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Rural and Remote Physician Services Coordination in Northern Ontario:

A Brief Discussion Paper on the Model from British Columbia

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By: Bryanne de Castro Rocha

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We recognize and appreciate the historic connection that Indigenous peoples have to these territories. We support their efforts to sustain and grow their nations. We also recognize the contributions that they have made in shaping and strengthening local communities, the province, and Canada.

Permission Statement

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About the Author

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Bryanne holds a Master of Arts in Political Science from the University of Calgary, where she analyzed the relationship between sustainable development, environmental clauses in international trade agreements, and agricultural lobbying. Her Bachelor of Arts (Honours) in International Relations explored the measurement and conceptualization of sustainable development. She is also interested in the relationship between mining operations and Indigenous communities in Canada and abroad.

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Executive Summary

Northern Ontario residents (rural and urban) suffer from worse health outcomes than their counterparts in other parts of the province and have more precarious access to primary and emergency care (Laurent 2022, Rural and Northern Health Care Panel 2011, Ontario Medical Association 2023a). Much of this inequity is due to a more challenging time attracting and retaining physicians than in the rest of the province. In turn, one of the main reasons why some physicians are reluctant to practice in rural and remote communities in Northern Ontario is their limited connection to peers and specialists. This restricts their ability to consult others, get second opinions, and obtain patient support on complex cases (Asghari et al. 2017, 92, 96, Healthcare Excellence Canada 2023, 3). There is, however, an alternative model that has been proven to ease the pressure on rural and northern health systems by attracting and retaining more physicians and healthcare workers. This system has improved working conditions for physicians in regions and circumstances that are very similar to those found in Northern Ontario.

The Rural Coordination Centre of British Columbia (RCCbc) improves working conditions for physicians and healthcare professionals in northern and rural British Columbia. It connects them to immediate specialist advice and peer support. It coordinates physician services, supports professional development, and facilitates rural and northern-focused medical training. It also manages rural locums for clinical deployment (RCCbc, 2023e). Further, the RCCbc coordinates rural health projects and helps partners launch rural initiatives to ensure that they run smoothly. On the public policy side, it facilitates rural health policy discussion by creating a network of rural physicians and healthcare professionals, rural residents, municipal leaders, First Nation, Métis, and Inuit leaders, provincial policymakers, and other community partners (ibid.).

An organization mirroring the RCCbc in Northern Ontario could:

a. **Connect** physicians to rural and remote locums in Northern Ontario;
b. **Support accountability** by measuring the progress of programs and strategies, ensuring their implementation, and reporting on their impact;
c. **Support the coordination** of northern health programs and physician services;
d. **Reinforce the northern lens** in policy, leading to solutions targeted to the needs of rural and remote communities in Northern Ontario—not one-size-fits-all policies; and
e. **Develop and implement programs** tailored to rural and remote Northern Ontario.

a. Connect physicians to rural and remote locums in Northern Ontario:

Physician attraction could be improved by programs such as RCCbc's Rural Locums Initiative, which provides coordination to match physicians with rural locums (RCCbc 2023a). Retention could be increased, for example, by improving working conditions for rural physicians through access to peer and specialist consultation. RCCbc's Real-Time Virtual Support program is an example of an initiative that successfully achieves this goal (RCCbc 2023g). The Real-Time Virtual Support project from RCCbc connects "physicians, residents, nurse practitioners, nurses, midwives, and in some cases first responders" 24/7 with specialists to support "consultations, second opinions, [and] ongoing patient support," among others (Healthcare Excellence Canada 2023, 3).

Ensuring that physicians and healthcare professionals have the support they need to practice in rural and remote communities in Northern Ontario can make these professionals more at ease to move to and stay in these communities, increasing attraction and retention of professionals and, therefore, access to and quality of health care in these communities.

b. Support accountability by measuring the progress of programs and strategies, ensuring their implementation, and reporting on their impact:

An organization mirroring the RCCbc can support accountability by monitoring the design, implementation, and outcomes of strategies, frameworks, and programs, including those proposed or agreed to by the government, the organization itself, and third parties. Accountability is much needed for Northern Ontario. The Office of the Auditor General of Ontario found in 2023 that "the Ministry [of Health Ontario] and Ontario Health… did not routinely measure and publicly report the results and effectiveness of their Northern Ontario programs" (Office of the Auditor General of Ontario 2023, 3).

Such exercises ensure that planned strategies and frameworks are implemented so that the resources (e.g. time, money, personnel) that went into their development are not wasted. It promotes continuous healthcare improvement by ensuring that good practices and recommended solutions are not forgotten. It mitigates the continuation and creation of programs that deliver funding but have little to no impact (offer no improvement and waste resources) and informs the allocation of tax dollars to the programs with the most impact, producing the most benefit for each tax dollar spent.

c. Support the coordination of northern health programs and physician services

The RCCbc model provides a centralized source of information about incentives, supports, and opportunities for clinicians. Such exercises are critical to align initiatives across the province, reducing fragmentation and disjointed and uncoordinated efforts and leveraging lessons already learned (Rural and Northern Health Care Panel 2011, 40).

d. Reinforce the northern lens in policy, leading to solutions targeted to the needs of rural and remote communities in Northern Ontario—not one-size-fits-all policies — and conveying information on the needs of communities, physicians, and healthcare professionals directly from front-line workers and community members to policymakers.

The regions of Northern Ontario have "unique healthcare needs, including challenges related to geography, the healthcare workforce, Indigenous health and other health inequities" (Office of the Auditor General of Ontario, 2023, p. 12). Therefore, policies created based on realities for the entire province "do not address all the unique challenges of Northern Ontario" (ibid., p. 13).

The RCCbc model can help address the need for solutions targeted at the specific needs of Northern Ontario by building a network of rural physicians and other healthcare providers, healthcare administrators, community members, educators, researchers, First Nations, Métis, and Inuit peoples, policymakers, and non-profit and business leaders (RCCbc 2023e). Through this network, the RCCbc model serves as a platform for rural health discussion among these partners, building relationships and allowing front-line healthcare workers and community members (ibid.) to convey their insights directly to policymakers and each other.

The ability to convey this information and deliver programs that fill gaps is critical since front-line healthcare workers and community members are those most in contact with the local challenges and who best know the reality and needs of communities.

e. Develop and implement programs tailored to rural and remote Northern Ontario:

Along with its partners, RCCbc co-identifies rural healthcare gaps (needs that are not being addressed by existing initiatives) and co-creates and delivers initiatives presenting solutions to the unique needs of rural British Columbia (RCCbc, 2024b). RCCbc also works "with partners to get innovative rural-based projects off the ground and running smoothly" (RCCbc, 2023e). When these projects are ready, they "are handed off to a partner, such as a health authority, to sustain" (ibid.).

Developing and implementing such programs in Northern Ontario is essential to ensure that policies and programs are created based on the realities of rural and remote communities in these regions. On the other hand, one-size-fits-all approaches miss "an opportunity to identify all the elements that are needed to provide the best health care possible in Northern Ontario and work more effectively to address them" (Office of the Auditor General of Ontario 2023, 13).

Main Possible Contributions:

Such an organization would improve care and health equity in Northern Ontario by attracting and retaining physicians and creating solutions targeted at the needs of rural and remote communities in these regions (Joint Collaborative Committees n.d.-a, RCCbc 2023e).

It would address the lack of a dedicated health strategy for northern care to address the unique needs of Northern Ontario(Office of the Auditor General of Ontario 2023, 2) and the notable absence of an organization that coordinates physician support, measures the progress and impact of programs, and holds the government accountable to implementing drafted strategies and plans (Rural and Northern Health Care Panel 2011, 40-41).

Even though significant initiatives are in place, the lack of accountability and inconsistent measurement and reporting have, at times, led to unfruitful planning exercises and lower productivity for initiatives that use resources but that have not been shown to successfully attract, support, and retain physicians and healthcare workers in rural and northern communities (Office of the Auditor General of Ontario 2023, 2, 20-28). This gap is particularly pronounced when it comes to an organization involving physicians, healthcare professionals, educators, researchers, policymakers, First Nations, Métis, and Inuit peoples, and other partners. Since no network involving these partners exists, channelling on-the-ground insights to policymakers becomes more challenging.

Recommendations for Next Steps

The following first steps would be necessary for those interested in creating an organization based on the RCCbc in Northern Ontario:

1. **Learned Lessons:** It would be essential for those interested in creating an organization based on the RCCbc in Northern Ontario to engage in extended discussions with the RCCbc to learn about their successes and failures over the years, what has or has not worked, and adapt the model to the specific needs of Northern Ontario;
2. **Organization:** Physicians, healthcare professionals, and communities in Northern Ontario would need to come together to organize, identify challenges, and discuss opportunities in implementing the model in rural and remote Northern Ontario;
3. **Negotiation:** Rural and remote physicians in Northern Ontario (through the Ontario Medical Association) and the government of Ontario would need to negotiate the allocation of resources to this organization during their next period of negotiations on the Ontario Physician Services Agreement; and
4. **Funding:** Early and sustained funding from the provincial government would need to be available for the successful creation and long-term existence of an organization based on the RCCbc in Northern Ontario.

1. Learned Lessons

It would be recommended for those interested in establishing such an organization to engage in a series of discussions with key RCCbc contacts (current and departed) to gain insights into learned lessons, share learnings, and then adapt proven programs to meet specific needs in Northern Ontario. There is also potential to explore partnerships that can provide guidance in the founding and formation processes (Healthcare Excellence Canada 2023, 6). Valuable lessons can also be learned from similar organizations, such as the Rural Health Professions Action Plan in Alberta (Rural Health Professions Action Plan n.d.).

2. Organization

The success of an organization based on the RCCbc in Northern Ontario will require some organization from physicians, health professionals, and communities in these regions. RCCbc was created in 2007 by four rural doctors and two staff members and is still led by rural doctors (RCCbc 2023e). Previous recommendations to form a government body with these functions have gone unimplemented, such as the Rural and Northern Health Care Framework/Plan and Ontario Medical Association's engagement as part of the 2023 audit from the Office of the Auditor General of Ontario on northern hospitals (Office of the Auditor General of Ontario, 2023, p. 14; Rural and Northern Health Care Panel, 2011, p. 40).

3. Negotiation:

The success of a coordinating organization for rural health professionals in Northern Ontario would also depend on negotiations between physicians in rural and remote Northern Ontario, the Ontario Medical Association, and the provincial government of Ontario to allocate funding from the Ontario Physician Services Agreement to support the organization, following the model that created RCCbc, funded through the Physician Master Agreement (Joint Collaborative Committees n.d.-b).

4. Funding:

It would also depend on the availability of early and sustained funding from the provincial government, which was in place in British Columbia when RCCbc was created. The health funding structure in Ontario is compatible with the RCCbc model. As mentioned, Moat, Mattison, and Lavis (2016) indicated that funding from the Ministry of Health in Ontario mostly flows to independent organizations with a separate board of directors instead of directly funding programs and services. An organization mirroring this structure in Northern Ontario would, therefore, be recommended to have its own board of directors, as done by the RCCbc. In British Columbia, the RCCbc provides a functional model for an independent organization outside of the government that would address these needs. Despite being currently funded by the provincial government in British Columbia and having the necessary funding structure in place when it was created (the Joint Standing Committee on Rural Issues), the establishment of this model was not led by governments.

In conclusion, an initiative mirroring the RCCbc could be created in Northern Ontario if physicians in rural and remote Northern Ontario and the provincial government are successful in negotiating a funding allocation for this goal. Building on the lessons learned in British Columbia, these efforts can potentially improve health care in numerous underserved areas in Northern Ontario, reducing health equity and improving the quality of life of northern residents.

Introduction

Northern Ontario residents (rural and urban) suffer from worse health outcomes than counterparts in other parts of the province (Laurent 2022, Rural and Northern Health Care Panel 2011). Northern communities also have less access to primary and emergency care due to a more challenging time attracting and retaining physicians (Ontario Medical Association 2023a). The limited connection to peers and specialists in smaller and northern communities and the restricted ability of physicians to consult others, get second opinions, and obtain patient support on specific cases comprise some of the main reasons why physicians decide not to practice in rural and remote communities in Northern Ontario (Asghari et al. 2017, 92, 96, Healthcare Excellence Canada 2023, 3). However, some initiatives can ease the pressure on rural and northern health systems by attracting and retaining more physicians and healthcare workers and improve working conditions for physicians by connecting them to immediate advice.

A good example of such an initiative is the Rural Coordination Centre of British Columbia (RCCbc). RCCbc improves access to high-quality health care in rural British Columbia by coordinating information, connecting physicians, monitoring project implementation, and developing and implementing programs that improve care equity (Healthcare Excellence Canada 2023, 1, Johnston et al. 2021, 2, 7-8, Joint Collaborative Committees n.d.-a, RCCbc 2023e). The RCCbc model underscores the importance of community-driven initiatives, with the active involvement of physicians, healthcare professionals, researchers, community partners, and First Nation, Métis, and Inuit communities.

The Rural Coordination Centre of British Columbia fulfills its goals in practice by building partnerships to centralize and share information and coordinating projects to advance recruitment and retention, physician wellness, use of healthcare technology, research, innovation, mentorship, and other initiatives (RCCbc 2023e, 2023i). The organization acts as a facilitator, linking and promoting initiatives that enhance healthcare accessibility in rural and remote communities in British Columbia.

In Northern Ontario, there is no dedicated health strategy for northern care to address these regions' unique needs (Office of the Auditor General of Ontario 2023, 2). There is also a notable absence of an organization that measures the progress and impact of programs, holds the government accountable to implement drafted strategies and plans (Rural and Northern Health Care Panel 2011, 40-41), and coordinates physician support. This gap is particularly pronounced when it comes to an organization that actively involves physicians, healthcare professionals, educators, researchers, policymakers, First Nations, Métis, and Inuit peoples, and other partners. Since no network involving these partners exists, it also becomes more challenging to channel on-the-ground insights to policymakers.

Even though significant initiatives are in place, communication gaps can lead to overall inadequate accountability (Rural and Northern Health Care Panel 2011, 40-41). In turn, the lack of accountability and inconsistent measurement can lead to insufficient reporting of initiatives' progress and success (Rural and Northern Health Care Panel 2011, 40-41), unfruitful planning exercises, and lower productivity for initiatives that use resources but that have not been shown to successfully attract, support, and retain physicians and healthcare workers in rural and northern communities (Health Quality Ontario 2018, 2, 20-28).

An organization mirroring the RCCbc in Northern Ontario could provide supports to address these challenges by improving working conditions for rural physicians, measuring programs' progress and impacts, providing coordination, and delivering key policy insights from physicians to policymakers in order to design policies that fit the specific needs of Northern Ontario. Those wishing to apply this model elsewhere should contact RCCbc to partner, share learnings, and tailor the program to their specific needs (Healthcare Excellence Canada 2023, 6).

The Ontario Physician Services Agreement can provide an opportunity to establish an organization mirroring the RCCbc in Northern Ontario. In British Columbia, a standing committee was created through negotiations between Doctors of BC and the provincial government to allocate some of the agreement's funding for the overall governance of rural programs and now supports RCCbc (Joint Collaborative Committees n.d.-a, RCCbc 2023e). In Ontario, negotiations between the Ontario Medical Association and the provincial government could allocate some of the funding from the Ontario Physician Services Agreement to support an organization mirroring the RCCbc.

Northern Ontario physicians and healthcare professionals, the provincial government, the Ministry of Health Ontario, and Ontario Health can leverage best practices and insights from successful approaches in other jurisdictions. Embracing lessons learned from locations similar to Northern Ontario could catalyze advancements in healthcare coordination, ultimately enhancing care delivery and health outcomes over the medium and long term.

Purpose and Scope

This commentary intends to serve as a discussion paper to encourage conversations about the possibility of creating an organization in Northern Ontario to inform health policy in the province and provide coordination, community engagement, enhanced accountability, and support for physicians, health professionals, and service providers in these areas.

The present discussion is based on best practices and lessons learned from RCCbc, which is the most advanced example of such an organization in Canada. It follows a brief analysis of such a framework for rural and northern physician services in British Columbia and general comparisons between British Columba and Ontario's health system and government structures. A focus on RCCbc is simply an example of a best approach and does not exclude the possibility of opening the discussion to other best practices, such as those known in Alberta and Nova Scotia, for example.

Identifying the Need for Change

There is no centralized framework or coordinating organization or agency for rural and northern physician services in Ontario. Existing services and initiatives are spread across different organizations, and information about them is hard to obtain, hindering efforts to attract, retain, and support physicians in Northern Ontario (NOSM University 2023).

In 2011, the government of Ontario released an assessment on how to improve health care in rural, remote, and northern Ontario—the Rural and Northern Health Care Framework/Plan (Rural and Northern Health Care Panel 2011). The report, put together by a purposely built panel, presented many strategies to achieve such a goal. Some of the guidelines suggested were, for example, setting targets for care access in rural, remote, and northern areas, providing incentives for working in these communities, and close engagement between the Ministry, Home and Community Care Support services, providers, and local communities (ibid.).

The plan also discussed accountability. It argued that accountability could align initiatives across the province to share lessons learned and best practices and assess whether set goals are being achieved (Rural and Northern Health Care Panel 2011, 40). Assigning "roles and responsibilities can [also] ensure a rural perspective is applied for planning activities at the provincial level" (ibid., 41). The plan, however, suggested the creation of a point of accountability within the Ministry of Health, not by another organization. The single "point of accountability" main roles would be to ensure the plan's implementation, lead collaborative initiatives, promote engagement, support research, disseminate best practices, support professional planning, establish links and coordination, steward policy coordination in the province, apply a rural, remote, and northern perspective, and implement flexible funding models (Rural and Northern Health Care Panel 2011, 41). Apart from working with funding models, such roles are similar to the work developed by RCCbc.

Since 2011, many strategies have been implemented to improve health care in Northern Ontario (Ministry of Health Ontario 2023d). These strategies include tuition support, financial incentives for physicians to practice in rural and remote communities and stay in Northern Ontario, and funding to support travel by healthcare professionals to assess whether they would like to relocate to rural and remote communities (ibid.). Health Quality Ontario also presented other implemented strategies in a report in 2017, such as providing access to specialists through telemedicine, offering mobile health units for services such as mammography, eye exams, and diabetes check-ups, and grants to help cover travel-related expenses when patients need to travel to access health services (Health Quality Ontario 2017). These latter three are not specific to physician services but are critical patient supports.

Notably, in 2018, Health Quality Ontario released a strategy for health equity in Northern Ontario (Health Quality Ontario 2018). The single main recommendation of this strategy was the creation of a "Northern Network for Health Equity." The Network would serve to build partnerships and coordinate health priorities for the North. The Local Health Integration Networks (LHINs; now rolled into Ontario Health North) were recommended as hosts for the Network in their capacity to host cross-sectoral tables and promote collaboration. The structure and makeup of the proposed Network differed from that of RCCbc. The former followed a top-down approach to its founding and formation, along with centralized decision-making. In contrast, the latter adopted a more bottom-up starting process, emphasizing less centralized decision-making. RCCbc focused more on building connections and instigating direct change in communities with grassroots involvement (RCCbc 2023j).

Despite the proposed strategies and frameworks, Ontario still does not have an organization that provides coordination, physician support, network connection, and specialized program delivery for rural and northern health care. There is no single point of accountability in Northern Ontario to ensure that the various strategies and frameworks drafted and discussed are being implemented and that initiatives are achieving their goals. Furthermore, the lack of such a framework, network, or organization for the North also weakens the strength of a northern and rural lens in provincial healthcare policy.

Existing Initiatives in Northern Ontario and the Province

Many exciting programs in Northern Ontario aim to improve rural and remote healthcare, including the Ministry incentive programs (Ministry of Health Ontario 2023d). Virtual critical care programs led by Health Sciences North and Thunder Bay Regional Health Sciences Centre provide remote access to critical care specialists to support safe care and transfer of critically ill or injured patients in rural hospital settings (Ontario Telemedicine Network 2023). Ontario Health has launched Emergency Department Peer-to-Peer, enabling emergency physicians to access an experienced physician to support care in rural and remote settings (Ontario Health 2023b). In Marathon, PRACTISS supports simulation-based education through an open-access online platform, allowing health professionals to prepare for medical situations that might not occur as often in rural settings, making professionals more confident to practice in rural areas (PRACTISS 2023). NOSM University is a government strategy that trains physicians and other healthcare providers to meet Northern Ontario's needs, including rural, remote, francophone, First Nation, Métis, and Inuit people (Newbery 2021).

There are also many initiatives in Southern Ontario. Some examples are the Rural Ontario Medical Program, which arranges medical rotations in rural locations for students and residents (Rural Ontario Medical Program 2023), and the Rural Northern Initiative, which takes faculty members and residents for 2-week locum visits to some communities in Northern Ontario (University of Toronto 2023).

Rural physicians in Northern Ontario can refer to some organizations for a voice of advocacy and policy, such as the Ontario Medical Association and the Society of Rural Physicians of Canada (SRPC) through their Ontario Representative (Society of Rural Physicians of Canada 2023b). These organizations have some initiatives that focus on coordination and partnership, such as SRPC's mentor program for students, but are primarily focused on advocacy and not coordination or local initiative implementation (Ontario Medical Association n.d., Society of Rural Physicians of Canada 2023a, 2023b).

While these initiatives exist and are likely helpful, there is no unified framework to connect them nor a single point of information to assist physicians in discovering relevant resources. Organizations or initiatives independently share information on their respective web pages and social media channels. This fragmentation poses a challenge for students and physicians exploring rural medicine who may not be familiar with these resources, and the absence of coordination and shared information can also lead to gaps and unnecessary duplication.

Another notable deficiency is the lack of accountability. Ensuring that initiatives are implemented and goals achieved is done on a case-by-case basis. "Without defined accountability, the implementation of initiatives may be fragmented, disjointed and uncoordinated" (Rural and Northern Health Care Panel 2011, 40).

Therefore, even though significant initiatives are in place, communication gaps and lack of coordination can lead to unclear roles, responsibilities, and expected outcomes (Rural and Northern Health Care Panel 2011, 40-41), health and social inequities (Health Quality Ontario 2018, 7), and overall inadequate accountability (Rural and Northern Health Care Panel 2011, 40-41). In turn, the lack of accountability and inconsistent measurement can lead to insufficient reporting of initiatives' progress and success (Rural and Northern Health Care Panel 2011, 40-41), unfruitful planning exercises, and lower productivity for initiatives that use resources but that have not been shown to successfully attract, support, and retain physicians and healthcare workers in rural and northern communities (Health Quality Ontario 2018, 2, 20-28).

Best Practice in British Columbia: Rural Coordination Centre of British Columbia (RCCbc)

The Rural Coordination Centre of British Columbia (RCCbc), an organization formed by informal and formal networks of rural physicians and health professionals in British Columbia, supports rural healthcare in the province by coordinating initiatives and delivering programs to improve health care in rural areas. In turn, these projects receive support and funding from British Columbia's Joint Standing Committee on Rural Issues (ibid.). It presents a best practice that can be applied to Northern Ontario's rural and remote communities to increase healthcare quality and equity.

What It Is and What It Does

The Rural Care Coordination Centre is a not-for-profit organization that improves "access to safe, high-quality, team-based primary care" in northern, rural, and remote communities in British Columbia (Healthcare Excellence Canada 2023, 1). Its "mission is to improve rural health education and work to advocate for rural health in BC" (Grzybowski, Abu-Laban and Christenson 2020, 2).

It was created in 2007 by rural doctors to first "improve rural training opportunities for medical students and residents," bridging "gaps in rural healthcare delivery" (RCCbc 2023e). According to Dr. Granger Avery, one of the four founding members, he and his colleagues "conceived, obtained funding, and developed RCCbc because of the need for a co-ordination body for rural health care due to the disparate and different problems and solutions to training, practice and living in rural BC" (RCCbc 2022).

The organization developed over the years, expanding its goals and members from the original "pentagram partners" to currently include different healthcare providers, from "healthcare administrators, community members, policymakers, educators, [and] researchers… [to] non-profit and business leaders" (ibid.). With 23 core members and 119 total people in its team, including directors and consultants (RCCbc 2023k), RCCbc's main goals today are to foster engagement and coordination among rural healthcare providers, to create solutions targeted at rural, remote, and First Nation, Métis, and Inuit health care, and to improve health equity in British Columbia (Joint Collaborative Committees n.d.-a, RCCbc 2023e); thus coordinating and improving rural health care in British Columbia (Johnston et al. 2021, 2).

In practice, the RCCbc:

- Supports networking among rural physicians, rural residents, municipal leaders, First Nation, Métis, and Inuit leaders, and provincial policymakers;
- Facilitates rural health policy discussion;
- Helps partners launch innovative rural health projects to ensure that they run smoothly and have an impact;
- Co-develops continuing medical education, professional development, and mentoring to advance learning for rural healthcare practitioners, including coaching and mentoring for clinical service;
- Advocates for an improvement in rural healthcare in British Columbia by performing evidence-based research and sharing lived experiences;
- Encourages rural and cultural healthcare research through grants and other supports;
- Develops healthcare leaders (RCCbc 2023e); and
- Provides a centralized source of information about incentives, supports, and opportunities for clinicians.

The RCCbc also plays a vital role in shaping rural healthcare policy through report publications and discussion forums. A notable instance of this influence is when data from the Rural Site Visit Project, presented during an RCCbc-hosted discussion, directly contributed to a provincial initiative to enhance rural emergency transportation (Johnston et al. 2021, 7-8).

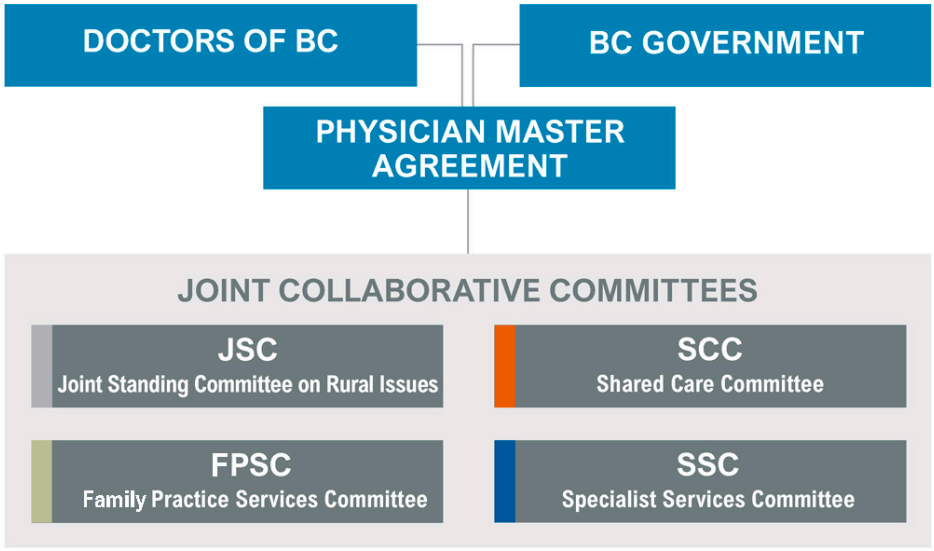
Funding and Resources

The RCCbc can support these initiatives primarily through funding from the Joint Standing Committee on Rural Issues (Joint Collaborative Committees n.d.-a). This is one of four committees created to advise the government of British Columbia and Doctors of BC on how to improve the quality of healthcare in rural areas of the province (ibid.).[1] It was established under the Rural Practice Subsidiary Agreement, which it now oversees (Avery 2007). The Joint Standing Committee on Rural Issues comprises "equal numbers of provincial Ministry of Health representatives and rural physicians" (Johnston et al. 2021, 1). The relationship between the two organizations goes further, with the Joint Standing Committee on Rural Issues co-chairs forming RCCbc's board of directors (RCCbc 2023a).

In turn, the Joint Standing Committee on Rural Issues is funded by the Physician Master Agreement (PMA; Joint Collaborative Committees n.d.-b). The latter is a three-year agreement negotiated between Doctors of BC (British Columbia's professional organization and association of doctors) and the provincial government of British Columbia, first signed in 2012 and most recently renegotiated for 2022–2025 (Ministry of Health of BC 2022a). The agreement sets the terms through which funds flow from the Ministry of Health of BC to many health agencies, organizations, and professionals in British Columbia. The Rural Practice Subsidiary Agreement is its subsidiary, focusing on rural services and communities (Ministry of Health of BC 2022b).

[1] The other committees focus on Family Practice, Specialist, and Shared Care services (Joint Collaborative Committees n.d.-b).

Figure 1. Funding Structure for the Four Joint Collaborative Committees in British Columbia



Source: Joint Collaborative Committees (n.d.-b).

Therefore, in sum, the Joint Standing Committee on Rural Issues serves as the primary funding and structure support for the existence of the RCCbc, funnelling most of its funding from the province of BC, going through the Ministry of Health, the Physician Master Agreement, the Rural Practice Subsidiary Agreement, and the Joint Standing Committee on Rural Issues, respectively.

Initiatives and Programs

The Rural Coordination Centre of British Columbia fulfills its goals in practice by building partnerships to centralize and share information and coordinating projects to advance recruitment and retention, continuing medical education relevant to rural settings, physician wellness, healthcare technology, research, innovation, mentorship, and others.

An excellent example of an RCCbc project is the Real-Time Virtual Support program, one of the most well-known programs from RCCbc. It connects "physicians, midwives, residents, nurse practitioners, nurses," and other healthcare professionals in rural and remote communities to specialist and peer advice through video calls (RCCbc 2023g). Connections are instant and available 24/7 for "all urgent or non-urgent patient cases, including case consultations, second opinions and ongoing patient support, patient transport coordination, point-of-care ultrasound, and simulations" (ibid.). This program provides mentoring and educational support, increases confidence, and reduces the isolation of "healthcare providers who provide patient care in rural, remote, and First Nations communities in British Columbia" (ibid.). Its impacts are improving the recruitment and retention of healthcare providers in such communities and improving health equity in the province (ibid.).

Another example is the Rural Locums Initiative. The initiative aims to facilitate the recruitment of locum physicians by centralizing information on locum work in British Columbia and providing financial support and coordination. Physicians interested in rural medicine and locuming can access the initiative's website to know where to find locum job ads, how to access continuing medical education and professional development, and how to get a mentor—all available through partners, but for which RCCbc has centralized information. In 2022–2023, the initiative attracted 17 professionals interested in rural locuming and achieved 66 members in the Rural Locums Initiative Forum (RCCbc 2023a). Additionally, the initiative's page also hosts two of RCCbc's own programs:

- The *Resident Locum Matching Program* matches residents looking for rural training with rural and remote locums and connects applicants to funding to offset travel and accommodation costs; and

- The *BC Rural Locum Discussion Group* is a virtual forum where rural locums can discuss "practice, billing, rural community amenities," among others (RCCbc 2023i).

Relationship with First Nations, Métis, and Inuit Communities and Organizations

There are around 135,000 First Nation, Métis, and Inuit people in the area served by the RCCbc. The organization has built partnerships with "First Nations Health Authority, Métis Nation BC, BC Métis Federation, Team Atleo, Harley Eagle, Bianca Mitchell, and Elders," which are included in RCCbc' partnership model, the Partnership Pentagram Plus model (RCCbc 2023c, RCCbc 2024a). RCCbc has established a reference group to "foster network relationships and advance the Truth and Reconciliation Commission of Canada Calls to Action" inside the organization and published a "report to assess if and how the RCCbc and its … initiatives are contributing to the calls to action (RCCbc 2023c).

Importantly, the RCCbc works with First Nations, Métis, and Inuit-led or "co-created health projects and initiatives," which directly address the needs of these communities in northern and rural British Columbia (RCCbc 2023c). An example of such an initiative is the "Indigenous Physicians Network," which "engages and provides opportunities for connection among" First Nations, Métis, and Inuit "students, residents, physicians and health allies across British Columbia" (ibid.). Another is the Rural Site Visits, in which a First Nations, Métis, or Inuit research consultant guides the project team in incorporating First Nations, Métis, or Inuit "ways of knowing, being and thinking into its operations, community engagement practices, and research" (ibid.)

As a model, such partnerships and health initiatives led, co-created, or counting with the engagement of First Nations, Métis, and Inuit peoples is an applicable model highly relevant for Northern Ontario, where there were around 138,000 First Nations, Métis, and Inuit people in 2021.[2]

[2] The First Nations, Métis, and Inuit population counts are likely higher in reality because of "the incomplete enumeration of certain reserves and settlements in the [Statistics Canada] Census of Population" (Statistics Canada 2023b).

RCCbc's Main Contributions to Healthcare

The organization acts as a facilitator, linking and promoting initiatives that enhance healthcare accessibility in rural and remote communities. Such a connecting role is critical for health care. For example, one of the main reasons why physicians decide not to practice in rural and remote communities is their limited "ability to connect with specialists" (Asghari et al. 2017, 92, 96). The Real-Time Virtual Support project from RCCbc connects "physicians, residents, nurse practitioners, nurses, midwives, and in some cases first responders" 24/7 with specialists to support "consultations, second opinions, [and] ongoing patient support," among others (Healthcare Excellence Canada 2023, 3). This initiative increases support for "rural providers and improve[s] the quality of care for rural patients they care for" (ibid., 4).

According to Healthcare Excellence Canada (2023), RCCbc initiatives are adaptable to other jurisdictions, which would benefit from connecting with the RCCbc to partner, share learnings, and adapt the program to their specific needs (ibid., 6).[3] An illustrative case is the adoption of an RCCbc program by the Ontario government, leading to the launch of the Emergency Department Peer-to-Peer program in October 2022 (Varner 2023).

Comparing the RCCbc Region to Northern Ontario

Best practices from other locations are powerful tools for public policy. They provide examples of what has or has not worked in other locations. By doing so, they supply proven policy designs that can be applied in other jurisdictions. When selecting best practices, it is essential to ensure that the practices are drawn from a jurisdiction that is similar to that one is working on to ensure that policies are applicable. For example, policies ensuring safe road conditions in the southern United States might represent a good practice for warmer weather but would likely not apply to Northern Ontario, given the difference in climate. Therefore, it is necessary to verify if the general area serviced by RCCbc is comparable to Northern Ontario to ensure that the model is applicable to the latter.

By analyzing the number of communities, geographic area size, population, population density, and number of First Nation, Métis, and Inuit people, the area serviced by RCCbc looks generally like that of Northern Ontario. Both regions encompass a comparable geographic area size, population count, population density, and number of First Nation, Métis, and Inuit people. One difference between the regions is the number of communities, which is 37% larger in Northern Ontario (280) than in rural British Columbia (205). This difference suggests that the population in Northern Ontario is more spread out into smaller communities than in rural British Columbia. However, the area covered by the RCCbc is comparable to Northern Ontario in the other selected variables. Absent an analysis of comparing health systems, determinants, and outcomes, this simple data overview indicates that the RCCbc model should be compatible with Northern Ontario's geography and population distribution.[4]

[3] For more details on useful strategies on how to best disseminate best practices from the RCCbc to other jurisdictions, please refer to appendix A.

[4] For a more detailed analysis, please refer to appendix B.

Ontario's Healthcare Organizations and Funding Structure

In Ontario, the Ministry of Health Ontario, Ontario Medical Association, Ontario Physician Services Agreement, and Ontario Health, although very distinct from one another, can be included in this discussion as possible supports for a future version of the RCCbc in Ontario.

Ministry of Health Ontario

The Ministry of Health in Ontario administers the provincial health system, including health care and public health, and provides health services, such as "health insurance, drug benefits, …long-term care, home care services, community and public health, health promotion, and disease prevention" (Government of Ontario 2023). It defines the "strategic direction and priorities" of the provincial health system by developing and enforcing "legislation, regulations, standards, policies, and directives" (Public Health Ontario 2020). The Ministry is affiliated with many independent agencies, such as Ontario Health, Public Health Ontario, and Home and Community Care Support Services organizations (Ministry of Health Ontario 2023c). The Ministry also provides funding to the health system and monitors and reports on the provincial health system. It uses results from this monitoring to improve health outcomes (Public Health Ontario 2020). The Ministry of Health Ontario is the equivalent of the Ministry of Health BC.

Ontario Medical Association

The Ontario Medical Association is the province's physician advocacy organization. It represents Ontario's physicians, advocating for their well-being and the provincial population's health (Ontario Medical Association 2023b). Its mission is to "advocate for and support doctors" and "strengthen the leadership role of doctors in caring for patients" (ibid.). The Ontario Medical Association is the equivalent of Doctors of BC.

Ontario Physician Services Agreement

In Ontario, a similar agreement to the British Columbia Physician Master Agreement is the Physician Services Agreement, signed between the Ministry of Health and the Ontario Medical Association and most recently effective April 01, 2022 (Ministry of Health Ontario 2023a). This agreement includes the Rural and Northern Physician Group Agreement, which, among other funding for rural and remote physicians, provides remuneration for physicians working in several rural and northern communities in Ontario (Society of Rural Physicians of Canada n.d.-a). The Physician Services Agreement doesn't currently include funding for committees or coordinating and networking activities such as those developed by RCCbc.

However, this primary structure is similar to that of British Columbia, where Doctors of BC and the provincial government negotiated to allocate funding to "improve access to care… building physician capacity, and coordinating system services" through four Joint Collaborative Committees (Karimuddin and Meyer 2021). If following the RCCbc model, physicians in Northern Ontario and the provincial government could consider the opportunity to allocate funding in the Ontario Physician Services Agreement to create a committee similar to the Joint Standing Committee on Rural Issues in Northern Ontario. Whether creating such a committee would be successful depends on negotiations between the Ministry of Health and the Ontario Medical Association.

Ontario Health

Ontario Health is an independent agency affiliated with the Ministry of Health. It was created in 2019 by the Government of Ontario with the mandate to:

"…connect, coordinate and modernize our province's health care system to ensure that the people of Ontario receive the best possible patient-centered care, when and where they need it. Ontario Health oversees health care planning and delivery across the province, which includes ensuring frontline providers and other health professionals have the tools and information they need to deliver quality care in their communities." (Ontario Health 2023a, 3)

Their mission is to connect the health system, improving health outcomes and equity. To do so, it integrates 22 agencies and organizations that were previously separate (Ontario Health 2023a, 6).

Reducing health inequities in "equity-deserving, high-priority, and communities with geographic disparities in access to care" is the first strategy presented in Ontario Health's 2023–2024 strategic map (Ontario Health 2023a, 15). Organizations working on rural and remote health care in Northern Ontario may find that their goal aligns with this strategy, given the inequity of care experienced by these communities (ibid., 16). The strategy's details, however, are limited to extending virtual care in rural and remote areas; it does not touch on coordination, rural and northern lenses on care, or rural pathways in training, for example. The strategy to "stabilize and transform health human resources" mentions "locum coverage supporting crisis response, stabilization, recruitment, and retention in rural and northern communities" (ibid., 19). Ontario Health's strategy to "strengthen system supports and accountabilities" (ibid., 15) may also be compatible with an organization mirroring the RCCbc.

Discussing Possibilities for Rural and Remote Northern Ontario

An organization mirroring the RCCbc in Northern Ontario would be beneficial to support coordination, evaluate progress, and develop and implement programs. It would also measure programs' impact, connect physicians to rural and remote locums in Northern Ontario, and reinforce the northern lens in policy. By creating solutions targeted at rural and remote care in Northern Ontario, such an organization would improve care and health equity in these regions (Joint Collaborative Committees n.d.-a, RCCbc 2023e).

Establishment and Funding

In British Columbia, the RCCbc was first founded by physicians and healthcare professionals; therefore, the government did not lead its establishment, and the organization is still not government-led or housed within a governmental agency or department (RCCbc 2023e). Bottom-up approaches may be better able to connect with communities and develop a people-centered system (Sturmberg and Njoroge 2017).

It benefited, however, from having a funding structure in place through the Joint Standing Committee on Rural Issues and receiving early government funding. Presently, the Ontario government may be more receptive to financing initiatives after an initial community-driven effort to organize and propose a structure rather than initiating government-led endeavours. Since two recent government-led frameworks for rural and northern health care failed to be completely implemented (Health Quality Ontario 2018, Rural and Northern Health Care Panel 2011), a new and proven bottom-up, community-based, and physician-led approach, such as the RCCbc, may be more likely to succeed.

In the Joint Standing Committee on Rural Issues, RCCbc also found governance and financial support, with the committee providing continuous government funding and having some of its members on the RCCbc board. The creation of joint standing committees on health that are able to funnel funding from the provincial government to and support the governance of "grassroots approach[es] to enhance patient care and improve professional satisfaction for doctors" (Karimuddin and Meyer 2021) is compatible with the funding system in Ontario.

The Ontario Physician Services Agreement could host joint collaborative committees with different foci and mandates to "improve access to care by centering it on patients and families, building physician capacity, and coordinating system services" (Karimuddin and Meyer 2021). The creation of these committees would depend on successful negotiations between the provincial government of Ontario and the Ontario Medical Association to allocate some of the funding from the Ontario Physician Services Agreement to such committees. If a Northern Ontario-based version of the Joint Standing Committee on Rural Issues is successfully created, the infrastructure would be in place to support the funding and governance for an organization in Northern Ontario mirroring the RCCbc.

Regardless of which organization would channel such financial support in Ontario, the health funding structure in the province is compatible with the RCCbc model. As Moat, Mattison, and Lavis (2016) indicated, funding from the Ministry of Health in Ontario mostly flows to independent organizations with a separate board of directors instead of directly funding programs and services, which is RCCbc's structure.

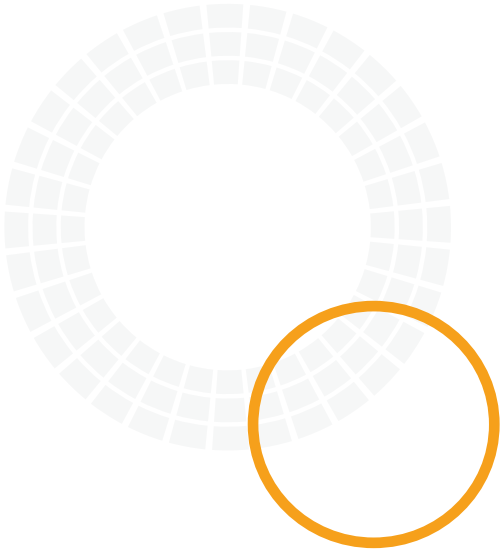
It would be recommended for those interested in establishing such an organization to contact the RCCbc to gain insights into learned lessons, share learnings, and then adapt proven programs to meet their specific needs. There is also potential to explore partnerships that can provide guidance in the founding and formation processes (Healthcare Excellence Canada 2023, 6). Valuable lessons can also be learned from similar organizations, such as the Rural Health Professions Action Plan in Alberta (Rural Health Professions Action Plan n.d.).

Main Challenges and Opportunities that Could Be Addressed by a Coordinating Organization in Northern Ontario

Physician Supports: Increasing Attraction and Retention

Physician attraction could be improved by programs such as RCCbc's Rural Locums Initiative, which provides coordination to match physicians with rural locums (RCCbc 2023a). Retention could be increased, for example, by improving working conditions for rural physicians through access to peer and specialist consultation. RCCbc's Real-Time Virtual Support program is an example of an initiative that successfully achieves this goal (RCCbc 2023g).

By providing supports to physicians, these initiatives attract more physicians to Northern Ontario's rural and remote communities since these professionals may feel more at ease to practice in these locations. Increasing the number of physicians and access to peer and specialist consultations, in turn, improves access to primary and emergency care.



Accountability and Measurement

The main goal of accountability is to assess whether the desired vision and goals have been achieved by programs (Rural and Northern Health Care Panel 2011, 40-41). That is accomplished first by clearly defining roles and expected outcomes for agencies and programs, verifying whether programs were implemented, and measuring if the programs did reach the expected outcomes using a reasonable amount of resources (ibid.).

The lack of accountability causes strategies to be produced but remain unimplemented, wasting resources and hampering progress. The Rural and Northern Health Care Panel's 2011 framework and the Health Quality Ontario's 2018 Northern Ontario Health Equity Strategy were developed with the support of the Ministry of Health Ontario and Ontario Health but not implemented (Office of the Auditor General of Ontario 2023, 2). Some provincial programs to improve health care in Northern Ontario were irregularly or never evaluated, such as the Northern and Rural Recruitment and Retention Initiative, the Northern Physician Retention Initiative, and the Tuition Support Program for Nurses (ibid., 20-28). "Without defined accountability, the implementation of initiatives may be fragmented, disjointed and uncoordinated" (Rural and Northern Health Care Panel 2011, 40).

Measuring programs' progress and impacts ensures that they improve care (effective) and achieve the best results while preventing the waste of resources (efficient). Such exercises ensure that planned strategies and frameworks are implemented so that the resources (e.g. time, money, personnel) that went into their development are not wasted. It promotes continuous healthcare improvement by ensuring that good practices and recommended solutions are not forgotten. It aligns initiatives across the province reducing fragmentation, disjointed and uncoordinated efforts, and leveraging lessons already learned (Rural and Northern Health Care Panel 2011, 40). It mitigates the continuation and creation of programs that deliver funding but have little to no impact (offer no improvement and waste resources) and informs the allocation of tax dollars to the programs with the most impact, producing the most benefit for each tax dollar spent. In fact, a quality measurement and evaluation process can strongly influence a program's success (Bedasso 2021).

An organization mirroring the RCCbc can support accountability by monitoring the design, implementation, and outcomes of strategies, frameworks, and programs, including those proposed or agreed to by the government, the organization itself, and third parties. Accountability is much needed for Northern Ontario. The Office of the Auditor General of Ontario found in 2023 that "the Ministry [of Health Ontario] and Ontario Health… did not routinely measure and publicly report the results and effectiveness of their Northern Ontario programs" (Office of the Auditor General of Ontario 2023, 3).

Purposefully Built Policies: No One-Size-Fits-All

Policies especially designed for rural and remote communities in Northern Ontario are essential to "better meet the unique healthcare needs of Northern Ontario residents" (Office of the Auditor General of Ontario 2023, 3). These regions have "unique healthcare needs, including challenges related to geography, the healthcare workforce, Indigenous health and other health inequities" (ibid., 12).

Therefore, policies created based on realities for the entire province "do not address all the unique challenges of Northern Ontario" (Office of the Auditor General of Ontario 2023, 13). In fact, the 2023 health plan for the entire province, titled Your Health: A Plan for Connected and Convenient Care, "did not provide any specific strategies for addressing the longstanding health inequities identified in Northern Ontario" (ibid.). Such one-size-fits-all approaches miss "an opportunity to identify all the elements that are needed to provide the best health care possible in Northern Ontario and work more effectively to address them" (ibid.).

The RCCbc works with partners to identify gaps in rural health care and co-creates and delivers initiatives that allow physicians and healthcare providers to deliver better care to rural patients (RCCbc 2024b).

An organization mirroring the RCCbc in Northern Ontario can also ensure that policies and programs are well designed for rural and remote communities in Northern Ontario, applying a northern lens to policy. Through its partnership model (Partnership Pentagram Plus), the RCCbc builds a network of rural physicians and other healthcare providers, healthcare administrators, community members, educators, researchers, First Nations, Métis, and Inuit peoples, policymakers, and non-profit and business leaders (RCCbc 2023e). Through this network, the RCCbc serves as a platform for rural health discussion among these partners, building relationships and allowing front-line healthcare workers and community members (ibid.) to convey their insights directly to policymakers, who are part of the network, and to each other. The ability to convey this information and deliver programs that fill gaps is critical since front-line healthcare workers and community members are those most in contact with the local challenges and who best know the reality and needs of communities.

The RCCbc model, therefore, actively engages both front-line workers and those designing policies and provides leadership for northern and rural healthcare issues, which the Rural and Northern Health Care Framework/Plan recommended as one of the strategies to enhance governance and accountability in rural, remote, and Northern Ontario (Rural and Northern Health Care Panel 2011, 40-41).

Coordination and Information

Northern Ontario has no centralized framework, coordinating organization, or agency for rural and northern physician services. Existing services and initiatives are spread across different organizations, and information about them is hard to obtain, hindering efforts to attract and retain physicians in Northern Ontario (NOSM University 2023). "Provincial initiatives and tools to manage healthcare staffing shortages in Northern Ontario [are] fragmented" (Office of the Auditor General of Ontario 2023, 2).

RCCbc provides a platform with centralized information about physician supports, locums, initiatives, and programs that advance health care in rural British Columbia and connects physicians and healthcare professionals to the support they need to deliver quality care. Such a model makes navigating a large amount of information more accessible to encourage physicians and health professionals to practice in rural communities. It also avoids duplication by promoting integration through stronger relationships and knowledge of partner programs and initiatives.

Possible Partnerships in Northern Ontario

Organizations interested in creating a future organization modelled after the RCCbc in Northern Ontario and building partnerships with it should be encouraged to do so. In turn, if the organization followed the RCCbc model, it would need to lean on early government support. The RCCbc counts on multiple partnerships in British Columbia through their Partnership Pentagram Plus model (RCCbc 2024a).

Health providers and professionals, such as individual physicians, BC Ambulance, Allied Health Care Professionals, and Shared Care, partner with RCCbc to lead healthcare coordination and delivery, providing support for early-career professionals and bottom-up, on-the-ground insights into policy and program development.

Academia provides a connection between the RCCbc, research, and medical students and residents. Some of the academic partners in British Columbia are the Faculty of Medicine of UBC, the Selkirk College Rural Pre-Med Program, the Centre for Rural Health Research, and the University of Northern BC Health Research Institute. Medical universities in Ontario can partner with such an initiative if they choose to do so. These partnerships could connect the rural health coordination organization in Northern Ontario to medical students and residents to support continuing education, professional development, rural and northern-focused medical training, and rural locums for clinical deployment. It could also involve supporting research by rural doctors, residents, and medical trainees in Northern Ontario (RCCbc 2023f) and mobilizing physicians to contribute to such an initiative. NOSM University is uniquely positioned to do so in Northern Ontario if it so decides. Pre-med and other regional health education institutions—nursing, paramedic, laboratory technology, and others—would also be well-positioned to form partnerships (Ministry of Colleges and Universities Ontario 2022). The Northern Ontario and Rural Medicine Committee and the Rural Ontario Medical Program could successfully engage medical students and residents in the province.[5]

Health administrators such as the First Nations Health Authority, Provincial Health Services Authority, Northern Health, and Specialists of BC connect the organization to planning and supervising health services.

Linked sectors with an interest in health, such as non-profits, forestry, oil and gas, and mining, partner with RCCbc to increase access to care by, for example, leveraging virtual care in mining camps and remote communities which economies are based on such industries (ERM 2015, RCCbc 2023b). Ontario Public Health Association (OPHA), in its capacity as a supporter of networks, professional development opportunities, and advocacy initiatives, may also be a good fit to partner, support, and connect with a possible organization mirroring the RCCbc in Northern Ontario (Grzybowski, Abu-Laban and Christenson 2020, 2). OPHA's status as a registered charity might also provide an aligned goal with an organization mirroring the RCCbc (a not-for-profit). In Northern Ontario, relevant industries are similar to those of British Columbia, such as mining, forestry, and tourism, and may have similar interests in the health of its employees and the local population that lead these industries to partner with RCCbc in British Columbia.[6]

Community representatives from First Nations, municipalities, First Nations Health Council, and BC Rural Health Network, among others, strengthen a family and community-centered framework. First Nation, Métis, and Inuit health centres, treatment programs, friendship centres with health services, and traditional healing and wellness centres, among others, would also be uniquely positioned to partner with an organization mirroring the RCCbc in Northern Ontario. Municipal and municipal service organizations in Northern Ontario include the Federation of Northern Ontario Municipalities (FONOM), Northern Ontario Municipal Association (NOMA), NorthEastern Ontario Municipal Association (NEOMA), and Northern Ontario Service Deliverers Association (NOSDA). In rural Ontario, the Rural Ontario Municipal Association (ROMA) represents all municipalities with self-identified rural interests.

Finally, policymakers connect the RCCbc with governmental and sectoral policies and regulations, such as the Ministry of Health of BC, the Ministry of Mental Health and Addictions, the College of Family Physicians of Canada, and the BC College of Nursing Professionals.

[5] Organizations in Northern Ontario mentioned in this section are illustrative, not exhaustive.

[6] For details on how public health organizations, Public Health Ontario and Ontario Public Health Association, can partner in Ontario, please refer to appendix C.

Some Steps to Establish and Fund a Physician Services Coordinating Organization in Northern Ontario

According to Healthcare Excellence Canada (2023), RCCbc initiatives can be replicated and applied in other locations (6). If the goal is to implement such a model in Northern Ontario, regional and provincial actors would need to follow a couple of steps, mirroring RCCbc's founding process and current funding model while adapting specific characteristics to Ontario's provincial health structure and institutions.

Funding

The Ontario Medical Association and the provincial government of Ontario would need to negotiate the allocation of resources from the Ontario Physician Services Agreement to a future organization mirroring the RCCbc in Northern Ontario.

In British Columbia, Doctors of BC and the provincial government negotiated to allocate funding to "improve access to care… building physician capacity, and coordinating system services" through four Joint Collaborative Committees (Karimuddin and Meyer 2021). One of these committees is the Joint Standing Committee on Rural Issues, which now funds RCCbc (Avery 2007, Joint Collaborative Committees n.d.-b, Ministry of Health of BC 2022).

The Physician Services Agreement signed between the Ministry of Health and the Ontario Medical Association is comparable to the agreement that funds RCCbc in British Columbia, the Physician Master Agreement (Ministry of Health Ontario 2023a, RCCbc 2023e). Both the agreement in Ontario and the one in British Columbia have subsidiary agreements that address rural practice: the Rural and Northern Physician Group Agreement in Ontario and the Rural Practice Subsidiary Agreement in British Columbia (RCCbc 2023e, Society of Rural Physicians of Canada n.d.-a).

Following the BC model, an option is to allocate resources to a joint standing committee on Northern Ontario's rural health care issues first, which can then provide funding to an organization mirroring the RCCbc in Northern Ontario (Avery 2007, Joint Collaborative Committees n.d.-a, n.d.-b, Ministry of Health of BC 2022). In British Columbia, the Joint Standing Committee on Rural Issues is not part of the government but a partnership between Doctors of BC and the provincial government (Joint Collaborative Committees n.d.-b). It is formed by "equal numbers of provincial Ministry of Health representatives and rural physicians" (Johnston et al. 2021, 1) and is responsible for the overall governance of the rural programs (Joint Collaborative Committees n.d.-a)

Government Willingness to Support

The Ontario provincial government, the Ministry of Health, and Ontario Health would need to be open to approve funding and allocate resources for the creation, operation, and maintenance of this organization, similar to what the British Columbia government and the Ministry of Health in that province did through their agreement with Doctors of BC (Physician Master Agreement; Joint Collaborative Committees n.d.-b).

The health funding structure in Ontario is compatible with the RCCbc model. As mentioned, Moat, Mattison, and Lavis (2016) indicated that funding from the Ministry of Health in Ontario mostly flows to independent organizations with a separate board of directors instead of directly funding programs and services. An organization mirroring this structure in Northern Ontario would, therefore, be recommended to have its own board of directors, as done by the RCCbc.

If mirroring the process of establishing the RCCbc, funding would be critical for its establishment and success (either dedicated or not, following the RCCbc model). According to Ontario Health, the absence of funding in Ontario has previously impeded a northern health strategy from being implemented when the Ministry of Health did not approve the required funding to establish the Northern Network for Health Equity (Office of the Auditor General of Ontario 2023, 2).

Ontario Health should welcome an organization mirroring the RCCbc in Northern Ontario since it would be aligned with Ontario Health's mission to connect the health system, improving health outcomes and equity (Ontario Health 2023a, 6). It would also be aligned with Ontario Health's mandate to "…connect, coordinate and modernize our province's health care system to ensure that the people of Ontario receive the best possible patient-centred care, when and where they need it" (Ontario Health 2023a, 3). In fact, reducing health inequities in "equity-deserving, high-priority, and communities with geographic disparities in access to care" is the first strategy presented in Ontario Health's 2023–2024 strategic map (Ontario Health 2023a, 15).

Organization of Physicians, Health Professionals, and Communities

The RCCbc was created in 2007 by four rural doctors and two staff members and is still led by rural doctors (RCCbc 2023e). According to Dr. Granger Avery, one of the four founding members, he and his colleagues "conceived, obtained funding, and developed RCCbc because of the need for a co-ordination body for rural health care due to the disparate and different problems and solutions to training, practice and living in rural BC" (RCCbc 2022).

Some calls to action have been made over the last few years to create a dedicated northern health strategy, improve accountability, and encourage leadership from Northern Ontario's rural and remote communities within the provincial government in Ontario. The Rural and Northern Health Care Framework/Plan recommended creating a "point of accountability within the MOHLTC leadership focused on rural, remote and northern health, and responsible for leading the definition and monitoring of standards for health care access" (Rural and Northern Health Care Panel 2011, 40). The Ontario Medical Association expressed that "a government body needs to be identified to be responsible for monitoring that the strategy is being implemented effectively and that it is leading to improvements in the health outcomes of residents in the North" as part of their engagement in the 2023 audit from the Office of the Auditor General of Ontario on northern hospitals (Office of the Auditor General of Ontario 2023, 14).

However, the RCCbc provides a functional model for an independent organization outside of the government that would address these needs. In British Columbia, the RCCbc was first founded by physicians and healthcare professionals (RCCbc 2023e). Despite being currently funded by the provincial government in British Columbia and having the necessary funding structure in place when it was created (the Joint Standing Committee on Rural Issues), the establishment of this model was not led by governments.

Physicians and healthcare professionals in Northern Ontario would benefit from connecting with the RCCbc to learn from their experiences and share learning to adapt initiatives to the specific needs of Northern Ontario (Healthcare Excellence Canada 2023, 6). By doing so, they could set up an organizational structure that mirrors the RCCbc in Northern Ontario, supporting physician services, centering information on health supports and services, creating a point of accountability, providing northern leadership in the province, and many other roles successfully played by RCCbc.

Conclusion

Northern Ontario lacks an organization coordinating rural physician services, connecting physicians to rural locums, supporting mentoring, providing virtual peer support, connecting health initiatives and partnerships, and evaluating initiatives' progress and programs' impact. However, other jurisdictions present best practices on how to provide such support to improve northern and rural care, such as the RCCbc in British Columbia.

The creation of an organization mirroring the RCCbc in Northern Ontario has the potential to improve physician services in these regions by improving working conditions for physicians and, therefore, increasing physician recruitment and retention. Such effects would increase access to and the quality of health care in these regions, ultimately decreasing the present inequity of care faced by northern residents. It would also be compatible with Ontario's health structures and funding systems. However, its success would depend on the political will and negotiations between physicians, healthcare professionals, and policymakers in the province to make adjustments to funding structures to support the initiative.

The RCCbc model would also need to undergo some modifications before being implemented in Northern Ontario. Adaptations would ensure the integration of best practices from British Columbia, tailoring them to the unique needs and conditions of Northern Ontario. Implementing modifications in organizations and policies to align with best practices from other jurisdictions is a recognized approach. There are established factors, strategies, and connections that interested parties can leverage to support this implementation process.

Thus, if physicians in rural and remote Northern Ontario and the provincial government are successful in negotiating an allocation for a provincial standing committee on Northern Ontario's rural healthcare issues, an initiative mirroring the RCCbc could be created in Northern Ontario, building on the learned lessons in British Columbia. If successful, these efforts have the potential to bring about improvements in numerous underserved areas in Northern Ontario, which, in turn, is likely to garner support from the provincial government and its agencies.

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Appendix A: Strategies For Disseminating Best Practices

According to Healthcare Excellence Canada, the factors listed below facilitate the spread of best practices from RCCbc to other jurisdictions. Those wishing to mirror the RCCbc model in Northern Ontario would benefit from following this set of strategies designed by Healthcare Excellence Canada:

- Cultivate strong relationships with partners to promote awareness of supports and services to increase their participation;
- Assess partnerships to measure their quality and track progress to "assist in course correction";
- Build relationships intentionally to ensure that programs meet the needs of communities who will be served;
- Communicate the value of the initiative through evidence on outcomes and knowledge transfer; and
- Plan progress in the long term through a road map by identifying new needs and aligning partners' goals (Healthcare Excellence Canada 2023, 7).

Appendix B: Comparing RCCbc to Northern Ontario

RCCbc serves all communities included in the Rural Practice Subsidiary Agreement (Ministry of Health of BC 2022b, RCCbc 2023h). These comprise all areas of British Columbia outside of "Greater Vancouver, greater Victoria, Nanaimo, Kelowna, Kamloops, Vernon, Penticton, and the Fraser Valley west of Agassiz/ Harrison Lake" (Ministry of Health of BC 2022b, 78).

RCCbc works in an area similar to Northern Ontario and to communities in Ontario with a Rurality Index for Ontario (RIO) higher than 40. Communalities with Northern Ontario are found in terms of geographic area size, number of communities served, population, population density, and First Nations, Métis, and Inuit populations. The biggest difference between the regions is the number of communities, which is 37% larger in Northern Ontario but much closer to the number covered by RCCbc than rural Ontario. Being a comparable area to Northern Ontario indicates that the RCCbc model should be compatible with rural healthcare coordination in the North.

In Ontario, communities with a score of 40 or more in the Rurality Index for Ontario can receive additional support to increase access to health care in rural and Northern Ontario, designated as underserviced areas (Ministry of Health Ontario 2023d). This area is comparable to that covered by the RCCbc in terms of the number of communities, total population, and First Nations, Métis, and Inuit population.[7]

However, the RCCbc area is different than that of rural Ontario. Rural Ontario has more than double the number of communities, population, and population density than the area covered by the RCCbc. Only the area size is similar, and an argument can be made that rural Ontario's First Nations, Métis, and Inuit population is 37% larger than that of rural British Columbia. The area that comprises rural Ontario and "Northern and rural Ontario" combined might be too large and different from that covered by the RCCbc to be compatible with the model at this stage. Therefore, it is preferable to test the application of the model first in Northern Ontario, and if there is success, then expand to all of rural Ontario.

[7] It is difficult to compare the total kilometres squared covered by Rural Northern Physician Group Agreement since the area includes communities and surrounding area (Society of Rural Physicians of Canada n.d.-b, 2), and the area for RCCbc, Northern Ontario, and northern and rural Ontario were all exclusionary calculations, by subtracting areas not included, such as CMAs for rural Ontario and Northern and rural Ontario and "Greater Vancouver, greater Victoria, Nanaimo, Kelowna, Kamloops, Vernon, Penticton, and the Fraser Valley west of Agassiz/Harrison Lake" for RCCbc (Ministry of Health of BC 2022b, 78). The total kilometres squared of communities with an RIO higher than 40 summed is 87,269 and, therefore, does not include unorganized areas and neighbouring communities, which may still access services and are included in the other calculations in Table 1. As such, the calculated population density, which is the population divided by kilometres squared, also cannot be compared.

Table 1. Comparative Table on Region and Population Covered by the RCCbc and Northern and Rural Ontario

Region	Number of Communities	Area (km2)	Population	First Nations, Métis, and Inuit people	Average Population Density
RCCbc area[8]	205	902,000	1,085,753	~135,000[i]	1.2
Northern Ontario	280	787,309	789,519	137,665[i]	1.0
Northern and Rural Ontario[9]	482	865,282	2,775,616	220,845[i]	3.2
Rural Ontario	469	858,544	2,481,753	184,905[i]	2.9
RIO > 40 Communities - Ontario[10]	214	87,269[ii]	1,017,832	69,145[i]	11.7[ii]

Sources: RCCbc statistics were calculated or sourced from Capital Regional District (2017), the Ministry of Health of BC (2022b, 78), Statistics Canada (2023b), and RCCbc (2023h, 2023c); for Northern Ontario from Statistics Canada (2017); for northern and rural Ontario from the Ministry of Agriculture, Food, and Rural Affairs Ontario (Ministry of Agriculture, Food, and Rural Affairs Ontario 2023), Statistics Canada (2023a), Rural Ontario Institute (2023); and for communities with a RIO higher than 40 from the Ministry of Health Ontario (2023b) and Statistics Canada (2023b).

Notei: The First Nations, Métis, and Inuit population counts are likely higher in reality because of "the incomplete enumeration of certain reserves and settlements in the [Statistics Canada] Census of Population" (Statistics Canada 2023b).

Note[ii]: Please see the footnote on area and population density calculations for communities with an RIO score higher than 40.

The rural British Columbia area is different from Northern Ontario in the ratio of physicians per population, being closer to that of rural Ontario. Northern Ontario has 140 physicians for every 100,000 people (including urban physicians). That number is 80 in rural British Columbia and 60 in rural Ontario (rural physicians only). However, that difference is a positive factor for Northern Ontario. A higher ratio of physicians per population should not be an impediment to applying the RCCbc model to the region.

Table 2. Comparative Table on the Number of Physicians/Population Ratio Between Rural British Columbia, Northern Ontario, and Rural Ontario

Region	Number of Physicians	Physicians per Population Ratio (per 100,000 people)
Rural British Columbia	865	80
Northern Ontario	1,108	140
Rural Ontario	1,479	60

Sources: Canadian Institute for Health Information (2023) and Statistics Canada (2017, 2023b).

Note: Rural British Columbia and rural Ontario use the Canadian Institute for Health Information (CIHI) definition for rural since data was sourced from CIHI publications.

[8] Area and population were calculated by the author as the total area of British Columbia minus the communities excluded from the Rural Practice Subsidiary Agreement, "Greater Vancouver, greater Victoria, Nanaimo, Kelowna, Kamloops, Vernon, Penticton, and the Fraser Valley west of Agassiz/Harrison Lake" (Ministry of Health of BC 2022b, 78), based on 2021 census profiles and Victoria Capital Regional District Administrative Boundaries (Capital Regional District 2017, Statistics Canada 2023b).

[9] Rural Ontario was defined as all Ontario municipalities (or census subdivisions, CSDs) outside of census metropolitan areas (CMAs) according to Rural Ontario Institute's definition, from where data for Rural Ontario was sourced for this table (Rural Ontario Institute 2023). CSDs and CMAs followed Statistics Canada definitions (Statistics Canada 2022, Statistics Canada 2023c). Northern and Rural Ontario was calculated by summing the statistics of Rural Ontario and Northern Ontario's two CMAs, Thunder Bay and Sudbury.

[10] The area covered by the Underserviced Area Program in Ontario is defined by the Rural Northern Physician Group Agreement as municipalities with a Rurality Index for Ontario, RIO, score of 40 or greater (Ministry of Health Ontario 2023d, Society of Rural Physicians of Canada n.d.-b, 2). Area and population were calculated by the author as the total area of the communities included in the Underserviced Area Program based on their 2021 census profiles (Ministry of Health Ontario 2023d, Statistics Canada 2023b). For a list of communities with an ROI higher than 40, see also https://www.health.gov.on.ca/en/pro/programs/northernhealth/rio_score.aspx.

Appendix C: Other Organizations for Potential Partnerships in Northern Ontario and Ontario

Public Health Ontario

As a hub organization, the Ontario Agency for Health Protection and Promotion (or Public Health Ontario) is the Ontario government agency that is most closely related to RCCbc in terms of its goals of connection to scientific and technical knowledge. It advises governments and organizations and links practitioners, front-line workers, and researchers to knowledge (Government of Ontario 2023). Its mandate is to "provide scientific and technical advice" to government entities such as the Ministry of Health Ontario, the province's health care system, and organizations working in health care (Public Health Ontario 2023). Public Health Ontario's mandate does not include health care delivery, being more aligned with broader public health initiatives.

Public Health Ontario hosts four non-board committees which address policies on antimicrobial stewardship, immunization, public health emergencies, and infectious disease prevention (Ontario Agency for Health Protection and Promotion 2023).[11] Membership in these committees is mixed between health professionals and government representatives, as in the Joint Standing Committee on Rural Issues, but at different ratios. In Ontario, membership consists mostly of physicians and practitioners, with a minority of Public Health Ontario representatives (ibid.), compared to the equal proportions of physicians and provincial representatives in British Columbia (Johnston et al. 2021, 1).

Unlike the Joint Standing Committee on Rural Issues, these are not standing committees, meaning they can be created and dissolved with time (Public Health Ontario 2021). For example, the Smoke-Free Ontario Scientific Advisory Committee no longer exists (Public Health Ontario 2017), while the Ontario Immunization Advisory Committee was created in 2021 (Public Health Ontario 2021). Significantly, non-standing committees are less effective in sustaining a long-term framework to enhance health care in rural, remote, and northern areas compared to standing committees.

Ontario Public Health Association

The Ontario Public Health Association (OPHA) is the not-for-profit organization in Ontario that is closest to RCCbc in terms of its goals and format. OPHA is a "non-profit organization… committed to providing a forum for public health practitioners, citizens, and volunteers" interested in improving health care in Ontario (Drobot and Bielska 2015, 188). It provides access to professional development information and hosts workgroups and multidisciplinary networks to inform policy decisions in Ontario through advocacy (Ontario Public Health Association 2023a, 2; 2023b; 2023c). However, OPHA is also not focused on healthcare delivery and would likely be unable to provide support for direct program delivery and the coordination of rural and northern networks of care, context-specific medical education, measuring progress and initiative impact, among other such roles of RCCbc.

[11] The full names of these committees are the Antimicrobial Stewardship Advisory Committee, the Ontario Immunization Advisory Committee, the Ontario Public Health Emergencies Science Advisory Committee, and the Provincial Infectious Diseases Advisory Committee on Infection Prevention and Control (Ontario Agency for Health Protection and Promotion 2023).

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