

Underserviced Area Program Redesign and Consultation Public Qs and As

Q1: What is the UAP?

A1: The UAP was created in 1969 to provide recruitment and retention support for northern and rural communities experiencing chronic problems recruiting and retaining physicians. Over time, the UAP has expanded beyond the north to include communities throughout the province.

The UAP includes a wide range of health care initiatives for rural and northern communities, including the Northern Ontario Health Professional Development Program, Dental Outreach Program, Nursing Stations, and Tuition Support Program for Nurses.

This redesign is intended to address only physician recruitment and retention initiatives.

Q2: What is the intention of the UAP redesign?

A2: The redesign is intended to strengthen physician recruitment and retention initiatives in Ontario to meet the unique needs of northern and rural communities that face chronic problems recruiting and retaining physicians. It is also intended to help all Ontario communities experiencing physician shortages.

Q3: What specific changes are being proposed?

A3: Physician recruitment and retention programs under Ontario's Underserviced Area Program are being redesigned. The government is proposing a **financial incentive program designed specifically to attract physicians to northern and rural communities**. This program would combine existing physician recruitment and retention funding from the Incentive Grant and Free Tuition Programs into a single fund. Eligibility for the incentives would be based on an objective, stable rurality index measure known as the Rurality Index for Ontario (RIO) score. The program would provide scaled financial incentives to physicians to practice in eligible communities (those in census subdivisions – CSDs – with RIO scores of 40+). This involves a shift from the current system, in which eligible communities must be designated by the MOHLTC as underserved.

The government is also proposing changing to a **province-wide Return of Service (ROS) program** designed to give all Ontario communities – except the Greater Toronto Area and Ottawa that do not have the same recruitment and retention challenges – access to the growing number of physicians graduating with ROS obligations. This also involves a shift from the current system in which physicians can only return service in designated underserved communities.

Q4: Why are the UAP physician recruitment and retention programs being redesigned?

A4: With changes to the program over time, concerns have arisen around the physician recruitment and retention initiatives under the UAP. The redesign is intended to address these program challenges.

Although originally created to support rural and northern communities, designated underserved areas in the south now greatly outnumber the ones in the north. Also, under the current program, physicians may receive the same or similar financial incentives to practice in a small rural community as they would in a larger urban community. This makes it more difficult for northern communities to compete for physician resources. The current program is not meeting its original objectives.

There is also evidence that Return of Service (ROS – a commitment by certain physicians to work in underserved areas for a designated period of time in exchange for a training position or financial assistance to offset tuition costs) has not been effective as a recruitment and retention tool for the most rural and northern communities.

For example, while all international medical graduates (IMGs) in specialty medicine training programs are expected to fulfill ROS commitments in designated underserved communities in the north, only about eight per cent of this group of physicians actually complete ROS in northern communities.

The proposed redesign is a shift intended to ensure that the most rural and northern communities will benefit from the program as originally planned. It will be cost-neutral, refocusing program funding that is already directed to physician programming.

Q5: Why change the program now?

A5: Recent developments in physician training and workforce planning are improving access to physician services across the province. These complementary initiatives promote recruitment and retention of physicians. The time is right for redesigning the UAP:

- **Physician training and distribution initiatives:** Government has established a range of initiatives aimed at increasing access to physician services, including: Family Health Teams, Health Care Connect, the Northern Ontario School of Medicine (established in 2005), Medical Education Campuses in southern sites and Distributed Medical Education.
- **Increase in number of physicians with Return of Service (ROS) commitments:** There has been a significant increase in the number of physicians graduating with ROS obligations who cannot all be accommodated in the communities currently designated as underserved. The redesign proposes lifting restrictions on where ROS commitments can be filled. Part of the reason the redesign is being proposed now is to help ensure the practice and lifestyle needs of this growing group of physicians is accommodated as they enter practice.
- **2008 OMA-Ministry of Health and Long-Term Care *Physician Services Agreement*:** Adopting the Rurality Index for Ontario (RIO) as the basis for eligibility for UAP physician funding is consistent with key initiatives in the recent agreement between the MOHLTC and the Ontario Medical Association.

If the benefits of this redesign are to be realized in the short to medium term, the process needs to begin now.

Q6: How will the UAP redesign be aligned with other Government, MOHLTC and Ontario Medical Association (OMA) initiatives?

A6: The redesigned UAP will align with other government priorities to strengthen healthcare in northern and rural communities, and help Ontarians in those communities and throughout the province receive care closer to home.

Beginning April 1, 2009, the MOHLTC and the Ontario Medical Association (OMA) have been using an updated RIO index (developed in 2008) to determine community eligibility for several programs. Redesigning the UAP to use RIO as the basis for eligibility would align physician incentive funding with these physician programs to further strengthen support to rural and northern communities.

Incentives in the *2008 Physician Services Agreement* between the MOHLTC and the OMA, as well as other Government initiatives (e.g., Health Care Connect

program and the addition of 50 Family Health Teams), would provide communities throughout the province with more physician recruitment support. Detaching ROS from the UAP will also offer communities more physician recruitment support by expanding options for those with ROS commitments.

Q7: Our community has difficulty recruiting physicians. How will this new plan help us?

A7: Physicians with ROS obligations tied to postgraduate training (commitments to work in a specified location for a designated period of time after training) will be able to fulfill those obligations in any community in the province other than Ottawa and the GTA. This will increase the likelihood of a “good fit” between community and physician and in turn, will help keep physicians in the community. This group of physicians is a large one – more than 600 international and Canadian medical graduates are currently in training programs that have ROS commitments attached to them. Almost all of these physicians will begin ROS over the next few years.

For eligible communities – those in census subdivisions (CSDs) with RIO scores of 40+ – the redesigned UAP will improve recruitment by enhancing financial incentives available to physicians who choose to practice there. The redesign will also reduce the competition for financial incentives with more southern or urban communities. And all communities will continue to benefit from a range of programs aimed at increasing access to physician services; e.g., Family Health Teams and the new Health Care Connect program.

We’ve also increased the overall supply of physicians by opening up new medical school seats and creating the Northern Ontario School of Medicine (NOSM) in 2005. Other government initiatives will help address recruitment challenges as well – for example, training opportunities like Distributed Medical Education take medical students and residents into a variety of settings, increasing the chance they will return to those settings to practice.

HealthForceOntario Marketing and Recruitment Agency is another effective physician recruitment resource. The Agency helps communities advertise and market job opportunities. It provides community information to nurses, physicians and their families. Through its Community Partnership Program (CPP), HealthForceOntario provides on-the-ground physician recruitment support to community recruiters, healthcare organizations and providers across Ontario.

Finally, the Government and MOHLTC are looking to communities themselves during the consultation process for suggestions and recommendations to address physician recruitment difficulties.

Q8: What changes are being made to ROS and how will they improve recruitment and retention?

A8: Physicians with ROS commitments linked to postgraduate training opportunities will now be able to fulfill those commitments anywhere in Ontario, other than Ottawa and the Greater Toronto Area (GTA).

There are many physicians with these commitments. In particular, there are over 600 international medical graduates (IMGs) in postgraduate training positions who will be entering practice over the next few years; all of them will have ROS obligations. There are also Canadian medical graduates who participate in ministry-funded training programs that have ROS obligations.

We estimate that more than 175 physicians each year will be entering practice with ROS commitments. The communities currently designated as underserved cannot continue to accommodate these numbers. Under the redesign, communities throughout the province will be able to recruit physicians from this pool to meet their physician supply needs.

Q9: Why are the GTA and Ottawa being excluded from eligibility for ROS and how will their boundaries be defined?

A9: Ottawa and the GTA are already well supplied for physicians. They have internationally renowned medical facilities and resources that help them attract and retain physicians and are not dependent on physicians with ROS obligations. According to the 2007 Ontario Physician Human Resources Data Centre, 42 per cent of all physicians in Ontario were practicing in the cities of Toronto and Ottawa, while these centres account for approximately 27 per cent of the population.

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.

Q10: Have physicians been involved in the development of the plan to redesign these components of the UAP?

A10: Yes, the MOHLTC and physician stakeholder groups, including the Ontario Medical Association (OMA), have discussed the need to renew these

components of the UAP for several years. In June 2007, a joint Ministry-OMA working group recommended that:

- Financial incentives be structured to help rural and northern communities recruit and retain physicians;
- Program eligibility be based on rurality score; and
- Return of service be delinked from the underserved designation.

The Rurality Index for Ontario was developed by the OMA and is widely used in joint programs.

Q11: Who will be involved in the consultation process and how will this be carried out?

A11: The consultation plan is designed to ensure that the diverse views of a broad range of communities, provincial stakeholders and opinion leaders are captured.

The consultation will be led by government representatives and supported by senior MOHLTC staff. Information will be provided to stakeholders and there will be an opportunity for them to express their views and concerns, as well as discuss impacts, benefits and outcomes. The consultation paper and comments form can be accessed at www.health.gov.on.ca.

Q12: How is this consultation process different from the Rural and Northern Health Care Panel review?

A12: The government has established a Rural and Northern Health Care Panel to provide recommendations on how best to coordinate the delivery of health care services for residents in rural and northern communities, recognizing their unique health care realities. The Panel's scope is a broad one.

In contrast, this consultation is specifically focused on how best to renew the MOHLTC's Underserved Area Program to improve physician recruitment and retention in the province. We are looking for advice from stakeholders on how we can implement the proposed changes most effectively.