

POLICY BRIEF

Issues in Rural Maternity Care Series

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Primary Maternity Care in Rural BC — Time for Action

Centre for Rural Health Research

The Problem

Over the past decade, rural communities across Canada have experienced the precipitous decline of local health care services. This is perhaps most acutely recognized in maternity care where longer distances to care have been correlated with worse outcomes for mothers and infants.¹ Beyond health outcomes, traveling outside the local community for care has also been shown to lead to increased stress and financial and logistical challenges for birthing families.²

- In BC, the Rural Pregnancy Stress Scale (RPSS) finds that rural women are 7 times more likely to experience moderate to high stress during pregnancy.³
- Aboriginal women are particularly vulnerable to the effects of traveling for care, as they become alienated from the supportive kinship ties found in their family, community, and connection to the land.
- Diminished access to care impacts maternal and newborn outcomes. Infants whose mothers live more than 4 hours from maternity services have higher rates of perinatal death than those living close to care.¹

→ Out of hospital births are higher for women living 1-2 hours from care. As well, rural birthing women are 1.3 times more likely to receive an induction of labour if they live 2-4 hours from care.⁴ Qualitative investigation indicates that these “geographic inductions” reflect women’s desire to return home.

While the percentage of rural women who are able to deliver locally increases significantly with the availability of surgically trained maternity care providers and specialists (see Figure A), there are significant shortages of skilled rural maternity care providers and existing professionals are stressed and over-worked.

→ Newly graduating nurses often have had little exposure to labour and delivery and lack appropriate time off and funding to

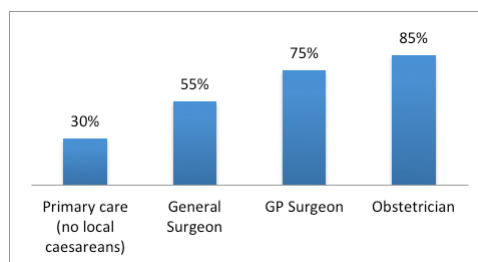


Figure A: Percentage of Rural Women who Deliver Locally by Service Level

SUMMARY

Closure of small, rural hospitals across BC has been linked to negative maternal-newborn outcomes, increased financial and logistical challenges for families, and stress leading to burn-out for care providers. Solutions to this crisis in rural maternity care have included initiatives promoting primary maternity care inter-professional collaboration. However, successful collaboration depends in large part on the development of appropriate, sustainable funding models. This policy brief proposes the creation of physician-based, midwifery-based, and collaborative team funding initiatives. By focusing on funding issues as the lynchpin to positive change, we can begin to create sustainable rural primary maternity care.

access continuing medication education.⁵

- Rural family physicians are giving up maternity care due to the stress of providing continuous, on-call coverage without any remuneration.⁶
- GP Surgeons (generalists with limited enhanced skills), the backbone of many rural surgical services, are under siege due to the lack of a certified training program and regulatory structure. Many are reaching retirement.
- Midwives face significant challenges integrating into rural communities, including difficulties obtaining hospital privileges from physician-led boards and low volume of deliveries leading to burn-out.⁷

Several solutions have been sought to improve access to rural maternity care including physician incentive plans and initiatives to support inter-professional collaborative care.^{8,9} However, these initiatives have not adequately addressed solutions that consider the unique context and needs of rural communities. For example, appropriate and sustainable inter-professional models of primary maternity care must be adapted to suit low-resource environments with a limited provider group who may or may not choose to work together.

The most significant barrier to primary maternity care is the *funding structure* of how physicians and midwives are paid, creating significant disincentives to maternity care for physicians and impediments to collaborative care between the professions. In the absence of financial equity and appropriate funding models for midwives and physicians, any initiatives promoting inter-professional models of care will be unsuccessful.

Improving Access to Care

- In instances where local access to rural maternity care exists, measures must be taken to strength-

en and sustain the system.

- Where viable services have closed due to challenges to providing rural health services, a rational assessment of need should be undertaken to determine if the community should be supported in resuming services.
- Where it is likely that sustainable services cannot be maintained, a robust system of intrapartum care should be established in conjunction with the community where care will be provided.

Opportunities for Action: New Funding Priorities

Appropriate access to primary maternity care for rural birthing women depends on services that support the sustainability of care providers, the development of collaborative, inter-professional teams, and the involvement of communities in the planning process. The foundation of sustainable services currently rests with equitable models of funding that encourage inter-professional collaboration. This includes both physician-based initiatives, midwifery-based initiatives, and initiatives that will support collaborative care.

Physician-Based Initiative: MOCAP for On-Call Primary Maternity Care⁶

Background

- In British Columbia, the only area of practice exempt from the Medical On-Call Availability Program (MOCAP) agreement is maternity care. This is because of a perception that some physicians cover only patients from their own practice and the on-call stipends were not intended to support doctors covering their own patients. Because of the significant number of rural service closures, however, more and more women are traveling to referral centres to give birth, creating an influx of “orphaned patients” in these communities. The responsibility for their

care falls on the family physicians in these centres.

The Solution

- To this end, we advocate for the creation of a rural primary maternity care on-call stipend paid to one call group of primary care providers per community, in communities that do not have full-time coverage by a specialist obstetrician.⁶ This stipend could be based on current MOCAP payment levels, with the assumption that eligible communities will provide level-1 on-call services (\$225,000/year/call group).
- In British Columbia, if we restrict the application of this scheme to rural communities with maternity services (roughly 35 locations), the total cost of this initiative would be less than \$8 million annually and would assist in reversing the disincentives to rural primary maternity practice that have been inadvertently created.
- The introduction of this on-call payment scheme for rural coverage of primary maternity care will support the retention, recruitment, and repatriation of rural maternity care providers. As more practitioners take up rural maternity care and individual workloads decrease to reasonable levels, overall quality of life and sustainability of practice will improve.⁶ These changes will strengthen the quality of care provided to birthing women, as well as enable them to access intrapartum services closer to home.

Midwifery-Based Initiative: Alternative Payment Plans⁷

Background

- Of the 17 rural maternity services that have closed since 2000, most have been challenged by low volume of births. For midwives who rely on a course-of care funding scheme, low volume of deliveries creates a financially unsustainable situation.

- Many low-volume rural communities are isolated First Nations reserves with a high-needs population. These communities sometimes lack other important health services that fall within midwives' expanded scope of practice.
- The MCP2 Final Report (June 2006)⁸ recommended the creation of collaborative inter-professional maternal/newborn care sites to test alternative funding mechanisms. This model of alternative payment currently exists with physicians in isolated rural communities.

The Solution

- Communities with a population of less than 10,000 cannot adequately support midwifery care (based on two practicing midwives and 40% transfer to higher levels of care). These settings are conducive to Alternative Payment Plans for midwives.
- Alternative payment could include remuneration for community sexual health (sexual education in schools, STD testing, etc.), well-woman gynaecological care, well infant/baby care, breastfeeding support, and community outreach.

Inter-professional Collaboration: Reducing Barriers to Practice

Background

- Currently midwives and family physicians are not paid the same amount for a course of care. This inequity has led to physicians feeling undervalued as maternity care providers.
- Additionally, the way physicians and midwives are paid (per visit and labour and delivery versus per trimester and labour and delivery, respectively) creates barriers to collaborative call as midwifery funding mechanisms do not allow flexibility for discrete tasks in a collaborative environment, such as being on call or working in clinic.

The *Issues in Rural Maternity Care* policy brief series addresses current issues in the provision of maternity care in British Columbia and provides timely recommendations for improving the quality and safety of rural intrapartum care. Targeted at policy makers and maternity care providers, it is produced by the Centre for Rural Health Research.

NEXT STEPS

This policy brief has addressed funding issues that are at the heart of sustainable rural primary maternity care services. However, other issues need to be considered including:

- Scope of practice issues: *Midwives, physicians, and nurses have different scopes and styles of practice, leading to different expectations in care and confusion of roles and responsibilities.*
- The need for comprehensive care at a community level: *Rural surgical services require full teams of skilled providers, but such specialization is challenging in a generalist environment.*
- Health Care Transition challenges: *Rural women often fall through the cracks during the postpartum period due to ineffective communication between care providers.*
- Recruitment and retention of providers: *Recruitment and retention of skilled rural care providers is an ongoing challenge.*
- Continuing Professional Development: *It is challenging to find funding and locum coverage for primary maternity providers to leave their rural communities to participate in CPD.*

The Solution

→ There are significant constraints on adjusting disciplinary funding models in health care. Innovative solutions need to be considered such as the South Community Birth Program in Vancouver. If this fundamental barrier is not addressed, inter-professional collaboration in rural communities will remain severely constrained.

Moving Forward

The process of comprehensive change must be one of collaborative discussion with all key stakeholders including parturient women in rural communities. However, by focusing on funding issues as the lynchpin to positive change, we can begin what otherwise could be an overwhelming process of creating sustainable rural primary maternity care.



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