



PODIUM: DOCTORS SPEAK OUT LA PAROLE AUX MÉDECINS

Rural maternity practice: How can we encourage family physicians to stay involved?

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THE CHALLENGE

During the past decade, many rural jurisdictions in Canada have witnessed precipitous closures of maternity services.^{1,2} Although reasons for closures are often location-specific, they tend to be related to human resource challenges involving nurses, general practitioner surgeons, family physicians and specialists;^{1,3-5} lack of access to specialized services (e.g., limited access to epidural anesthesia, labour augmentation or cesarean delivery back-up);^{1,5} and a trend toward centralization across the spectrum of delivery of health care services in Canada.^{1,6,7}

It is becoming clear that, among these contributing factors, the most significant challenge is the recruitment and retention of providers in rural locations and the need for appropriate incentives to improve physician participation.

Across Canada, the proportion of births attended by family physicians is diminishing and varies considerably from a low of 23.6% in Prince Edward Island to more than 77.2% in British Columbia.⁸ Many provinces have already lost most of their family physician involvement in maternity care and British Columbia is poised to experience the same decline in family doctors who practise obstetrics.

These challenges to the provision of care are characteristic of a rural context and have given rise to innovative solutions for sustaining services. One such solution is on-call remuneration agreements, as have occurred across rural Canada during the past 10 years. For

example, in British Columbia an on-call remuneration agreement was reached in 2001 between the BC Medical Association and the British Columbia Ministry of Health, which included financial support for coverage of emergency and specialist services, but not maternity care provided by family physicians.

Other provinces have implemented on-call coverage plans for emergency care in rural environments, such as the Rural On-Call Remuneration Program in Alberta, the Emergency On-Call Coverage Program in Saskatchewan and the Hospital On Call Coverage Program in Ontario, and have included support for on-call maternity services in an attempt to staunch the loss of family physician involvement in obstetrics.

A review of the Alberta Rural On-Call Remuneration Program has demonstrated high satisfaction among rural physicians with the program.⁹ In Ontario, the pilot program for the Hospital On Call Coverage Program started in 2000 and has been re-funded and expanded in response to positive pilot outcomes.¹⁰

THE MEDICAL ON-CALL AVAILABILITY PROGRAM — THE BRITISH COLUMBIA EXAMPLE

The working agreement of British Columbia's Medical On-Call Availability Program (MOCAP) specifies that payments are made "to physician(s) and physician groups who provide coverage for patients, other than their own or

their call groups', as required and approved by Health Authorities."¹¹ Coverage of the MOCAP is differentiated based on the availability and proximity of the provider, with level-1 coverage requiring availability by telephone within 10 minutes, and on site urgently, but no later than within 45 minutes; level-2 availability by telephone within 15 minutes and on site within 2 hours; and level-3 availability by telephone within 15 minutes and on site within 16 hours of receiving the call.¹¹

There are also contingencies for on site, on call and call back. The level of remuneration reflects the availability of the provider and ranges from \$70 000 to \$325 000 per call group per year,¹¹ with call groups requiring a minimum of 3 providers.¹² Other provinces with rural on-call funding provide similar levels of remuneration. In Ontario, for instance, the amount of funding a call group receives from the Hospital On-Call Coverage Program also depends on the number of care providers within the group and level of hospital services, and ranges from \$103 200 to \$172 000 per year.¹⁰

The purpose of the MOCAP initiative is to ensure that physicians providing coverage as part of an established call rotation (or physician group) are compensated for providing emergency care for patients other than their own. The MOCAP facilitates continuous, sustainable on-call service and ensures that on-call workloads do not contribute to burnout for participating physicians. Underpinning this solution was a recognition of the importance of robust health care services to rural communities within the context of rational decision-making regarding level of care based on population need. Practice areas covered in the agreement include pediatric, emergency, psychiatric and surgical call. In small communities, these call rotas rely on the participation of general practitioners who have gained expertise in 1 or more of the practice areas.

THE MOCAP AND MATERNITY CARE

In British Columbia, the only area of practice exempt from the 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 travelling to centralized community and referral hospitals to give birth, creating an influx of "orphaned patients" in referral centres. The burden of respon-

sibility for their care falls on the family physicians in these communities.

Perhaps more importantly, as more and more physicians retire and new physicians enter rural practice with lifestyle expectations that allow them time off call, patterns of call coverage have changed. This has led to call group formations that may cover several local practices in addition to bearing the responsibility for women from outlying communities.

DISINCENTIVES TO RURAL MATERNITY CARE

When new physicians enter rural practice, they are faced with competing opportunities to participate in call rotas and recognize that many on-call groups, emergency services for example, provide on-call remuneration and obstetric call does not. The consequences of this is a disincentive to the recruitment of physicians to maternity care, leading to increased stress for existing providers, heavier workloads, burnout and, potentially, the closure of a given maternity service altogether.

Additionally, the cascade effect of the closure of small services leads to the increased burden on physicians in referral centres who receive "orphaned patients" and the subsequent destabilization of referral services.¹³ To say that we are approaching a crisis in maternity care is to miss the fact that, in British Columbia alone, 20 services have closed since 2000 with many others on the brink of closure.¹⁴ The question that we must grapple with is, Will we prioritize best care (care closer to home)^{15,16} or will competing priorities win out?

OUR PROPOSAL

We have unintentionally created significant disincentives to rural practitioners to provide maternity care. If we want to sustain rural maternity care, we need to rectify this situation and fund on-call obstetric practice for general practitioners. To this end, we advocate for the creation of a rural primary maternity care on-call stipend paid to 1 call group of primary care providers per community, in communities that do not have full-time coverage by a specialist obstetrician.

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/yr/call group). Care providers would receive only 1 stream of funding per on-call shift (i.e., a physician on call for maternity care may not

also receive MOCAP payments for emergency or anesthesia call groups during that shift). 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 cascade of destabilization that we have 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.¹⁷ These changes will strengthen the quality of care provided to birthing women, as well as enable them to access intrapartum services closer to home.

CONCLUSION

The way we choose to resolve this health care services dilemma rests in the core values enshrined in the Canada Health Act, which include equitable access to services for all, including families in rural and remote communities.¹⁸ We can no longer afford to overlook the importance of the role of birth, not just in the health care infrastructure of rural communities, but also in the social fabric of rural communities themselves.

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