SOCIETY OF Rural Physicians OF CANADA
SOCIÉTÉ DE LA Médecine Rurale DU CANADA

Position Statement **July 2022**

Enhancing Canada's Rural Physician Workforce Through Effective Health Human Resource Planning

Access to health care in rural communities

Having equitable access to health care is an ongoing challenge for rural, remote, and Indigenous communities in Canada. The physician workforce available to serve these communities is inadequate due to the lack of a comprehensive health human resource (HHR) plan that would enable rural physicians to commit to practising, teaching, and living in these areas over the long term. Health care needs in rural areas go beyond comprehensive primary care. Recent Canadian Medical Protective Association data show that between 20% and 30% of family doctors who identify as rural family physicians/general practitioners include a broader range of services in their scope of work than non-rural physicians.[i] Rural generalist physicians provide emergency care and hospital in-patient care as part of their core services, and they participate in networks of care that deliver anesthesia, obstetrical, surgical, palliative, population health, and home care services. These components must be part of an HHR plan for rural populations. However, while many programs have been implemented to recruit and support rural physicians, barriers[1] still exist that hinder their ability to expand rural generalist care in Canada.[2][ii]

Rural physician workforce supply

Policies designed to improve the geographic distribution of physicians and enhance access to care for people living in underserved areas have had uneven success.[iii] According to the Canadian Institute for Health Information, growth in the supply of family physicians practising in rural communities has actually slowed over the past three years.[iv] Physician distribution in rural regions remains problematic despite a growing number of government interventions.[v] One effective way to address the maldistribution of physicians for rural, remote, and Indigenous communities is to graduate family physicians with broad skill sets and provide opportunities for them to acquire additional skills based on rural communities' needs.

[1] Barriers include the lack of national medical licensure, inequitable access to virtual health care, a lack of mobility across provincial borders, the focus of medical school curricula on urban-based education, rural physician funding models, shifts in scope of practice, regulatory and legislative issues, siloed geographical HHR planning, and the use of outdated health workforce data.

[2] The Australian College of Rural and Remote Medicine defines rural generalism as "a distinct and identified body of core clinical skills, practices and values which provides the foundation for these doctors to responsively meet their diverse local communities' needs. The body of core clinical skills is defined by a series of generic clinical disciplines and by what is required of the doctor practicing these disciplines in a rural and remote context. It is recognised that the clinical, professional and personal implications of the rural or remote context impact all aspects of practice and the competencies and aptitudes for addressing these are viewed as core to the Rural Generalist scope."[2]

Factors affecting the rural physician workforce

- ***Rural medical education*** – The medical education system is not geared to producing rural generalists. Research has shown that physicians are more likely to settle in communities where they have been educated and trained.[vi] While rural generalist residency programs have helped with the supply of rural physicians, much work still needs to be done to support these programs through faculties and provincial governments.[vii] Medical education leaders must engage in dialogue with health system planners to define the competencies and approaches required for teaching, learning, and assessing the generalist skills required for rural practice; this includes establishing requirements not only for formal training during medical school and residency but also for continuing professional development. Including rural education in physician resource workforce planning is critical.
- ***Rural health care delivery*** – Challenges in rural retention include physicians' frustrations in trying to access services that are not available in their communities for their patients and in being unable to work to their full scope as generalists. Rural medical practice thrives when physicians can work with others, through networks of care and as parts of teams, to provide comprehensive generalist care to their patients. Training in enhanced skills—such as surgery and anesthesia, palliative care, and addiction medicine—allows rural physicians to expand the availability of much needed services in rural settings. Having established generalist physicians mentor new physicians in rural practice may help encourage longer-term retention.
- ***Rural physician data*** – National and provincial databases report different information on physician supply, and none consistently provide details on physician demographics, where they work, and their scopes of practice, which are crucial for workforce planning.[viii] Most provinces and territories use forecasting planning tools to help guide planning; however, the robustness of these tools varies, with some having minimal abilities to factor in all the elements of system needs and physician workload trends. The absence of a common definition of "rural" and the lack of a centralized database present challenges for physician workforce planning.

Recommendations for rural physician workforce planning

The Society of Rural Physicians of Canada calls for a coordinated and systemic approach to rural physician workforce planning. It should build on existing successful programs that have been implemented in rural communities in collaboration with the health care and education systems.

1. Implement a pan-Canadian rural physician workforce strategy that includes rural medical education: Execute a comprehensive, robust strategy with the goal of gathering workforce data and developing solutions to tackle the shortage of rural physicians and address the factors hindering recruitment and retention. This would require federal, provincial, and territorial collaboration to prioritize and establish a national strategy to address systemic shortages and to identify models of rural generalist care and credentialing that would allow

seamless entry into the workforce. The strategy must recognize the realities of rural health care in planning national initiatives. Specific actions would include:

a) Define the role of rural medical education informing/supporting HHR planning.
b) Expand rural training opportunities for medical students and residents.
c) Support physicians in transitioning to rural practice.
d) Align rural medical education with rural health care needs.

2. Ensure the ongoing development of an adequate supply of rural physicians with the necessary skill sets to ensure access to rural health care: Structured medical training delivered in rural communities at both the undergraduate and postgraduate levels can serve as an effective educational intervention to develop competent physicians and as a health services strategy to promote interest in working in rural contexts. This should include government commitments to provide sustainable funding for the training of rural generalists. Specific actions would include:
   a) Develop a comprehensive strategy to help rural physicians integrate socially and professionally into local communities and rural hospitals.
   b) Facilitate continuing professional development for rural physicians in enhanced skills.
   c) Reduce regulatory and administrative barriers to allow rural physicians to practise to their full scopes in the provision of generalist care.
3. Provide sustainable support for existing rural physicians: Appropriate infrastructure, funding, and resources are needed to retain family physicians and other specialists who are already practising in rural communities. This should include dedicated funding for continuing professional development that lets them to work to the full extent of their scopes of practice. This will not only allow them to serve the needs of rural communities but will also enhance physician retention. Specific actions would include:
   a) Provide incentives to attract physicians and their families to relocate to or remain in rural communities.
   b) Tie education subsidies for physicians to agreements for return of service in rural areas.
   c) Create a rural health workforce support network that includes mentorship.
   d) Fund rural networks of care—including funding for virtual health care, infrastructure, and technological support for clinical practice—and new collaborative work models in settings such as rural hospitals.
4. Establish a national regulatory/policy framework to ensure access to health care services regardless of geography: This would include establishing national licensure that allows rural physicians to work anywhere in Canada; developing standards/guidelines for legislative initiatives that will permanently reduce barriers to cross-provincial/territorial practice for physicians; and allowing access to networks of care such as primary care, mental health care, virtual health care, and patient medical transport. Specific actions would include:

a) Make planning population based.
b) Base rural health care systems on generalists.

Summary

Currently, Canadians living in rural communities do not have equitable access to health care services. There is no national, provincial, or territorial rural health care strategy to address the needs of rural populations. There are gaps in knowledge about effective HHR strategies and policies that may enhance our rural physician workforce. Engagement is needed through a set of federally, provincially, and regionally supported networks that would encourage collaboration across Canada among rural health care practitioners, policy-makers, federal, provincial, and territorial leaders, and rural and Indigenous communities. Policy-makers need to recognize how aligning rural medical education with rural physician workforce planning can successfully influence the development of a rural physician workforce pipeline and the longer-term retention of physicians in rural communities.

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[iii] Bosco C, Oandasan I. *Review of Family Medicine Within Rural and Remote Canada: Education, Practice, and Policy*. Mississauga, ON: College of Family Physicians of Canada; 2016.
[iv] Canadian Institute for Health Information. National Physician Workforce Data 2020. https://www.cihi.ca/en/physicians#_Reports_and_Analyses
[v] Taylor T. *The Best Rural Physicians are not yet physicians. Sustainability Strategy for Rural, Remote and Indigenous Physicians in Northern British Columbia. Final Report November 2020*. Rural Coordination Centre of British Columbia: University of British Columbia; 2020.)
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[viii] Bourgeault I, Simkin S, Chamberland-Rowe C. Poor health workforce planning is costly, risky and inequitable. *CMAJ*. 2019;191(42):e1147-8. doi: 10.1503/cmaj.191241