host specialists providing service for at least 9 months of every year can request up to 28 days of locum services per year. Each request must be at least 2 days in duration. There is no fee to the specialist for using the program.

The RSLP applies to the following RSA communities: Campbell River, Comox, Courtenay, Cranbrook, Dawson Creek, Fort St. John, Kitimat, Nelson, Port Alberni, Powell River, Prince George, Prince Rupert, Quesnel, Sechelt, Smithers, Terrace, Trail and Williams Lake.

The following core specialties are eligible for RSLP: Anaesthesia, General Surgery, Internal Medicine, Orthopedics, Pediatrics and Obstetrics. To access RSLP, there must be less than 5 specialists in the core specialty.

Specialist locum physicians are guaranteed minimum of $1,000 per day for provision of direct services for each day on assignment and a travel time honorarium to a maximum of $1,000 per return trip through the Medical Services Plan (MSP) payment system (Health Insurance BC). Specialist locums provide service in the host community, for the duration of each assignment, including the provision of on-call/availability services as per HA requirements.

MSP recovers 60 percent of the locum's FFS claims and the host physician receives 40 percent of the locum's paid MSP claims. In cases where 60 percent of the paid MSP claims are greater than $1,000 per day (averaged over the length of the assignment), top-up will be calculated and paid to the locum on a quarterly basis. Where the locum provides solely medical on-call availability services for emergency care as per MOCAP policy, as designated by the HA, the host physician will not receive an overhead component.

The Health Authorities reimburse locum travel expenses and provide accommodation for the locum while on assignment.

A budget of $600,000 is available for the RSLP. The RSLP program and budget is to be re-evaluated on an annual basis.

The RSLP is seen as a contributor to making rural practice in BC attractive both for Specialists and for other rural health care professionals who rely upon Specialist support.

Rural Specialist Locum Program (continued)

Community Type	Specialty	Number of Days Worked 2006/07	Average Number of Days of Assignment 2006/07
A	Anaesthesia	4	4
A	General Surgery	125	10.42
A	Internal Medicine	24	12
A	Obs/Gyn	65	13
A	Paediatrics	4	4
B	Anaesthesia	9	4.5
B	General Surgery	99	9.9
B	Internal Medicine	22	22
B	Obs/Gyn	66	22
B	Orthopedics	86	5.38
B	Paediatrics	28	7
B	Obs/Gyn	11	11
B	Paediatrics	14	14
C	General Surgery	106	13.25
C	Internal Medicine	26.5	8.83
C	Obs/Gyn	6	6
C	Orthopedics	36	12
C	General Surgery	15	7.5

Designated RSLP Specialties

There is an inconsistency between NITAOP and RSLP in the range of designated specialties eligible for program support.

RSLP Designated Specialties	NITAOP Designated Specialties
Anaesthesia	
	Cardiology
	Dermatology
	ENT
General Surgery	General Surgery
Internal Medicine	Internal Medicine
	Neurology
Obstetrics	Obstetrics & Gynaecology
	Oncology
	Ophthalmology
Orthopaedics	Orthopaedic Surgery
Paediatrics	Paediatrics
	Plastic Surgery
	Psychiatry
	Radiology
	Urology
	Methadone Program

The NITAOP and RSLP programs support specialist physician services in RSA communities. There are a number of specialists living in RSLP eligible RSA communities who do not have access to the RSLP. Examples include Radiologists, Psychiatrists and ENT specialists who live in RSA communities. In those circumstances the community is eligible for outreach services and yet the resident physician is not eligible for locum support. At least one Health Authority matches RSLP rates in other specialties, but only in their largest centres.

In anticipation of the development of a BCCA - Northern Cancer Centre it would be prudent to be proactive by adding Oncology be added as a designated specialty to the RSLP.

It is desirable that the distribution of physician specialist services is guided by the availability of informed physician supply plans. Physician supply plans developed through a reasonable planning process should have a positive impact on the ability of residents to access a range of specialist services in their home communities or in accessible regional and sub-regional centres.

Recommendation 41:
That Psychiatry, Radiology, ENT, Gynaecology and Oncology be added as designated specialities eligible for RSLP support.

Recommendation 42:
That Anaesthesia is added as a designated specialty eligible for NITAOP support.

Recommendation 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.

Payments to Locums

Specialist locum physicians are guaranteed minimum of $1,000 per day for provision of direct services. There is no distinction made in payments made to specialist locums who provide services in RSA communities based on the 'rurality' of the community. Preference for locum support through the RSLP should be given to the most isolated/vulnerable communities. It is desirable that there be a fee incentive to provide service in British Columbia's most rural communities as defined by the assignment of RSA isolation points. The following RSLP Daily Rate Premium is suggested:

Medical Isolation Points	Communities Affected	Proposed RSLP Daily Rate Premium
> 40		Not Applicable
> 30 to 40	• Dawson Creek • Kitimat • Prince Rupert • Smithers	25%
> 20 to 30	• Cranbrook • Fort St. John • Terrace • Williams Lake	20%
> 10 to 20	• Campbell River • Nelson • Powell River • Prince George • Quesnel • Trail	10%
6 to 10	• Comox • Courtney • Port Alberni • Sechelt	No Daily Rate Premium
< 6		Not Applicable

Recommendation 44:
That the RSLP guaranteed minimum of $1000 per day for the provision of direct services be adjusted by a RSLP Daily Rate Premium.

Sole Practice Specialists

Being a sole practice specialist is very difficult. Unless the specialist is able to participate in a regional call group, it is difficult to limit the amount of after hours on-call provided to the community as there is often a personal commitment to the community to meet their health care needs. Often the overall workload burden is difficult to manage. With the changes in health care practice it is important that sole practice specialists be active participants of local, regional, provincial and national continuing education events to be able to remain current with their skills. Sole practice specialists find it difficult to be able to participate in ongoing medical leadership initiatives, whether it is with the Health Authority, the BCMA or joint MOH/BCMA forums or committees. Not being able to leave the community on a regular basis for vacation, continuing medical education or for medical leadership activities can lead to burn out. The shortage of specialists in each discipline makes it difficult to for sole practice physicians to locate specialists who can provide locum coverage. It is suggested that an increase to the number of RSLP locum days combined with a proposed RSLP Daily Rate Premium, it may help reduce burnout by sole practice specialists.

> **Recommendation 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.

Performance Measurement

It is desirable that the effectiveness of the RSLP 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. Potential performance measures include:

- Number of RSLP locum days provided to eligible RSA communities. This would assist in observations on whether British Columbia's most vulnerable rural communities are benefiting from the RSLP.

- Number of RSLP locum days provided in each of the designated specialties. This measure would assist in observations on which rural specialties benefit the most from the RSLP and whether or not adjustments need to be made to the RSLP to encourage greater RSLP support for core hospital based services such as general surgery, radiology and anaesthesia.

  The Ministry of Health is developing a comprehensive data base for the Rural Programs. When established it is likely that it will be possible to develop additional performance measures.

Later in the report, a performance measurement program is recommended for all the Rural Programs, including the RSLP.

Annual Evaluation of RSLP

The RSLP is the newest Rural Program. The early indications are that the RSLP is a desirable program that supports the ability of specialists in RSA communities to arrange for locum specialists. It is desirable that this new Rural Program and budget be re-evaluated on an annual basis.

Recommendation 46:

That the RSLP and budget be re-evaluated on an annual basis.

3.8. Rural Continuing Medical Education Program

The Rural Continuing Medical Education Program provides physicians with funding opportunities for medical education to update and enhance medical skills and credentials required for rural practice. These benefits are in addition to the CME entitlement provided for in the Working Agreement between the BC Government and the BCMA.

Benefit levels are based on the remoteness of a physician's practice community and their years in rural practice.

Physicians may use funds for individual or group education purposes, to cover overhead expenses while attending medical training, or to purchase new technology or upgrades necessary for participation in CME.

The budget for the program is $4,700,000. The amount paid to Health Authorities is determined by the number of physicians eligible and the according benefits provided. Total funding provided to Health Authorities based on benefit eligibility has been consistently over budget. The budget was increased in 2007/08.

RCME Funding - Year Over Year Comparison (Budget and Actual)					
2005/06		2006/07		2007/08	
Budget	**Actual**	**Budget**	**Actual**	**Budget**	**Projected Actual**
3,700,000.00	5,432,406.64 47% over budget	3,700,000.00	4,907,525.00 33% over budget	4,700,000.00	5,136,600.00 9% projected over budget

Physicians apply to their Health Authorities for reimbursement of RCME funds. If the annual budget is under spent, the funds remain with the Health Authorities for rural physician CME. The programs provide up to $5,200 per year, per physician. The amount a physician receives depends on whether the community they practice in is designated an A, B, C or D community, and their length of service.

When a physician has practiced in one or more of the communities covered by the RSA for the number of years set out in the table below, the physician is eligible for the annual RCME as set out below, according to the degree of isolation of the community.

A physician may bank RCME for up to three years; however eligibility for RCME for any year expires at the end of two subsequent years. Upon expiry of eligibility or when physicians leave RSA communities, any sum remaining for a physician transfers to the Health Authority.

Physician Eligibility for RCME Program				
	Isolation Points	**2 years or less**	**3 – 4 years**	**More than 4 years**
'A' communities	20 or more	$1,200	$3,200	$5,200
'B' communities	15 to 19.9	$400	$2,400	$4,400
'C' communities	6 to 14.9	$0	$2,000	$4,000
'D' communities	0.5 to 5.9	$0	$1,000	$2,000

Continuing Medical Education Key to Rural Physician Services

The RCME program provides targeted funding for rural physicians, who face unique factors of geographic distance, locum coverage and financial cost in seeking CME. Depending on the nature of the medical education or training a physician wishes to pursue, eligible physicians can apply for funding under the Rural Education Action Plan (REAP), which is addressed elsewhere in this report.

Training in enhanced skills in core services including emergency, surgery, gynaecology and obstetrics for rural physicians is highly important to effective physician services, and to recruitment, retention and career satisfaction among rural physicians.

Skills in these core services were highlighted by participants across jurisdictions in the Rural Review as key requirements for rural physicians. The scope of practice for rural physicians can also create need for specialized training outside core services. The BCMA Rural Survey reported the RCME program as important to recruiting, retaining and maintaining satisfaction of rural physicians (BCMA 2006). About two thirds of respondents viewed it as effective or very effective in recruitment, and 76.1% as effective or very effective in retention.

Participants in the Rural Review were consistently positive about the importance of continued medical education, and valued the program highly. Ongoing CME support for rural physicians is essential to maintaining the level of service required in British Columbia's rural and remote areas.

Under Utilization a Primary Concern

Rural Review participants expressed concern about under utilization of the program by rural physicians. This was often attributed to lack of time or locum support for travel outside their communities for CME. Lack of awareness of the flexibility in use of the funds for technology upgrades was also noted, and confusion between the roles of REAP and the RCME programs. The use of a separate administration through Health Authorities for RCME funding could be viewed as adding complexity, though most physicians using the program and participating in the Rural Review did not have this concern.

Approval of physicians' requests for RCME funding rests with each Health Authority. There appears to be inconsistency between Health Authorities in criteria and in efficiency of RCME administration. In some cases, delays in approvals were cited as barriers to registering in CME events and scheduling locums. In addition to the need for administrative efficiency, use of consistent application criteria based on the existing physician agreement is needed.

Recommendation 47:
That Health Authorities provide physicians quarterly statements of their RCME account.

Recommendation 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.

Recommendation 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.

A communication strategy is needed to promote physicians' awareness of the RCME program, including the flexibility in using the funding for new technology or upgrades necessary for participation in CME. Recommendations for communication on all Rural Programs are provided later in the report.

Health Authorities are currently holding large amounts of unspent RCME funds. These accounts are sometimes referred to as 'community funds'. Physicians may accumulate RCME funds for up to three years, however eligibility for RCME for any year expires at the end of two subsequent years. The Health Authority holds the expired RCME funds.

The fund maintained by the HEALTH AUTHORITY is normally accessed for local Medical Advisory Committees (MAC) and physician groups to support local CME events that contribute to physician education or training. Initiatives are underway in Health Authorities to develop rural CME programs to address the unique training needs of rural physicians, and to promote increased use of these funds by physician community groups. Collaboration among Health Authorities and their MAC's with

other jurisdictions and key stakeholders to develop rural CME programs designed for rural physicians and delivered locally is recommended later in this section of the report.

Recommendation 50:

That the current policy that unspent RCME funds remain with Health Authorities stays in place.

Recommendation 51:
That Health Authorities provide regional and local Medical Advisory Committees with regular reports on RCME activity and balances within the Community Fund.

As with all other Rural Programs, the Rural Review highlighted the need for improved data collection to support decisions and ongoing monitoring of outcomes and program effectiveness. A recommendation is provided later in the report that performance measures be defined for the RCME program and all Rural Programs, implementing data collection and a methodology to monitor and report program effectiveness.

Rural CME Designed for Rural Physicians

In general, there is need for co-ordination and innovation to provide rural continuing medical education programs specifically designed for rural physicians. Co-ordination of training at the community level and collaboration across the province was advocated by stakeholders. The Rural Review identified the need for programs designed to meet the CME needs of rural physicians, delivered locally, using technology more effectively and jointly designed by CME stakeholders.

1. CME Needs of Rural Physicians

The Joint Standing Committee for Rural Programs funded a needs assessment for continuing medical education for rural physicians in British Columbia (Lindley, Bluman 2006). The study reported barriers to access due to factors of geographic distance, locum coverage, financial cost, professional isolation and timing and location of CME events. It cited rural physicians' preference for hands-on, small group sessions, for CME to be relevant to a rural context and to focus on the essential elements of what they needed to know.

Participants in the Rural Review pointed to a limited understanding by many CME educators of the differences between rural and urban practices and resources. They saw benefits in having rural regional specialists deliver training, including better quality of rural training, mentorship relationships with specialists, collegial networking, and reduced travel cost.

2. Rural CME Delivered Locally

Providing training customized for rural physicians as geographically close to their communities as is feasible would strengthen support for rural practice. Developing programs delivered locally, taught in part by local specialists with use of simulation technology, and broadening availability of on line training could improve CME access for rural physicians.

Better access to local training in core services including emergency, anaesthesia, general surgery, obstetrics and chronic disease management would provide professional support highly valued by rural physicians. Low volume rural services such as obstetrics would benefit from increased availability of local training. Where needed, urban specialists trained in the unique requirements for rural physicians could deliver locally based training.

Training locally delivered would reduce travel time required, time away from practice, and therefore demand for locum support. Networking with physician colleagues and specialists yields more than knowledge. Every opportunity to foster collegial support is of tremendous value to rural physicians, their patients, and their communities. Including other disciplines, for example nurses in emergency training, was considered highly desirable by participants in the Rural Review, adding to potential cost savings. Both training and a social component should be included.

Successful rural CME programs and events initiated in rural communities could be repeated in other communities. Similarly, programs successful in other provinces, such as Alberta's General Emergency Medicine Skills Program, could be reviewed for a starting point on course design and curricula.

The wide scope of service was identified by student focus groups in the review as a strong part of the appeal of rural practice. But it can seem daunting at first, and can be hard to stay up to date. Local RCME would strengthen the appeal of rural communities to new physicians. Collegial support is also a consideration for new physicians, and could be fostered by the ability to network at local CME events.

Collaboration to Strengthen Rural CME

Already, several organizations have demonstrated interest in strengthening rural CME. Health Authorities are in the process of developing initiatives to provide local programs. In some communities, local physicians, their Medical Directors and Medical Advisory Committees organize successful CME events for their physician community. UBC has proposed a rural CPD outreach program based in Vancouver, transitioning to a northern or interior location within five years. The Closer to Home Program offered in rural areas under REAP was cited as highly successful. These efforts could provide greater impact if undertaken collaboratively.

Numerous jurisdictions and stakeholders contribute to rural continuing medical education. The JSC, Ministry of Health, Health Authorities, BCMA, UBC, UBC's Northern Medical Program, College of Physicians and Surgeons, Medical Advisory Committees, Medical Directors and individual physicians all play multiple roles. To bring continued medical education designed for rural physicians to local rural communities in a cost effective manner, co-ordination of these efforts could bring better results.

There may be potential for cost savings through collective effort and local delivery shared across the province. Successful co-ordination of efforts and commitments by these organizations is dependent on engagement of their decision makers in defining their joint effort. Development of new rural CME initiatives requires engagement from all of these players to address the goal of meeting the needs of rural physicians in locations close to their communities.

Recommendation 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:

1. Conduct a planning session to define key rural CME initiatives short term and long term, objectives, outcomes, resources and expertise available from each stakeholder group, and potential timelines. Staff support for the planning session will be required. Representation from the each of the following is recommended, listed in alphabetical order, though others can be added as required:
    - Health Authority officials and physician administrators - Northern, Interior and Vancouver Island
    - JSC members from both Ministry of Health and BCMA
    - UBC CPD-KT
    - UBC's Northern Medical Program

2. Document and present the outcomes and recommendations from the planning session at a meeting of decision level executives from each organization.

3. Based on executive guidance, prepare an implementation plan and proposal to improve rural CME in British Columbia, defining the deliverables, organizational roles, budget and performance measures for each component of the program.

3. Non-Local Training Remains Important

While this report highlights local CME as a gap that needs to be addressed, continuation of RCME eligibility for training in urban locations is equally important. To allow flexibility in scheduling and specialized training outside the core services, a wide range of options are important. The isolation and demands of rural practice are ameliorated by the opportunity to get away.

4. Technology in Rural CME

Better use of technology was cited by participants in the Rural Review as a means of improving rural CME. Videos, telehealth, videoconferencing, online training, and PDA's were identified as ways to improve access by rural physicians. Physicians interviewed said use of video needs to be increased in existing online training. Some cited the need for improvement of high speed internet access in their locations. Technology is an important component of infrastructure for rural physicians, not only for CME. Rural communities vary in availability of technology infrastructure.

Task Force Two, established by the Government of Canada and the medical community to develop a long-term human resource strategy for physicians, recommended "a 'wired medical world' encompassing a wide range of interoperable communication and information technologies to support optimal information management, knowledge transfer, service delivery, and secure sustainable funding for the appropriate use of these technologies."

> **Recommendation 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.

5. Performance Measurement

As with all other Rural Programs, the Rural Review highlighted the need for improved data collection to support decisions and ongoing monitoring of outcomes and program effectiveness. A recommendation is provided later in the report that performance measures be defined for all Rural Programs, implementing data collection and a methodology to monitor and report program effectiveness.

> **Recommendation 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

3.9. Recruitment Incentive Fund and Recruitment Contingency Fund

There are currently two programs targeted toward recruitment of rural physicians, the Recruitment Incentive Fund and the Recruitment Contingency Fund.

The Recruitment Incentive Fund is 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). These incentives provide up to $10,000 for physicians recruited from outside eligible RSA communities. The total budget is $2,374,000 annually.

Expenditures in the past fiscal year 2006-2007 were approximately 60% of budget. Northern Health Authority, Interior Health Authority, Vancouver Island Health Authority and Health Match BC received over $300,000. Vancouver Coastal Health Authority and Fraser Health Authority received proportionately less.

Recruitment Incentive Fund Expenditures Fiscal 2006/2007			
Health Authority	**Commitments (CO)**	**Reimbursed to HA (RAH)**	**RAH as a % of CO**
IHA	$340,000.00	$340,000.00	100.00%
NHA	$335,000.00	$330,000.00	98.51%
VIHA	$305,500.00	$305,500.00	100.00%
VCHA	$75,000.00	$75,000.00	100.00%
FHA	$19,000.00	$19,000.00	100.00%
Total	**$1,074,500.00**	**$1,069,500.00**	**99.53%**
HEABC	$305,000.00	$305,000.00	100.00%
Grand Total	**$1,379,500.00**	**$1,374,500.00**	**99.64%**

Recruitment Incentive Fund and Recruitment Contingency Fund
(continued)

Approximately 50% of the physicians receiving the $10,000 allocation were general practitioners.

Recruitment Incentive Fund Expenditures by Specialty Fiscal 2006/2007			
Specialty	**Commitment (CO)**	**Reimbursed to HA (RAH)**	**RAH as a % of CO**
GP	$673,500.00	$668,500.00	99.26%
Urology	$315,000.00	$315,000.00	100.00%
Internal Medicine	$60,000.00	$60,000.00	100.00%
Radiologist	$60,000.00	$60,000.00	100.00%
Anaesthesia	$50,000.00	$50,000.00	100.00%
Psychiatry	$36,000.00	$36,000.00	100.00%
Emergency	$30,000.00	$30,000.00	100.00%
General Surgery	$30,000.00	$30,000.00	100.00%
Orthopaedics	$30,000.00	$30,000.00	100.00%
Ob/Gyn	$25,000.00	$25,000.00	100.00%
Paediatrics	$20,000.00	$20,000.00	100.00%
Pathology	$20,000.00	$20,000.00	100.00%
ENT	$10,000.00	$10,000.00	100.00%
GP-Anaesthesia	$10,000.00	$10,000.00	100.00%
Ophthalmology	$10,000.00	$10,000.00	100.00%
Total	**$1,379,500.00**	**$1,374,500.00**	**99.64%**

Data provided by the Ministry of Health

The Recruitment Incentive Fund was approximately 60% utilized over the past two years. The amount expended annually is determined by the number of physicians eligible and the according benefits provided.

Recruitment Incentive Fund and Recruitment Contingency Fund
(continued)

The Recruitment Contingency Fund assists communities served by the RSA with recruiting expenses where the difficulty in filling a vacancy is, or is expected to be, especially severe or would have a significant impact on the delivery of medical care required. Health Authorities apply based on vacancies and anticipated needs. The total budget is $300,000 annually.

Because of high demand for the Recruitment Contingency Fund for tougher recruitment situations, the JSC began in 2006 to allocate the funds based on isolation points to ensure the most remote communities receive more of the fund. Funds are allocated based on isolation points to each Health Authority. The fund is normally fully spent, with Health Authorities needs for recruitment funds exceeding the budget.

The Recruitment Contingency Fund allows more flexibility for Health Authorities in customizing the incentive and expenses benefits relative to the difficulty in filling a vacancy. For positions where recruitment is unsuccessful, funds are not reimbursed. As a result, the budget was not fully spent in 2006/07. All data was provided by the Ministry of Health.

Recruitment Contingency Fund Expenditures 2006/07		
Health Authority	**Commitments**	**Reimbursed to HA**
VIHA	$143,937.61	$44,808.26
IHA	$52,179.70	$33,472.95
NHA	$145,027.68	$135,999.24
FHA	$5,000.00	$5,000.00
VCHA	$10,300.00	$10,300.00
TOTAL 06/07	**$356,444.99**	**$229,580.45**
Budget 06/07	**$300,000.00**	

Recruitment Contingency Fund Budget 2007/08		
Health Authority	**Commitments**	**Reimbursement in Progress**
VIHA	$78,000.00	
IHA	$87,000.00	
NHA	$108,000.00	
FHA	$3,000.00	
VCHA	$18,000.00	
Nisga'a	$6,000.00	
TOTAL 06/07	**$300,000.00**	

Recruitment Incentive Fund and Recruitment Contingency Fund
(continued)

The data available for the Rural Review did not permit a quantitative analysis of the direct impact of the Recruitment Incentive Fund. BCMA's survey reported that 96.1% of physicians who had only been practicing medicine for 5 years were aware of the recruitment incentive program (BCMA 2006).

Stakeholders in the Rural Review supported the allocation of funds proportionate to isolation and challenges in recruitment. Health Authorities and medical administrators providing input to the Rural Review stated that instances where recruitment incentives fall short are increasing, particularly in recruitment of specialists. If recruitment becomes more challenging, requirement for contingency funds will increase, and additional funds may be required.

Recommendations 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, length of tenure by physicians recruited, # of physician positions not filled, strategies used for recruitment, length of time to fill vacant positions and, where possible, identifying barriers to successful recruitment in difficult situations.

Recommendation 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.

For flexibility in allocating recruitment funds year by year, the Recruitment Incentive Fund and the Recruitment Contingency Funds could be combined, allowing unused incentive funds for contingencies when required.

Recommendation 57:
That the Recruitment Incentive and Recruitment Contingency programs be combined to one recruitment fund for flexibility in allocating funds, maintaining the existing programs as two components of the fund and documenting terms of reference.

Trends in Recruitment

The Rural Review highlighted the significance of both financial and non-financial factors in recruitment. Without the financial incentives provided in the suite of nine programs, British Columbia would not fare well in comparison with other provinces. Our rural physicians value and appreciate the financial support to address isolation and the demands of rural practice.

While financial incentives remain important, there is increasing evidence that non-financial factors are the strongest determinants of physician career choices, for both urban and rural physicians. Family and community factors consistently rate above economic considerations when physicians are surveyed (Canadian Health Services Research Foundation 2003). In a study recently reported in the BC Medical Journal, University of British Columbia medical students, residents, and BC physicians were asked to rank seven factors that influenced their career choices. “Personal interests” was ranked first among all the respondents, followed by “previous positive experience,” “personal reasons,” and “job opportunities.” Selection factors that were considered less important were “influence from a mentor,” “lifestyle and financial rewards,” and “geographical location.” (Ko et. al. 2007).

BCMA’s survey of rural programs identified five major themes in recruitment and retention: physician background (rural or urban), professional issues such as infrastructure and resources, lifestyle, attitudes toward rural and general practice, and community involvement (BCMA 2006). In the 2008 Rural Review, both existing physicians and student focus groups highlighted physician infrastructure and resources, lifestyle, community and personal factors.

Stakeholders participating in the Rural Review highlighted new recruitment trends. Rural physicians interviewed said their primary considerations in choosing rural practice were preference for living in a rural community and for the unique characteristics of rural practice. The medical student focus groups saw rural practice as an opportunity to utilize a greater breadth of skills, and develop a practice with wider scope. Some specialists prefer practicing in major ‘rural’ health centres because of the opportunity to focus on low risk surgeries more so than are typical for specialists in the larger urban centres.

In focus groups conducted for this review, student residents stated that financial incentives would not override career, personal and family interests. Several indicated that providing locum service over a few months was preferred over British Columbia’s Family Physicians for BC (FPs4BC) incentive program in order to retain flexibility in choosing their practice.

The desire to live and practice in a rural community is paramount to many rural physicians. Stakeholders interviewed frequently stated that the $10,000 Recruitment Incentive is too small to impact their practice location choice.

These factors signal that the impact of the $10,000 recruitment bonus may be lessening, and that new investment in other areas of rural physician satisfaction may have more impact on recruitment. However elimination of this bonus could be

perceived as a diminished appreciation of the unique demands placed on rural physicians. Similarly sized grants exist in other provinces as part of an overall mix with larger incentives like FPs4BC. And in some cases, the incentive has been considered a compensation for relocation expenses.

Recommendation 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).

Impact of Other British Columbia Incentive Programs

The effectiveness of recruitment bonuses from new physician incentive programs are intertwined with rural incentive programs. The Family Physicians for BC (FPs4BC) program currently underway provides up to $100,000 incentives for physicians establishing practices in areas of demonstrated need. The cross country review showed that FPs4BC helps to position British Columbia well relative to other provinces in drawing new physicians to rural practice.

Rural Review participants stated that FPs4BC has had a negative effect in some rural communities where new physicians recruited were not awarded an FPs4BC incentive. In some cases, there is a sense that fairness was compromised. But overall, FPs4BC has been well received.

The Medical On Call / Availability Program MOCAP was regarded positively by Rural Review participants. One physician said he would not practice in a community designated for the Isolation Allowance Fund because MOCAP funding is not available to physicians practicing in IAF communities.

Recommendation 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.

Key Factors in Successful Recruitment

While the Rural Review recommends some improvements to British Columbia's recruitment and retention financial incentives, they are fundamentally strong and have been adjusted progressively over several years. As non-financial factors in recruitment and retention are becoming better understood, there is considerable opportunity to expand the reach. Below are listed the key priority factors.

1. Undergraduate and Post Graduate Training

It has long been understood that doctors who grew up in rural and remote communities are more likely to practice there (BCMA 2006; Task Force Two 2005). The Rural Education Action Plan (REAP), discussed later in this report, includes a high school strategy that promotes consideration of medicine careers.

The distributed medical education programs established by UBC in Prince George, Victoria, Chilliwack and, in the future, Kelowna, have aided in exposing existing students to rural practice. The imminent introduction of medical residencies in Ft. St. John and Terrace is viewed as another step forward. Opportunities for clinical training and residencies in other rural communities could significantly improve preparation and attraction for rural practice.

The Alberta Rural Physician Action Plan offers two financial support initiatives to medical students: the Rural Medical School Award and a Rural Medical Student Bursary. These two initiatives aim to encourage students who come from a designated rural area to pursue a career in rural medicine by reducing their financial burden.

> **Recommendation 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.

> **Recommendation 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.

The Rural Education Action Plan funds participation of rural physicians in the medical school selection process (see page 105).

Canadian students enrolled in international medical schools, particularly Ireland, were identified by participants in the Rural Review as a significant pool for recruitment.

> **Recommendation 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, particularly those who grew up in rural communities in Canada.

2. Work Life Balance

Younger physicians place a higher priority on work life balance than their more senior colleagues (BCMA 2006; Task Force Two 2005). This is now common across most professions and industries, and generally considered a healthier, productive approach. Practices which demand higher on call schedules and less time away for vacation and education are less conducive to healthy balance. Group practices and availability of locum support ease the demands of rural practice and improve recruitment and retention.

If present trends continue, women are projected to make up 40% of the physician workforce by 2015 (Task Force Two, 2005). Women have a greater tendency to work part time for some period of their careers.

Partners and spouses are more likely to work outside the home than in the past. Spouses and children's needs impact location choices and feature prominently in physicians' career plans.

In cases where there is a limited number of physicians in a community, high on call schedules and limited time away, burn out is a serious threat. Communities and patients who wish to retain their physicians long term would have more success if they supported periods of leave for physicians with heavy practices.

Workload, working hours, and flexible working arrangements are now important to retaining physicians as in many other professions.

Recommendation 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.

3. Professional Infrastructure and Resources

Professional infrastructure and resources are prominent factors, including collegial support, time spent on call, access to specialists, allied health professionals, diagnostic tools, hospital, and support staff. Students in focus groups conducted in this review, stated strong preference for a community with a hospital and considered the availability of C-section essential. The sustainability of rural maternity care and surgical programs is deemed tenuous as infrastructure and support for low volume surgery diminishes (Iglesias, Caron 2007). Rural Review participants stated the importance of local access to imaging and diagnostic testing.

The unique characteristics of each rural practice are factors considered by candidates and, as to be expected, they vary from community to community and from candidate to candidate.

An existing office infrastructure diminishes the demand placed on a new physician to source equipment, supplies, staff, internet access and resources for a new practice. Participants in the review noted that some rural physicians desire autonomy and self determination, yet some new medical graduates are looking for “turnkey” opportunities, where everything is ready to start work the first day.

Younger doctors are far more likely to practice in group practices, while older doctors have a slight tendency towards solo practice (Task Force Two, 2005). Task Force Two’s report cites a growing interest in and willingness to develop collaborative, multidisciplinary practices.

Some physicians interviewed said the quality of care established in the community greatly influenced their choice to practice there. Again showing unique variations, one physician initially chose his community because there were no doctors there, providing an opportunity to collaborate with the Health Authority and build an interprofessional collaborative team which now has four doctors, a nurse practitioner, a chronic disease nurse, two case nurses, a mental health worker and other professionals. The weight given to professional infrastructure and resources appears high, even when initiated from scratch.

> **Recommendation 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.

Health Authorities have shown resilience in addressing the new challenges in recruitment, increasing their focus and staffing for physician recruitment. Ongoing efforts after the physician is recruited are needed to ensure career satisfaction and improve quality of service. From time to time, too little care and attention is provided after the recruitment.

Consultation with local physicians in developing physician resource and community care plans aids in keeping in touch. Medical administrators can and often do provide ongoing support to community physicians. Overall career planning, normally a key aspect of human resource management, benefits from a proactive approach, reducing the likelihood of sudden departures.

Recommendation 65:
That Health Authorities assess whether career planning support for physicians is being adequately resourced.

4. Community Involvement

In the past, recruitment of rural physicians relied heavily on the active involvement of the local physicians. Now, communities also are important in informing prospective physicians of the opportunities, environment and lifestyle considerations. Partners or spouses, children, recreation and leisure, cultural environment, isolation, resources and ultimately the quality of life are elements cited in BMCA's literature review as considerations made when choosing a community (BMCA 2006).The support of the community in the choice and transition to a new location is increasingly playing a visible role.

Local communities are becoming active participants in successful recruitment and retention of physicians. Eleven municipal representatives provided input to the Rural Review, and clearly stated their willingness to support rural physicians and health authorities. One BC community funded a residence for locums jointly with local physicians. Recent press reports cite Ontario communities providing housing and financial incentives up to $150,000 (National Post, 2008). These reports note, however, that financial incentives have less influence than other factors. Local communities increasingly participate in hosting visits by potential physician candidates, and informing them of local amenities and lifestyle considerations.

Municipal representatives participating in the Rural Review viewed their commitment to physician services as central to their communities' success. Both elected representatives and municipal officials demonstrated sensitivity and knowledge on the issues and efforts required to sustain physicians in their communities. Communities across the country participate more actively in physician recruitment.

British Columbia municipalities participating in the Rural Review stated that, in the past, they were sometimes held at arms length in physician recruitment. They invited health authorities to engage communities and work collaboratively. Similar to their goals to provide an attractive business climate, communities recognize that local amenities are important to attracting health professionals. They recommended that economic development offices be engaged in physician recruitment.

Recommendation 66:
That Health Authorities continue to increase involvement of communities in recruitment strategies, including mayors, municipal officials and economic development offices.

Recommendation 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.

Recommendation 68:
That Health Authorities, their Medical Directors, their specialists and communities actively contact and support locums providing service in their community to assess their interest in establishing a practice, and increase potential candidates awareness of physician infrastructure, resources and local amenities.

5. Co-ordination of Recruitment Efforts

Health Authorities have increased their endeavours in recruitment, particularly where the difficulty in filling a vacancy is severe. Staffing for physician recruitment has been increased in some areas. Historically, some participants in the Rural Review said when they were recruited, the Health Authority was either not involved or had almost a negative effect. Now, Health Authorities often play a co-ordination role, collaborating with local physicians, community organizations and the municipality.

Recommendation 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.

6. Recruitment of Senior Rural Physicians

Task Force Two states that the average Canadian physician is 48 years old (Task Force Two, 2005). They report that the retirement rate, based on findings from the National Physician Survey (NPS) data, for the next two years averages out to 3.1% per year. Regional population patterns differ, and the rate cannot be directly applied to BC's rural physicians. However, it suggests a significant number.

Recommendation 6 earlier in the report recommends a survey of long term physicians residing in RSA communities to seek an understanding of incentives to encourage ongoing or part time service. Recommendation 33 also suggests consideration of new approaches to recruit locums such as 'Adopt a Community' which may be attractive to senior physicians.

7. Financial Incentives

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. British Columbia's current suite of programs includes sound financial incentives, with incremental improvements recommended in this review.

As with all other Rural Programs, the Rural Review highlighted the need for improved data collection to support decisions and ongoing monitoring of outcomes and program effectiveness. A recommendation is provided later in the report that performance measures be defined for the recruitment programs and all Rural Programs, implementing data collection and a methodology to monitor and report program effectiveness.

3.10. Rural Education Action Plan

The Rural Education Action Plan (REAP) supports advanced skills training for physicians in rural practice, provides undergrad medical students with rural practice experience, and provides funds for rural physician participation into the medical school selection process.

REAP programs are managed and administered collaboratively by the BCMA and UBC, with the primary office location at UBC. Numerous initiatives have been added to the REAP program since its inception in 2000, under the leadership and management of BCMA and UBC.

A REAP program evaluation was funded by the JSC in 2006 to objectively evaluate the effectiveness of various REAP strategies at recruiting and retaining physicians to rural communities. The report is scheduled to be received in 2008.

The data below was provided by the BCMA and UBC's REAP program.

REAP Budget and Actuals 2006/07			
	2006/07		
	Budget	Actual	Variance
BCMA			
REAP - Funding to BCMA			
Medical School Selection Committee Faculty	54,000	10,594	43,406
Undergraduate Teacher's Stipend	30,000	1,200	28,800
Advanced Skills & Training			
Enhanced Skills & traineeships	1,042,661	1,216,562	-173,901
1st Year Practice Enhancement	61,000	62,680	-1,680
Urban Skills Enhancement	40,000	49,247	-9,247
Undergraduate Rural Practice Participation Program			
Medical Students Phase 3	290,000	271,974	18,026
Medical Students Phase 5	117,800	61,440	56,360
Sub-Total Program Budget	1,635,461	1,673,697	-38,236
High School Strategy	10,000	10,000	0
Specialty Training Bursary	50,000	50,000	0
BCMA Administration	97,500	131,008	-33,508
Research Position & Assistant	72,000	40,437	31,563
BCMA Sub-Total Program & Administration Budget	1,864,961	1,905,142	-40,181
UBC			
REAP Faculty Program	250,000	239,425	10,575
Administrative Support Program	90,000	75,823	14,177
Undergraduate & Postgraduate Promotional Strategies Program	35,000	30,833	4,167
Subtotal - UBC	**375,000**	**346,080**	**28,920**
MINISTRY			
Secretarial support to JSC	35,000	35,000	0
PROGRAM TOTALS	2,274,961	2,286,223	-11,262

REAP Program Components

1. Undergraduate Rural Practice Participation Program

The University of British Columbia manages this program for medical students, which provides $250 per week for up to 8 weeks and up to $800 travel stipend for undergraduate medical students wishing to gain rural practice experience.

The Undergraduate Rural Practice Participation Program has a combined budget of $1,635,461. Expenditures in 2006/07 were $1,673,697, 2% over budget.

Data provided by the REAP program shows undergraduate rural practice programs have increased in usage over the lifetime of the program.
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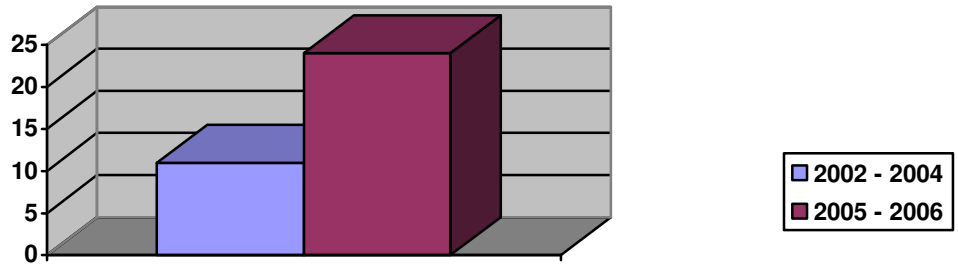
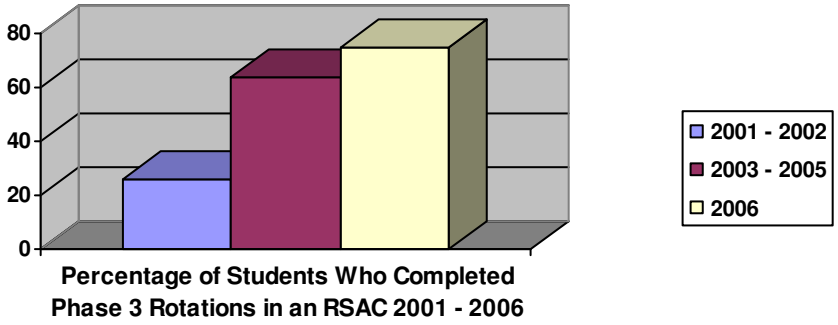
Phase 3 & Phase 5 Rotations 2002–2006:



Percentage of students who received REAP funding for both Phase 3 and Phase 5 Rotations 2002 - 2006

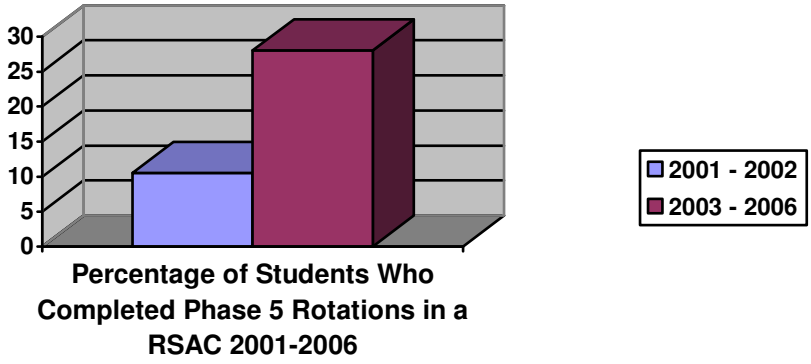
2002 – 2004 – 11%
2005 – 2006 – 24%
[1] As of 2007, Phase 3 and Phase 5 are now known as Year 3 and Year 4.
[1] Student numbers have been standardized.
Data and charts provided by Dr. Carl Whiteside, UBC

Phase 3 Rotations 2001–2006:



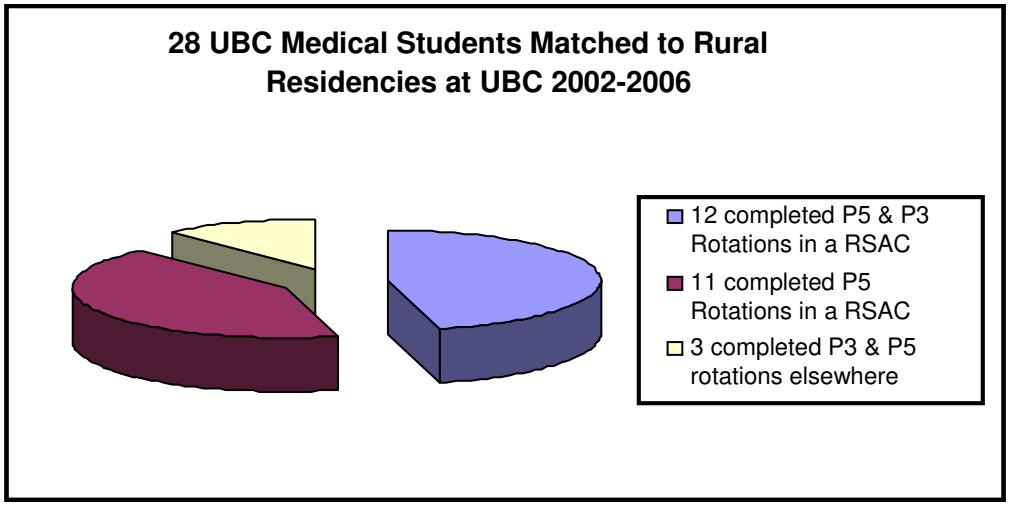
2001-2002 – 25.8%
2003-2005 – 63.7%
2006 – 75%

Phase 5 Rotations 2001 – 2006:



2001-2002 – 10.5%
2003-2006 – 28%

Undergraduate Rural Rotations and Application to Rural Residencies

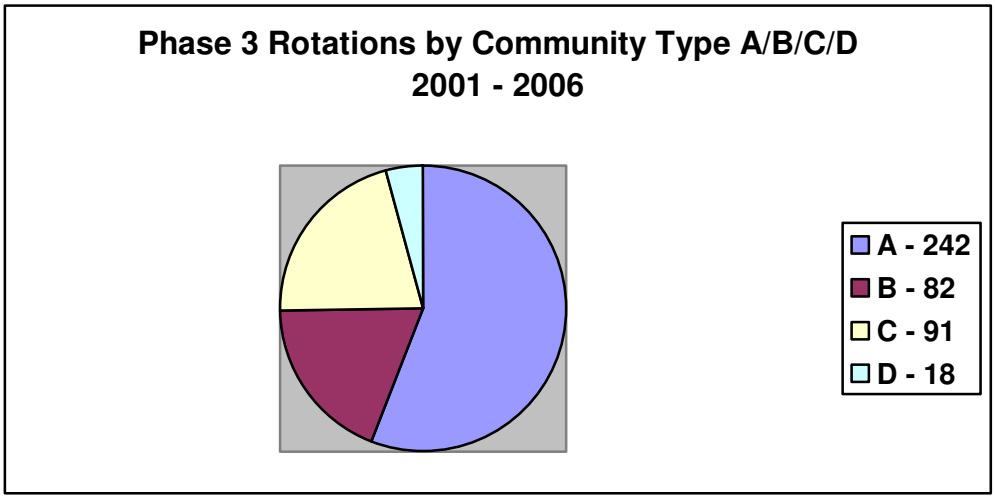


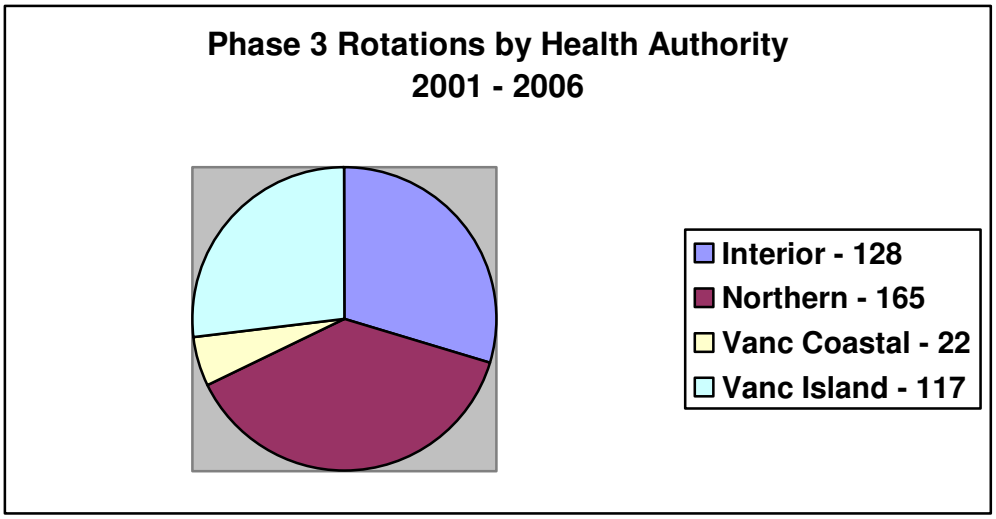
Of the 28 UBC medical students from grad classes 2002–2006 who matched to Rural Residencies at UBC, 23 (82%) completed a Phase 5 rotation in a RSAC. 14 (50%) of these residents completed a Phase 3 rotation in a RSAC.

Phase 3 Student Placement Information 2001–2006

433 medical students received REAP funding to pursue Phase 3 rotations from 2001-2006.

Students undertaking these rotations are able to obtain an authentic rural experience. Over half of the rotations took place in A communities.



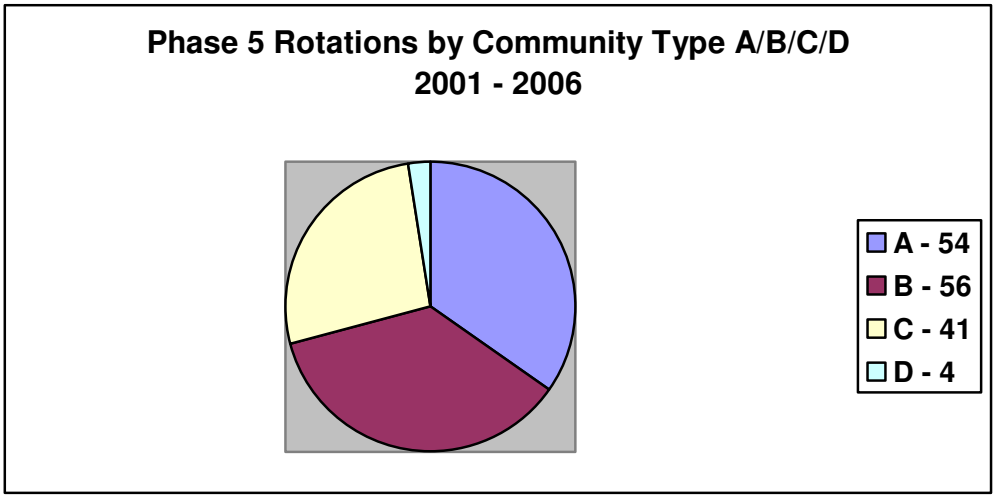


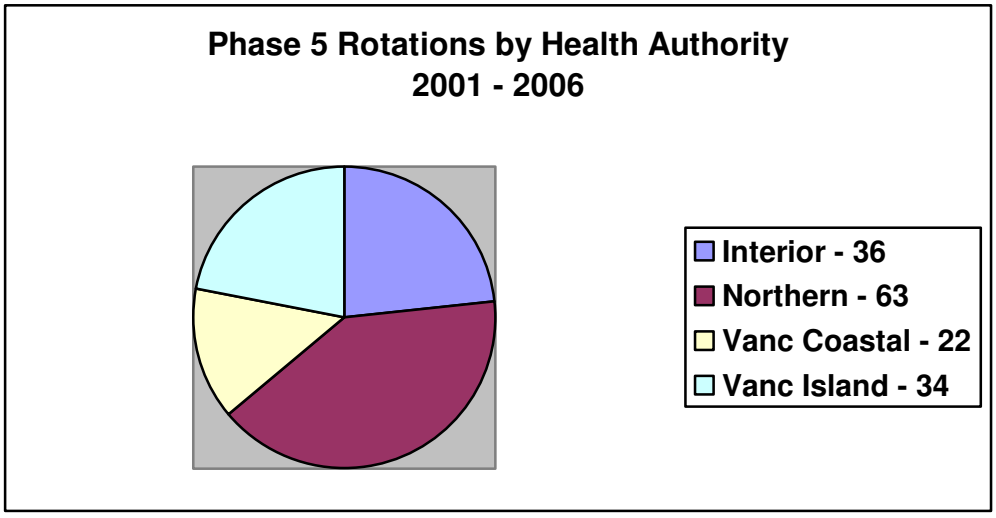
The majority of Phase 3 rotations took place outside of the Vancouver Coastal Health Authority.

Phase 5 Student Placement Information 2001-2006

155 medical students received REAP funding to pursue Phase 5 rotations from 2001-2006.

The majority of rotations took place in A, B and C communities.





2. Advanced Skills and Training

REAP funding for enhanced skills and traineeships is available to increase educational opportunities for rural physicians and training of locums. The program funds advanced training ranging from 1 week to 3 months. Funding for qualifying physicians will be applied to income loss, program tuition, travel expenses, and accommodation for the training period.

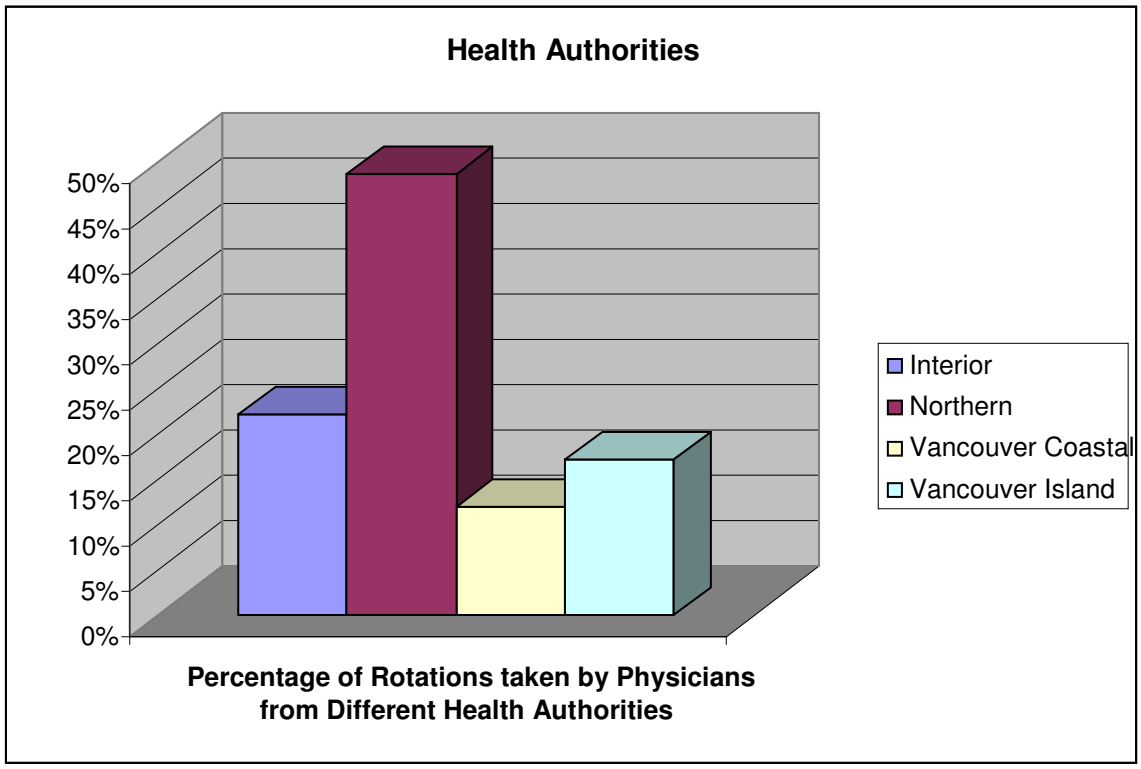
Rural Review participants viewed REAP's advanced skills training as highly positive, addressing the need for rural physicians to access special training for the broad demands of their practices.

Funding includes a stipend of up to $3,400 per week, up to $1500 travel costs for one return trip from a physician's community, and up to $1000 per week for accommodation.

From 2002-2007, 806 weeks were claimed through the Advanced Skills Training Program.

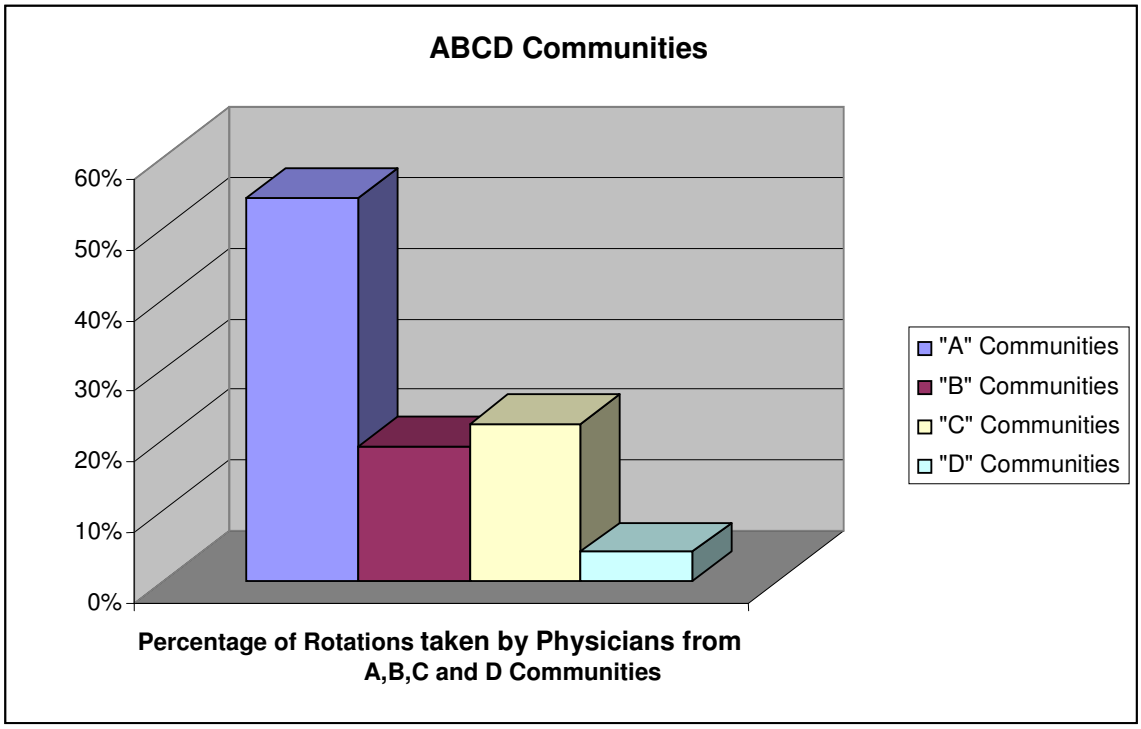
Weeks of training taken from 2002 - 2007 distributed among physicians practicing in the Health Authorities were:

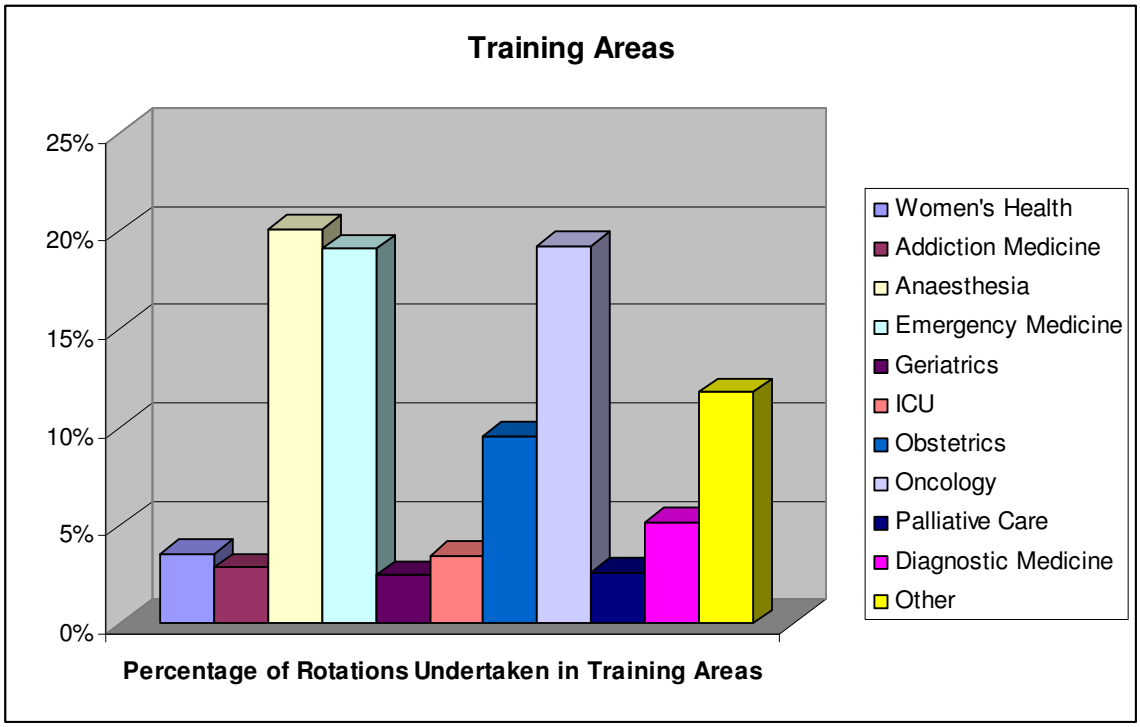
Northern Health Authority	49%	(392 weeks)
Interior Health Authority	22%	(179 weeks)
Vancouver Island Health Authority	17%	(138 weeks)
Vancouver Coastal Health Authority	12%	(97 weeks)



A – 54% (438 weeks)
B – 19% (154 weeks)
C – 22% (180 weeks)
D – 4% (34 weeks)

The majority of training (438/806 weeks) was taken by physicians practicing in “A” defined communities.





The training areas funded from 2002 – 2007 were:

Anaesthesia	20% (162 weeks)
Emergency Medicine	19% (154 weeks)
Oncology	19% (155 weeks)
Other	12% (95 weeks)
Obstetrics	10% (77 weeks)
Diagnostic Medicine	5% (42 weeks)
Women's Health	4% (29 weeks)
Addiction Medicine	3% (23 weeks)
Geriatrics	2% (20 weeks)
ICU	3% (28 weeks)
Palliative Care	3% (21 weeks)

Training areas classified under "Other" include paediatrics, cardiology, surgery and mental health.

The Enhanced Skills Program provides funding for 1 to 52 week training periods. It is the largest budget component of REAP's Advanced Skills. Budget in 2006/07 was 1,042,661 and expenditures were $1,216,571, 17% over budget.

First Year Practice Enhancement Program (FYPEP) and Rural Locum Service Upgrade are also components of Advanced Skills training. This makes funding available to those undertaking their first year in full-time rural practice in BC and those enrolled in the Rural Locum Service Program. A stipend of $3,400 per week is paid for 5 days Advanced Skills Training for every 1 one month of service within the first year. Budget in 2006/07 was $61,000 and expenditures were $62,680, 3% over budget

The Urban Skills Enhancement Program (USEP), another component of Advanced Skills training**,** makes funding available to physicians not living and practicing in rural communities, for the purpose of enhancing education so that a physician can qualify as a rural locum. Urban physicians who take advantage of the USEP must agree to provide rural locum services to an RSA community for a minimum of 4 weeks, within 1 year (12 months) of completing their training. Budget in 2006/07 was 40,000 and expenditures were $49,247, 23% over budget.

The three components of Advanced Skills Training have a combined budget of $1,143,661. Expenditures in 2006/07 were $1,328,489, 16% over budget.

Core services including anesthesia, surgery, obstetrics and emergency were highlighted by stakeholders throughout the Rural Review as critical to physician services and foremost to support in Rural Programs. In more remote or underserviced locations, time and cost barriers to advanced training are highest. Higher incentives based on isolation points are recommended to increase training in the core services as shown on the following page.

Recommendation 70:

That the Enhanced Skills Program provides 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:

Example of Increase in Core Service Enhanced Skills Funding			
Isolation Points	**Stipend up to**	**Travel up to**	**Weekly Accommodation up to**
> 40	$4,000	$1,200	$1,200
> 30 to 40	$3,800	$1,200	$1,200
> 20 to 30	$3,700	$1,200	$1,200
> 10 to 20	$3,600	$1,000	$1,000
6 to 10	$3,500	$1,000	$1,000
< 6	$3,400	$1,000	$1,000

3. High School Program

In 2006/07, REAP conducted several presentations to high schools in northern and south eastern British Columbia, with a goal to inform students of the opportunities that exist in rural health care, and encourage them to pursue a medical profession. The 2006/07 budget was $10,000 and expenditures were on budget.

Although the impact is difficult to measure, early exposure could influence career decisions. It is widely reported in research that physicians who were raised in rural communities are significantly more likely to choose and remain in rural practice (BCMA 2006).

Engaging the University of Northern British Columbia in northern high school visits has been initiated. More involvement of local physicians and medical students from UBC's Northern Medical Program, UBC's Vancouver Island Medical Program, and the Vancouver Fraser Medical Program can develop as the high school program evolves.

Stakeholders in the Rural Review acknowledged the importance of Rural Programs across the lifecycle, from high school through medical school and through a physician's practice.

4. Specialty Training Bursary

Two bursaries of $25,000 per annum are available to assist 2 positions in specialty residency programs. The resident must already have a funded position on an approved program and, in return, guarantee a return of service of 1 year for each year of bursary in a RSA community. Residents are only eligible in the last 2 years of their residency.

5. Undergraduate Teacher's Stipend

The Faculty of Medicine provides payment to physicians for the first 4 weeks of training. REAP provides a stipend of $300 per week to physicians in eligible rural communities who train medical students for above 4 weeks. Eligible physicians receive a lump sum payment from the BCMA upon completion of the student's placement.

6. Rural Physicians Participation in Medical School Selection Process

The objective of this program is to ensure an ongoing presence on the admissions selection, admissions policy selection, and the Northern and Island admissions committees to reflect rural medicine in the determination of medical school entry.

Recommendation 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.

Recommendation 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.

7. Undergraduate and Post Graduate Promotional Strategies Program

The University of British Columbia manages a rural club, which provides the opportunity for medical students and residents interested in rural practice to meet several times throughout their studies. REAP provides the funds to sponsor medical students and residents interested in rural practice to attend conferences including the WONCA Conference each year.

New REAP Programs Under Development

Seed money totalling $130,000 has been provided by the JSC for REAP to explore a rural co-ordination centre with a focus on interprofessional student placement programs. The objectives, programs and delivery models are under development.

> **Recommendation 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.

Awareness of REAP Programs

The BCMA Rural Survey found rural physician awareness of REAP limited to 55% and, of those, only 22% had made use of the program. Difficulty in taking time away from practice was cited as a barrier.

Most stakeholders interviewed in the Rural Review were aware of REAP, however it was evident that many individuals were not aware of the program components within it. None of the medical student residents participating in the focus groups in the Rural Review were aware of REAP`s programs

A recommendation to improve communication for all of the Rural Programs, including REAP, is provided later in the report.

Administration

The REAP program was piloted in 2002 and has been stewarded for its lifetime by a medical co-ordinator with strong knowledge of the programs and needs in rural education. Knowledge and understanding of REAP programs outside those directly involved in the program is limited. With the medical co-ordinator`s retirement upcoming, planning for succession is needed to ensure continued delivery and enhancement of REAP programs. Stakeholders participating in the Rural Review suggested that it would be timely to engage UBC's Northern Medical Program in REAP planning and delivery, taking advantage of guidance and participation by the current medical co-ordinator.

The BCMA Survey of Rural Programs (BCMA 2006) noted from its literature review that schools of medicine have been urban-oriented and prepare graduates for urban medicine. But new rural and northern based medical schools are demonstrating success in influencing practice locations. A recent study demonstrated that between two thirds and three quarters of graduates from rural and northern based medical schools in Ontario establish their practice in rural or northern areas (Heng 2007). UBC's Northern Medical Program, an integral part of the expansion of UBC's Faculty of Medicine, states its goal is to train physicians for northern and rural practice.

In two other provinces, Ontario and Manitoba, key components of Rural Programs for physicians are based in rural centres.

Engagement of UBC's Northern Medical Program in future REAP program design and delivery could strengthen REAP's link with rural oriented students and new rural medicine physicians. UBC's Northern Medical Program could collaborate with the Vancouver Island Medical Program and the upcoming medical school expansion into Kelowna for future programs, enhancing the already positive achievements of the REAP program.

Initiating this engagement with participation of the current co-ordinator would smooth the process and capitalize on his guidance and experience.

Recommendation 74:

That the JSC explore engagement of UBC's Northern Medical Program in the future design and delivery of REAP programs.

The overall staff and administration cost, including faculty, appears to be 20% of the program budget.

Recommendation 75:

That the JSC review the administration costs of REAP to determine if there are opportunities for cost savings.

As with all other Rural Programs, the Rural Review highlighted the need for improved data collection to support decisions and ongoing monitoring of outcomes and program effectiveness. A recommendation is provided later in the report that performance measures be defined for the REAP programs and all Rural Programs, implementing data collection and a methodology to monitor and report program effectiveness.

3.11. *Rural Programs Funding: Year over Year Budget vs. Actual*

Table and data below provided by the Ministry of Health, who advised that any discrepancies between this chart and others in the document may be due to expenditures recorded in fiscal years following budget.

	2005/06		2006/07		2007/08	
Program	**Budget**	**Actual**	**Budget**	**Actual**	**Budget**	**Projected Actual**
Payments Based On Agreement						
Recruitment Contingency	300,000.00	378,260.00	300,000.00	300,000.00	300,000.00	300,000.00
Isolation Allowance	600,000.00	600,000.00	600,000.00	600,000.00	600,000.00	600,000.00
GP Locum Program	1,850,000.00	2,309,881.26	1,850,000.00	1,850,000.00	1,850,000.00	1,702,441.00
Rural Education Action Plan (REAP)	2,250,000.00	2,157,901.78	2,250,000.00	1,296,667.00	2,250,000.00	2,250,000.00
Physician Outreach Program (POP)	1,946,000.00	2,131,706.86	2,051,000.00	2,051,000.00	2,701,000.00	2,745,024.00
Unallocated					1,850,000.00	-
Sub-Total	**6,946,000.00**	**7,577,749.90**	**7,051,000.00**	**6,097,667.00**	**9,551,000.00**	**7,597,465.00**
Payments Based on Utilization						
Specialist Locum Program	600,000.00	695,789.41	600,000.00	427,560.60	600,000.00	660,308.00
Recruitment Incentives	2,374,000.00	795,097.29	2,374,000.00	1,496,500.00	1,340,000.00	780,000.00
Rural Continuing Medical Education	3,700,000.00	5,432,406.64	3,700,000.00	4,907,525.00	4,700,000.00	5,136,600.00
Retention	45,735,000.00	52,561,012.76	48,735,000.00	56,295,214.75	52,552,706.00	55,273,059.00
Sub-Total	**52,409,000.00**	**59,484,306.10**	**55,409,000.00**	**63,126,800.35**	**59,192,706.00**	**61,849,967.00**
Total Rural Programs	**59,355,000.00**	**67,062,056.00**	**62,460,000.00**	**69,224,467.35**	**68,743,706.00**	**69,447,432.00**

Accruals Remaining	2005/06	2006/07
Recruitment Contingency	23,010.27	
Isolation Allowance		3.08
GP Locum Program		269,055.21
Rural Education Action Plan (REAP)	10,000.00	50,000.00
Physician Outreach Program (POP)		283,713.77
Specialist Locum Program		72,980.85
Recruitment Incentives		**172,477.02
Rural Continuing Medical Education	92,089.97	104,040.54
Retention	618,508.22	3,130,979.83

**Includes Recruitment Contingency as both are shown together in General Ledger

3.12. Communication and a Rural Office for Rural Programs

The suite of Rural Programs is comprehensive, targeted at recruitment, retention, support and continuing education. The point system defining rurality and the eligibility criteria for each program are justifiably complex. The comprehensive scope and complexity require an adequate level of resources for effective management, administration and communication. At this time, these resources are not well integrated across the programs. There are multiple points of communication across the Rural Programs. In some areas, such as the GP Locum Program, participants in the Rural Review felt the quality of communication was a major concern.

Other provinces have established organizations in rural locations. Ontario's Underserviced Areas Program is based in Sudbury and works with Community Development Officers located in Thunder Bay, Timmins, Goderich, Kingston, Collingwood and Sudbury. Their Rural Ontario Medicine Program is based in Collingwood, Ontario. Manitoba's Office of Rural and Northern Health is located in Dauphin, Manitoba.

Alberta's RPAP (Rural Physician Action Plan) and Ontario's ROMP (Rural Ontario Medical Program) are examples of organizations that establish early and constant communication with the medical students in the province and play a continued role in recruitment and retention programs. This continuity builds a sense of community and support for rural physicians.

Both Alberta and Ontario have a Rural Health Week to promote awareness among the students as well as the public.

Locum programs would benefit by being administered by a physician-oriented rural office, with improved personal communication and an on line locum registry as has been successful implemented in other provinces. Nova Scotia's Maritime Physician Recruitment Initiative (www.mpri.ca) and Alberta's Physician Link (www.ruralphysicianlink.ab.ca) are examples of well-integrated recruitment interface for those seeking and posting positions, both locum and permanent opportunities.

While the role of the Health Authorities in approval and processing of RCME funds should remain with them, the Ministry of Health's role in processing RCME physician designation forms from the Health Authorities could be performed by the rural office.

UBC's Northern Medical Program established in Prince George in 2004 places its focus on training physicians for rural and northern health. Affiliation of the Rural Programs with UBC's Northern Medical Program would add synergy by collocation with a program which has already established a rural focus.

As mentioned earlier in the report, the retiring Medical Co-ordinator of REAP`s depth of experience would be valuable in engaging UBC's Northern Medical Program.

> **Recommendation 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.

An overall communication strategy would provide guidance to the JSC on ways to ensure physicians are aware of the benefits of Rural Programs, understand how to access the multiple programs, and aware of the policies of the JSC. The rural physician community would feel a greater sense of stability and support if they were better informed. The Rural Programs Handbook was a good step forward in providing quick reference for physicians, and will continue to be useful as it is updated with program changes.

For the future, other media and forms of communication, particularly the internet and peer to peer networking opportunities, could be explored. A communication strategy could be developed to address objectives, target audiences, priority themes and channels such as newsletters, events, displays, printed, electronic and web based materials.

> **Recommendation 77:**
> That the JSC develop a comprehensive communication strategy, including objectives, target audiences, priority themes and channels such as networking, newsletters, events, displays, printed, electronic and web based systems.

The community of rural doctors in British Columbia play key roles in rural medicine, both in the delivery of physician services and in the development of their practices. At Visioning Day in the Rural Review, physicians and other stakeholders described ways they have addressed their challenges, for example in recruitment, in building group practices and providing locum support to neighbouring physicians.

Opportunity for rural physicians, Health Authorities and communities to provide more detailed presentations on their successes and learnings could be provided on an annual basis. The JSC has supported the annual conference of the BC Chapter of the Society of Rural Physicians. While the BCSRP conference is often clinically focused, an added evening or day for presentations on successes, such as those brought forward on Visioning Day, could showcase their learnings. Similarly, Health Authorities and communities could share experiences with recruitment strategies.

Communication and a Rural Office for Rural Programs
(continued)

Recommendation 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.

In addition to their work in rural medicine, rural physicians contribute to the quality of rural life in many unique ways. Recognition of these contributions and professional work helps to demonstrate the value British Columbia places on rural physician service.

Recommendation 79:
That the JSC provide annual awards in recognition of the contributions of rural physicians.

3.13. Policy Development and Planning for Rural Programs

The Joint Standing Committee (JSC) is required to meet a minimum of six times a year, and is mandated to enhance the delivery of rural healthcare in accordance with the duties imposed and the powers conferred by the Subsidiary Agreement for Physicians in Rural Practice. The current membership of the JSC has strong experience and expertise in rural physician programs and includes representatives who are practicing physicians, Health Authority administrators, and Ministry of Health and BCMA staff.

The JSC holds a key role in advising the government and the BCMA on programs to enhance availability and stability of physician services in remote and rural areas. Both the expertise among members and that which each can draw from the stakeholders they represent is well grounded for input on policy development and planning for Rural Programs.

The JSC also considers all case reviews and appeals concerning rural funding allocations and eligibility for individual communities and individual physicians. Exceptions, marginal or contentious cases are brought before JSC meetings. Examination of these cases has contributed positively to the evolution of British Columbia's Rural Programs over the years. The unique requirements of rural communities justifiably demand detailed policy discussion.

At the same time, heavy JSC agendas limit time available for examining long term policy options or innovation as input to strategic planning by the Ministry and the BCMA.

Structured Strategic Planning for Rural Programs

Structured strategic planning sessions are needed to tap the planning capabilities of the JSC. 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. As outlined previously, the BCMA identified five major themes that have an impact on physicians' recruitment and retention: physician background, professional issues, lifestyle, attitudes toward rural and general practice and community involvement in recruiting new physicians (BCMA 2006). Interviews and input to the Rural Review confirm these themes and highlighted the importance of infrastructure and resources such as diagnostics services, specialist support, health care facilities and allied health professional teams. Undergraduate and post graduate training was also highlighted. The impacts of these and other themes and trends highlight the need for JSC to undertake structured planning sessions on a regular basis as a way to ensure the Rural Programs are proactively responding to the changing environment.

For joint planning, Health Authorities play a key role. Their work in physician supply planning, recruitment, establishing professional environments, collaborating with communities and administering some components of Rural Programs is central to Rural Program planning.

Recommendation 80:
That the JSC consider ensuring that Northern Health Authority, Interior Health Authority and Vancouver Island Health Authority are all represented in the JSC membership.

Recommendation 81:
That structured annual planning and policy development sessions for Rural Programs, hosted by the Ministry and the BCMA, be held with attendance by the JSC and at least two representatives from each Health Authority which have RSA communities.

Physician Supply Plans

It is desirable that the distribution of physician specialist services is guided by the availability of informed physician supply plans developed through a reasonable planning process. This should have a positive impact on the ability of residents to access physician services. Physicians, medical directors, Ministry of Health representatives and Health Authority administrators participating in the Rural Review highlighted the need to improve the quality of physician supply plans. Because physician supply plans factor in eligibility policies in the RSA's programs, the quality of the plans affects the effectiveness of the programs.

Recommendation 82:
That guidelines be provided to the Health Authorities for developing physician supply plans as part of community care plans.

Recommendation 83:
That physician supply plans be developed by Health Authorities as part of overall community care plans for each rural community.

Recommendation 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.

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Recommendation 85:
That Health Authorities, in their development of physician supply plans, consider input from local communities and physicians on local needs, trends and community plans.

To facilitate increased strategic planning and policy development, added staff support for the JSC and for planning sessions will be required. Improved advance planning and briefing documents for JSC agenda items, especially case reviews and appeals, would also make JSC meetings more efficient and allow more time for discussion of policy and innovation on a regular basis. Research and background information for strategic planning could be delegated to staff by the JSC.

Recommendation 86:

That MOH and BCMA staff support for the JSC and for planning be increased.

Recommendation 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.

Performance Measurement in Rural Programs

The purpose of the Rural Review was to assess the effectiveness of Rural Programs under the mandate of the JSC in achieving appropriate levels of physician services in communities in which such programs are applicable. Data made available for the Rural Review provided some useful information about usage of the programs. The BCMA rural survey (BCMA 2006) provided input regarding awareness and usage of physician programs. Qualitative input was provided by interviews, medical student focus groups, a facilitated group consultation and a cross country review conducted in the Rural Review. All of these sources made valuable contribution to the recommendations herein.

Stronger performance measurement is required to support future planning. It is clear the programs target the recruitment, retention and education of rural and remote physicians and, accordingly, physician services to patients. But determining whether the programs achieve their intended purpose requires a deeper, ongoing performance measurement strategy.

A key to assessing effectiveness is how the program defines its success, and thereby measures, monitors and reports the outcomes. These elements of performance management need to be developed for Rural Programs. Ways to evaluate success that go beyond awareness of the programs and usage, and address whether the programs reduce the burden on rural physicians as well as improve services to patients should be considered.

The JSC has reviewed their programs periodically over the years. With improved data collection and analysis, recruitment and retention can be monitored on an ongoing basis. Input from health authorities on trends and changes in recruitment and retention will add significantly.

Recommendation 88:
That a performance measurement strategy be developed for each Rural Program, establishing definitions of success, desired impact, measurement indicators and reporting.

Data to analyze effectiveness of Rural Programs is not easily accessible from existing sources. Data on ways benefits are differentiated among physicians and communities is limited. Improvement of data collection and ease of analysis would go hand in hand with a performance measurement strategy. The JSC has allocated funds in the next fiscal year to address the need for planning and decision support.

Recommendation 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.

Recommendation 90:
That regular performance reports on each Rural Program be provided to the Joint Standing Committee on a quarterly basis.

4. Methodology

The JSC designed the Rural Review to consist of

1. Information from the 2006 BCMA rural physician survey
2. Interviews of members and staff support of the Rural JSC
3. Interviews of physicians on the BCMA Rural Issues Committee, and a representative of the College of Physician and Surgeons
4. Interviews of a sample of senior Health Authority representatives, a sample of rural mayors, and a sample of rural physicians
5. Two focus groups of BC medical student and residents, one in Chilliwack and one in Prince George, regarding ways to encourage them into rural practice
6. A "Visioning Day" with stakeholders
7. A quantitative analysis of data available on utilization rates in the various Rural Programs.
8. A cross country review
9. Information available on Rural Program budgets/expenditures

The methodology was predominantly qualitative, including interviews, focus groups, a facilitated stakeholder consultation and a review of programs in other provinces. The Rural Review also included analysis of limited data available on program utilization, budgets and expenditures. The review and report were completed by Harbour Peaks Management Inc. The project steering committee was appointed by the JSC.

Programs Reviewed

The nine existing Rural Programs were reviewed:

1. Rural Retention Program (RRP)
2. Isolation Allowance Fund (IAF)
3. Northern & Isolation Travel Assistance Outreach Program (NITAOP)
4. Rural GP Locum Program (RGPLP)
5. Rural Education Action Plan (REAP)
6. Rural Continuing Medical Education (RCME)
7. Recruitment Incentive Fund (RIF)
8. Recruitment Contingency Fund (RCF)
9. Rural Specialist Locum Program (RSLP)

Interviews

Interviews were conducted to explore stakeholders' views on what is currently working well, what can be improved, and suggested innovations in the Rural Programs. Interview candidates were identified by the Ministry of Health and the BCMA, and were comprised of

- Members and alternate members of the Joint Standing Committee, seven of whom are rural physicians, one of whom is a Medical Director, four of whom are Ministry of Health representatives, and two of whom are Health Authority representatives
- Practicing rural physicians
- MOH staff
- BCMA staff
- Health Authority administrators who are physicians
- Health Authority administrators and staff
- Mayors of rural municipalities
- Municipal official

In total, over 60 interviews were conducted. Interviews were conducted in person and by telephone between early October 2007 and end of January, 2008. Places of residence and practice were geographically spread across four health British Columbia health authorities. In Northern Health and Interior Health, about twice as many were interviewed as in Vancouver Island Health and Vancouver Coastal Health.

Focus Groups

Two focus groups of medical students and residents were conducted, one with eight participants in Chilliwack and one with twelve participants in Prince George.

Visioning Day

A Visioning Day was conducted at the Bayshore Hotel in Vancouver in January 2008, with over seventy participants including:

- Thirty four rural physicians,
- Eight JSC members (six of whom are rural physicians),
- Seven municipal mayors,
- One municipal councillor,
- Two municipal officials,
- Eight health authority administrators
- Thirteen staff from the Ministry of Health and the British Columbia Medical Association.

A full group, open feedback session was conducted for three hours in the morning, followed by two and a half hours breakout groups focused on each of the nine Rural Programs. Ideas and input were transcribed by the BCMA with assistance from the Ministry of Health, and made available to all participants.

Quantitative Data Analysis

All data was provided by the Ministry of Health, the BCMA and UBC's REAP program. In general the data was developed to support the day to day administration of the Rural Programs. As such the spreadsheets provided did not support a thorough assessment of utilization trends by community, Health Authority, community type (A,B,C,D), or by physician type (General Practice and each of the Specialist areas). It was not possible to associate the available utilization data to physician payments. As a result of these shortfalls, there is a general understanding by the Joint Standing Committee the available data does not lend itself to meaningful trend analyses that would support policy recommendations. In recognition of these shortfalls, the Ministry of Health has recently embarked on the initiative to develop a comprehensive, linked data base. Some preliminary utilization data has been shared with the Joint Standing Committee.

Limitations

It should be emphasized that the methodology for the Rural Review was primarily qualitative, complemented by a quantitative analysis of data available from the Ministry of Health and the British Columbia Medical Association. Data available for each program varied.

The Rural Review findings are based predominantly on stakeholders input and expertise, combined with the data available at this time. Nevertheless, the findings provide compelling insight into rural physician recruitment and retention, given the number of participants, the depth of expertise and experience among participants, the review of other provinces programs, use of the data available, as well as the quantitative BCMA survey of rural physicians (BCMA 2006).

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.

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:

- 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 if 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 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.

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 tree 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

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

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

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.

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Appendix A Cross Country Review

A.1 Cross Country Review Summary:

A high-level review of the programs offered by other provinces and territories within Canada was undertaken to asses whether BC's programs were similar in breadth of coverage and benefits to other provinces. Best practices or alternative ideas were identified for consideration by the JSC as it continues to evolve its existing programs or create new ones.

Breadth of programs: The breadth of programs offered in British Columbia meets or exceeds that found by other provinces. There is strength in the overall balance between a focus on supporting education (both of new physicians and practicing physicians), along with improving the work life and financial remuneration to those who are consistently providing patient care in rural and remote areas. Gaps identified compared to program offerings in other provinces include programs focused on older physicians, and retention incentives based on years of service.

Competitiveness of Benefits: The benefits offered in comparable programs were reviewed at a high level. In addition, alternative practices were noted in terms of the program options, administration or trends. These include:

Benefit type	
Tuition/Debt Relief Programs	• Flexibility of Return of Service Options • Increased focus on recruiting rural students for medical school admission
Recruitment	• Candidate and Spouse Visit Programs • Programs to support skills assessment and licensing • Moving Costs/Relocation Grants • Strong supporting internet sites and technology
Undergraduate/Post-Graduate Medical Education	• Provide housing to Support Rotations, Residencies • Increase exposure to rural practice in medical school
GP & Specialist Locum Programs	• Explore synergies between locum services and other programs • Strong customer service orientation of the locum organizing body • Explore weekend locum options • Utilize templates for locum contracts • Implement evaluation processes
Continuing Medical Education	• Consider simplification of program administration • Explore options for coordinated planning for Rural CME • Bringing Learning Opportunities to the Physician

Definition of Rural Areas: A relatively small number of provinces have a rating scale or set of criteria applied which results in a "points" scoring such as used in BC. Ontario has developed the Rurality Index of Ontario (RIO), and Alberta has Rural, Remote Northern Program (RRNP) which is modeled directly on BC's RRP model.

Alternative ideas for consideration: Throughout the course of research, the following programs or initiatives were deemed to be of note or interest to the work of the JSC:

- Experience with "Part-Time" Definitions
- Building Public Awareness of Rural Medicine
- Approaches for classifying General Practitioners
- Pension Programs
- Programs targeting International Medical Graduates

A.2. Approach

In order to benchmark British Columbia's programs within the Canadian context, a high-level review of the programs offered by the other provinces and territories within Canada was undertaken.

The key objectives were:

1) To determine whether BC's Rural Programs were ***comparable in scope*** to provinces with similar geography or within close proximity to BC – given that theses provinces likely draw upon the same pool of physicians for programs such as locum programs;
2) To identify where BC may need to adjust its benefits or incentive programs in order to **re*main competitive*** in the Canada; and,
3) To identify ***best practices*** from other provinces which the JSC may wish to consider as it continue to evolve its existing programs or create new ones.

The review included review of government websites and associated "grey" literature. Where additional information was required, individuals at various provincial Ministries of Health or Medical Associations were contacted for further clarification.

A limitation on the scope of this review was the limited availability of English-language publications for the province of Quebec. Therefore, rather than under-represent the scope of programs available in that province, it has been excluded for the purposes of this review.

A.3. Breadth of Programs Compared to Other Canadian Provinces

Overall, the breadth of programs offered in British Columbia meets or exceeds that found by other provinces. There is strength in the overall balance between a focus on supporting education (both of new physicians and practicing physicians), along with improving the work life and financial remuneration to those who are consistently providing patient care in rural and remote areas.

The following chart (next page) summarizes the types of programs offered by provinces and territories within Canada to recruit and retain rural physicians.

Some areas of strength in terms of breadth of programs include:

- A comprehensive approach to supporting undergraduate and postgraduate rural placements: BC's programs clearly create a strong base of exposure to rural practice. The focus of providing benefits to both the preceptor and the student is a good balance which is not found in other provinces.
- While not formally within the set of programs covered by the Rural Subsidiary Agreement, the Family Practitioners for BC (FPs4BC) program ensures that BC is staying competitive against other recruitment incentives offered to new graduates.
- Programs such as NITAOP, which target the provision of service to remote communities through visits, are not very common in other provinces. Ontario has a similar program, as does Manitoba with its "fly in" program.
- BC's scope of continuing education, re-training and re-entry programs are comparable to those offered in other provinces of its size and scope.

Summary Table: Scope of Benefits

	Type of Program	BC	AB	SK	MB	ON	NS	NB	PEI	NF	YK	NWT
Training (Undergrad/Postgrad)	Tuition Reimbursement	●	●	●	●	●	●	●	●		●	●
	Undergraduate Placement Support	●	●	●		●		●	●	●	●	●
	Postgraduate Placement Support	●	●	●	●	●		●	●	●	●	●
	Housing Services/Reimbursement		●			●					●	
	Student Conference/Education Grants					●		●				
	Honorariums for Undergraduate Teaching	●										
	Student Summer Programs/Experience		●			●	●	●	●	●		
Recruitment	Recruitment Bonuses	●	●	●		●		●	●		●	●
	Visit Programs		●			●			●			
	Relocation Funds (*separate from other recruitment programs)*			●			●		●		●	
	Incentives targeted to first-year or early years of practice	●	●	●	●		●	●	●		●	
Retention Initiatives/ Bonuses	Rural/Remote Top-Ups/Premiums	●	●			●	●			●		●
	Premiums tied to ER or other services					●		●				●
	Retention Bonuses *(based on years of service)*		●		●	●				●	●	
	Vacation Leave											●
	Paid Parental/Maternity Leave	●	●		●	●		●				●
	Sick Leave											●
Locums/Coverage	Locums - GP	●	●	●	●	●	●				●	●
	Locums - Specialist	●	●			●						
	Visiting Specialist Clinics	●		●		●						
	Visiting GP/Primary Care Clinics	●				●						
CME	Financial Reimbursement for CME	●	●	●	●	●	●				●	
	Skills Enhancement opportunities for practising MDs	●	●	●	●	●			●		●	
	Training programs targeted at early career MDs	●		●								
	Urban/Rural Cross-Training	●										
	Allowance for Textbooks/Journals											●
Other	Awards		●									
	Pension/Retirement Plan											●
		BC	AB	SK	MB	ON	NS	NB	PEI	NF	YK	NWT

Note: Information about Quebec's programs was not available at completion of this report and was provided separately.

Given that each province's set of programs reflects a current negotiated agreement which is in place for several years, one must recognize that there may be time delays before a province is able to address an emerging issue or trend in its next negotiation. For this reason, some provinces have added new foci to their programs or enhanced benefits to certain target groups. While a discussion of nuances or competitive issues within comparable programs can be found in the following section, there are a couple of key gaps which are of particular note:

Retention of Older Physicians
As the physician supply challenge continues to increase, the continued participation of older physicians in the system will be an important source of teaching expertise and service. Alberta has a *Seniors' Weekend Locum Program* which is open to physicians over age 54 who have practiced in Alberta for over 9 years, and are in a community with less than 16 physicians. This program offers additional locum coverage to further reduce or eliminate their weekend call.

Retention Bonuses
While BC has flat fee bonus payable within the Rural Retention Program, variations on this theme have emerged in various provinces. Alberta has launched a new Retention Benefit program which is based on the number of years of service, with four categories (ex. 1-5 years, 6-15, 16-25, and 26+ years). This type of program is also in effect in the Northwest Territories, Newfoundland and Yukon, but with an earlier maxing out of the scale of benefits (either at 3 or 4 years). Ontario's Physician Retention Initiative also presents with a similar benefit which is based on a minimum number of 4 years of continuous service. What differentiates these retention bonuses from the RRP is that the bonus is a generally predictable amount, and creates an incentive for continuous service.

A.4. Comparisons of Similar Programs

In situations where there are comparable programs within other Canadian provinces, some of the key eligibility criteria and benefits have been evaluated against those offered elsewhere to assess BC's competitiveness within the Canadian market for physicians. While this is not meant to act as an exhaustive comparison of all aspects of the program, it does highlight certain areas which may merit further consideration as BC continues to shape its programs.

Throughout the course of completing the cross-country review, a number of different ideas were noted as "food for thought" for the JSC as it considers which types of investments it wishes to make in future programs. These are nested within this thematic discussion.

Tuition/Debt Relief Programs

Most large provinces offer a tuition reimbursement program. There are variations in the amount per year, but most are approximately $10,000 per year for medical school, and $15,000 per year of residency. BC's Family Practitioners for BC (FPs4BC) program does not fall within the scope of this review, however, it is important to note a few findings when reviewing these programs and their impact on recruitment to rural areas.

A Return of Service agreement is almost universal in these programs. Most require one year of service for each of tuition paid. Feedback from focus groups of family practice residents in this review was that the return of service commitment can be deterrent because it forces an early choice in community. BC has been strategic in the use of 3 years return of service for the $40,000 portion of the FPs4BC grants – which will give BC competitive edge in this area.

Flexibility of Return of Service Options

It is of interest that Saskatchewan has developed alternatives for completion of return of service to create options for the candidate. Those who receive grants in Saskatchewan can return their service in one of the following ways: (for each year of tuition received)

- 8/12 months in a rural community, OR
- 16/24 months in a regional centre, OR
- 6 months in the Rural Relief Program (locum)

This type of approach may address some of the concerns of residents and young practicing physicians who wish to maintain some flexibility early in their career.

Increased focus on recruiting rural students for medical school admission

Alberta appears more aggressive than other provinces in specifically targeting rural students for coverage of their medical school tuition through their two awards – the RPAP Medical Student Bursary, and the RPAP Medical School Award. It has been demonstrated that there is a relationship between the origin (rural or urban) of medical students, and where they decide to set up practice.

Recruitment Benefits

Prior to the launch of the FPs4BC program, BC's rural recruitment bonuses ($10,000 offered under Recruitment Incentive Fund) did not fare well compared to other provinces. With this program now in place, some of the following observations may be moot. However, FPs4BC is currently a one-time funding initiative, and therefore it may be wise to be fully aware of the impact of its discontinuation, should it occur. Other provinces are more competitive in the following ways:

- Ontario's Incentive Program provides payment of $40,000 over 4 years, which provides some longevity to the benefit. New Brunswick offers $50,000 per GP with only a 3 year return of service agreement.
- The Northwest Territories offers differential benefits depending on the length of service, which creates an incentive for a longer commitment

- Some provinces provide a cushion in the first year in terms of guaranteed earnings (ex. New Brunswick), or exempt certain physicians from billing caps in their first year of practice (Ontario).

Some of the services or trends noted in other provinces include:

Candidate and Spouse Visit Programs:
Programs which encourage visits by clinicians to a potential employer community. Ontario's *Community Assessment Visit Program* (administered by UAP) reimburses health care professionals and their spouses for travel and accommodation expenses within Ontario to visit a designated underserviced community to assess practice opportunities. Air travel from the point of entry into Ontario (Winnipeg or Montreal) or Toronto is covered, as well as standard accommodation costs. Alberta has a similar program which pays up to $3,000 for an interview visit.

Programs to support skills assessment and licensing:
In Alberta, there is a program where honorariums are paid for both Candidates and Assessors in situations where the candidate has been asked by the College to undergo assessment for licensure or approval of additional skills/privileges. The payment is $1,500/week up to a maximum of $6,000 per candidate for new recruits, and $500/week up to a maximum of $2,000 for currently practicing rural physicians. This program encourages candidates to take time out of practice to upgrade skills.

Moving Costs/Relocation Grants:
Some provinces offer grants which are dedicated to addressing relocation costs (NWT, Saskatchewan). Should the FPs4BC program be made a permanent program, some consideration could be given by the JSC to refocus the "Recruitment Incentive Fund" as a Relocation Fund.

Strong supporting internet sites and technology:
Nova Scotia's Maritime Physician Recruitment Initiative (www.mpri.ca) and Alberta's Physician Link (www.ruralphysicianlink.ab.ca) are examples of well-integrated recruitment interface for those seeking and posting positions, both locum and permanent opportunities. All opportunities to increase the transparency of the recruitment process, provide community information and ease the process will increase BC's competitiveness for reaching the newly-graduated physician who is accustomed to the internet as a primary search tool.

Undergraduate/Post-Graduate Medical Education

As discussed previously, the breadth and benefits of BC's medical school and residency programs are very strong, and there is little variation from province-to-province in terms of overall stipends or cost reimbursement for rotations and residency, although some are "marketed" as stipends, and some "marketed" as travel and accommodation cost reimbursement.

However, while the components are strong, it seems that other provinces have models of organization and administration for these programs which improve the clarity of communication, transparency of application processes, and student knowledge of the programs. Alberta's RPAP (Rural Physician Action Plan) and Ontario's ROMP (Rural Ontario Medical Program) are examples of organizations that establish early and

constant communication with the students in the province. It is important to note that having a focal point such as RPAP or ROMP is also important for students external to the province who may be considering electives or seeking CaRMS matches in other provinces.

Some of the supporting services or trends noted in other provinces include:

Housing to Support Rotations, Residencies
RPAP has a housing service in which up to 42 properties are managed by RPAP in placement communities. Similarly, the Rural Ontario Medical Program provides a coordinating function which allows for individuals in the communities to list their rental property with ROMP, and pay them directly for the rent to minimize administration. In addition, some free properties are available for placements for which there is no reimbursement available (ex. pre-clerkship placements). A service such as this breaks down barriers to the short-term move for potential recruits and will provide a favourable impression of the community and the province.

Exposure to rural practice in medical school
Rural placements are mandatory within Alberta. This is also supported by other types of short-term, low-commitment opportunities to gain exposure to rural settings through tours and skills days organized by the 2 universities. Students can also sign up to shadow a rural clinician for a weekend.

GP & Specialist Locum Programs

All provinces have some form of GP locum program, but the scope of the program may range from simply providing some funding to offset annual locum costs (ex. Yukon), through to fully developed locum programs which provide the recruitment and administration for locums. The comparable large scale programs are in Alberta, Saskatchewan, Manitoba, Ontario, and the Northwest Territories. Specialty locum programs are less well-developed in Canada, with fewer provinces providing the service.

A table providing a synopsis of locum benefits, compared across provinces is provided. (Source: S. Walker, MOH)

2007/08 Canadian Rural GP Locum Programs by Geographic Location

	BC	Alberta	Saskatchewan	Manitoba	Ontario	NS	NFL	Yukon	NWT
Budget	1.85 million	Unknown	Unknown	$819,526.00	No specific budget	$1,000,000	NA	$200,000	No budget
Locum maximum request (days) per year	28	28	No maximum	40	37/21	28	None	Undefined	Undefined
Minimum days requested	5	5	4 to 12 days	None	5	0.5	1	Undefined	No minimum
Daily rate guaranteed	$750	$800	No daily rate	$825 max.	Up to $800/day	$510	$662	$1979/fiscal	$900 - $1200
Travel honorarium maximum per trip	$600	Yes	No	$200 max.	Up to $500/day	$.3987/km	None	$250/day	Yes
Host Physician retain for overhead	40% FFS	30% FFS	30%	$150/day FFS	Negotiated	$160/day FFS	NA	Undefined	NA
Travel expenses paid	Yes	.48/km	Mileage only	Yes	$.44/km	Mileage only	Yes	Yes	Yes
Accommodation provided	Yes	Yes	Yes	Yes	Yes	None	Yes	Yes	Yes
Certificates needed	Fully Licensed	Fully Licensed	Fully Licensed	Fully Licensed	Fully Licensed	Fully Licensed	NA	Fully Licensed	Fully licensed

2007/08 Canadian Rural Specialty Locum Programs by Geographic Location

	BC	Alberta	Saskatchewan	Manitoba	Ontario	NS	NFL	Yukon	NWT
Budget	$600,000	Unknown	NA	$819,526.00	No specific budget	$1,000,000	NA	$200,000	No budget
Locum maximum request (days) per year	28	28	NA	40	37/21	28	None	Undefined	Undefined
Minimum days requested	2	5	NA	None	5	0.5	1	Undefined	No minimum
Daily rate guaranteed	$1,000	$1,500	NA	$825 max.	$590	$1,000	$782	$1979/fiscal	$1,550
Travel honorarium maximum per trip	$1,000	$250 each way	NA	$200 max.	Up to $500/day	$.3987/km	None	$250/day	Yes
Host Physician retain for overhead	40% FFS	30% FFS	NA	$150/day FFS	Negotiated	None	NA	Undefined	NA
Travel expenses paid	Yes	$.48/km	NA	Yes	$.44/km	None	Yes	Yes	Yes
Accommodation provided	Yes	Yes	NA	Yes	Yes	Yes	Yes	Yes	Yes
Certificates needed	Fully Licensed	Fully Licensed	NA	Fully Licensed	Fully Licensed	Varied	NA	Fully Licensed	Fully Licensed

Source: S. Walker, BC Ministry of Health

The locum programs' benefits to ***host physicians*** are competitive in the following areas:

- BC's GP Locum program compares favourably with respect to its eligibility criteria for the program (7 or few physicians). Many other provinces impose stricter criteria which render the program inaccessible unless you have less than 3-5 physicians in a community.
- Similarly, BC's Specialist locum program has a lower threshold for enabling specialists to obtain locum coverage. This compares favourably to Ontario, for example, where if a community has more than 3 specialists, the locum program only offers travel costs and minimal accommodation costs to the locum physician. Therefore BC specialists have a competitive edge in attracting specialist locums.
- The overhead percentage allocation to the host physician to cover overhead costs exceeds that of other provinces. (With the caveat that this is negotiated individually in Ontario).

However, there are issues with respect to the competitiveness of the benefits in the following areas.

- The number of days available annually through the plan (28) is comparable to Alberta, but falls short of the much higher allowances of Manitoba (40) and Ontario (37). Based on consultation with key BC stakeholders, this is a key issue for host physicians.

The locum programs' benefits to ***locum physicians*** are competitive in the following areas:

- The GP Locum per diem rate offered by BC ($750) is lower than its immediate neighbours of Alberta ($800), Northwest Territories ($900-$1,200) and Ontario ($800).
- The gap is larger in the Specialist locum program with BC's rate of $1000 per day being dwarfed by rates of $1,500 in Alberta, and $1,550 in Northwest Territories.
- The degree to which the locum physician must take on the work of sourcing the placement, completion of licensing, obtaining hospital privileges and sourcing accommodation varies from province to province. Services such as Alberta's locum program provide an integrated service which eases the administrative burden to their locum physicians.

It is not only the benefits which are important. The administrative systems must support easy access to the locum program from both a host and locum physician perspective. The following trends and best practices from other provinces may guide the JSC in its ongoing development of the locum programs:

Synergies between locum services and other programs:
Currently, BC's locum service is not integrated with other services. Other provinces have capitalized on synergies with two key areas.

Recruitment: In Alberta, RPAP has both management of locums and physician recruitment within its mandate. Therefore, there are economies of scale in the investments made in creating community profiles, etc. It also allows for encouraging connection between short-term locum placement and opportunities for longer-term practice. In Ontario, the OMA's locum registry and physician job registry are linked on their website. Health Match BC's listing of locums on its website is helpful, but it is not the organizing body for rural locums. Online access to this process is not intuitive.

Continuing Medical Education: In Saskatchewan there is overlap in mandate between the arrangement of locums and the administration of continuing medical education. Locums are viewed as a key enabling tool for the success of the CME program, and therefore the knowledge of both sides of the equation assists the office in trying to successfully meet the host physician's needs and schedule.

Strong customer service orientation of the locum organizing body
The overall objective is to try to bring together as many pieces of the administrative puzzle (e.g. posting, community profiles, application, matching of candidates, screening, licensing, privileges, contracts, accommodation, payment, evaluation) under one roof to provide a clear focal point for both the host and locum physician. Good examples of success in this area include: AMA Physician Locum Services.

Weekend locum options
Alberta provides a Seniors' Weekend Locum Program for older physicians which eases the pressure of weekend call. Alberta also offers a Weekend Program for those communities where locums are necessary to attain a maximum of 1:4 weekend call, similar to Saskatchewan's program to provide weekend locums in "Category B" communities. BC has no such program, as it requires a minimum 5 day locum placement for GPs. BC may wish to consider the feasibility of addressing these weekend needs through increased recruitment of urban physicians to provide relief to these target groups.

Template for locum contracts:
The Ontario Medical Association has a standard form contract which can be used between the host and locum physician to clarify the roles and financial arrangements of the locum. This is particularly important in Ontario given that the percentage of the fee-for-service billings retained as overhead by the host physician is subject to negotiation.

Evaluation processes
Several provinces have online tools or forms for the evaluation of the locum process. In the case of Ontario, the completion of the form is a pre-requisite for the completion of the payment of the locum. This gives immediate feedback to the locum service about the quality of service provided by the locum. These types of tools are also in place from a locum physician's perspective to give feedback on the program and how it could be improved.

Continuing Medical Education

BC is competitive in its Rural Continuing Medical Education program benefits. The maximum allowance of $5,300 is exceeded only by $5,500 in Ontario (max). BC's approach to determining total compensation (defined by years of service + rurality) is similar to Ontario which also employs the rurality index. Other such as Saskatchewan or Northwest Territories only employ years of service as a criterion.

One of the defining features of the Rural CME benefit is its flexibility for a physician to accumulate benefits over time. This is also permitted in other provinces (such as Alberta) and is mirrored in the Educational Leave program in Newfoundland which allows for a greater continuous period of time off if all leave time is accumulated and taken as one leave every 3 years.

Streamlined program administration
Very few provinces make a distinction between a "regular" CME benefit, and "rural" CME. In most cases, the base amount of CME may just be adjusted upwards based on some function of rurality or location. Ontario does operate a separate program (CME for Rural and Isolated Physicians) but it is also administered by the OMA who administers the main CME fund.

Coordinated planning for Rural CME
For Continuing Medical Education in Manitoba, the Rural and Northern Physicians Committee brings together a rep from each of the 2 universities which 7 physicians representing "communities" for the purposes of planning and administering CME. An annual learning needs assessment of members is undertaken every year. The programs delivered include the Friday@Noon videoconference, the monthly on-site speakers series, and the annual Winter Conference.

Bringing Learning Opportunities to the Physician:
Alberta's *General Emergency Medicine Skills Program (GEMS)* is a self-study program which enables physicians to build upon their emergency skills. This is an excellent example of a remote learning program which uses technology such as simulators and multi-media to address key skill development. There is interest from BC stakeholders in emergency medicine learning opportunities, and this program seems like an excellent candidate for a potential shared educational resource between the two provinces.

Ontario's *Visiting Speakers Program* allows communities of physicians to bring forward their own proposal for speakers in their own community. The Ontario Medical Association then pays the speaker directly for the trip. In Manitoba, a monthly on-site speakers series brings education to the communities. Both of these are similar to the concept behind the "pooled" resources for Rural CME in BC, but are funded at the outset as group learning.

Manitoba's "Friday@Noon" videoconference series brings weekly learning opportunities to the desktop of the rural physician.

A.5. Defining Rural and Remote Communities

A relatively small number of provinces have a rating scale or set of criteria applied which results in a "points" scoring such as used in BC. Ontario has developed the Rurality Index of Ontario (RIO), and Alberta has Rural, Remote Northern Program (RRNP) which is modeled directly on BC's RRP model. In smaller provinces (such as the Maritime Provinces), it is often the case that rurality simply includes the entire province except the urban centres.

Ontario

The OMA develops and maintains the ***Rurality Index of Ontario (RIO)*** which assesses a community's degree of rurality and provides a resulting score (possible maximum of 175), which translates into variable benefits for physicians in those communities based on the score. The following shows the current factors in the formula, and also notes the factors the OMA is considering for removal (*shown in strikeout, e.g. "~~availability of EMS~~")* in its new iteration of the formula which will be finalized in March 2008:

- **Physician Supply**
  - Active GPs or FPs
  - Population to GP Ratio
  - **New in 2008: Physician turnover for the last 3 years ("Churn")*
- **Hospital**
  - ~~Availability of EMS~~
  - Availability of Anaesthesiologist
  - Low Volume Specialists **New in 2008 – deletion of availability of GP Anaesthesia or Obstetrics as a factor*
  - Presence of Specialists
- **Town**
  - Travel time to basic referral centre
  - Travel time to advanced referral centre **New in 2008: Winnipeg added even though it is out of Ontario*
  - Population: bonus for > 46,000, low density ~~or aboriginal~~
  - Lack of college or airport
  - Extreme ~~rain~~, snowfall or temperature
  - **New in 2008: Percent of population with a Bachelor's Degree*

In the past, this formula has updated when a new release of census data has been made available, given that the unit of geography used in the formula is the Census Sub-Division (CSD). However, the OMA is moving towards annual updating of the variables of the formula which have new data available each year. The formula is administered by the Economics Section of the OMA in concert with the Rural Section of the OMA.

A community's score impacts the availability of benefits to physicians in the following programs: CME for Rural and Isolated Physicians, Rural Medicine Investment Program, GP Locum Program, and flat fee benefits offered through the Hospital On Call Coverage (HOCC) and various primary care rural premiums. When the RIO score was introduced as an eligibility factor for the CME program, for example, those who lost funding as a result were grandfathered for a period of 15 months.

The formula has come under some criticism by the Society of Rural Physician's Resident Committee (Aird & Kerr, 2007) for disregarding some identified key factors such as availability of general surgery, high levels of on-call responsibility, difficulty obtaining a locum, lack of equipment and limited/non-existent public transportation.

Ontario is similar to BC in that there is a second way of defining communities of need. The Primary Health Care Team (Sudbury) of the Ministry of Health and Long-Term Care manages the ***Underserviced Areas Program***. The use of this system is similar to BC's "Communities of Designated Need" for the Family Practitioners of BC program.
This program enables communities to complete a self-assessment of their need for assistance in recruitment and retention. Their application is assessed using the following criteria:

- Long-standing and unresolved difficulties recruiting and retaining physicians,
- health care professional data (how many serve the community),
- population and physician-to-population ratios,
- previous recruitment efforts,
- local demand for services,
- additional health service needs and resources,
- support of local health care professionals

Any geographic area may be designated for the purposes of recruiting General Practitioners. However, only northern communities are designated for the purposes of recruiting specialists. It is of note that the UAP uses the Council of Faculties of Medicine recommended physician-to-population ratio of 1:1,380 as a guide to determining the physician complement.

Placement of the community on the LADAU (List of Areas Designated as Underserviced) results in benefits such as: Recruitment incentive grants for GPs or Specialists; Free Tuition program for medical students/recent graduates; Specialist Respite Locum Program; and, Specialist Urgent Locum Program.

Alberta
Alberta has a points system for assessing medical isolation which is based on the BC model, and is used to administer the Rural, Remote, Northern Program, which is similar in scope to the RRP as it offers both premiums and flat-fee payments.

The Points Criteria are identical to BC's points system with respect to both the criteria and the points per criteria. There is one exception:

The Specialist Centre criterion does not appear in its formula. Instead, their formula includes a factor to recognize "High Growth Communities", in which Fort McMurray receives an additional 80 points, and Grande Prairie receives an additional 60 points.

A.6. Concepts for Consideration in Future Program Planning by JSC

Throughout the course of research, the following programs or initiatives were deemed to be of note or interest to the work of the JSC. This list is not meant to function as a formal list of recommendations, but simply a resource of some initiatives which may be helpful to refer to in further work:

Part Time Definitions:

There has been considerable discussion of how part-time should be defined. Throughout the course of research a few precedents were noted.

- Saskatchewan defines part-time for the purposes of CME benefits. Full time = Over $60k; Part-Time = $30-60k; Less than $30k = ineligible
- The Yukon defines full-time as earning more than $125,000; Part-time as earning between $50,000 and $125,000. No Retention Program benefits are paid to physicians earning less than $50,000.

Building Public Awareness of Rural Medicine:

Other provinces have aimed to promote the role and value of rural medicine to the broader community. These strategies may be effective in informing high school students and other potential medical school applicants of a career in rural medicine:

- Awards program in Alberta to honour the achievements of those practicing rural medicine, both those who are new to practice, and those who have made long-standing contributions to service
- Rural Medicine Weeks are held in Ontario and Alberta to promote awareness both within the health professional student community, as well as the province.

Classification of General Practitioners:

- The Northwest Territories uses a scale which provides some differential benefits to GPs based on their scope of service. There are six classifications which cover the range from GPs who provide only office care through to those who are GP Surgeons or GP Anaesthetists. The categorization of the physician within this scale derives their base salary, and in addition the amount of their various benefits such as CME.
- Similarly, the Yukon has two categories of General Practitioners, which are essentially defined as those who provide hospital services, and those who do not.

Pension Programs:

- In provinces where there is significant shift towards salaried positions (e.g. Newfoundland, Northwest Territories) there are variations on retirement/pension plans in place. Newfoundland has a group RRSP, in which salaried members contribute 5% of their earnings, and the employer contributes 5%. On a larger scale, in the Northwest Territories has a contributory pension plan to which doctors contribute 7.5% of earnings (less CPP) and employers contribute 15% of earnings (less CPP).

Programs Targeting International Medical Graduates:

As provinces struggle with physician supply, some have developed programs specifically targeted towards foreign-trained medical graduates:

- Saskatchewan has a Rural Practice Establishment Fund for Foreign-Trained Physicians which provides $25,000 in funding.

- The *Nova Scotia Nominee Program* is designed to assist International Medical Graduates in the immigration process in order to address critical workforce shortages
- PEI seeks to *recruit graduates of foreign medical schools* by offering 2 individuals up to $100,000 for up to 2 years of training. A five year return-in-service agreement is required.

A.7. Alternative Models for Organization and Administration of Programs

The mandate for the planning, organization and delivery of rural programs varies from province to province. Each province needs to customize its delivery system to enact the responsibilities as outlined in the negotiated agreement. BC is clearly contemplating the development of new structures, such as the proposed Rural Coordinating Centre. In fact, in 2004, the JSC received a report from a co-op student outlining some of the benefits of different models such as RPAP and ROMP. Over the course of the next several years, BC may wish to observe the ongoing development of these structures in other provinces to determine what best practices have applicability in BC.

Office of Rural and Northern Health (located in Dauphin, MB, with a secondary office at Boundary Trails Medical Centre) Website: www.ornh.mb.ca	
Mandate	• Develop financial supports for rural and northern students, and assist them throughout medical school and placement process • Expand rural and northern training opportunities, make rural health a more important part of the curriculum • Work with communities and RHAs on recruitment and retention • Involved with Locum Tenens Program • Liaise with CME department to ensure rural physicians have access to the training opportunities they require • Implement contact management system to monitor individuals who are interested in a career in medicine, enrolled, or practising
Accountability	Regional Health Authorities of Manitoba Inc. (RHAM)
Founded In	2002, as a component of the Manitoba Rural Physician Action Plan
Staffing	2.5 FTEs (Admin Director, Admin Asst, part-time Medical Director)
Comments	• Focus on “management of talent” through following individuals and helping them navigate the process of training • Innovative programs that partner with communities, such as the “Home for the Summer Program” for students • Have standard return of service agreement template

Rural Ontario Medical Program (located in Collingwood, ON) Website: www.romponline.com	
Mandate	• Facilitate undergraduate and postgraduate training with physicians in rural communities across South Central Ontario • Community Development Office arm coordinates physician recruitment and retention strategies for the same geographic area
Accountability	Ministry of Health and Long-Term Care
Staffing	Executive Director, Program Director of Community Development Office, Postgraduate Coordinator, Undergraduate Coordinator + Assistant; Program Assistants (3) and Administrative positions (2)
Comments	• Close alliance between training opportunities, locums (outside of the OMA's Rural Locum Program), and longer term recruitment and retention issues. Gives a full picture of the potential physician supply for the community and engages fully with communities and individual physicians • High degree of on-line tools for applications, placement management, etc.

Rural Physician Action Plan (located in Edmonton, AB) Website: www.rpap.ab.ca	
Mandate	• Large focus on education as the main physician supply strategy • For students/residents: bursaries, tours, placements, additional skills training • CME Programming (video teleconferences, etc); Virtual Library • Alberta Physician Link – recruitment; recruitment fairs • Awards programs • Enrichment program (skills for practising MDs); Royal College Re-Entry positions • Weekend and Seniors Rural Locum Program (regular rural locum program administered by Alberta Med Assoc) • Recruitment and Retention grants • Supports for spouses and families • Rural Health Week
Accountability	Independent, not-for-profit company funded by Alberta Health and Wellness
Founded In	1991
Comments	• High degree of integration between almost all components of rural program incentives and programming, as only the rural locum program, RRNP and CME reimbursement are not part of the service mandate • Governed by a coordinating body populated with members from AMA and MOH

J.A. Hildes Northern Medical Unit (located in Winnipeg, MB)
Website: www.umanitoba.ca/faculties/medicine/units/northern_medical_unit

Mandate	• Delivery of health care to rural and remote areas with predominantly aboriginal populations within Manitoba and Nunavut • Programs include diabetes programs, renal health, retinal screening, rehab, fly-in visits, staffing of Norway House Hospital and specialist visits • Manitoba Locum Tenens Program • Offers summer placements, undergraduate electives, and postgraduate placements
Accountability	Part of University of Manitoba; administered Locum program on behalf of the Manitoba Health
Founded In	1970
Comments	This model may be of interest in terms of looking at programs like NITAOP and its integration with health service planning for communities, temporary staffing needs/locums, and longer-term planning.

A.8 Summary of Programs Offered, by Province

A.8.a Alberta

Rural Physician Action Program (RPAP) (www.rpap.ab.ca)
Alberta Health and Wellness (www.health.gov.ab.ca)
Alberta Medical Association (www.albertadoctors.org)
Alberta Rural Family Medicine Network (www.arfmn.ab.ca)

Undergraduate & Postgraduate Training	• All students and residents are required to do a rural rotation • Students and Residents completing rural rotations receive reimbursement of additional expenses such as travel or accommodation. • Students are encouraged to gain exposure to rural settings through *tours* and *skills days* held in rural communities. These are arranged through interest groups at the University of Calgary and University of Alberta. In addition, students can *shadow* a clinician for a weekend. • The *Summer Externship Program* offers 10 students a year a grant of $10,000 for their rural summer placement. • RPAP has 42 leased fully furnished, family friendly properties across the province for students to rent while on placements • The *RPAP Medical Student Bursary* provides full tuition ($12,000-$16,000) in any year of the program for students who have lived in a rural area for 5 years prior to medical school. A return in service of 5 years pro-rated for the number of years of funding received is required. • The *RPAP Medical School Award* provides $5,000 in funding per year for students who have lived in a rural area for 5 years prior to medical school and are a member of student Rural Medicine Interest Group. • Family Medicine Residents who sign a minimum 1 year return of service agreement in the year they graduate receive a *Matching Signing Bonus for Practice* of $10,000. • *Additional Skills Training Positions* are available to provide 1 additional year of training in areas such as anaesthesia, surgery, obstetrics, etc. to further prepare them for rural practice. Candidate complete a return of service agreement with a RHA or the Rural Locum Program. • The Northern Alberta Development Council offers additional bursaries and incentives to fund the education of health professionals who provide service in the north after graduation.

Recruit	• The *Recruitment Expense Program* has two objectives:
	  ○ Reimbursement of costs for clinician visits for interviews (max of $3,000)
	  ○ Honorariums for both Candidates and Assessors in situations where the candidate has been asked by the College to undergo assessment for licensure or approval of additional skills/privileges
	• *Recruitment and Retention Grants* are granted to up to a maximum of $10,000 once every 3 years. The application process looks for financial contributions by the local physicians/community towards the overall recruitment plan.
	• Centralized website is used for the posting of information about practicing in AB, plus community profiles (www.RuralPhysicianLink.ab.ca)

Practice Support	• The *Rural, Remote, Northern Program (RRNP)* provides premiums and additional flat fee payments to physicians who practice in communities identified as rural, remote and northern, plus "communities in crisis". The maximum payment is $60,000 per year. This program is retroactive to September 1/07. • The *Rural Locum Program* provides locum coverage for communities with fewer than 4 physicians. This provides up to 8 weeks of locum coverage. • The *Weekend Program* provides weekend coverage to communities to ensure that physicians have a weekend call schedule of no more than 1 in 4. • The *Seniors' Weekend Locum Program* (open to physicians over age who have practiced in Alberta for over 9 years, and are in a community with less than 16 MDs) offers additional locum coverage to further reduce or eliminate their weekend call. • A new $47 million *Retention Benefit* is being introduced in February 2008 and will be administered by the AMA which will reward physicians for years of service in Alberta with payments of $4,000-$10,000.
CME	• The *CME Reimbursement Program* reimburses for costs such as registration fees, transportation, meals, office overhead and reference materials for courses up to a max of $1,300 per year. • The *Enrichment Program* offers physicians the opportunity to upgrade their skills through programs between 2 weeks – 12 months in length. The physician receives an honorarium of $80,000 per year, prorated for the length of the training. Preceptors also receive $1,000 honorarium per month. • The *Emergency Medicine Enrichment Program* is an opportunity for rural physicians to complete 1-6 months of emergency training in an urban setting. • The *General Emergency Medicine Skills Program (GEMS)* is a self-study program which enables physicians to build upon their emergency skills. • The *Royal College Re-Entry Program* enables a very limited number of rural physicians to re-enter for specialty training. There has been intermittent availability of funding for this program.
Other	• Awards program designed to recognize contributions. Nominations are sought from the pubic for two categories:

	○ *Early Careerist*- Under twelve years in practice who are innovative, energetic and passionate about rural medicine and the rural lifestyle ○ *Award of Distinction* – Over twelve years of practice who provide Alberta rural communities with outstanding medical services and who also make huge contributions through teaching, conducting research and volunteering in their community. ○ Public awareness increased by holding an annual "Rural Health Week" in the 3rd week of June every year. ○ Alberta offers Family and Spousal programs at conferences and other events throughout the year to create a network of spouses. In addition, RPAP offers referrals to services within the province.

A.8.b Saskatchewan

Saskatchewan Ministry of Health (www.health.gov.sk.ca)
Saskatchewan Medical Association (www.sma.sk.ca)

Undergraduate & Postgraduate Training	• The *Undergraduate Student Bursary* provides $15,000 for up to 3 years of funding. The student can complete their service to the province in either rural, regional centre or locum service. • The *Medical Resident Bursary* provides $25,000 in bursary support for 2 years. The return of service commitment can be completed in different locations, as above. Similarly, a *Specialist Resident Bursary* is available for $25,000 up to a maximum of 3 years. However, each year of funding in this program requires one year of return-in-service in Saskatchewan. • The *Special Needs Loan Program* provides financial assistance for extreme situations. The student is required to repay the principal amount only if he/she practices in the province.
Recruit	• New practices are eligible for the *Rural Practice Establishment Grant* of $25,000. The family practice must be located in a centre with a population of less than 10,000. • The *Rural Practice Establishment Grant for Foreign-Trained Physicians* provides $25,000 in funding after the first 18 months of practice in a community of less than 10,000. The physician must then complete a minimum of another 18 months of practice. • The *Regional Practice Establishment Grant* provides $10,000 for family physicians setting up practice in a defined list of regional communities. • The *Practice Establishment Grant for Employed Physicians* provides $10,000 in funding for setting up a practice for a minimum of 18 months. • The *Specialist Practice Establishment Grant* provides $30,000 to a specialist who establishes practice for a minimum of 36 months. • A *Relocation Grant* of $5,000 is available for those relocating to Saskatchewan. • The *Northern/Rural/Hard to Recruit "work" Grant* offers various grants based on the location of the practice, and whether the MD is already working in the province or relocating to SK. The payments range from $5,000-$15,000 and have a return-in-service requirement.
Practice Support	• The *Rural Relief Program* provides locum relief for physicians who practice in communities with five or fewer MDs. • The *Weekend Relief Program* provides "Category B" communities who require additional support with locums. • Expenses for physician travel between rural communities for the purposes of providing specialty care, anaesthesia, or practice coverage are reimbursed under the *Rural Travel Fund* up to a max of $3,500 per year.
CME	• Physicians can take 1-6 weeks of leave for upgrading their skills through the *Rural and Regional Extended Leave Program.* The funding is up to $4,000 per week for 6 weeks. • The *Rural and Regional Physician Enhancement Training Program* funds

	2 practicing MDs and 2 second-year family medicine residents to complete a third year of training in obstetrics, anaesthesia, general surgery, emergency medicine, geriatrics or psychiatry. The practising MDs receive $80,000 per year in replacement funding, and must complete a return-in-service. • Up to 3 rural physicians per year can return to a specialty residency training program through the *Re-Entry Training Program.* For each year of funding, 2 years of return-in-service is required. • The *Rural and Regional Emergency Care Continuing Medical Education Fund* covers registration and up to $250 in expenses to attend courses. • *CME* Reimbursement is available to a maximum of $3,000 per year. This amount is discounted to reflect part-time physicians.

A.8.c Manitoba

Manitoba Health (www.gov.mb.ca/health)

Office of Rural and Northern Health (www.ornh.mb.ca) is funded by Manitoba Health, and oversees the CME program, GP Anaesthesia Training Program, Preceptor Development Workshop, Return of Service Agreements, Enhanced Rural Curriculum, Summer Work Experience and Training and Rural Week. It is located in Dauphin, MB.

J.A. Hildes Northern Medical Unit oversees the locum program. (www.umanitoba.ca/faculties/medicine/units/northern_medical_unit)

Undergraduate & Postgraduate Training	• The *Medical Student and Resident Financial Assistance Program (MSRFAP)* provides $15,000-$20,000 per year. Students in the province (Educational Assistance Option) or new graduates establishing a practice (Practice Assistance Option) are eligible. One year's return of service is required for each year of funding. The maximum funding allowed is 4 years.
Recruit	• The *Medical Licensure Program for International Medical Graduates* assists foreign-trained physicians in obtaining their license to practice in MB.
Practice Support	• The *Physician Retention Program* provides an annual benefit to physicians who have been practicing more than 5 years in Manitoba. The benefit increases based on years of practice. • The *Manitoba Locum Tenens Program* supports communities of 4 physicians or less with locum placements of 5-28 days. The objective is to facilitate CME.
CME	• The *CME Rebate Program* reimburses physicians for CME costs. • The *GP Anaesthesia Training Program* provides short term funding for training in anaesthesia, dependent on a job offer and return-of-service contract equivalent to the funded time, which utilizes the newly-acquired skills. • The Rural and Northern Physicians Committee brings together a rep from each of the 2 universities which 7 physicians representing "communities" for the purposes of planning and administering CME. An annual learning needs assessment of members is undertaken every year. The programs delivered include the Friday@Noon videoconference, the monthly on-site speakers series, and the annual Winter Conference. Physicians can pay for these events as a series for the year, or for individual sessions.

A.8.d Ontario

Ontario Ministry of Health and Long-Term Care (www.health.gov.on.ca) **has several branches/programs involved with the administration of rural programs:**

- Provider Services Branch - Rural Medicine Investment Program (RMIP): administers a $4M program negotiated under the Physician Services Agreement between the MOHLTC and the OMA.
- Medical Service Payment Committee (MSPC) of the Ministry of Health & Long-Term Care (MOHLTC)
- The Underserviced Areas Program (UAP), based in Sudbury, coordinates the
- Community Development Officers (CDO): CDOs facilitate and co-ordinate the independent recruitment initiatives of physicians, by communities, government agencies and other stakeholders to address regional physician health human resources issues. Six CDOs provide service to the entire province and are located in Thunder Bay, Sudbury, Timmins, Goderich, Kingston and Collingwood.

Ontario Medical Association (OMA) (www.oma.org)**:** The OMA develops and maintains the Rurality Index of Ontario (RIO) scores which assess a community degree of rurality, which translates into variable benefits for physicians in those communities based on the score. In addition, it administers the Rural CME programs and the Northern Physician Recruitment Incentive Program (NRPI)

Rural Ontario Medicine Program (ROMP) (www.romponline.com)**:** A Ministry of Health-funded organization to organize training opportunities for undergraduates and postgraduates from all Ontario Medical Schools. Located in Collingwood, ON.

Health Force Ontario Jobs (HFOJobs) (www.hfojobs.ca)**:** Maintains a comprehensive job website designed to connect physicians-in-training, established physicians and International Medical Graduates with Ontario's underserviced, rural and urban communities for recruitment and retention purposes.

Undergraduate & Postgraduate Training	• *Free Tuition Program* offers up to $40,000 (or $10,000 per year) in exchange for a three or four year return-of-service commitment. The program has two components: the reimbursement of medical undergraduate tuition fees and a location incentive fund. The Free Tuition Program will compensate medical students and postgraduate trainees for actual medical tuition payments (to a maximum of $10,000 annually), in exchange for a return-of-service commitment in a community designated as underserviced or an undersupplied specialty. • Students who completed undergraduate *clerkships* for of 4 weeks or longer in one community are reimbursed for up to $800 in accommodation costs and $450 in travel costs (based on mileage of $0.37/km). • Similarly, *Family Medicine Residents* who complete placements of 4 months or longer, or *Specialty Residents* who complete placements of 1 month or longer are reimbursed for costs of up to $800 in accommodation costs and $450 in travel costs (based on mileage of $0.37/km).

	• ROMP offers a limited number of *conference registration + travel/expense grants* of $500 for medical students and residents to travel to the Society of Rural Physicians of Canada Rural and Remote Medicine Course. • *Rural Medicine Week offers first and second year medical students the opportunity to complete nine ½ day rotations in selected communities in south-central Ontario.*
Recruit	Several types of *Incentive grants* are made available to target specific types of recruitment: • GPs/FPs and psychiatrists who relocate to designated northern communities: up to $40,000 paid over 4 years • GPs/FPs and psychiatrists who relocate to designated southern communities: up to $15,000 paid over 4 years • Specialists who relocate to designated northern communities: up to $20,000 paid over 4 years. In addition, specialists may access an additional grant of $20,000 paid over 4 years if they provide a minimum of 12 days of outreach services per year • The *Specialist Retention Initiative* exempts specialists and certain family doctors from OHIP caps in the year that they are receiving an incentive grant. • *Community Development Officers* coordinate recruitment of MDs; 6 cover the whole province • The *Community Assessment Visit Program* (administered by UAP) reimburses health care professionals and their spouses for travel and accommodation expenses within Ontario to visit a designated underserviced community to assess practice opportunities
Practice Support	• Rural and Northern Physician Group Agreement (RNPGA) (administered by MOHLTC) provides several benefits for physicians in specified communities with 1-7 MDs including: guaranteed remuneration; overhead funding; specialized service incentives; funding for 24 hour on-call or emergency department coverage; access to locums for up to 37 days leave per year; and maternity benefits for up to 17 weeks at 50% of salary. • The Northern Physician Retention Initiative (administered by OMA) provides an incentive grant of $7,000 to full-time physicians who have already completed 4 continuous years of service in a northern community. • The Rural Medicine Investment Program (administered by MOHLTC) commences in January 2008 and will allocate $4M in funding proportionately between physicians in communities with a RIO ≥ 45. The funding allocated per physician is based on the breadth of his/her practice and the characteristics of his/her community. • *GP Locum Program* (administered by OMA) offers the coordination and funding of locum relief for physicians who meet eligibility criteria. • *Specialist Urgent Locum Program* (administered by UAP) provides specialist locum support to communities with fewer than 2 specialists or

	in the process of active recruitment. Guaranteed per diems plus travel and accommodation expenses for the MD are covered. • *Specialist Respite Locum Program* (administered by UAP) provides longer term coverage for communities with a full complement of over 3 specialists to cover educational leave or vacation. The benefits only include travel expenses and minimal accommodation costs. • *Visiting Specialist Clinic Program* (administered by UAP) supports communities who are unable to maintain full-time specialist coverage. • *Physician Outreach for General/Family Practitioners* (administered by UAP) provides regularly scheduled primary care clinics to outlying communities with Underserviced Area Program (UAP) funded nursing stations or medical clinics and 24/7 telephone physician backup to the nurse/NP working in the community. • The *Hospital On Call Coverage program* provides a *Rurality Premium of $15,000 for those with a RIO score of 45 or greater.*
CME	• The OMA manages the *CME for Rural and Isolated Physicians Program.* Physicians must be eligible for the NPRI, and are reimbursed for varying amounts based on their community's RIO score to a max of $5,500. • In addition, the *Northeastern Ontario Health Professional Development Program* (NOHP-Dev) provides educational opportunities • The Visiting Speaker Program (administered by OMA) provides funding assistance for physicians to organize CME events in their own communities. The OMA directly reimburses the speaker for travel, accommodation, meal and honorarium. • The Clinical Traineeship Program (administered by OMA) is eligible to those with an RIO ≥ 60 are eligible to enhance their skills in addition to the regular CME funds for 2 weeks or more.
Other	• The Northern Ontario Virtual Library provides online access to databases and full-text journals as well as assistance with searches

A.8.e New Brunswick

Department of Health and Wellness (www.gnb.ca/0051/index-3.asp)
New Brunswick Medical Society (http://www.nbms.nb.ca/home.php)

Undergraduate & Postgraduate Training	• *Medical Student Bursaries* - 40 bursaries of a $6,000 value to 40 third and fourth year medical students who are in financial need. In order to receive the bursary, students will need to sign a one-year return of service agreement with the Province. • *Resident Grants* – paid to those in the last 2 years of their residency, with a return of service requirement of 3 years. • The province's *Tuition Tax Cash Back Program* provides a tax rebate of up to $10,000 equal to 50 per cent of total eligible tuition costs against provincial personal income tax payable, for each post-secondary student who works in New Brunswick and files a provincial income tax return • The *Supernumerary Residency Training Program* subsidizes a physician to complete his or her training in a specialty for which there is a shortage in New Brunswick. The program is open to new students, those wishing to re-train or switch specialties, or international medical graduates. • The *Summer Preceptorship Program* pays students $10.25/hr for summer training opportunities in rural practice. • *Rural Studentship Program*, in which medical students spend the summer learning with rural family physicians in New Brunswick and Nova Scotia.
Recruit	• The *Location Grant* program provides grants for newly-recruited physicians and specialists who agree to establish their practice in hard-to-recruit areas. The program pays up to $50,000 per GP and $40,000 per specialist with a return of service requirement of 3 years. • The *Extension of Current Location Grant Program* is paid to residents in their last 2 years of residencies, providing them payment to stay on for an additional 3 years. • *Business Grants* of $15,000 are available to those MDs setting up practices in areas 40 km outside of Moncton, St. John and Fredericton where a practice has been vacant for a year. A one-year return of service is required. • The *Guaranteed $175,000 Income Program* is on top of the Location Grant and is available to those who set up a fee-for-service practice in designated communities. This is for the first year of practice. • *Emergency Medicine Recruitment Program* – A $50,000 grant for those who commit to providing service for 3 years in a regional Emergency Department. • In addition, a *Stabilization Fund* is available to bonus those who provide care in a regional Emergency Department. It is based on a sliding scale of hours/week.
Practice Support	• Organization of *Locums* takes place through Regional Health Authorities posting the positions on a centralized website.

	• The *Parental Leave Program* provides benefits to those who have been residing and practicing in NB for 1 year and making an annual income of at least $56,481. Benefits of $700/week are paid up to 17 consecutive weeks, and physicians can also bill up to $1,000 per week while receiving benefits.
CME	

A.8.f Nova Scotia

Nova Scotia Department of Health (http://www.gov.ns.ca/health/)
Maritime Physician Recruitment Initiative (www.mpri.ca)
Medical Society of Nova Scotia (www.doctorsns.com)

Undergraduate & Postgraduate Training	• The *Debt Assistance Plan* for new graduates provides $15,000 per year for three years to new physicians prepared to establish a medical practice in a designated community. This is a limited program. • *Rural Studentship Program*, in which medical students spend the summer learning with rural family physicians in New Brunswick and Nova Scotia.
Recruit	• The *Maritime Physician Recruitment Initiative (MPRI)* is a confidential and centralised means for physicians searching for practice opportunities throughout the Maritimes. MPRI is a joint project of the Professional Association of Residents in the Maritime Provinces (PARIMP) and the Province of Nova Scotia. It is a conduit between communities and physicians seeking job opportunities. • The *Nova Scotia Nominee Program* is designed to assist International Medical Graduates in the immigration process in order to address critical workforce shortages
Practice Support	• *Alternate Payment Program (APP) for Underserviced Areas* guarantees a minimum of $194,926, plus a $10,000 bonus per year for 5 years, as well as CME allowance of $1,000/year and a one-time moving allowance of $5,000. • *Rural Stabilization Fund* provides extra $25k per year to physicians who practice in communities more than 45 km from an Emergency Room. • The *Locum* program provides support to physicians through guaranteeing per diem billings for the locum physician and a daily overhead allowance for the requesting physician.
CME	• Dalhousie piloted the Rural CME/Locum project, in which doctors bring specialized training to rural communities and take care of a rural doctor's practice while he/she takes this training

A.8.g Prince Edward Island

Prince Edward Island Department of Health (www.gov.pe.ca/hss)
Medical Society of PEI (www.mspeio.pe.ca)

Undergraduate & Postgraduate Training	• The province ensures that its own residents have access to medical school through a formal agreement to hold 2 seats at Memorial University each year, and an informal agreement to hold 6 seats at Dalhousie. In addition a francophone medical student from PEI is assured access to a Quebec medical school. • Financial assistance for *travel and accommodation expenses* for medical students and residents. • Benefits to medical students include stethoscope & diagnostic kit; book allowance, and social events. • The *Summer Program for Students* is administered by the Medical Society of PEI for 10 week paid placements for first and second year students. • The *Medical Residency Debt Reduction Program* offers $30,000 to GPs and $40,000 to specialists in exchange for return-in-service.
Recruit	• *Site Visits* give prospective physicians an opportunity to visit with their spouses or families for 3-5 days. • *Return-in-Service Grants* offer $30,000 for family physicians and $40,000 for specialists who move in from out of province. There are $5,000 bonuses for family practitioners moving to rural communities. Two years of return-in-service is required. • Moving costs are covered under the *Moving Allowance* assistance program, in the range of $8,000 to $20,000. • *Specialist Training Initiative* provides funding to physicians pursue training in areas of need for the province, with a return-of-service agreement. • The province seeks to *recruit graduates of foreign medical schools* by offering 2 individuals up to $100,000 for up to 2 years of training. A five year return-in-service agreement is required.
Practice Support	• Physicians who relocate to the province will have a *guaranteed Fee for Service Income* of $200,000 for full-time work. • The *Locum Support Program* provides funding support to physicians filling temporary vacancies. There are additional fees paid to those providing rural emergency room services. • The *Office Medical Equipment Fund* supports physicians in their acquisition of technology to support PACS, EPR and expensive diagnostic and therapeutic technology.
CME	• The *Continuing Medical Education Program* develops and delivers 2 educational sessions per year for all PEI physicians. • The *Clinical Skills Fellowship Fund* funds supervised clinical work, post-fellowship training and fellowship opportunities. • The *Physician Leadership Bursary Program* provides 4 bursaries to Chiefs of Staff and Medical Directors for physician leadership courses.

A.8.h Newfoundland & Labrador

Newfoundland Department of Health and Community Services (www.health.gov.nl/ca)
Newfoundland and Labrador Medical Association (www.nlma.nl.ca)

Undergraduate & Postgraduate Training	• The *Resident and Medical Student Practice Incentive* provides funding to either fourth year medicine student who have been matched to a Family Medicine Program inn CaRMS, or 1st/2nd year Family Medicine Residents. A year of return-in-service is required for each year of funding received. • The *Medical Resident Bursary Program* provides a maximum of 2 years' of bursary support for those in their last 3 years of residency training in specialties other than Family Practice. Specialties required under the Provincial Physician Resources Plan are a priority. • For programs not offered within the province at Memorial University, the students of the *Travelling Fellowship Program* are paid at the attended university's rate. One year of service for each year of funding is required. • The *Psychiatric Resident Bursary Program* supports residents in their 3rd and 4th years of residency. One year of service for each year of funding is required.
Recruit	• The Provincial Recruitment Officer is located at Memorial University. http://www.nlphysicianjobs.ca/default.asp • Standard offer of up to 3 months of housing provided after arrival
Practice Support	• GPs that are salaried make in the range of $120,360 to $144,432 per annum. *Retention bonuses* are paid after each year ($10,000 per year x the number of years) for up to a total of $30,000 for 3 years or more. This depends on the geographic location. • Specialists who are salaried make in the range of $144,432 to $173,319 per annum. *Retention bonuses* are paid after each year ($12,000 per year x the number of years) for up to a total of $36,000 for 3 years or more. This depends on the geographic location. • On average, rural FFS physicians bill $274,000 per year. • Salaried physicians are entitled to *annual leave* on a sliding scale based on their years of service. For example: 20 days for those with 1-10 years of service; 25 days for 10-25 years of service; 30 days per year for those with over 25 years of service. This is an accumulative benefit which is payable on termination. • *GP Locums* are paid $662 per day, Specialist locums are paid $732 per 24 hour day.
CME	• Salaried physicians are entitled to 10 days *paid study leave* per year. Up to 60 days can be taken in year 3, if the physician does not take any leave in the previous 2 years.

A.8.i Northwest Territories

Organizational Structure/Players:
Government of Northwest Territories Health and Social Services (http://www.hlthss.gov.nt.ca/)
Northwest Territories Medical Association (www.nwtma.ca)

Undergraduate & Postgraduate Training	• The *Medical Student Bursary* for NWT residents provides up to $40,000 ($10,000 per year) of medical school, and $15,000 per year for 2 years of Residency. A 4 year return of service agreement must be signed with a health and social service authority. Up to 2 new candidates are approved per year. • The *Resident Family Practice Bursary* provides up to $30,000 ($15,000 per year for 2 years) with a return of service agreement of 2 years. • The *Medical Resident Travel Bursary* Program reimburses residents for air travel costs to their residency location. • The *Emmett Hall Clerkship Bursary* assists clerks with the cost of air travel from their university to their placement location.
Recruit	• *Recruitment Bonuses* are paid with differential amounts for length of service – 1 year $6,000, 2 years $14,500, 3 years $25,000. • *Moving assistance* is provided
Practice Support	• Salary ranges for General Practitioners are defined based on a *system of six levels of practice* ranging from a physician who provides clinic coverage only (G1) through to a physician with full medical coverage as well as training in surgery/anaesthesia (G6) *See Table at bottom* • Salary ranges for Specialists are defined based on a system of three groups; they are required to participate in a on-call group structure which compensates $400/weekday and $600/Sat, Sun or Stat. Call back compensation and time in lieu accumulates at up to 5 days per year. • A *Northern Allowance* is payable for service in 5 defined communities. Different amounts apply to each community, ranging from $2,302 to $8,552 annually for GPs, and $2,302 for specialists. • A *Retention Bonus* is payable upon the completion of each year of services in 6 defined communities. The amounts for GPs range from $7,500 to $20,000 per year, and the amount for specialists is $7,500 per year. • Differing levels of *Vacation Leave* are available based on the number of years of service: Under 10 years = 26.5 days/year; 10-14 years = 31.5 days/year; Over 15 years = 35 days/year. • *Special Leave* accumulates at 0.5 days/month to a max of 25 days. The physician's CEO can grant the use of these up to 5 days at a time for deaths, illnesses, births/adoption of children and other circumstances. • *Self-funding leave plan* • *Sick leave* accumulates at 1.5 days/month
CME	• GPs have two levels of *reimbursement for CME activities*: Levels GP1-GP4 receive up to $7,500 per year; Levels GP5-GP6 receive up to $10,000 per year. • Specialists in their first 2 years of practice receive 10 days paid leave

	plus up to $12,500 for CME. After 2 years, that increases to 15 days paid leave plus up to $15,000 for CME. • Reimbursement of up to $1,000 per year in *Medical Textbooks or Journals*.
Other	• Coverage of up to $1,500 in *Professional Fees*. • *Pension Plan* – GPs contribute 7.5% of earnings (less CPP) and employers contribute 15% of earnings (less CPP). • *Canadian Medical Protective Association Fees* are paid by the health and social services authorities.

A.8.j Yukon

Yukon Medical Association (http://www.yukondoctors.ca/index.html)
Government of Yukon Health and Social Services (http://www.hss.gov.yk.ca/)

Undergraduate & Postgraduate Training	• *Tuition support* is available for 2 new individuals per year through the Medical Education Bursary. The funds provide support for $10k in tuition per year for 4 years; or 2 years of family medicine residency of $15k per year. A return of service agreement is not required. • The *Medical Student Assistance Fund* (administered by the YMA) provides $300 in expense reimbursement for travel, meals and accommodation while completing an elective placement. • The *Resident Student Assistance Fund* (administered by the YMA) provides 2 residents with a total of $1,000 each in expense reimbursement for travel, meals and accommodation while completing an elective rotation. • The *University of Calgary Resident Student Assistance Fund* reimburses students from U of C who are completing a core rural rotation in the Yukon for a potential total of $2,120 in expenses for travel, food and accommodation.
Recruit	• The *General Physician Incentive Program* provides up to $50,000 in financial support in the repayment of student loans for recently graduated physicians (in last 5 years) who commence a practice in the Yukon and maintain service for 5 years. Up to 4 new grants are approved each year. • The *Physician Relocation Fund* provides up to $10,000 to fee for service physicians to offset their moving and relocation costs. A year of service is required for each $5,000 in funding.
Practice Support	• The *Locum Support Program* provides a limited amount of funding ($1979/year) per practice to reimburse resident physicians for the costs of travel and accommodation for their locums.
CME	• Physicians receive reimbursement for CME. • Rural Training Program supports physicians in upgrading their critical care skills. Up to 6 physicians a year can access $1250 from the fund for

	ACLS, ATLS, etc. • Educational Support Program provides practicing physicians $5,000 in funding for each 4 week block, up to a maximum of $25,000 in a 52 week period. A year of service is required for each $5,000 in funding, up to a maximum of 2 years.

Appendix B Participants

Interview Participants

Mr. Jim Aikman, BCMA
Dr. Abdul Aleem, Joint Standing Committee
Ms. Amanda Anderson, Northern Health Authority
Ms. Anne Ardiel, Vancouver Island Health Authority
Dr. Granger Avery, Joint Standing Committee
Mr. Clay Barber, Interior Health Authority
Mr. Ken Barton, Health Service Society
Dr. Jane Bishop
Dr. Doug Blackman, CPSBC
Mr. Hank Bood, Mayor of Port Hardy
Ms. Meredith Bourhis, BCMA
Ms. Ella Brown, Mayor of Logan Lake
Dr. Jan Burg
Dr. David Butcher, Northern Health Authority
Dr. Richard Crow
Mr. Walter Despot, Mayor of Keremeos
Mr. Greg Dines, BCMA
Mr. John English, Joint Standing Committee
Dr. Gary Feindstadt
Mr. Eric Foster, Mayor of Lumby
Mr. Rod Frechette, Joint Standing Committee
Ms. Barbara Golder, Joint Standing Committee
Ms. Jan Goode, Health Match BC
Dr. Robert Halpenny, Interior Health Authority
Dr. Ken Harder, UBC Chilliwack Residency Program
Dr. Stuart Iglesias
Dr. Lawrence Jewitt
Dr. Mary Johnston
Dr. Stuart Johnston, Joint Standing Committee
Ms. Anne Keeble, BCMA
Dr. Joe Kotlarz, Joint Standing Committee
Mr. Vitali Kozubenko, Joint Standing Committee
Mr. Calvin Kruk, Mayor of Dawson Creek
Ms. Carol Kulesha, Mayor of Queen Charlotte
Dr. Peter Lake
Dr. Trina Larsen Soles
Ms. Toni Leis, Ministry of Health
Dr. James Levins
Ms. Bev Little, Northern Health Authority
Dr. Garth Loughead
Dr. Paul Mackey, Joint Standing Committee
Ms. Brandy Marleau, UBC REAP
Dr. Ed Marquis, Joint Standing Committee
Dr. Rod McFadyen, Vancouver Island Health Authority
Ms. Jennifer McKay, Ministry of Health
Dr. Clarence Moise
Dr. Shiraz Moola
Dr. Peter Newbery
Dr. Tracy Parnell, UBC REAP
Dr. John Pavlowich
Ms. Kelly Phipps, Northern Health Authority
Mr. Scott Randolph, Powell River Econ. Dev. Society
Dr. Allan Ruddiman, Joint Standing Committee
Dr. Richard Scragg
Dr. Don Shea
Dr. Mike Smialowski
Dr. David Snadden, UBC Northern Medical Program
Dr. Becky Temple
Ms. Sandra Walker, Ministry of Health
Dr. Carl Whiteside, UBC REAP
Dr. Galt Wilson, UBC Northern Medical Program
Dr. Peggy Yakimov, Interior Health Authority

Rural Visioning Day Participants, Westin Bayshore, Vancouver, January 21, 2008

Mayors & City Officials: (10)

Mr. Hank Bood, Mayor of Port Hardy
Ms. Ella Brown, Mayor of Logan Lake
Mr. Eric Foster, Mayor of Lumby
Mr. Calvin Kruk, Mayor of Dawson Creek
Ms. Carol Kulesha, Mayor of Queen Charlotte
Ms. Myrna Leishman, Councillor, City of Powell River
Mr. Dave Murphy, Director, Electoral Area D
Mr. Larry Pepper, Mayor of Port Alice
Mr. Scott Randolph, Powell River Economic Development Society
Mr. Joe Snopek, Mayor of Creston

Health Authority Representatives: (8)

Ms. Anne Ardiel, Vancouver Island Health Authority
Dr. Clay Barber, Interior Health Authority
Dr. Richard Crow, Vancouver Island Health Authority
Ms. Jan Goode, Health Match BC
Mr. Stefan Grzybowski, UBC
Dr. Robert Halpenny, Interior Health Authority
Dr. Rod McFadyen, Vancouver Island Health Authority
Dr. Peggy Yakimov, Medical Director – Kootenay Boundary

Rural Physicians: (34)

Dr. Nancy Anderson, Bella Coola
Dr. Murray Archdekin, Chemainus
Dr. Alex Barss, Lumby
Dr. Jan Burg, Prince George
Dr. Suzanne Campbell, Vanderhoof
Dr. James Chrones, Queen Charlotte
Dr. William Cunningham, Mill Bay
Dr. Andre de Wit, Port Hardy
Dr. Garry Feinstadt, Vancouver
Dr. Pamela Frazee, Tofino
Dr. Lloyd Hildebrand, Sydney
Dr. Stuart Iglesias, Gibsons
Dr. Lawrence Jewett, Cranbrook
Dr. Carolyn Jones, Fort St. John
Dr. Diana Kelland, Nakusp
Dr. Trina Larsen-Soles, Golden
Dr. Neil Leslie, Revelstoke
Dr. James Levins, Salmon Arm
Dr. Garth Loughead, Parksville
Dr. Faye Mackay, Creston
Dr. Paul Mackey, Fort St. John
Dr. Shiraz Moola, Nelson
Dr. Peter Newbery, Hazelton
Dr. William Newsome, Cranbrook
Dr. Bruce Nicolson, 100 Mile House
Dr. John O' Brien, Tofino
Dr. Donald Paterson, Sorrento
Dr. John Pawlovich, Fraser Lake
Dr. Sarah Pawlovich, Fraser Lake
Dr. Rand Rudland, Halfmoon Bay
Dr. Robin Saunders, Sooke
Dr. Kelly Silverthorn, Nelson
Dr. Becky Temple, Fort St. John
Dr. Abe Zacharias, Cranbrook

Rural Visioning Day Participants (continued)

Joint Standing Committee on Rural Issues Committee Members: (9)

Dr. Abdul Aleem, Cranbrook
Dr. Granger Avery, Port McNeil
Mr. John English, Victoria
Mr. Rod Frechette, Victoria
Dr. Stuart Johnston, Gibsons
Dr. Joseph Kotlarz, Cranbrook
Dr. Edward Marquis, Prince George
Dr. Alan Ruddiman, Oliver
Ms. Laurie Stein, Victoria

BC Medical Association Representatives: (10)

Mr. Jim Aikman
Dr. Geoffrey Appleton
Ms. Meredith Bourhis
Ms. Elisa Chan, Rural Coordination Centre
Mr. Greg Dines
Ms. Linda Grime
Ms. Lea Harth
Ms. Brandy Marleau, REAP Administrative Coordinator
Dr. Alexandra Tcheremenska
Dr. Carl Whiteside, REAP Program Coordinator

Ministry of Health Representatives (5):

Ms. Toni Leies
Ms. Sandra Walker
(Three additional Ministry of Health Representatives were in attendance as members of JSC)

Harbour Peaks Management Inc. Representatives: (4)

Mr. Dennis Cleaver
Ms. Heather Martin
Ms. Victoria Ostler
Dr. Jill Konkin

Appendix C Rural Retention Program Descriptions

Appendix C1: Overall Allocation of Medical Isolation Points

Medical Isolation Points Gain/Loss Over Four Years			
Community	Isolation Points 2006/07	Isolation Points January 2003	Difference in RRP Points
100 Mile House	23.00	23.00	0.00
Agassiz/Harrison	5.50	6.00	-0.50
Ahousat	26.25	26.25	0.00
Alert Bay	34.20	33.40	0.80
Anahim Lake	39.00	39.00	0.00
Armstrong/Spallumcheen	0.80	0.00	0.80
Ashcroft	22.35	22.35	0.00
Atlin	51.25	51.25	0.00
Bamfield	22.95	23.25	-0.30
Barriere	17.00	17.00	0.00
Bella Coola	39.00	39.00	0.00
Big White	17.00	17.00	0.00
Blueberry River	35.75	0.00	35.75
Blue River	35.40	35.40	0.00
Bowen Island	8.90	8.50	0.40
Bridge Lake	30.60	30.60	0.00
Burns Lake	33.40	37.40	-4.00
Campbell River	10.20	10.20	0.00
Canal Flats	34.60	34.60	0.00
Castlegar	16.20	16.20	0.00
Chase	13.00	13.00	0.00
Chetwynd	34.20	38.20	-4.00
Christina Lake Grand Forks	25.40	27.40	-2.00
Clearwater	26.20	26.20	0.00
Clinton	22.65	22.65	0.00
Cortes Island	24.15	23.85	0.30
Courtenay Comox Cumberland	9.90	9.90	0.00
Cranbrook	20.00	18.00	2.00
Creston	23.80	25.40	-1.60
Dawson Creek	33.00	33.00	0.00
Dease Lake	51.25	51.25	0.00
Denman Island	13.65	13.35	0.30
Doig River	35.75	0.00	35.75
Duncan/N. Cowichan	5.00	5.00	0.00
Edgewood	31.00	31.00	0.00

Elkford	35.00	31.00	4.00
Enderby	8.80	14.80	-6.00
Fernie	31.00	27.00	4.00
Fort Nelson	51.25	51.25	0.00
Fort St. James	32.60	36.60	-4.00
Fort St. John	29.00	39.00	-10.00
Fort Ware	51.25	51.25	0.00
Fraser Lake	36.60	36.60	0.00
Gabriola Island	8.50	8.50	0.00
Galiano Island	15.70	15.30	0.40
Gold Bridge Bralorne	23.85	23.85	0.00
Gold River	23.55	23.55	0.00
Golden	32.60	28.60	4.00
Granisle	38.60	38.60	0.00
Greenwood/Midway/Rock Creek	30.60	30.60	0.00
Halfway River	34.25	0.00	34.25
Hartley Bay	41.00	41.00	0.00
Hazelton	44.75	44.75	0.00
Holberg	33.80	33.80	0.00
Hope	8.85	11.85	-3.00
Hornby Island	22.65	22.65	0.00
Hot Springs Cove	26.25	26.25	0.00
Houston	38.20	38.20	0.00
Hudson's Hope	48.75	48.75	0.00
Invermere	30.20	30.20	0.00
Kaslo	32.60	32.60	0.00
Keremeos	13.65	13.65	0.00
Kimberley	20.00	18.00	2.00
Kincolith	51.25	51.25	0.00
Kingcome	35.00	35.00	0.00
Kitimat	34.00	40.00	-6.00
Kitkatla	41.00	41.00	0.00
Kitsault	41.00	41.00	0.00
Kitwanga	50.25	50.25	0.00
Klemtu	39.00	0.00	39.00
Kootenay Bay Riondel	33.00	33.40	-0.40
Kyuquot	35.00	35.00	0.00
Ladysmith Chemainus	5.00	5.00	0.00
Lake Cowichan	5.40	5.40	0.00
Lillooet	19.95	19.95	0.00
Logan Lake	12.75	12.75	0.00
Lower Post	51.25	0.00	51.25
Lumby	0.80	0.80	0.00
Lytton	22.95	22.95	0.00
Mackenzie	35.00	35.00	0.00
Madeira Park	7.70	13.10	-5.40
Masset	51.25	51.25	0.00

Mayne Island	15.50	15.30	0.20
McBride	37.40	37.00	0.40
Merritt	17.85	17.85	0.00
Mill Bay	0.00	5.00	-5.00
Miocene	24.20	23.80	0.40
Nakusp	31.40	31.80	-0.40
Nelson	16.60	20.60	-4.00
New Aiyansh	51.25	51.25	0.00
New Denver	32.20	32.20	0.00
Nitinat	13.95	13.65	0.30
Ocean Falls	39.00	39.00	0.00
Oliver Osoyoos	6.15	6.15	0.00
Parksville Qualicum	1.50	9.00	-7.50
Pemberton	13.95	13.95	0.00
Pender Island	15.30	15.30	0.00
Port Alberni	9.60	12.60	-3.00
Port Alice	33.40	33.40	0.00
Port Clements	51.25	51.25	0.00
Port Hardy	29.40	33.40	-4.00
Port McNeill	32.60	33.00	-0.40
Port Simpson	51.25	51.25	0.00
Powell River	12.00	10.50	1.50
Prince George	18.00	18.00	0.00
Prince Rupert	35.00	35.00	0.00
Princeton	19.95	20.25	-0.30
Quadra Island	14.25	13.95	0.30
Queen Charlotte	51.25	51.25	0.00
Quesnel	15.20	27.20	-12.00
Revelstoke	25.00	25.00	0.00
Rivers Inlet	35.00	35.00	0.00
Salmo	20.60	20.60	0.00
Salmon Arm Sicamous	13.20	17.20	-4.00
Saltspring Island	16.10	10.90	5.20
Saturna Island	15.90	15.30	0.60
Sayward	23.55	23.55	0.00
Sechelt/Gibsons	7.00	10.40	-3.40
Seton Portage	23.55	0.00	23.55
Slocan Park	16.60	20.60	-4.00
Smithers	31.00	35.00	-4.00
Sointula	33.80	33.00	0.80
Sooke	1.50	0.00	1.50
Sorrento	12.80	16.80	-4.00
Sparwood	31.00	27.00	4.00
Spences Bridge	22.65	22.65	0.00
Squamish	6.00	6.00	0.00
Stewart	51.25	51.25	0.00
Summerland	0.00	0.00	0.00

Tahsis	24.15	24.15	0.00
Takla Landing	51.25	51.25	0.00
Tatla Lake	34.20	0.00	34.20
Telegraph Creek	51.25	51.25	0.00
Teppella	15.90	0.00	15.90
Terrace	28.00	28.00	0.00
Texada Island	16.65	18.45	-1.80
Tofino	23.25	23.25	0.00
Trail	16.20	16.20	0.00
Tsay Keh Dene	51.25	51.25	0.00
Tumbler Ridge	39.40	39.40	0.00
Ucluelet	23.25	23.25	0.00
Valemount	36.20	36.20	0.00
Vanderhoof	31.80	31.80	0.00
Waglisla	39.00	39.00	0.00
Wardner	23.00	23.00	0.00
Whistler	13.65	12.15	1.50
Williams Lake	22.40	18.40	4.00
Winlaw	21.00	20.60	0.40
Woss	23.85	24.15	-0.30
Zeballos	24.45	24.45	0.00
Total Medical Isolation Points	3973.70	3769.25	204.45

Appendix C2: Rural Retention Program – Calculation of Isolation Points

The purpose of the RRP is to provide a provincial rural incentive program that enhances the supply and stability of physician services in eligible RSA communities. Communities are assessed annually for RRP eligibility and community eligibility may change from one year to the next. RRP eligibility is determined through the application of 7 variables, each of which allocates 'medical isolation points to a community'. Overall, the medical isolation points are quite well distributed among RSA eligible communities with very remote communities receiving the highest points and hence have the highest economic incentives to reside/practice in those communities. The medical isolation points are allocated to communities through the application of the following 7 variables:

Factor 1. Number of Designated Specialties within 70 km

Factor 2. Number of General Practitioners within 35 km

Factor 3. Distance from a Major Medical Community

Factor 4. RSA Specialist Centre

Factor 5. Community Size

Factor 6. Degree of Latitude

Factor 7. Location Arc

Rural Retention Premiums are based on the Medical Isolation Point Assessment and are set annually by the JSC. A physician in an eligible community who is funded by an alternative payment arrangement will receive a retention payment, equivalent to the FFS premium.

The total medical isolation points result must be at least 6.0 for a community to be eligible for a fee premium and/or flat fee allowance. If the annual review by the Joint Standing Committee results in a community falling below the minimum isolation points required to qualify, the community will be deleted from the RRP list. Eligible physicians in that community are entitled to receive 50 percent of the previous year's retention allowance (fee and flat fee premiums – if received previously) for a one-year period.

The fee premium is 70 percent of the total isolation points to a maximum of 30 percent for communities with a minimum of one resident physician or a vacant position, as per health authority Physician Supply Plans. The flat fee allocation is based on the remaining 30 percent of the total isolation points multiplied by a per point dollar figure determined annually by the JSC. For communities without a resident physician or vacancy, the total isolation points are applied as a fee premium, to a maximum 30 percent.

Physicians *practicing* in eligible rural communities will receive a fee premium on claims paid by the Medical Services Plan. This approach rewards physicians who provide more service. The more fee-for-service (FFS) work a physician performs results not only in more basic FFS income but will also generate a greater fee premium earnings.

A physician *living and practicing* in a qualifying rural community for at least 9 months of the year and earning greater than $50,000 in MSP billings also receive a flat sum premium allocated to the community. Having a flat fee is seen to be a positive feature of the RRP as this recognizes all full time physicians and most part time physicians who reside and provide services in RSA communities. The earnings threshold is seen to be an incentive to provide a minimum level of service.

A physician in an eligible community who is funded by an alternative payment arrangement will receive a retention payment, equivalent to the Fee-For-Service (FFS) premium.

Those practitioners eligible for the fee premiums include resident physicians, itinerant physicians and locum tenens that provide medical services *directly in* eligible rural communities as outlined in the RSA. A physician who practices in an eligible rural community and provides radiology or pathology services to an approved hospital or facility may be eligible to receive the RRP on the professional component of outpatient radiology and category I, II, and III laboratory medicine services. A listing of the professional component, provided by the BCMA, is used in the RRP calculation process.

For the purpose of determining isolation points, Health Authorities report physician numbers and vacancies on an annual basis. That information will be integral to the development of the Health Authority regional Physician Supply Plans. Annually the Ministry of Health asks the Health Authorities to complete a 'Physician Count' form by November 30 of each year. The forms are completed by the Ministry to include the previous year's physician count by community. The Health Authorities update the physician count information as of December 31, for each community and return the updated form to the Ministry of Health by mid-January. The physician count information is needed to determine:

6.1. The number of Specialties available within 70 kilometers of each community

6.2. The number of General Practitioners within 35 kilometers of each community.

For each general practice physician included in the December 31 count, the Ministry confirms whether their MSP billings income during the calendar year is greater than the 40th percentile of MSP billings income for physicians in the Province. Each person with an annual MSP billing of over the 40th percentile is counted as 1 Full Time Equivalent (FTE) physician. The incomes of physicians below the 40th percentile are added together to form additional FTE physician positions for the purpose of counting the number of General Practitioners within 35 kilometers of a community.

For each of the eight designated specialties (General Surgery, Orthopaedics, Paediatrics, Internal Medicine, Obstetrics/Gynecology, Anaesthesia, Psychiatry, and Radiology) included in the December 31 count, the Ministry confirms whether at least one of the specialist's in each designated area of specialty has a MSP billing income greater than the 40th percentile of MSP billing income for physicians in the Province. For each specialty service where someone earns more than the 40th percentile, the Ministry counts the number of different specialty services available in a community or within 70 kilometers of other communities.

Having the physician account information, the Ministry is then able to assign the number of medical isolation points to each RSA community as follows:

Factor 1. Number of Designated Specialties within 70 km

All designated specialties within 70 km (by road or ferry) of the community where the specialist(s) meet the FTE income figure are counted. Medical isolation points are then allocated to each RSA community as follows:

Number of Designated Specialties within 70 km	
0 Specialties within 70 km	60
1 Specialty within 70 km	50
2 Specialties within 70 km	40
3 Specialties within 70 km	20
4+ Specialties within 70 km	0

Discussion: The 'Number of Designated Specialties with 70 km factor supports recruitment and retention in rural and remote areas. The communities benefiting from this factor are communities primarily supported by general practitioners. Most general practitioners prefer to work where there is a nearby a network of specialist support services. The further a general practitioner is from specialist support services requires a general practitioner to have a wide range of experience and skills to be able to support a community's medical needs. A higher point allocation to communities further from specialist supports is seen to be appropriate as it recognizes and rewards physicians for working in communities with reduced access to specialist services.

Factor 2. Number of General Practitioners within 35 km

General Practitioners practicing within 35 km (by road) of the community and who meet the FTE income figure as defined below are counted. General Practitioners practicing in a community within 35 km of the community by ferry are not counted. Medical isolation points are then allocated to each RSA community as follows:

Number of General Practitioners within 35 km	
Over 20 Practitioners	0
11-20 Practitioners	20
4 to 10 Practitioners	40
0 to 3 Practitioners	60

Discussion: This factor recognizes the desirability of working in a network of nearby general practitioners. In communities where there are greater numbers of general practitioners, there is often a number of general practitioners who have advanced skills and an interest in providing specialized services such emergency room care, obstetrical care, and anesthesia. Where there are clusters of general practitioners, they often work in shared practices and develop rotations to be able to cover each other's patients while on call or while one or more physicians is away.

In communities where there are reduced numbers of general practitioner often require each general practitioner to have an increased range of experience and skills to be able to collectively support a communities medical needs. Most general practitioners prefer to work in or very near to communities where there adequate numbers of general practitioners to support each other. A higher point allocation to communities with a reduced number of general practitioners is seen to be appropriate as it recognizes and rewards physicians for working in smaller communities.

Factor 3. Distance from a Major Medical Community

The designated Major Medical Communities are Kamloops, Kelowna, Nanaimo, Vancouver, Victoria, Abbotsford and Prince George. A Major Medical Community is defined as those communities with at least 3 specialists in each of the Designated Specialties. Maximum points are awarded for communities with no road or ferry access. Medical isolation points are then allocated to each RSA community as follows:

Distance from Major Medical Community (provided by Davenport Maps)	
(Kamloops, Kelowna, Nanaimo, Vancouver, Victoria, Abbotsford, Prince George)	
first 70 km road distance (70km-104km)	4
for each 35 km over 70 km	2
to a maximum of	30

Discussion: This factor recognizes the desirability of working in a nearby network of specialist support services. The further a general practitioner is from specialist support services often requires a general practitioner to have a wide range of experience and skills to be able to support a communities medical needs. Most general practitioners prefer to work in or very near to communities where there is a range of specialist skills available. A higher point allocation to communities further from specialist supports is seen to be appropriate as it recognizes and rewards physicians for working in communities with reduced access to specialist services.

Factor 4. RSA Specialist Centre

Points are assigned to a community where the regional Physician Supply Plan requires designated specialists to provide services for a community. A community must be included in Appendix A of the RSA in order to be considered an RSA Specialist Centre. An RSA community located within 35 km (by road) of an RSA Specialist Centre will receive the same points as the RSA Specialist Centre for this factor. Medical isolation points are then allocated to each RSA community as follows:

RSA Specialist Centre	
- 3 or 4 designated specialties in physician supply plan	30
- 5 to 7 designated specialties in physician supply plan	50
- 8 designated specialties and more than one specialist in each specialty as set out in the physician supply plan	60

Discussion: This factor recognizes the desirability of there being centres throughout the Province where there is a wide range specialists working together and in close co-operation with general practitioners residing in the RSA Specialist Centre and the throughout a geographic region. The RSA Specialist Centre awards greater number of medical isolation points to centres with larger numbers of designated specialties as a way to support specialist recruitment and retention to those regional RSA centres. It is noted that that being a RSA Specialist Centre also supports the recruitment of general practitioners to those centres a general practitioners tend to favour working in communities with excellent specialist support.

The communities that benefit from this factor and have a final 2006/07 total medical isolation point assessment of 6 or greater are listed in the following table. On average, this application supports communities with 5 designated specialties in their medical supply plan and communities with an average population of approximately 16,400. Note, the application of this factor allows for two nearby communities (e.g. Sparwood and Fernie) to work together to attract specialists.

RSA Community	Population	Number of Designated Specialties
Campbell River	30,810	7
Castlegar	7,889	7
Courtney Comox	37,302	8
Cranbrook	19,774	7
Dawson Creek	11,394	4
Enderby	16,800	8
Fernie (within 35 km of Sparwood)	5,126	0
Fort St. John	17,781	4
Golden	4,399	1
Kimberly	19,774	7
Madeira Park	9,751	5
Nelson	9,780	5
Port Alberni	18,688	7
Powell River	13,831	5
Prince George	77,148	8
Prince Rupert	14,974	5
Salmon Arm/Sicamous	19,843	8
Saltspring Island	9,381	1
Sechelt/Gibsons	14,100	5
Slocan Park	9,780	5
Smithers	5,509	2
Sorrento	16,800	4
Sparwood (within 35 km of Fernie)	5,126	0
Squamish	15,276	8
Terrace	12,556	5
Trail	7,889	7
Williams Lake	11,872	5
Average	**16,420**	**5**

Factor 5. Community Size

Where a community is within 35 km by road of a larger community, the points are based on the population of the larger community. Where a community is within 35 km of a larger community by ferry, the population of the larger community is not counted. When two communities are combined in this Agreement, the populations will be amalgamated.

Community populations are established annually using the most recent National Census-based estimate for the preceding calendar year, which is supplied by BC STATS, Ministry of Finance and Corporate Relations. They are based on regional districts defined by the Ministry of Community, Aboriginal and Women's Services. In case of changes to regional districts from one year to the next, population assignment is determined by the Ministry, based on all available information (available on request). Medical isolation points are then allocated to each RSA community as follows:

Community Size (If larger community within 35 km then larger pop is considered)	
30,000 +	0
10,000 to 30,000	10
Between 5,000 and 9,999	15
Up to 5,000	25

Discussion: This factor recognizes the difficulty in recruiting physicians to smaller communities.

Factor 6. Degree of Latitude

Points are allocated for those communities in British Columbia located at and above the 52 degrees of latitude. Medical isolation points are then allocated to each RSA community as follows:

Degree of Latitude	
Communities between 52 to 53 degrees latitude	20
Communities above 53 degrees latitude	30

Discussion: No concerns were raised during the review regarding this factor. This factor is reasonably successful at contributing to the notion of 'rurality'.

Factor 7. Location Arc

Four differential multipliers have been established for the purpose of determining the final point total for determination of retention allowances. Arcs are based on air distance from Vancouver and multiplied by the applicable factor to determine the community's final point total. Medical isolation points are then allocated to each RSA community as follows:

Location Arc	%
- communities in Arc A (within 100 km air distance from Vancouver)	0.10
- communities in Arc B (between 100 and 300 km air distance from Vancouver)	0.15
- communities in Arc C (between 300 and 750 km air distance from Vancouver)	0.20
- communities in Arc D (over 750 km air distance from Vancouver)	0.25

Discussion: No concerns were raised during the review regarding this factor. This factor is reasonably successful at contributing to the notion of 'rurality'.

Flat Fees

Physicians are entitled to the flat fee sum, retroactively, upon successful completion of the annual residency requirement in an eligible RSA community. Health Authorities are required to submit notification of completion of the residency requirement to the Rural Practice Programs office. Reconciliation and payment of the retroactive flat sum fee is done on a quarterly basis.

If a physician lives in an eligible RSA community but practices in a different eligible RSA community (for at least nine months of the year), s/he will receive the fee premium and flat sum premium for the community where s/he practices.

Before a flat fee is determined, 70% of the total medical isolation points (to a maximum of 30 points) designated for a community is allocated as a fee premium. For example, physicians providing service in 100 Mile House receive a fee premium of 16.10% (effective April 1, 2007) on all MSP fee billings.

If a physician lives and practices in an eligible RSA community for at least nine months of the year and bills $50,000 or greater in MSP billings for the previous calendar year, s/he also receives the full flat fee sum. If s/he bills < $50,000, s/he receives no flat fee premium. To continue with the 100 Mile House example, physicians who reside in that community for at least nine months will receive a flat fee of $14,076 in addition to the fee premiums collected for services provided within the community.

The amount of the flat fee available to eligible physicians is determined by the overall number of medical isolation points remaining after the 70% allocation is made as a fee premium. After considering each of the seven factors, the total medical isolation points allocated to 100 Mile House is currently 23. Of those points, 16.10 (i.e.70% of 23) is allocated as a fee premium of 16.10%. The remaining 6.9 medical isolation points are then assigned toward the flat fee. To determine the value the flat fee, the remaining points available are multiplied by the value of each remaining medical isolation point. The value of a flat fee point has been $2,040 since 2003 when the program was first established. The Joint Standing Committee has not been able to agree on a revised value since that time. As noted above, physicians who reside in 100 Mile House receive a flat fee of $14,076 (=6.9 x $2040).

A listing of the flat fees assigned to communities is provided below. It can be seen the flat fees available to physicians ranges significantly with the most rural resident physicians receiving the largest flat fees.

There are two variables to determining the flat fee: the overall number of medical isolation points assigned to a community and the financial value of the medical isolation points available for the flat fee. Both of these variables are subject to change. This can cause a lack of certainty among rural and remote physicians regarding the amount of the flat fee they are entitled to on a yearly basis. This also provides uncertainty to the JSC and the Ministry regarding the overall cost of the RRP flat fee. An alternate model whereby the flat fee amounts were established at set amounts for different ranges of community medical isolation points would introduce greater certainty for everyone.

Full Time Physician

For the purposes of the Rural Programs a physician is deemed to be a full time physician in any given year if s/he bills the MSP > $50,000 in that year.

Appendix C3: RRP Retention Program Points, 2006/07 Fee Premiums and Flat Fees

06/07 Rural Retention Program (RRP) Points - implemented April 1, 2007

Community		Service Clarification Code (SCC)	06/07 Total Isolation Points (implemented April 1, 2007)	06/07 Fee Premium (implemented April 1, 2007)	06/07 Annual Flat Fee (implemented April 1, 2007)	Community	Service Clarification Code (SCC)	06/07 Total Isolation Points (implemented April 1, 2007)	06/07 Fee Premium (implemented April 1, 2007)	06/07 Annual Flat Fee (implemented April 1, 2007)
100 Mile House		MH	23.00	16.10	$14,076.00	Fort Nelson	F2	51.25	30.00	$31,365.00
Agassiz/Harrison	**	A6	5.50	2.10	1,836.00	Fort St. James	F3	32.60	23.62	$21,951.22
Ahousat		A4	26.25	26.25	$0.00	Fort St. John	F4	29.00	25.30	$23,390.64
Alert Bay		A1	34.20	23.94	20,930.40	Fort Ware	F6	51.25	30.00	$0.00
Anahim Lake		A5	39.00	30.00	$0.00	Fraser Lake	F5	36.60	25.62	$22,399.20
Armstrong/ Spallumcheen		A7	0.80	0.00	0.00	Gabriola Island	G7	8.50	5.95	$5,202.00
Ashcroft		A3	22.35	15.65	$13,678.20	Galiano Island	G5	15.70	10.99	$9,608.40
Atlin		A2	51.25	30.00	$31,365.00	Gold Bridge/Bralorne	G6	23.85	23.85	$0.00
Bamfield		B8	22.95	22.95	0.00	Gold River	G2	23.55	16.49	$14,412.60
Barriere		B4	17.00	11.90	$10,404.00	Golden	G1	32.60	22.82	$19,951.20
Bella Coola		B3	39.00	27.30	$23,868.00	Granisle	G4	38.60	30.00	$0.00
Big White		B7	17.00	11.90	$10,404.00	Greenwood/Midway/Rock Creek	G3	30.60	21.42	$18,727.20
Blue River		B5	35.40	30.00	$0.00	Halfway River	H9	34.25	30.00	$0.00
Blueberry River		B9	35.75	30.00	$0.00	Hartley Bay	H6	41.00	30.00	$0.00
Bowen Island		B6	8.90	6.23	5,446.80	Hazelton	H1	44.75	30.00	$27,387.00
Bridge Lake		D1	30.60	30.00	$0.00	Hollberg	H2	33.00	30.00	$0.00
Burns Lake		B2	33.40	24.18	22,431.02	Hope	H8	8.85	6.30	$7,107.16
Campbell River		CR	10.20	7.14	$6,242.40	Hornby Island	H5	22.65	15.86	$13,861.80
Canal Flats		C5	34.60	30.00	$0.00	Hot Springs Cove	H7	26.25	26.25	$0.00
Castlegar		CA	16.20	11.34	$9,914.40	Houston	H4	38.20	26.74	$23,378.40
Chase		CH	13.00	9.10	$7,956.00	Hudson's Hope	H3	48.75	30.00	$29,835.00
Chetwynd		C2	34.20	24.74	22,910.83	Invermere	VM	30.20	21.14	$18,482.40
Christina Lake/ Grand Forks		C7	25.40	17.78	16,433.42	Kaslo	K1	32.60	22.82	$19,951.20
Clearwater		C8	26.20	18.34	$16,034.40	Keremeos	K8	13.65	9.56	$8,353.80
Clinton		C3	22.65	15.86	$13,861.80	Kimberley	KM	20.00	14.00	$12,240.00
Cortes Island		C4	24.15	16.91	14,779.80	Kincolith	KK	51.25	30.00	$0.00
Courtenay/Comox/Cumberland		CC	9.90	6.93	$6,058.80	Kingcome	K6	35.00	30.00	$0.00
Cranbrook		CB	20.00	14.00	12,240.00	Kitimat	K2	34.00	26.00	$23,990.40
Creston		C6	23.80	16.66	15,233.90	Kitkatla	K9	41.00	30.00	$0.00
Dawson Creek		D1	33.00	23.10	$20,196.00	Kitsault	K3	41.00	30.00	$0.00
Dease Lake		D3	51.25	30.00	$31,365.00	Kitwanga	K4	50.25	30.00	$0.00
Denman Island		D2	13.65	9.56	8,353.80	Klemtu	KL	39.00	30.00	$0.00
Doig River		D5	35.75	30.00	$0.00	Kootenay Bay/Riondel	K5	33.00	30.00	$0.00
Duncan/N. Cowichan		D4	5.00	0.00	$0.00	Kyuquot	K7	35.00	30.00	$0.00
Edgewood		E2	31.00	30.00	$0.00	Ladysmith/ Chemainus	L4	5.00	0.00	$0.00
Elkford		E1	35.00	24.50	21,420.00	Lake Cowichan	L5	5.40	0.00	$0.00
Enderby		E3	8.80	8.36	8,876.45	Lillooet	L1	19.95	13.97	$12,209.40
Fernie		F1	31.00	21.70	$18,972.00	Logan Lake	L3	12.75	8.93	$7,803.00

Appendix C2: Rural Retention Program (continued)

Community	Service Clarification Code (SCC)	06/07 Total Isolation Points (implemented April 1, 2007)	06/07 Fee Premium (implemented April 1, 2007)	06/07 Annual Flat Fee (implemented April 1, 2007)	Community	Service Clarification Code (SCC)	06/07 Total Isolation Points (implemented April 1, 2007)	06/07 Fee Premium (implemented April 1, 2007)	06/07 Annual Flat Fee (implemented April 1, 2007)
Lower Post	L7	51.25	30.00	$0.00	Saltspring Island	SS	16.10	11.27	$9,853.20
Lumby	L6	0.80	0.00	$0.00	Saturna Island	S7	15.90	11.13	$9,730.80
Lytton	L2	22.95	16.07	$14,045.40	Savory Island	SV	26.25	26.25	$0.00
Mackenzie	M1	35.00	24.50	$21,420.00	Sayward	S1	23.55	16.49	$14,412.60
Madeira Park	M5	7.70	11.10	0.00	Sechelt/Gibsons	SG	7.00	5.28	$6,237.50
Masset	M3	51.25	30.00	$31,365.00	Seton Portage	SP	23.55	23.55	$0.00
Mayne Island	M7	15.50	10.85	9,486.00	Shawnigan Lake	SL	5.00	0.00	$0.00
McBride	M2	37.40	26.18	22,888.80	Slocan Park	S8	16.60	12.42	$12,355.06
Merritt	M4	17.85	12.50	$10,924.20	Smithers	S2	31.00	22.50	$20,991.60
Mill Bay	MB	5.00	0.00	$0.00	Sointula	S6	33.80	30.00	$0.00
Miocene	M6	24.20	24.20	0.00	Sooke	SK	1.50	0.00	$0.00
Nakusp	N1	31.40	21.98	19,216.80	Sorrento	S9	12.80	9.76	$10,075.97
Nelson	N5	16.60	12.42	12,355.06	Sparwood	S3	31.00	21.70	$18,972.00
New Aiyansh	N2	51.25	30.00	$31,365.00	Spences Bridge	SB	22.65	22.65	$0.00
New Denver	N3	32.20	22.54	$19,706.40	Squamish	SQ	6.00	4.20	$3,672.00
Nitinat	N4	13.95	13.95	0.00	Stewart	S4	51.25	30.00	$31,365.00
Ocean Falls	CF	39.00	27.30	$0.00	Summerland	SU	0.00	0.00	$0.00
Oliver/Osoyoos	LS	6.15	4.31	$3,763.80	Tahsis	T2	24.15	16.91	$14,779.80
Parksville/Qualicum	PQ	9.00	6.30	$5,508.00	Takla Landing	T6	51.25	30.00	$0.00
Pemberton	P1	13.95	9.77	$8,537.40	Tatla Lake	TL	34.20	30.00	$0.00
Pender Island	P8	15.30	10.71	$9,363.60	Tatlayoko Lake	T8	34.60	24.22	$21,175.00
Port Alberni	PA	9.60	6.82	7,556.98	Telegraph Creek	TC	51.25	30.00	$0.00
Port Alice	P2	33.40	23.38	$20,440.80	Teppella	TP	15.90	15.90	$0.00
Port Clements	P6	51.25	30.00	$0.00	Terrace	T3	28.00	19.60	$17,136.00
Port Hardy	P3	29.40	21.38	20,031.98	Texada Island	T1	16.65	11.66	$11,065.57
Port McNeill	P4	32.60	22.82	19,951.20	Tofino	T4	23.25	16.28	$14,229.00
Port Simpson	P9	51.25	30.00	$0.00	Trail	TR	16.20	11.34	$9,914.40
Powell River	PR	12.00	8.40	7,344.00	Tsay Keh Dene	T7	51.25	30.00	$0.00
Prince George	PG	18.00	12.60	$11,016.00	Tumbler Ridge	T5	39.40	27.58	$24,112.80
Prince Rupert	P5	35.00	24.50	$21,420.00	Ucluelet	U1	23.25	16.28	$14,229.00
Princeton	P7	19.95	13.97	12,209.40	Valemount	V2	36.20	25.34	$22,154.40
Quadra Island	Q1	14.25	9.98	8,721.00	Vanderhoof	V1	31.80	22.26	$19,461.60
Quatsino	Q4	35.00	30.00	0.00	Waglisla	W4	39.00	27.30	$23,868.00
Queen Charlotte	Q2	51.25	30.00	$31,365.00	Wardner	W5	23.00	23.00	$0.00
Quesnel	Q3	15.20	17.04	16,313.47	Whistler	W6	13.65	9.56	$8,353.80
Revelstoke	R1	25.00	17.50	$15,300.00	Williams Lake	W7	22.40	15.68	$13,708.80
Rivers Inlet	R3	35.00	30.00	$0.00	Winlaw	W3	21.00	21.00	$0.00
Salmo	S5	20.60	14.42	$12,607.20	Woss	W1	23.85	23.85	$0.00
Salmon Arm/ Sicamous	SA	9.20	10.04	$10,315.87	Zeballos	Z1	24.45	24.45	$0.00

For communities without a resident physician or vacancy, the total isolation points will be applied as a fee premium, to a maximum of 30 percent.

**Community falls below the minimum isolation points to qualify. Therefore, eligible physicians are entitled to receive 50 percent of the previous year's retention allowance.

Appendix C4: RRP Medical Isolation Point Rating System

RRP Medical Isolation Point Rating System		
Factor	**Points**	**Max Pts**
Number of Designated Specialties within 70 km		
0 Specialties within 70 km	60	
1 Specialty within 70 km	50	
2 Specialties within 70 km	40	
3 Specialties within 70 km	20	
4+ Specialties within 70 km	0	60
Number of General Practitioners within 35 km		
over 20 Practitioners	0	
11-20 Practitioners	20	
4 to 10 Practitioners	40	
0 to 3 Practitioners	60	60
Community Size (If larger community within 35 km then larger pop is considered)		
30,000 +	0	
10,000 to 30,000	10	
Between 5,000 and 9,999	15	
Up to 5,000	25	25
Distance from Major Medical Community (provided by Davenport Maps) (Kamloops, Kelowna, Nanaimo, Vancouver, Victoria, Abbotsford, Prince George)		
first 70 km road distance (70km-104km)	4	
for each 35 km over 70 km	2	
to a maximum of	30	30
Degree of Latitude		
Communities between 52 to 53 degrees latitude	20	
Communities above 53 degrees latitude	30	30
Location Arc	%	
- communities in Arc A (within 100 km air distance from Vancouver)	0.10	
- communities in Arc B (btwn 100 and 300 km air distance from Vancouver)	0.15	
- communities in Arc C (btwn 300 and 750 km air distance from Vancouver)	0.20	
- communities in Arc D (over 750 km air distance from Vancouver)	0.25	
RSA Specialist Centre		
- 3 or 4 designated specialties in physician supply plan	30	
- 5 to 7 designated specialties in physician supply plan	50	
- 8 designated specialties and more than one specialist in each specialty as set out in the physician supply plan	60	60