Rural Road Map
Questions and Answers

1. What is the Rural Road Map for Action?

The Rural Road Map for Action (RRM) is a series of 20 recommendations for a renewed approach to rural* physician workforce planning. The 20 recommendations fall under four directions that provide a pathway toward developing a comprehensive rural framework for strengthening the rural Canadian physician workforce. Working in team-based environments, it is expected that health care providers will have the competencies and skills to provide high-quality and culturally safe care in rural Canada. The recommendations call for collective action with outcomes that are measurable, sustainable, and impactful.

Based on a social accountability framework, the RRM insists that key stakeholders, such as educators, health system managers, policy-makers, health professionals, rural communities, and governments, must do their part to improve the health of everyone living in rural communities in Canada. The RRM recommendations focus on physician recruitment and retention strategies, but the strategies could be used by all health professionals practising in teams and within networks of care with adequate resources.

2. Why was the RRM created?

The RRM was created because rural populations still do not have equitable access to health care services. Rural populations in Canada are generally older, less affluent, and sicker. Almost one-fifth of Canadians (18%) live in rural communities but they are served by only 8% of the physicians practising in Canada. These communities face ongoing challenges in recruiting and retaining family physicians and other health care professionals.

Compared with other segments of the population, Indigenous people living in rural Canada experience pronounced disparities in health and in access to care. Major systemic change is needed to improve Indigenous health given the persistent inequity and inaction across the health system that the Truth and Reconciliation Commission of Canada identified.

Rural communities have difficulty attracting and retaining physicians as policy interventions often focus on the short-term rather than the long-term. There is little evidence-based physician resource planning at the national and provincial levels to provide direction. An integrated approach to identifying priorities and allocating resources is needed. A number of provincial programs have attempted to address these issues, but a comprehensive and cohesive pan-Canadian long-term strategy to support rural physician recruitment and retention is not yet in place. The time for solutions is now.

*“Rural” is defined as those communities that are geographically located in rural and remote regions of Canada and are distinctly or partly populated by Indigenous people.

3. Who developed the RRM?

The development of the RRM has been a collaborative effort led by the College of Family Physicians of Canada (CFPC) and the Society of Rural Physicians of Canada (SRPC), who joined forces in December 2014 through the Advancing Rural Family Medicine: The Canadian Collaborative Taskforce (the Taskforce). Their aim was to identify ways to advance the future of rural health care. The Taskforce received key input from leaders representing Indigenous communities, medical organizations, faculties of medicine, and rural communities, as well as from health administrators, family medicine residents, rural practitioners, and health departments from the federal, provincial, and territorial governments. The aim is to develop a solution to the challenge of providing adequately skilled physicians and address limitations in access to health care in rural Canada.

4. What information was used to create the RRM?

At the start of its work, the Taskforce drew upon information compiled for a background paper the CFPC and SRPC commissioned in 2014. Published in January 2016, the background paper highlighted findings from a focused reviewed of both peer and grey literature and interviews conducted with national and international rural education and practice experts. The review examined the status of rural medical education, rural practice models, and government (federal, provincial, and territorial) policies related to the health needs of rural communities in Canada (see www.cfpc.ca/ARFM_Resources). It concluded that positive trends have emerged in advancing the number of family medicine graduates practising in rural Canada. Yet significant challenges persist for rural physician recruitment and retention approaches. The background paper provided the Taskforce with a strong foundation upon which to build the RRM.

In January 2015, the Taskforce conducted an environmental scan to identify activities in Canada that successfully addressed rural physician and recruitment challenges. They sought information from:

- A survey conducted with medical education leaders to identify examples of both medical school and family medicine residency initiatives highlighting successful rural “pipeline” approaches used to support physician recruitment and retention
- Interviews with provincial and territorial governments to identify promising rural workforce policies
- Interviews with pre-identified rural communities, including Indigenous communities, on their health care workforce recruitment and retention experiences
- A qualitative study conducted by researchers at Memorial University of Newfoundland that explored factors influencing physicians’ decisions to practise in rural communities in Canada

The information gathered was provided to the Taskforce in December 2015. The Taskforce then began a process of reflection, debate, consultation, consensus building, and stakeholder validation to create the recommendations and actions now found in the RRM.

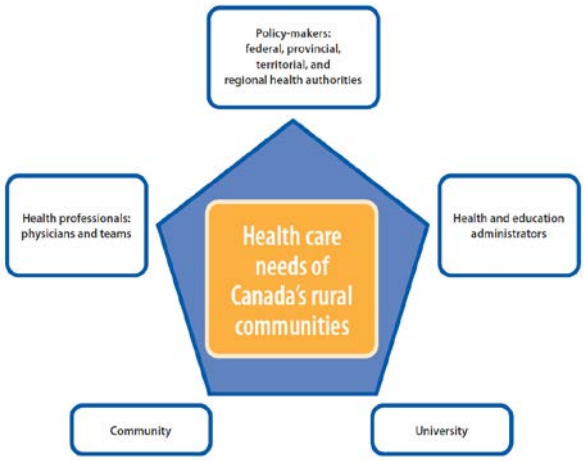
5. How will the RRM be used?

The RRM leverages examples of what has worked in the domains of education, policy, practice, and research to advance rural family medicine through the provision of comprehensive care. It provides a guiding framework for a pan-Canadian approach to physician rural workforce planning. This planning links relevant actions required in the areas of education, practice, policy, and government, and in rural communities. Recognizing that a large number of Indigenous people reside in rural communities in Canada, the RRM represents an opportunity to influence their population health outcomes in particular.

6. For whom is the RRM intended?

While the RRM aims to improve the medical workforce, it recognizes that all health care professionals play an important role in delivering primary care across rural Canada. The RRM uses a social accountability approach to sharing solutions and those targeted for action are stakeholders identified as "pentagram partners" (see Figure 1). Each of the partners has a role to play in the implementation of the RRM. By understanding who is responsible for what and by influencing the action to be taken, the RRM aims to provide a pathway to help support a more pan-Canadian, coordinated approach to enhancing rural access to health care.

Figure 1: Social accountability framework: the pentagram partners involved in implementing the Rural Road Map for Action.



Adapted with permission from Boelen C, *Educ Health* 2004:17(2):223-31.

7. How does this process differ from others?

The Taskforce's comprehensive process that has all stakeholders from different components of the health care and education systems working collaboratively and collectively is unprecedented. Other jurisdictions, such as Australia, have implemented elements of a plan similar to the RRM but not in a manner that uses the extensive stakeholder process conducted across the realms of education, practice, policy, government, and communities. Key to the RRM process has been the stakeholders' commitment to explore their roles in supporting access to care in rural Canada and willingness to work with others to ensure that rural health care delivery is equitable across Canada.

8. What will the RRM achieve?

The RRM identifies what needs to be done by different stakeholders. It provides opportunities to facilitate collaborative partnerships among all identified stakeholder groups. It introduces a framework from which successes can be collated and shared to reduce the duplication of efforts. It promotes more efficiency in the system by enabling existing initiatives to be scaled up. It also promotes the need for specific measures to provide evidence on improved rural health outcomes and equitable access to rural health care.

9. How is the RRM organized?

The RRM is organized around 20 actions under four directions that address what needs to be done:

- Direction 1 relates to the role of medical education
- Direction 2 relates to the linkage of policies needed to support the implementation of rural education and rural practice initiatives at local, provincial, territorial, and pan-Canadian levels
- Direction 3 focuses on changes needed to enhance rural practice
- Direction 4 describes the need to develop a rural research platform to provide evidence to improve policy directions

10. How can you be sure the stakeholders will collaborate?

The RRM calls for a social accountability approach that highlights the roles of the five pentagram partners (see Figure 1). The Taskforce recognized the need to engage stakeholders throughout the development of the recommendations. Through this process, the Taskforce was able to involve the Royal College of Physicians and Surgeons of Canada (RCPSC), the Canadian Medical Association (CMA), and Health Canada's Federal/Provincial/Territorial Committee on Health Workforce. Once the recommendations were ready for

consultation, the Taskforce asked to meet with national physician organizations, which resulted in endorsement in principle of the four directions by the organizations who are members of the Canadian Medical Forum. With this endorsement in principle, and the involvement of these organizations at the **Summit to Improve Health Care Access and Equity for Rural Communities in Canada**, it is anticipated that plans for implementation will be co-created and implemented. The Indigenous Physicians Association of Canada, RCPSC, CMA, Association of Faculties of Medicine of Canada, Resident Doctors of Canada, Federation of Medical Regulatory Authorities of Canada, Medical Council of Canada, and the Fédération médicale étudiante du Québec have all expressed interest in implementing the RRM after the Summit.

Collaborative partnerships and commitments from all key stakeholders will be critical to addressing both regional and national recruitment and retention needs and to delivering patient-centred care in rural Canada that is efficient, effective, and sustainable. System-wide alignment of education, practice, policy, and research is required to revitalize rural health care in Canada and positively influence the entire Canadian health system.

Leadership is needed to minimize the health inequities faced by rural Canadians. Leadership must come from all pentagram partners undertaking a similar journey to reach a common endpoint—improved health outcomes for all Canadians.

11. What are the financial implications of implementing the RRM?
The RRM is based on existing initiatives that have been successful within the health and education systems. The Taskforce acknowledges the fiscal constraints facing health care and health professions education. In working within these constraints, the RRM explores opportunities for action through existing organizational or jurisdictional committees or funded initiatives. By bringing together those working on similar solutions, the targeted outcome for rural Canadians is access to collaborative, team-based care.

12. How will the rural population benefit from the implementation of the RRM?
The Taskforce supports the federal government in its work to bring Canadian provinces and territories together in our publicly funded health care system. Individuals living in rural Canada deserve equitable health care services provided to them in their communities. This includes the need for providers and users of the education and health care systems to do their part to ensure resources are in place for critical services such as mental health care, rural surgical services, and effective Indigenous health programs. These services need to be streamlined through networks of care for efficient rural health care delivery.

A coordinated, comprehensive, and thoughtful alignment of educational and practice interventions using evidence-based policies can offer us a long-awaited, pan-Canadian solution to physician workforce planning that results in the provision of equitable access to health care in rural communities. The RRM provides an unprecedented opportunity to make a difference by articulating individual and collective actions that can be measurable, sustainable, and impactful.

13. What is planned for implementing the RRM?
The CFPC and SRPC are committed to moving the RRM forward as a guiding framework for collective action to improve rural health care in Canada. To catalyze the implementation of the RRM, more than 100 key stakeholders—including community leaders, educators, administrators, policy-makers, and government representatives—will meet on February 22, 2017, to consider the way forward. The Rural Summit will mark a key milestone on our collective journey to support equitable access to health care for those who live in rural Canada. In the next two years, the CFPC and SRPC will continue to meet to identify innovations and successes using the RRM as a guide and will seek opportunities for ongoing collaborations among the pentagram partners and those committed to this agenda.

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