

MOHLTC HealthForceOntario Underserviced Area Program Consultation

Submission from the Centre for Rural and Northern Health Research (Laurentian University)

Responding to Q.3:

The Centre for Rural and Northern Health Research (CRaNHR) at Laurentian University would like to make the following comments and suggestions with respect to the proposed changes to some aspects of the Underserviced Area Program (UAP).

1. We are in general agreement with the proposed approach to replace the current underserviced area designation process with a more objective and less cumbersome process using the Rural Index of Ontario (RIO) scores as the funding criteria. We also agree with HealthForceOntario (HFO) that since “so many southern communities are eligible for the same incentives, it is almost impossible for northern communities to compete for physicians” (p. 2 of Consultation Paper). The gradual shifting of UAP resources to southern Ontario communities has defeated the original and most important purpose of the UAP.
2. However, we urge HFO to reconsider its proposed cutoff point of 40 on the RIO. We suggest raising the cutoff point from 40 to 45 (with the exception of the five “northern urban referral centres” of North Bay, Sault Ste. Marie, Sudbury, Thunder Bay and Timmins as proposed). This is based on two considerations. First, it is stated that “The (redesigned) program will be cost neutral” (p. 13 of Consultation Paper). Although it is not known what the consolidated budget will be, “cost neutral” means there will be no additional resources for the redesigned program. Second, it is stated that the “proposed redesign is a shift intended to ensure that the most rural and northern communities will benefit from the program as originally planned” (p. 2 of Public Qs and As). Given finite financial resources, there may not be sufficient money to support the “most remote and northern communities”. Our suggestion is intended to avoid spreading limited resources too thin. By raising the RIO cutoff point to 45, 45 census subdivisions (CSDs) would be eliminated from the list of communities that would otherwise be eligible for UAP funding support. A review by CRaNHR shows that communities in CSDs with a RIO score of 40-44 are mostly within a relatively short distance from an urban centre and some are so small that it is doubtful that they can sustain a full-time physician, even with financial incentives. The resources saved could then be redirected to support communities with greater needs but with less ability to meet such needs.

3. Although we agree with the proposal to open the Return of Service (ROS) program to more Ontario communities and to not restrict ROS physicians to designated underserved communities “since there will be more supply than there is demand for some specialties in underserved communities” (p. 11 of Consultation Paper), we suggest that a ROS program with very little restrictions needs to be considered very carefully. This is because a ROS program with little restrictions would mean that almost all ROS physicians will choose not to practice in smaller or more remote communities, even for a limited period of time. While it is true that “return-of-service has not been effective in recruiting physicians to northern and rural communities” and that “only about 8% of IMGs in specialty medicine and 5% in family medicine have completed or are completing a return-of-service in northern or rural communities” (p. 4 of Consultation Paper), the reasons for such poor outcomes are unknown. We suspect that many IMGs, particularly those with cultural or ethnic minority backgrounds, may find rural or northern communities very isolating. However, if remedial approaches can be found, they may be more willing to work in such communities. We think it is premature to give up on IMGs entirely as a source of medical human resources for rural and northern Ontario when we know so little about the underlying factors that drive IMGs and ROS physicians away from underserved communities. Besides, some other provinces have many IMGs working in rural and more remote areas, and Ontario could learn from their experiences. Research is needed to find out why IMGs are reluctant to work in non-metropolitan areas and what can be done to reverse the trend.
4. Closely related to #3 is our concern that the “UAP consultation process will be an opportunity for stakeholders to provide their perspective on how the boundaries around Ottawa and the GTA will be defined” (p. 5 of Public Qs and As). It is likely that most bedroom communities surrounding Ottawa and “905” communities around Toronto will want to be exempted from the GTA and Ottawa “exceptions” and that this may make the redesigned ROS program even more open-ended. It will be an open invitation for IMGs and other ROS physicians to gravitate even more to the two major metropolitan areas in Ontario, thus further aggravating the geographic maldistribution of physicians. In short, we believe that the boundaries around Ottawa and the GTA should be defined more inclusively by including all surrounding or contiguous communities.
5. While we support the general directions of the proposal to redesign the UAP (with the exception of the above-mentioned concerns), we strongly urge HFO to conduct necessary monitoring, research and evaluations to assess how the redesigned programs work, how effective they are and the impact it may have on communities. Unless this is done, HFO will not know if the redesigned programs are more or less effective than current programs. Moreover, such monitoring, research and evaluations should not be conducted retrospectively years down the road. Instead, they should start even before the full

implementation of the new programs. Otherwise, there may be no baseline data, with which future outcomes can be compared.

In particular, there should be an evaluation of the impact of the RIO2008_BASIC weights. It is not known how the weights (28.6 for POP, 23.8 for TIME_a and 47.6 for TIME_b) of the RIO scoring system are derived and it is also not known whether POP/TIME_b/TIME_a is the most appropriate weighting system. While TIME_a and TIME_b may not change substantially over time, increases or decreases in population (POP) may skew RIO scores and adversely affect some rural or northern communities, where major population shifts can occur over a relatively short period of time. For instance, if a rural community loses population over time, its RIO score will get smaller, but its need for UAP support to recruit and retain physicians may actually become greater.