

## **Rural Disadvantage:**

### **The Accessibility of Doctors, Specialists and Medical Services in Rural Areas**

**By: Kylie Steedman**

Those living in rural areas lack healthcare resources such as general practitioners, prenatal care, cancer treatment and access to specialists (British Columbia Ministry of Health, 2015; Crowe, 2019; Fleet, Archambault, Plant & Poitras, 2013; Giesbrecht et al., 2016; Scott et al., 2013; Shah, Milosavljevic & Bath, 2017; Taplin, 2019; Zingel, 2019). Giesbrecht et al. (2016) state: “eligibility for, access to, and availability of healthcare services... is largely dependent upon where one lives” (p. 274). This inaccessibility can cause problems for small-town residents such as long wait lists, travel and lack of access (British Columbia Ministry of Health, 2015; Fleet, Archambault, Plant & Poitras, 2013; Giesbrecht et al., 2016; Taplin, 2019). Federal, provincial and municipal governments must intervene with policy and incentives to retain doctors in these areas. In this paper, I argue that those living in rural areas have inadequate medical services and resources, which require incentives to increase rural medical community supports.

## **Review of the Literature**

This review of the literature focuses on research discussing the effectiveness of incentives offered to doctors to increase practice in rural areas, organized chronologically.

Scott et al. (2013) found that regardless of the incentives, doctors preferred to stay in their current location (p. 39). The study presented general practitioners with four jobs offering differing rates of pay, hours and on-call frequencies. The study also found that demographic

factors greatly impacted choices, with gender, marital and family status as most impactful.

Overall, the study found that only eight per cent of the general practitioners were persuaded with incentives to move to a rural area (p. 39). The study concluded that incentivizing rural doctors is multi-faceted and cannot be solved with a blanket solution, but instead must be looked at from multiple perspectives and individual cases (p. 41).

Li, Scott, McGrail, Humphreys and Witt (2014) found that due to the shortage of rural doctors, those employed in rural practices feel overworked and overwhelmed (p. 60). Ultimately, the study found that single general practitioners preferred paid leave, and those with children preferred monetary incentives.

Holte, Kjaer, Abelsen and Olsen (2015) interviewed final year medical school students (p. 3). They found that the main factors for young doctors neglecting rural areas are “limited opportunities for professional development, a heavier workload and a smaller practice size” (Holte et al., 2015, p. 6).

### **Analyzing the Canada Health Act and Government Documents**

The Canada Health Act (CHA) is a document outlining Canadian health services (CHA, 1985). The primary objective of the CHA is to “protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services” (CHA, 1985). The CHA states that “in order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province” (CHA, 1985). From this act, we can conclude that every Canadian resident is entitled to access doctors, specialists and medical services.

Statistics Canada (2016) found that the most common problem Canadians faced with healthcare was long wait times for an appointment (para. 4). However, we must consider that

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Canada's population is concentrated in urban areas and this response is not reflective of rural populations. Interestingly, the data set ignores all rural difficulties; none of the options are centered around travel time or inaccessibility (para. 7). The survey declared that results pertaining to information about rural area responses on the survey were "not displayed due to lack of statistical significance" (para. 19). This raises the question: why aren't rural perspectives being taken into consideration?

Government surveys lack the information and sample size to identify the existence of problems facing rural Canadians regarding medical services. The survey concluded with a plan to reduce wait times for existing doctors (para. 9). After analyzing the research from Statistics Canada, it is apparent that the federal government has not conducted meaningful research to serve its rural constituents. From this analysis, we know that the issue of the rural disadvantage in relation to health services needs to be brought to the forefront of our leaders immediately.

Although the federal government does not have a rural healthcare plan, most provinces have their own. For the purposes of this paper, British Columbia's rural healthcare policy is analyzed. The purpose of this report is to dissect the shortcomings of rural health services and offer solutions (British Columbia Ministry of Health, 2015, p. 2). The British Columbia Ministry of Health describes the current state of rural civilians and their healthcare as follows:

Individuals who reside in predominantly rural communities tend to have comparatively poorer health outcomes and socioeconomic status compared to their urban counterparts.... Against this health status backdrop, three specific service challenges stand out in the context of rural and remote communities: ensuring access to quality primary care services; ensuring pathways to accessing specialized perinatal, medical, and surgical services when they are required; and how best to support aging in place. Access to specialized acute care services and access to ancillary health services is especially challenging, so residents are often required to travel for care. (British Columbia Ministry of Health, 2015, p. 2)

The document identifies the three key areas of improvement for rural health services as access to emergency services, long-term community healthcare and resources for special cases (p. 6).

Overall, the framework recognizes the problematic current system of rural healthcare and acknowledges that the government must intervene.

### **Branding of Government Documents: Consistent with Key Messages?**

As demonstrated with Statistics Canada reports, which omit data from rural communities, the government is selecting which elements they will present as key messages. Overall, the report was positive and demonstrated that most Canadians do not have trouble accessing medical services. By omitting the information pertinent to rural accessibility, the federal government is controlling its brand of providing services equitably (Statistics Canada, para. 4). Marland (2016) describes that “it is a truism that good public policy can be derailed by poor communications, but good communications cannot sell bad policy” (p. 112). This sentiment is important to keep in mind; the federal government does not have meaningful policies put into action for rural areas, so the branding of equitable accessibility is disingenuous and inconsistent with key messages.

As we see in the rural healthcare policy framework, the British Columbia Ministry of Health positions itself as one that is cognizant of the issues facing rural Canadians and healthcare. However, it is important to note that this document was written in 2015. As of 2019, there has not been any further updates on these steps. This is another example of policy branding; Marland (2016) defines this process in relation to policy branding as “a sense of calm and confidence to counter the communications maelstrom” (p. 102).

The reason that rural access to healthcare is not seen as a national issue isn't because the public is uninterested, but rather uninformed. Due to the successful branding of these central health agencies, most don't recognize the rural health crisis at the magnitude it demands. By lack

of representation in official government statistics, it is far too easy for the issue to get swept under the rug, especially for those who don't experience it firsthand.

### **Analyses of Rural Health Case Studies**

Crowe (2019) follows a particularly jarring case study of a young woman in Nova Scotia who waited several years to receive her cancer diagnosis due to a lack of health care services and being turned away from hospitals (para. 2). The article details the frustrations of patients with doctors due to having limited access to medical resources, and the frustrations of doctors dealing with their lack of resources (para. 6). Although the cases explored in the article are based around Nova Scotia's lack of family doctors, the stories are applicable to rural areas across Canada. Unfortunately, cases like this are not unusual. In the Northwest Territories town of Hay River, residents are so frustrated with the current lack of doctors many don't attempt to get an appointment, and some are leaving the town for a bigger centre seeking medical care (Zingel, 2019, para. 3).

Cohen (2019) discusses the lack of access to abortion in small towns, proposing that if one doesn't have access to a service, their right to that service is essentially waived (para. 4). This example is reflective of the larger issue: a lack of specialized services. Women are especially at risk in a small town; with no nearby specialty services, they are at risk facing inadequate care. Lack of specialized services also affects cancer patients, those suffering from mental illness, the elderly and those with chronic illness.

The Telegram newspaper, based in Atlantic Canada, conducted in-depth case studies in which they spoke with many residents in rural areas and discussed their feelings on the shortage of doctors and medical services (Taplin, 2019). Overall, the study found three main problems with medical services in rural areas: high turnover rate resulting in no relationships with general

practitioners, those in poverty not being able to access medical services and long travel times for services (para. 34). These issues are reflected in the BC rural healthcare policy framework, suggesting that this level of government is aware of these problems.

Fleet, Archambault, Plant & Poitras (2013) examine the access of emergency resources available to those living in rural areas. The study looks at an area in British Columbia that, after budget cuts, required patients to travel for many emergency services and specialized care (Fleet et al., 2013, p. 191). Trauma is the top cause of death in Canadians under 44; rural Canadians are more at risk due to limited services (p. 192). Access to emergency services is sparse in Canada's territories, with "Zero per cent of the population residing within the 1-hour catchment area" as compared to Ontario's 85 per cent (p. 192).

Shah, Milosavljevic, & Bath (2017) studied medical access across Alberta and Saskatchewan in relation to the population of seniors. The study found that geographically, the prairies had a below-average score in accessibility to these services, which is particularly harmful for seniors requiring more frequent care (p. 102).

To research how limited access to palliative care affected these rural communities, interview data was collected (Giesbrecht et al., 2016, p. 275). Participants of the study reported feeling isolated and politically powerless to change the way in which medical services are distributed amongst provinces (p. 278). The findings of the study suggest that "those residing in borderland areas and are required to travel across provincial or jurisdictional borders may not be receiving optimal palliative care" (p. 279). The lack of care may be due to differing provincial health priorities, budgets, and the overall coordination and communication between provinces (p. 279).

### **Discussion**

Canada has a decentralized approach to healthcare, meaning that multiple levels of government are involved, but the bulk of the responsibility falls upon the province (Giesbrecht et al., 2016, p. 274). Arguably, the main issue with rural healthcare is the inability of small towns to retain general practitioners. The high turnover rate in rural areas can affect the doctor-patient relationship, especially true for long-term patients who require frequent checkups, therefore they must re-introduce their medical history to a new figure regularly. Giesbrecht et al. analyzed the high turnover rate of doctors in rural areas and found that many students choose to complete their practicum in rural areas due to less competition (p. 279). The service currently being provided to rural areas does not meet the expectations of reasonable accessibility as described in the CHA (CHA, 1985). Additionally, it is important to note that in official Statistics Canada (2016) reports, lack of rural medicine is currently unreported. Governments can use the information from the above literature and case studies to their advantage to gain insight into what general practitioners desire and require for their workplaces. With this understanding, provincial, federal and municipal governments can better attract medical professionals to rural areas.

### **Recommendations and Potential Solutions**

In rural Ontario, nurses have been filling in to serve due to the lack of doctors. Favaro (2019) discusses that nurse practitioners have been attempting to fill the gaps in the services provided; unfortunately, the clinics do not receive enough funding to adequately staff nurses (para. 2). Nurse practitioners are educated and can “diagnose and treat minor illnesses and injuries” (para. 4). Due to the lack of funding, this solution is not a perfect one, but the idea of having nurses perform duties they have been trained to administer could certainly assist with overworked general practitioners.

Only 6.2 per cent of Canadian medical school graduates practice in rural areas (Bartlett & Neatby, 2019, para. 5). To see an increase in the accessibility of medicine in our rural areas, the first step is to increase this number by offering meaningful incentives for doctors to practice rurally. Sheila MacLean, a longtime Atlantic Canada healthcare recruiter, says that general practitioners are not willing to practice in rural areas because they are overworked (para. 3).

Li et al. (2014) agree with this sentiment; the study found that one of the main reasons that doctors were unsatisfied working in rural areas is that they felt overworked and were unable to get time off (p. 57). On the contrary, researchers found that many doctors enjoyed the variety and challenge of work in rural areas. Governments are able to use these areas of satisfaction to entice general practitioners to stay longer in rural areas. Overall, the study found that providing paid leave for general practitioners was the most appealing incentive (p. 61). With many researchers agreeing that feeling overworked is the most common complaint of rural doctors, practices can take this information into consideration when scheduling shifts and on-call time to ensure retaining doctors.

Holte et al. (2014) hypothesize what type of incentive best attracts young doctors to a rural area. This study, based in Norway, discovered that young doctors prefer flexible working hours and were provided opportunities for further training (p. 5). Rural practices can use this information by providing opportunities for professional development, perhaps online. It is also possible to provide a relatively flexible work schedule; a doctor working four days a week is better than no doctor at all, and these benefits could attract more doctors to these practices.

Scott et al. (2013) research the effectiveness of current government incentives. Ultimately, the study found that doctors simply don't want to relocate (p. 39). One potential solution that has been implemented in some eastern Canadian universities is a mandatory rural

practicum, with hopes of encouraging the student to return to a rural practice after they are licensed (Bartlett & Neatby, 2019, para. 62). If a student has previous experience with a small town, they are more likely to return to a rural area to practice medicine. If a doctor has a job and is settled elsewhere, they likely will stay.

It is also important to ensure that provinces work together to ensure adequate medical coverage for all Canadians; perhaps in the future the federal government can implement policy to assist the provinces in working together. Another important aspect is awareness; those in urban areas may not be familiar with the struggles their rural counterparts face. With adequate education, small towns are one step closer to achieving adequate representation. After analyzing the case studies and effectiveness of incentives, rural practices are able to gain a better understanding of how to attract and retain doctors to their rural practices.

### **Conclusion**

As Canada's population grows, the rural population gets left behind. The current state of medical affairs is disappointing and should be revised. Rural perspectives were not accounted for in the CHA; nor in the most recent government survey, demonstrating a lack of awareness about the issue generally. To receive any support from our governments, we need to make sure our voices are heard to protect rural communities. Canadians must band together and ask our government to fulfil its promises from the CHA. The British Columbia Ministry of Health (2015) has acknowledged that those living in rural areas typically have more health issues than urbanites (p. 2). With the right steps taken by federal, provincial and municipal governments we can reverse this unfortunate trend.

To combat the lack of rural doctors, we need to encourage doctors to practice in these areas. With the current system, many Canadians living in small towns do not have reasonable

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access to doctors, medical services and specialists. However, the federal government does not yet have a plan in place for dealing with rural medicine and passes the torch exclusively to the province. Holte et al. (2015) acknowledge that in order to retain general practitioners, municipalities find themselves constrained by their given budget and are left to create their own incentives to retain the doctors (p. 2). Moving forward, we must ask the federal, provincial and municipal governments to band together in order to solve this problem. The federal government has the jurisdiction to provide funding; the provincial government can distribute funds within the medical sector; the municipal government can allocate dollars to specific local programs focused on the retention of general practitioners. It is no exaggeration to say that the current state of rural accessibility to medical services is a crisis. Millions of Canadians are left compromised under the lack of general practitioners, specialists and general medical services. Investing in the health of Canadians is a priority, and one the government should consider sooner rather than later.

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