Canadian Collaborative Centre for Physician Resources

Bulletin

Rural and Urban Practices – Where they differ and where they don't

The following is an analysis of the 2013 National Physician Survey from the perspective of comparing the replies of rural and urban based physicians. The two groups are defined based on the primary populations their practice serves.

Demographics

The majority of rural respondents were family physicians (71%) whereas just under half (46%) of urban based respondents were family doctors. Almost 16% of all family physicians who answered the survey worked in rural areas but only 6% of specialists from all other disciplines did so.

The composition of rural doctors, with respect to age and gender, according the survey, was very similar to those serving city or town populations. Over a third (36%) in each group were female and the average age was 51 years old for urban and 49 for rural doctors.

Satisfaction

Overall satisfaction was good for both groups with three quarters of urban physicians reporting being satisfied or very satisfied with their professional life and rural physicians basically the same at 74%. Neither cohort was overwhelmingly pleased with the balance in their life between professional and personal commitments but urban physicians were slightly more likely to be satisfied or very satisfied at 52% compared to 47% for their rural colleagues.

Workload

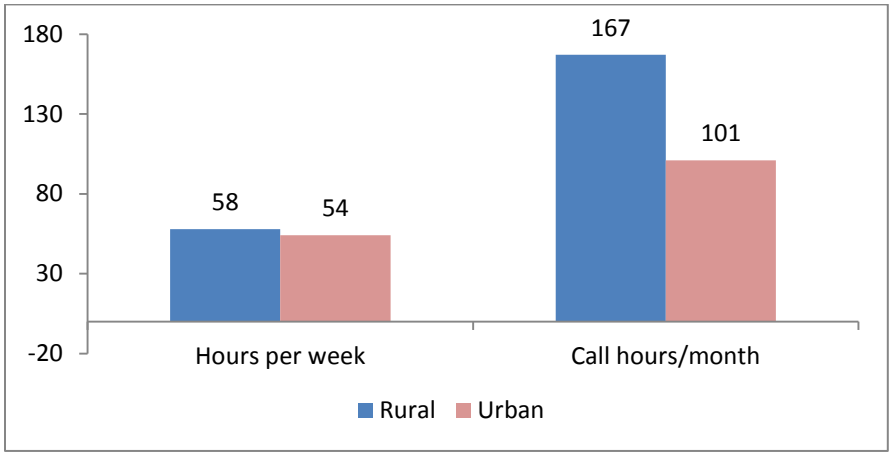
In some ways, it is surprising that the difference in satisfaction with balance wasn't larger between rural and urban physicians given what an examination of workload revealed. As has been noted in past National Physician Survey results[1], rural physicians reported both a greater number of weekly work hours and more on-call duties[2] than did urban based physicians.

Excluding on-call, the country doctors averaged 58 hours per week (39 hours in direct patient care) compared to 54 hours for physicians serving cities or towns with 35 hours spent in direct patient care. They were also more likely to have on-call responsibilities (80%) than their urban colleagues (68%) and were on-call an average of 167 hours per month, significantly more than the 101 hours/month for urban doctors. See graph 1.

[1] A Profile of Rural Family Physician Practices. http://www.cma.ca/multimedia/CMA/Content_Images/Policy_Advocacy/Policy_Research/29-Rural.pdf

[2] Time outside of regularly scheduled clinical activity during which you are available to patients.

Graph 1: Hours worked per week and hours on call per month



Recruitment and retention

Over a quarter of rural physicians (26%) had a return of service agreement provision in their first practice. A disproportionate number (39%) of this group obtained their medical degrees outside Canada. This is often the easiest way to begin practice here especially if the physician has not had Canadian postgraduate training.

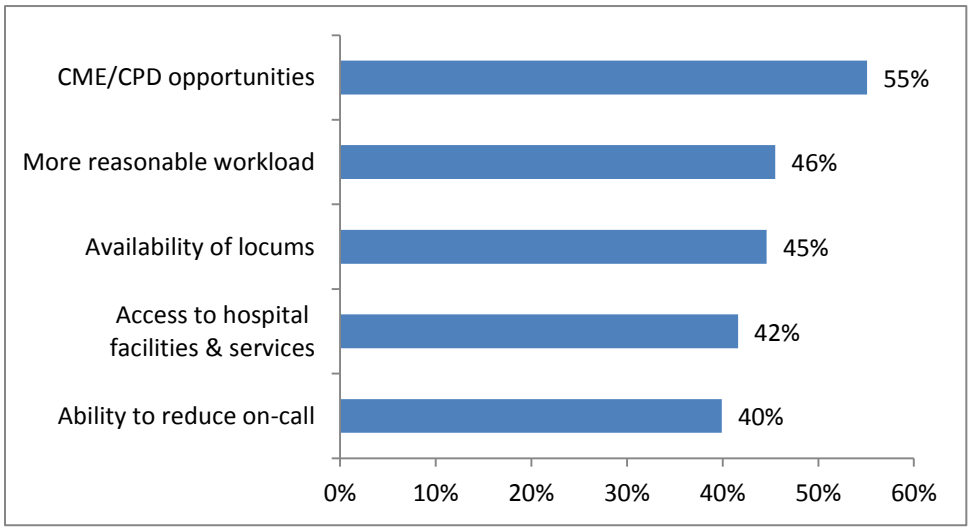
For the Canadian graduates there is often a financial incentive tied to the return of service. In fact, 39% of all rural doctors said they had received an incentive, either financial or otherwise, to set up their first practice compared to 8% of urban physicians.

Serving a rural or remote population also makes a physician more likely to receive a retention bonus to remain in their community. Forty-four percent (44%) of the rural respondents indicated they either currently receive a retention bonus or will in the future compared to only 14% of urban doctors.

Rural physicians do not always stay in the country for their whole career. From past surveys[3] we know there are both personal and professional reasons that can result in a move to the city. In this survey, the rural doctors were asked to indicate what improvements would influence them to remain in a rural community. The most frequently mentioned was opportunities for continuing medical education and professional development (55%) followed by a more reasonable workload (46%) and the availability of locums (45%). See graph 2.

[3] Chauhan T et al. Recruitment trumps retention: results of the 2008/2009 CMA Rural Practice Survey. *Can J Rural Med* 2010; 15(3)

Graph 2: Percentage of physicians indicating improvements that would influence them to remain in rural practice.



Access

Survey respondents were asked to indicate if they had seen, in the past two years, an increased need for the services they provide. Results were very similar for rural (65%) and urban (67%) physicians. Results were almost identical for the percentage saying there was an increase in the services they offer being provided by other health professionals at 31% and 30% for rural and urban respectively.

Physicians were asked to rate their satisfaction with access to a number of services and providers. Again we see consistent ratings for rural and urban physicians in some areas. The majority of both groups (over 70%) were dissatisfied with access to publicly funded physiotherapy and occupational therapy (about 65%). Almost half of each cohort found access to MRI scans to be unsatisfactory.

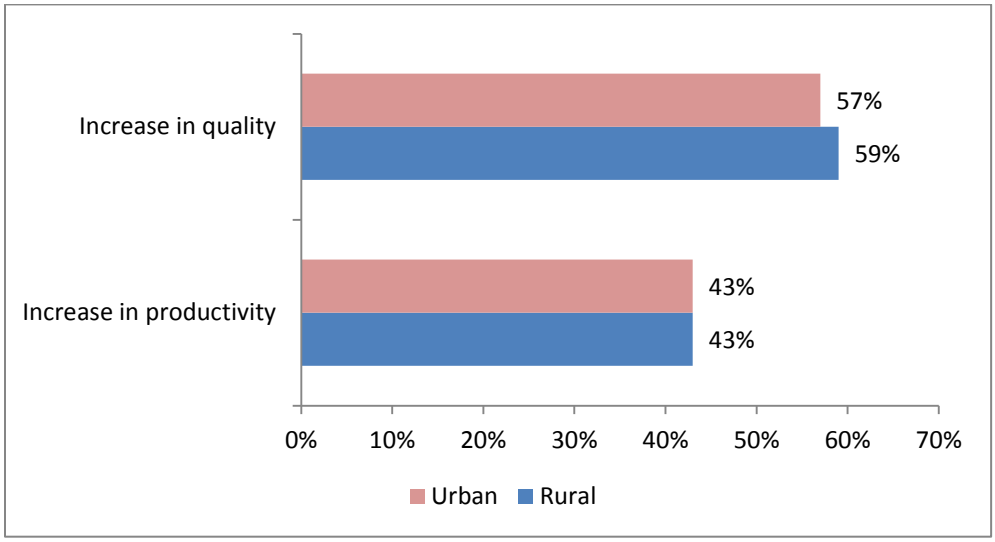
Where the two groups of physicians differed was with respect to operating room time (if applicable) with 31% of urban physicians claiming it was unsatisfactory compared to 21% of rural doctors. Urban physicians were more likely to report an increase in supply of physicians in their specialty (37%) than rural ones at 28% although identical percentages of both cohorts reported no change (38%).

Electronic Records

A sizeable proportion of both groups (40-42%) rated their access to electronic health records as unsatisfactory. Although not specifically defined in this survey, health records usually refer to core data from multiple sources and providers.

When specifically asked if they used electronic records to enter and retrieve clinical patient notes, 62% of urban physicians and 63% or rural physicians said they did. The same proportion of rural and urban doctors (43%) indicated that productivity within their medical practice had increased since electronic records were implemented. They also agreed on quality with over half of both groups (57-59%) saying the quality of patient care they provide was better since they adopted electronic records. See graph3.

Graph 3: Effects of electronic record implementation on productivity and quality



Remuneration

Physicians servicing urban populations are far more likely to be paid primarily fee-for-service (42%) than rural doctors (27%). Over half of the latter groups (53%) are paid by multiple methods with no one method accounting for 90% or more of their professional earnings. For urban physicians the percentages that were remunerated by this type of blended arrangement was equal to those primarily paid fee-for-service, i.e., 42%.

Summary

As in the past, we continue to see heavier workloads among rural physicians with them typically being on-call over 3 days per month more than their more urban colleagues. It is equally interesting to note, however, the similarities in accessing services and providers where it is often assumed the challenges will be greater in the more bucolic areas of Canada. They have embraced electronic health records to the same extent and over half of both groups say it has increased the productivity of their practice.

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