RURAL ON-CALL REMUNERATION

PROGRAM EVALUATION

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Presented to the RPAP Coordinating Committee by:

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EXECUTIVE SUMMARY

The AMA Section of Rural Medicine and Alberta Health and Wellness negotiated the implementation of the Rural On-call Remuneration Program in September 1998. This Program was designed to recognize that the provision of emergency on-call services in rural locations poses significant lifestyle and economic challenges for the physicians providing this important service, and that the recognition of and compensation for the provision of emergency on-call services would be a significant measure to enhance the recruitment and retention of physicians in rural Alberta. Such a program would also represent an important component of a broad array of measures to address rural physician issues as contained in the Rural Physician Action Plan.

In early December 2000, C. A. MacDonald and Associates were selected by RPAP to undertake the evaluation of the program. A project Steering Committee comprised of four members representing the RPAP CC, the AMA Section of Rural Medicine, Alberta Health and Wellness, and the Council of Medical Directors, was created by the RPAP and has advised the working team throughout this project.

This evaluation team undertook to ensure all stakeholders' views were incorporated, through distribution of a rural physician survey and interviews with a number of rural physicians. This was supplemented by information requests made to Alberta Health and Wellness as well as interviews with the regional medical directors and a number of other expert informants. The regional medical directors also facilitated an information request to the eligible facilities.

This evaluation of the Rural On-Call Remuneration Program has four primary objectives:

1. To evaluate the extent to which this program is meeting its stated goals and the goals of RPAP (i.e., to aid rural physician recruitment and retention);

2. To assess stakeholder participation and satisfaction with this program;

3. To recommend improvements to the on-going monitoring of the program by the RPAP Coordinating Committee and Alberta Health and Wellness; and

4. To assess whether administration of the program should be transferred to the Regional Health Authorities effective April 1, 2001.

The evaluators confirm that:

1. The Rural On-Call Remuneration Program is a crucial component of the overall Rural Physician Action Plan. The majority of rural physicians and regional medical directors confirm that the program is having a positive effect on recruitment and retention of rural physicians.

2. Over two-thirds of Alberta rural physicians are participating in the Rural On-Call Remuneration Program. This proportion seems to be fairly consistent across the regions. The largest group of non-participants are general practitioners with special skills. The remaining physicians who do not participate in the program tend to be close to retirement age. Satisfaction levels with the design and operation of the program are very high amongst both rural physicians and regional medical directors.

3. Since several facilities are approaching the current limit of 25,000 unscheduled emergency room visits, the Rural On-Call Remuneration Program should begin monitoring of unscheduled emergency room visits on an annual basis. This will increase facility accountability to the program.

4. All respondents felt that the administration of the Rural On-Call Remuneration Program and payments to physicians should not be transferred to the regional health authorities. However, Alberta Health and Wellness transferred administration effective April 1, 2001.

The complete set of recommendations made by this evaluation follows:

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Establishment of the Rural On-Call Remuneration Program

As a result of chronic difficulties in attracting physicians to rural and remote communities in Alberta, a working group of Alberta Health's External Advisory Committee on Physician Manpower was formed in 1990 to develop a comprehensive action plan for the recruitment and retention of rural physicians. An action plan was developed and approved by Cabinet in December 1990. The *Rural Physician Action Plan*, as originally conceptualized, comprised 16 initiatives focused on three distinct target groups: medical students and residents, currently practising rural physicians, and rural communities.

An Incentive Payment Plan, which had been in place since 1985 to encourage physicians to establish and maintain their primary location of practice and residence in rural communities, was incorporated into the Rural Physician Action Plan (RPAP) in 1991. After an evaluation determined that the Incentive Payment Plan was not meeting its objectives of increasing recruitment and retention of rural physicians, the program was cancelled in 1998.

Around the same period, the AMA Section of Rural Medicine and Alberta Health and Wellness negotiated the implementation of the Rural On-call Remuneration Program in September 1998. This Program was designed to recognize that the provision of emergency on-call services in rural locations poses significant lifestyle and economic challenges for the physicians providing this important service, and that the recognition of and compensation for the provision of emergency on-call services would be a significant measure to enhance the recruitment and retention of physicians in rural Alberta. Such a program would also represent an important component of a broad array of measures to address rural physician issues as contained in the Rural Physician Action Plan.

The Consensus Statement of August 26, 1998, which outlines the agreement between the parties regarding the new Rural On-Call Remuneration Program, is attached as Appendix 1, starting on page 34.

The 1998 Master Agreement between Alberta Health and Wellness and the Alberta Medical Association (AMA) provided for the termination of the Incentive Payment Program (IPP) and the re-allocation of the IPP funds to the new Rural emergency On-Call Remuneration Program, which began operation October 1, 1998. A transition plan was in place to bridge the IPP and the new program.

Program Objectives

The Consensus Statement relating to the Rural On-Call Remuneration Program outlined a number of objectives for the program:

- To give recognition to and compensate physicians for the unique lifestyle and economic circumstances of providing emergency on-call in rural areas and to provide an incentive to increase the number of physicians who provide rural emergency on-call services.

- To ensure that Albertans living in rural and remote locations of the province receive comprehensive and continuous emergency on-call services.

- To provide opportunities for physicians and Regional Health Authorities to work together more closely on issues concerning the delivery of medical and physicians services to their populations.

Current Program Status

There are currently 86 facilities eligible under the Rural On-Call Remuneration Program, up from the original 82 when the program started in October 1998. The list of eligible facilities is included as Appendix 2, starting on page 38. Over 600 physicians have benefited from the program since its inception. Pursuant to the Consensus Statement, the initial on-call rate increased from $17 to $21 per eligible on-call hour and from $400 to $500 per full 24-hour period, as of April 1, 2000.

Design of the Rural On-Call Remuneration Program

The Consensus Statement establishing the Rural On-Call Remuneration Program stipulated that the new program would be evaluated two years after implementation, with the Rural Physician Action Plan Coordinating Committee presenting an evaluation report to the Minister of Health no later than March 31, 2001. It was also determined that the Minister of Health will establish the features, terms and conditions of the Rural On-Call Remuneration Program as of April 1, 2001 in consultation with the AMA and the ASRM.

Facility Eligibility Criteria

The initial list of facilities eligible for emergency on-call payments for physicians was determined by the Regional Health Authorities, in consultation with physicians and Alberta Health and Wellness and were listed on a schedule. Subsequent changes to this schedule of eligible facilities requires the recommendation of the RPAP Coordinating Committee and the approval of the Minister of Health and Wellness.

The funding for emergency on-call services is provided to eligible facilities that meet these criteria:

- acute care facilities which offer to the general public emergency on-call coverage 24 hours per day, 365 days per year;

- facilities where the emergency department is not staffed by geographic full-time physicians practising emergency medicine; and

- facilities where there are 25,000 or fewer unscheduled visits annually to the emergency department.

Administration of the Rural On-Call Remuneration Program

The program was established as a provincial program, which was seen to be essential and significant. The then AMA President, Dr. Bill Anderson, stated in a press release, “In this way it

ensures equity in remuneration for the provision of emergency services and will help ensure access to emergency care throughout the province."

Under the Consensus Statement, the administration of the program budget was to be managed by Alberta Health and Wellness until March 31, 2001. The payment process originally established was for the RHAs to submit a computer text file weekly to the Claims Branch, Alberta Health and Wellness containing information relating to the physician(s) to be compensated, the facility number where the service was provided, the dates of the on-call services and number of hours per day, and the amount claimed for each date of service. Alberta Health and Wellness then processes the payments for the physicians. Unspent funds were retained by the Department.

The Rural Physician Action Plan Coordinating Committee (RPAP CC), which is the oversight body for the RPAP, is responsible to the Alberta Minister of Health and Wellness for providing policy advice on all issues related to the recruitment and retention of rural physicians. With respect to the Rural On-Call Remuneration Program, the RPAP CC has these responsibilities:

1. Recommending criteria for any changes in the list of eligible facilities including non-hospital facilities.

2. Providing recommendations to the Minister of Health and Wellness, upon his request, on specific applications for changes to the facility list from the regional health authorities.

3. Evaluating the program two years after implementation and no later than 31 March, 2001.

Effective April 1, 2001, the administration of the program budget is intended to be transferred to the Regional Health Authorities (RHAs). The program funds are to be transferred to the RHAs in a monthly block amount per facility and their use will be limited to the Rural On-Call Program, which will remain a provincial program.

Evaluation Methodology

In early December 2000, C. A. MacDonald and Associates were selected by the RPAP to undertake the evaluation of the program. A project Steering Committee comprised of four members representing the RPAP CC, the AMA Section of Rural Medicine, Alberta Health and Wellness, and the Council of Medical Directors, was created by the RPAP and has advised the working team throughout this project.

This evaluation team undertook to ensure all stakeholders' views were incorporated, through distribution of a rural physician survey and interviews with a number of rural physicians. This was supplemented by information requests made to Alberta Health and Wellness as well as interviews with the regional medical directors and a number of other expert informants. The regional medical directors also facilitated an information request to the eligible facilities. The text of the rural physician survey is attached as Appendix 3, starting on page 41. A total of 772 surveys were sent out to rural physicians, with 345 being returned prior to the cut-off, a response rate of 45%. 18 surveys were received after data entry was complete and were reviewed for contents of open-ended questions. Details of the respondent demographics can be found in Appendix 4, starting on page 49. Requests for information were sent to all 86 facilities,

with 73 being returned prior to the data cut-off. In addition, 15 medical directors, 16 rural physicians and 12 other key informants participated in in-depth interviews.

The following objectives were established by the project Steering Committee for the evaluation:

- To evaluate the extent to which this program is meeting its stated goals and the goals of the RPAP (i.e. aid rural physician recruitment and retention).
- To assess stakeholder participation and satisfaction with the Rural On-Call Remuneration Program.
- To recommend improvements to the ongoing monitoring of the program by the RPAP CC and Alberta Health and Wellness.
- To assess whether administration of the program should be transferred to the Regional Health Authorities effective 1 April 2001.

The evaluation Steering Committee felt it would be appropriate to take the opportunity afforded by the information collection process for this evaluation to explore additional related issues, such as the exclusion of general practitioners with additional competencies from compensation for on-call duties. ***Although this issue was not specifically raised by the project team in the survey nor in the interviews, the majority of regional Medical Directors, as well as other key stakeholders raised the matter as one with which they had a concern***.

Rural On-Call Remuneration Program Goal Achievement

Physicians Providing On-Call Services

There has been a steady increase in the number of physicians paid under the Rural On-Call Remuneration Program since program inception. The following table indicates the number providing emergency on-call services and the proportion of all rural physicians that this represents. Physicians in the five regional centres, the CHA (except for Leduc) and CRHA are excluded.

Table 1 - Participation in Emergency On-Call

	Number of Physicians Reimbursed	Total Number of Rural Physicians	Proportion Providing Emergency On-Call
Oct-98	482	686	~70%
Nov-98	479		
Dec-98	479		
Jan-99	489	753	~66%
Feb-99	487		
Mar-99	488		
Apr-99	500		
May-99	494		
Jun-99	503		
Jul-99	504		
Aug-99	516		
Sep-99	513		

	Number of Physicians Reimbursed	Total Number of Rural Physicians	Proportion Providing Emergency On-Call
Oct-99	512		
Nov-99	517		
Dec-99	523		
Jan-00	529	791	~67%
Feb-00	521		
Mar-00	520		
Apr-00	517		
May-00	533		
Jun-00	518		
Jul-00	527	~ 734	~ 73%
Aug-00	535		
Sep-00	533		
Oct-00	536		
Nov-00	533		
Dec-00	543		

> *30 years of on-call is enough!*
>
> *Rural physician*

It can be seen from the above table that approximately 2/3 of rural physicians participate in emergency on-call. 304 of the 345 physicians responding to the survey (88%) reported that they currently did on-call for the local emergency department, or in other communities in Alberta. This indicates that there was a greater likelihood of a physician responding to the physician survey if they did participate in on-call activities. Thirty-eight physicians who responded indicated that they did not do emergency on-call. Physicians were asked what might encourage them to do on-call in emergency services if they were not currently doing on-call. There were a total of 29 written responses to this question:

- 9 respondents indicated they have put in their time on-call and nothing would encourage them to participate at this time.
- 6 respondents indicated that better remuneration might encourage them to do on-call. (One respondent indicated that it would take his/her weight in gold.)
- 9 respondents stated that while they do not do emergency on-call, they do provide anesthetic/obstetrician/surgery services several days/nights per week, or that they provide on-call for their practices at their own expense.
- 4 respondents provided general information relating to their own situation, i.e., retired, other physicians wanted the shifts, etc.
- 1 respondent mentioned the need for a change in the public's attitudes about using emergency as a walk-in clinic.

The Consensus Statement that was developed when the program was first designed indicated that the desirable state of affairs was that on-call responsibilities should be no more than one in four. Physicians responding to the survey indicated a wide variety of expectations for their on-call responsibilities. The following table indicates the distribution of on-call responsibilities from the survey.

Table 2 - On-Call Workload

	Prior to Oct/1998		Current Schedule		Desired Schedule	
	Number	%	Number	%	Number	%
No on-call	18	5.5%	7	2.1%	46	14.1%
1:1	12	3.7%	10	3.1%	2	0.6%
1:2	15	4.6%	13	4.0%	7	2.1%
1:3	39	11.9%	36	11.0%	17	5.2%
1:4	45	13.8%	44	13.6%	38	11.6%
1:5	41	12.5%	37	11.3%	36	11.6%
1:6	43	13.2%	51	15.6%	27	8.3%
1:7	72	22.6%	104	31.8%	127	38.8%
Less than once per week	6	1.8%	9	2.8%	9	2.8%
No Response	34	10.4%	16	4.9%	18	5.5%
Total	327	100%	327	100%	327	100%

The facilities that responded to the evaluators' information request provided the number of physicians that routinely provided on-call services. The following tables shows how these facilities are distributed by number of physicians providing services.

Table 3 - On-Call Physicians by Facility

Number of Physicians providing On-Call Services	Number of Facilities Reporting
0 physicians	2
1 physician	4
2 physicians	2
3 physicians	9
4 physicians	11
5 physicians	6
6 physicians	7
7 physicians	7
8 physicians	2
9 physicians	6
10 physicians	3
11 physicians	3
12 physicians	2
13 physicians	2
14 physicians	1
16 physicians	2
19 physicians	1

Based on the survey results, there are at least 66 physicians (18.1% of those responding to the physician survey) in 26 facilities that are doing on-call more frequently than the desired one in four. This is only marginally better than the 20.2% who reported on-call responsibilities of greater than one in four prior to the introduction of the Rural On-Call Remuneration Program.

There has been a major influx of physicians into Alberta over the last few years. The table on the next page illustrates this changing profile by region. In the last two years, there have been

105 new physicians (addition of 243 and 138 left) added in rural Alberta. However, these physicians seem to be going to the somewhat larger communities, or there would have been a more marked effect on the number of physicians continuing to do on-call more than one in four.

Table 4 - Rural Physicians by Region, 1986 - 2000

Region	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Region 1 - Chinook	53	55	57	64	62	63	62	64	60	62	57	55	50	57	58
Region 2 - Palliser	20	22	21	23	23	23	23	23	22	23	19	21	18	22	23
Region 3 - Headwaters	55	54	54	62	64	66	68	71	75	80	86	84	90	94	104
Region 5	33	37	34	35	34	35	37	36	39	37	39	35	37	42	43
Region 6 - David Thompson	81	86	89	87	86	92	93	88	84	86	81	79	85	93	95
Region 7 - East Central	89	87	91	90	85	85	89	89	86	78	71	77	77	87	96
Region 8 - WestView	58	62	61	63	68	73	70	71	72	69	66	62	76	78	75
Region 9 - Crossroads	50	53	55	58	60	56	56	59	58	61	63	64	67	70	74
Region 11 - Aspen	41	41	44	43	38	44	44	47	45	46	42	38	42	50	54
Region 12 - Lakeland	80	82	88	91	89	85	90	81	87	86	85	81	81	88	95
Region 13 - Mistahia	23	23	26	23	24	26	25	24	24	24	24	22	24	25	24
Region 14 - Peace	17	17	14	15	15	14	16	17	17	17	13	13	13	15	18
Region 15 - Keeweetinok	16	15	18	16	16	16	16	15	17	16	15	15	15	18	20
Region 17 - Northwestern	12	11	12	11	8	11	10	10	10	10	11	10	10	13	12
TOTAL Rural Physicians	**628**	**645**	**664**	**681**	**672**	**689**	**699**	**695**	**696**	**690**	**672**	**657**	**686**	**753**	**791**

Table 5 - Turnover Rates in Alberta - 1986 - 2000

Region	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Region 1 - Chinook	+7 -5	+5 -3	+7 0	+1 -3	+4 -3	+2 -3	+6 -4	+3 -7	+5 -3	+4 -9	+3 -5	+3 -8	+9 -2	+4 -3
Region 2 - Palliser	+1 -1	+4 -3	+2 0	0 0	+2 -2	+1 -1	+2 -2	+2 -3	+2 -2	+0 -4	+3 -1	+2 -4	+6 -1	+3 -3
Region 3 - Headwaters	+3 -4	+1 -1	+13 -5	+5 -3	+5 -3	+7 -5	+7 -4	+11 -7	+13 -9	+14 -8	+3 -4	+10 -5	+9 -5	+15 -5
Region 5	+4 0	+3 -6	+7 -6	+3 -4	+1 0	+4 -2	+3 -4	+6 -2	+3 -6	+5 -3	+1 -5	+5 -2	+6 -2	+5 -4
Region 6 - David Thompson	+11 -6	+10 -7	+8 -10	+8 -9	+16 -10	+9 -8	+9 -14	+6 -10	+8 -6	+4 -9	+6 -8	+9 -3	+17 -9	+14 -12
Region 7 - East Central	+8 -10	+10 -6	+8 -9	+5 -10	+13 -13	+12 -8	+8 -8	+11 -14	+4 -12	+6 -13	+12 -6	+8 -8	+20 -10	+20 -11
Region 8 - WestView	+10 -6	+9 -10	+8 -6	+9 -4	+14 -9	+5 -8	+9 -8	+7 -6	+12 -15	+7 -10	+8 -12	+19 -5	+10 -8	+7 -10
Region 9 - Crossroads	+6 -3	+6 -4	+4 -1	+5 -3	+2 -6	+3 -3	+5 -2	+1 -2	+3 0	+7 -5	+3 -2	+7 -4	+11 -8	+10 -6
Region 11 - Aspen	+5 -5	+3 0	+2 -3	+5 -10	+7 -1	+3 -3	+6 -3	+1 -3	+7 -6	+7 -11	+6 -10	+14 -10	+15 -7	+11 -7
Region 12 - Lakeland	+22 -20	+14 -8	+14 -12	+16 -17	+10 -14	+16 -11	+8 -17	+12 -6	+7 -10	+4 -5	+2 -6	+6 -6	+9 -2	+17 -10
Region 13 - Mistahia	+1 -1	+5 -2	+3 -6	+3 -2	+7 -5	+2 -3	+1 -2	+2 -2	+3 -3	+4 -4	+5 -7	+5 -3	+1 -0	+1 -2
Region 14 - Peace	+1 -1	+1 -4	+1 0	+2 -2	+1 -2	+3 -1	+1 0	+1 -1	+1 -1	+0 -4	+1 -1	+2 -2	+5 -3	+4 -1
Region 15 - Keeweetinok	+2 -3	+4 -1	+6 -8	+2 -2	+2 -2	+2 -2	+1 -2	+3 -1	+1 -2	+3 -4	+3 -3	+2 -2	+5 -2	+5 -3
Region 17 - Northwestern	+2 -3	+3 -2	+2 -03	+1 -4	+7 -4	+1 -2	0 0	+4 -4	+2 -2	+1 -0	+0 -1	+1 -1	+4 -1	+0 -1
TOTAL Rural Physicians	**+83 -68**	**+74 -57**	**+85 -69**	**+65 -73**	**+91 -74**	**+70 -60**	**+66 -70**	**+70 -69**	**+72 -76**	**+66 -89**	**+56 -71**	**+92 -63**	**+127 -60**	**+116 -78**

> *I am getting old and tired, and I do not need to work this hard. On-call is stressful -- something that was exciting once, now is scary!*
>
> *Rural physician*

Physicians were also asked if they would like to change their on-call responsibilities. Just less than half of the physicians with on-call responsibilities of less than one in four are willing to stay with that schedule. Those physicians doing 1:1 on-call would like to move to 1:2 or 1:3. Physicians who *would like to* change their on-call responsibilities presented a mixed group of those who would like to increase their on-call because of financial obligations, and those who wished to decrease the amount of on-call because of a variety of lifestyle factors.

> *When I reach 55, if I cannot reduce my on-call dramatically, I will cease it by severing hospital privileges or moving away.*
>
> *Rural physician*

65 physicians (19.9%) indicated that they intended to actively change their on-call commitments. In most cases, this reflected hope that additional physicians would be recruited to the community. Some older physicians intend to slowly reduce their on-call responsibilities through trying to persuade younger physicians to take over some additional responsibilities, especially at night. Others want to talk to their colleagues regarding shifting to more 8-hour shifts instead of taking on 24-hour responsibilities.

When asked specifically what actions they plan to take to change their on-call responsibilities, a total of 73 physicians provided written responses:

- 19 respondents indicated they are planning for or hoping for additional physicians to help share the on-call responsibilities.
- 18 respondents stated they would like to decrease the number of shifts per week or the number of hours per shift (fewer shifts, fewer weekend shifts, 12 hour shifts, etc.), but did not indicate how they saw this happening.
- 12 respondents said they were planning to quit, take a sabbatical, move, retire, or to take maternity leave.
- 5 respondents indicated that they are willing to take more emergency on-call shifts, as they need the money.
- 5 stated they would try to use the locum program to help cover the on-call shifts.
- 4 respondents said they would just quit doing the on-call shifts and send the patients to the city for care.
- 2 stated they were planning to take specialty training, i.e., anesthesia.

48 physicians (14.7%) indicated that they intend to change the location of their practice within the next 5 years. Another 90 physicians (27.5%) are unsure if they will change their practice location. 44 physicians (13.5%) are planning to retire while 47 (14.3%) are thinking of moving to an urban practice in Alberta. For the physicians who are thinking about or planning to leave their current practice, 11% indicate that this is a direct result of on-call commitments, while 49% feel their decision was influenced by their on-call commitments, among other things.

Impact on Emergency Services to Albertans

In discussions with medical directors for the regional health authorities, it became clear that the Rural On-Call Remuneration Program has helped to ensure that rural medical facilities have physicians on-call continuously. Although one medical director raised a concern that there continues to be too many small facilities offering 24 hour emergency services in some areas of the province, generally, rural physicians cover emergency services at these facilities at all times.

Small facilities in relatively close proximity, however, stretch the capacity of the local physicians to provide on-call coverage. In one instance relayed to the evaluators, physicians from two small neighbouring communities (10 miles apart), each containing a facility, had combined forces so that when on-call, the physician would be available to both facilities. This effectively halved the frequency with which any one physician carried the responsibility for being on-call. In the case in point, the physicians went from 1:3 to 1:6 frequency of on-call. Unfortunately, it also resulted in only half as much on-call remuneration being available to the physicians as a group for performing these on-call duties. One of the physicians involved in this arrangement suggested that the Rural On-Call Remuneration Program should encourage these arrangements, by augmenting the remuneration for any physician covering more than one facility.

Physician Compensation

Information obtained from Alberta Health and Wellness demonstrates the impact of the Rural On-Call Remuneration Program on physician income for each quarter since the program's inception. The number of physicians in each income range for each quarter is presented below:

Table 6 - Physician On-Call Compensation, 1998 - 2000

	$0-$4,999	$5,000-$9,999	$10,000-$14,999	$15,000-$19,999	$20,000-$24,999
1998 Q 4	353	140	19	3	1
1999 Q 1	383	132	15	4	0
1999 Q 2	393	127	18	3	1
1999 Q 3	402	144	14	4	0
1999 Q 4	400	140	19	4	0
2000 Q 1	409	132	20	3	0
2000 Q 2	324	186	37	10	2
2000 Q 3	341	192	37	9	2
2000 Q 4	344	183	44	9	2
Average	372	153	25	5	1
Percent	66.9%	27.5%	4.5%	0.9%	0.2%

Physicians were directly asked as part of the physician survey whether the Rural On-Call Remuneration Program adequately compensates for the demands of emergency on-call. Their response to this question is shown in the following table.

Table 7 - Adequacy of On-Call Compensation

Is compensation adequate?	Number	%
Yes	103	31.5%
No	194	59.3%
No Response	30	9.2%
Total	327	100.0%

A total of 27 physicians provided written information indicating why they think the compensation **is adequate**:

- 19 physicians felt that the Rural On-Call Remuneration Program helped to compensate in a number of areas, including: helping to put up with long hours; allowing some time off the next day without loss of income; helping to compensate for time away from family; helping to get coverage for shifts; and helping to cover office overhead for times when the physician can't see patients due to on-call responsibilities.

- 4 respondents provided comments to the effect that the on-call payment has helped, but that the amount should be higher.

- 2 respondents noted that there is no compensation for times they are called away from their office during business hours.

- 1 respondent indicated that he/she got more compensation under the old program (IPP).

- 1 respondent said compensation was adequate, but he/she still does not want to be on-call.

A total of 168 physicians provided written information indicating why they think the compensation **is not adequate**:

- 67 respondents were adamant that the amount of compensation is woefully inadequate (pittance, insulting, token payment). Other comments: on-call is a strain added to an already busy workload, payment should be higher on weekends, payment is inadequate especially for quiet shifts, and payment should increase proportionately with the number of hours on-call.

- 43 respondents noted that the amount does not compensate adequately for lost hours away from the office during clinic hours, and that there should be on-call compensation for 08:00 to 17:00 hours, rather than only evenings and weekends.

- 24 physicians noted their concerns that there is presently no compensation for 'de facto' on-call coverage by physicians with special skills such as training in surgery or anesthesia. One physician indicated that this could amount to being on-call 20 – 25 days/month.

- 20 respondents feel that the amount is not adequate to compensate for being away from family and the disruption in family life.

- 6 respondents provided comments to the effect that they would provide on-call services regardless of compensation. For these individuals, providing service to the community is not a financial issue.

- 4 stated that the compensation for emergency on-call is adequate, but that the fee-for-service payments are not.

- 3 physicians noted specifically that Wetaskiwin is not eligible for the on-call payment, and that this is unfair – all rural facilities providing 24-hour coverage should be eligible.

- 1 respondent feels that the amount of compensation is not adequate to allow the rural areas to compete with urban areas for physicians.

Based on survey results and a number of interviews with rural physicians, the majority of the physicians feel that the Rural On-Call Remuneration Program does not adequately compensate them, but reflect that it is a vast improvement over previous systems. **In particular, physicians feel that the Rural On-Call Remuneration Program represents a concern and commitment of the Alberta government to rural physicians. This sense of being valued is very important to rural physicians**.

> *This (on-call) is something I would do anyway - it's part of my responsibility to my town. But it's nice to know that the government thinks this is important enough to try and compensate me for it.*
>
> *Rural physician*

Retention and Recruitment of Rural Physicians

Both in the rural physician survey, and through interviews, the effectiveness of the Rural On-Call Remuneration Program in recruiting and retaining rural physicians was explored. As the following table illustrates, generally the program was seen to be effective in attracting and keeping physicians in rural communities.

Table 8 - Retention/Recruitment Effectiveness

	Recruitment Effectiveness		Retention Effectiveness	
	#	%	#	%
Very Effective	32	9.8%	53	16.2%
Somewhat Effective	170	52.0%	178	54.4%
Not Effective	75	22.9%	54	16.5%
No opinion	29	8.9%	22	6.7%
No response	21	6.4%	20	6.2%
Total	327	100.0%	327	100.0%

The Rural On-Call Remuneration Program is seen to be marginally more effective in retaining rural physicians than it is in recruiting rural physicians. In the last few years, the number of new physicians moving to rural areas has increased significantly, primarily as the result of a targeted recruitment effort in 1998. As illustrated by Table 5, on page 9, there is still significant turnover

in the rural areas, with approximately 10% of the rural physician population changing each year. There was a somewhat reduced rate of physician departure during 1998 and 1999. However, this should not be attributed to the establishment of the Rural On-Call Remuneration Program. Rather, these two years represent the influx of a large number of foreign trained physicians under Section 5. These physicians would be unable to relocate to urban areas until they had completed the necessary certification.

> *The on-call money tipped the balance for us, allowing us to bring another physician to town. It meant the town could support three economically viable practices rather than just two.*
>
> *Rural physician*

In interviews with rural physicians and regional medical directors, it became clear that it was difficult to separate the recruitment and retention effects of the Rural On-Call Remuneration Program from the effect of the overall RPAP strategies. However, one area that was highlighted related to the impact of the Rural On-Call Remuneration Program in small two and three physician communities. The addition of over $100,000 per facility in annual on-call remuneration funds is a significant addition to the available income for physicians in a small community. In many cases, this funding made it possible to add an additional physician to the community without significantly reducing the income of the other physicians in the community.

In some cases, physicians reported being "protective" of the Rural On-Call Remuneration Program funds, reducing their demands on the Rural Locum program in order to keep the funds "in the community" to help cover the overhead costs of the local community physicians.

Stakeholder Satisfaction with the Rural On-Call Remuneration Program

As the following table indicates, over 70% of the physicians responding to the rural physician survey indicated that the establishment of the Rural On-Call Remuneration Program has increased their level of satisfaction with their on-call responsibilities.

Table 9 - Overall Satisfaction with On-Call Responsibilities

	Number	%
Much more satisfied	121	37.0%
Marginally more satisfied	109	33.3%
No change in satisfaction	55	16.8%
Marginally less satisfied	0	0
Much less satisfied	8	2.5%
No Response	34	10.4%
Total	327	100.0%

Many physicians, particularly those with on-call schedules of 1:3 or less, continue to be concerned about the demands resulting from on-call responsibilities. However, the fact that they are now compensated for those responsibilities has made on-call more desirable to physicians. This increase in satisfaction seems to be as much as result of the feeling of being more valued by the people of Alberta as the actual remuneration received from the Rural On-Call Remuneration Program.

Satisfaction with Program Design

The critical design factors for the Rural On-Call Remuneration Program are the hourly payments system and the facility eligibility rules. When asked about the appropriateness of the 25,000 unscheduled visits limit regarding facility eligibility, physicians indicated that:

Table 10 - Appropriateness of Emergency Visit Limits

	Number	%
25,000 is appropriate	164	50.1%
25,000 is too high	65	19.9%
25,000 is too low	47	14.4%
No Response	51	15.6%
Total	327	100.0%

Some physicians and regional medical directors who were interviewed raised the question of whether there should be a limit at all. In other words, if a facility is not in a regional centre, and emergency services are provided by community physicians rather than specialized emergency staff, then additional compensation should be provided regardless of the number of emergency visits. Another issue raised by some regional medical directors was the question of whether busy "near urban" facilities such as Spruce Grove or Leduc should qualify as a rural hospital.

Physicians were also asked whether hourly reimbursement was the most appropriate method of reimbursing physicians for on-call responsibilities. The overwhelming majority felt that hourly payments were an appropriate mechanism.

Table 11 - Appropriateness of Hourly Payments

	Number	%
Hourly Payments are appropriate	282	86.2%
Hourly Payments are not appropriate	23	7.1%
No Response	22	6.7%
Total	327	100.0%

In response to a question regarding what might be more appropriate than hourly payments, 15 respondents who felt that hourly payments **were appropriate** also provided written responses:

- 5 respondents noted that there should also be compensation for being on-call during weekdays.
- 4 noted that the amount paid is inadequate.
- 2 stated that the amount is adequate in addition to the fee-for-service payments.
- 3 noted the need to pay physicians with special skills.
- 1 noted that while the amount of compensation is adequate there should be a way of cutting back on-call responsibilities after a predetermined period of service.

Of those who felt that hourly payments were **not** appropriate, 18 respondents provided comments in response to "please explain what you would prefer":

- 4 respondents noted the need for 24-hour (include weekdays) coverage.
- 4 noted that there should be higher fees to compensate for the work done. One respondent stated that the amount should be $50 per hour.
- 2 would prefer to do less on-call work.

Other individual comments included:

- The compensation should be made via fee-for-service.
- There should be a daily fixed rate plus fee-for-service.
- There should be an hourly rate plus fee-for-service.
- The payment should be a flat monthly rate.
- There needs to be a more realistic fee-for-service to compensate for the level of complexity of cases in emergency.
- There is a need to educate the public regarding appropriate use of emergency facilities.
- There is no designated facility but still there is on-call responsibility for which we are not compensated.
- There should be compensation for the day after an on-call night shift.

Overall, as the following table indicates, three quarters of the physicians responding to the survey reported that they were satisfied with the design of the Rural On-Call Remuneration Program. Regional medical directors also expressed a high level of satisfaction with the design of the Rural On-Call Remuneration Program.

Table 12 - Satisfaction with Program Design and Compensation Level

	Very Satisfied		Satisfied		Neutral		Unsatisfied		Very Unsatisfied		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Overall Program Design	63	19.3	168	57.4	39	11.8	12	3.7	14	4.3	31	9.5
Level of Hourly Payments	21	6.4	95	29.0	64	19.6	80	24.5	33	10.1	34	10.4

However, only 35% of the physicians responding to the survey were satisfied with the level of the hourly payments. When asked for specific changes that would be desired to the design of the Rural On-Call Remuneration Program, 196 physicians provided written responses in the survey to this question:

- 78 responses related to the issue of the need for payment for weekday coverage compensate for the loss of clinic time, and to support the work done with "unattached patients".
- 48 relayed the need for a higher amount of payment (an amount of up to 50% more was mentioned by several) to provide appropriate compensation and to attract physicians to rural Alberta.

- 36 indicated the need to recognize special skills, the designated second on-call and general practitioners in hospitals with on-call commitments. Several respondents noted that the on-call physicians in their area pool the compensation to share with the GPs with special skills.

- 5 respondents feel that there should be a way to ensure that all physicians can get on the on-call schedule if they wish.

- 5 respondents requested increased remuneration for weekends and holidays.

- 4 respondents stated that the cut-off point of 25,000 unscheduled emergency visits should be waived.

- 3 stated that high volume facilities (15,000 to 25,000) should be excluded from the program or compensated at a lower level.

- 3 respondents feel that there should be a way to pay a higher rate to recognize length of time in practice or number of years providing on-call services.

- 2 respondents recommended both an increase in the rate of payment and an increase in the number of physicians.

- 2 physicians recommended that more needs to be done to discourage inappropriate use of emergency facilities for non-emergency problems.

- 3 physicians noted that they do not qualify for the on-call remuneration and linked this to difficulty in attracting physicians to their area.

Additional individual responses included the following:

- Have RNs screen patients to ensure appropriate emergency room visits.
- Program should pay physicians more the further they live from the facility.
- There should be some provision for splitting a shift.
- There should be a back-up system available for times when physicians cannot cover an assigned shift.
- The on-call payment should be greater for daytime shifts than for nighttime shifts.
- Physicians should be compensated according to extra qualifications (internal medicine, surgery, etc.).
- Rural on-call emergency hospitals should be visited by urban hospital emergency casualty officers in order to 1) suggest improvement 2) improve communication 3) gain support for urban physicians' facilities.

The evaluators note that the new Funding Agreement between the Alberta Medical Association and Alberta Health and Wellness identifies increases in fees over the next two years. However, there is no mention of increases for the Rural On-Call Remuneration Program.

> **Recommendation 1 - The RPAP Coordinating Committee should work with Alberta Health and Wellness and the AMA to develop a mechanism through which the hourly rate for the Rural On-Call Remuneration Program can be reviewed on a regular basis.**

When asked what design changes might increase the level of participation in the Rural On-Call Remuneration Program, 85 physicians provided written responses to this question:

- 21 noted that all physicians participate at this time at their facility.
- 20 indicated that an increase in the amount of remuneration would encourage more participation.
- 14 responses related to the need to include physicians with special skills in the on-call remuneration program.
- 8 respondents mentioned that extending the program coverage to include weekdays would be helpful.
- 7 feel that the solution is to recruit/attract more physicians in order to reduce the frequency of on-call requirements.
- 3 respondents stated that the cut-off for eligibility of 25,000 non-scheduled emergency visits per year should be removed. One of these mentioned that the size of the town or catchment area might be a better determining factor.
- 2 mentioned that there should be a bonus provided to physicians commensurate with years of emergency on-call service.
- 2 respondents suggested linking on-call responsibility to eligibility for hospital privileges.

Other individual responses included:

- There needs to be a better definition of “rural” and the more remote rural locations should be more highly compensated than “near urban” locations.
- One respondent noted that the program is counterproductive in his/her community.
- There should be consistent reimbursement of the second on call.
- More back-up support such as second on call or extra nurses.
- There should be no limit on callbacks and Alberta Health fees.
- Reduce the number of shifts.
- Provide more public education on appropriate use of emergency facilities.

Satisfaction with Program Operation and Administration

Satisfaction with program operations is equally as high as the satisfaction with program design, with approximately three-quarters of the physicians indicating that they are satisfied or very satisfied with program operations.

Table 13 - Satisfaction with Program Operation and Administration

	Very Satisfied		Satisfied		Neutral		Unsatisfied		Very Unsatisfied		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Overall Program Operation	66	20.2	175	53.5	33	10.1	8	2.4	13	3.9	32	9.9
Accuracy of Payment Amounts	74	22.6	174	53.3	29	8.9	8	2.4	8	2.4	34	10.4
Responsiveness to questions and queries	30	9.2	120	36.7	112	34.2	6	1.8	10	3.1	50	15.0
Responsiveness to complaints and concerns	29	8.9	114	34.9	114	34.9	8	2.4	13	3.9	49	15.0
Speed of receiving Payments	69	21.1	170	52.0	39	11.9	5	1.5	9	2.8	35	10.7

On the rural physician survey, physicians were asked what would improve program administration and management. Ninety-five physicians provided written responses to this question:

- 23 respondents indicated the program was working well as is.

- 16 stated that the amount of compensation must be increased. One of these respondents mentioned that physicians in small facilities with low unscheduled emergency visits should be paid more for their on-call responsibilities.

- 13 respondents noted that they feel the regional health authorities should not administer the program, but rather that the administration should stay as it is. One respondent recommended giving the local hospital some say in the disbursement of funds.

- 8 mentioned that compensation should be paid for weekday responsibilities as well as evening/nights/weekends.

- 5 mentioned that the on-call remuneration program should be extended to cover practitioners with special skills.

- 3 respondents raised the issue of the 25,000 unscheduled emergency visits cap:
    - Eliminate the arbitrary cap. It does not belong in the definition of rural ER patient care.
    - Change this criterion for eligibility.
    - 25,000 is too low. With physician shortage emergency is very busy.

- 19 of the respondents provided other comments relating to administrative processes. The following are illustrative of the issues raised:
    - I don't understand why we can't just submit our hours, like our billings, directly to AH. Seems to be a bureaucratic level in the middle that is campaigning for locums unnecessarily. There's a level of paperwork that's a pain for the person submitting a site's claims.
    - Biweekly payments.
    - Payments should be monthly, not every two weeks.
    - Our time sheets just get more complicated – simplifying would help.

- Payment should be directly to our clinic as with the rest of our billings. It is ridiculous that they have to keep sending cheques to my home.
- Monthly summary of on-call payments to help check accuracy against active on-call schedule.
- Suggest changing to a billing card so that on-call $$ can be billed by our clinic staff with the rest of normal billing.
- We should be able to send directly to AHC like FFS billings. Now one physician has to compile all the ledgers for each physician and submit it to the region.
- Send cheque with statement.
- Signature confirming service provision is a nuisance.
- Could we submit on line?
- We should be able to bill our hours worked weekly through our billing system of the clinics.
- It should be administered by adding extra code directly to AH fee schedule.
- I don't feel comfortable with this being operated on a signing sheet where the nurses, etc. view our income, or by the RHA.

Other general individual comments:

- Implement changes that would really draw people (MDs) to rural isolated areas.
- Perhaps payments could be matched to facility size/population to allow payments to multiple physicians in a busy institution and to target physicians who are actually on-call, not scheduled into shifts that provide their entire well paid employment.
- Here in Wetaskiwin, we find we feel we haven't had any support from AMA, AH, nor our RHA for on-call remuneration. How can all these groups justify that our city has been underserved by physicians and then not allow an on-call stipend because patients can't access MD's in their offices in a reasonable time?
- If there are too few physicians, it doesn't matter how much you pay for on-call - work is overwhelming if they do clinics.
- Physicians must be able to block recruitment to a town if they do not wish to share the on-call money.
- Rural practice complexity skills be addressed and compensated for.
- We feel we need to be able to work on it in our attempt to recruit physicians.

All physicians and regional medical directors interviewed indicated a desire for a more simplified administration for the program. Concerns were raised about the fragmentation of physician remuneration mechanisms, with the latest agreement creating several more stand-alone payment systems.

One-third of the physicians responding to the survey indicated that the introduction of the Rural On-Call Remuneration Program facilitated improved scheduling of on-call responsibilities.

Table 14 - Impact on Practice

	Much Better		Better		No change		Worse		Much Worse		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Scheduling of on-call responsibilities	34	10.4	75	23.0	177	54.1	1	0.3	3	0.9	37	**11.3**
Relationship with the local hospital	18	5.55	46	14.1	218	66.7	2	0.6	4	1.2	39	**11.9**
Relationship with other local physicians	14	4.3	67	20.5	202	61.8	0	0	6	1.8	38	11.6
Relationship with the Regional Health Authority	13	4.0	49	15.0	219	67.0	3	0.9	4	1.2	39	11.9

In addition, about 20% of the physicians responding to the survey felt that their relationships with each other and with the local hospital and the regional health authority have improved as a direct result of the introduction of the Rural On-Call Remuneration Program.

Many regional medical directors also felt that the introduction of the Rural On-Call Remuneration Program had improved relationships with the local physicians, although some pointed out that this is not really a regional program. One key area of concern to some regional medical directors was the issue of the skill levels of the physicians undertaking on-call responsibilities. Several regional medical directors pointed out that a certain level of experience and frequency of emergency practice is needed to ensure that skills stay current, and that the demands of emergency services are not overly onerous. The medical directors fell that physicians cannot maintain good emergency skills if they are not seeing a sufficient number of individuals on a regular basis.

> *In my larger communities… I have more physicians wanting to be on call than I need. I have been challenged legally when we have attempted to curtail the number of physicians on the roster and have difficulties removing physicians who have some lack of skill issues. Physicians are not as likely to retire, as it is so financially lucrative. This is not necessarily a good thing!*
>
> *Regional medical director*

In order to undertake emergency cover-off in the Rural Locum program, ACLS and CLS training is a requirement. Yet, there is no link between the Rural On-Call Remuneration Program and skills training for the physicians undertaking on-call responsibilities. Some medical directors suggested tying ACLS training to eligibility for on-call payments, and thought this might be one reason for the regions to administer the program (to permit the regions to have some control over having the physicians get this training). However, medical directors and RHAs currently have the authority/responsibility to recommend privileges and standards.

Recommendation 2 - The RPAP Coordinating Committee should promote the availability of training and encourage physicians to upgrade their training for undertaking on-call responsibilities.

Transfer of Administrative Authority

The Consensus Statement that established the Rural On-Call Remuneration program in 1998 suggested that administrative responsibility for the program, including the payment of participating physicians, would be transferred to the Regional Health Authorities effective April 1, 2001. The following information was gathered in January/February 2001, and provided in a preliminary form to Alberta Health and Wellness in early March.

Input from Regional Medical Directors

The regional medical directors provided input regarding this issue as part of the information gathering process. It is fair to say that no one is actively looking to take over this program, although three regional medical directors indicated that they could see no real problem in taking it over. While the regions indicate that they can handle it from an administrative perspective if they had to, most are not eager to do so. Following are some of the concerns raised:

- If the program administration and funding is turned over to the regions, it has to be tagged as money that must be used to support rural on-call, and come with the stipulation that the program must be administered in line with provincially established guidelines. There is fear that the program will lose its integrity and consistency if handed to the regions. In fact, some medical directors admitted they have plans for how they might use the money if it is turned over to them to meet needs they have as individual regions. Others expressed concerns that the funds could disappear into general revenue for the regions and the program might be compromised or lost altogether.

- If the program administration and funding is to go to the regions, the medical directors expressed concern that there must be a guarantee that the money will be increased to keep pace with the actual costs.

- There is a concern that the additional administration burden on the regions will not be recognized, and those additional costs will have to be borne by the regions.

- Several medical directors expressed a concern that, if they hold this pot of money, they are open to being "held to ransom" by their physicians to redistribute the funds differently, or to increase them significantly. This is a very real concern for some regions just now in light of the issues being raised by a number of GP specialists regarding the lack of remuneration for that group. If the regions administered this program, there would be real pressure for them to include the GP specialists as being eligible for this program.

The potential for inequality across the Province is the biggest concern raised. If the program administration and funding goes to the regional administrations, there is a fear that this would almost certainly lead to a loss of equity across the Province, and defeat the purpose of the program in terms of supporting recruitment and retention, especially in those regions who cannot afford to "sweeten the pot."

Interviews with Physicians

All physicians who were interviewed were quite negative about the potential transfer. It was seen to add another level of bureaucracy, and there were significant fears about the issues of

equity between physicians within a specific region and across regions. There were several aspects to this issue:

- "Rich" regions could supplement the provincial funds to compete for new physicians in recruitment;

- Regions could choose to supplement funds (or redistribute funds) to meet specific local conditions (like paying GP specialists, or covering an isolated physician working outside the facility structure);

- Regions could choose to support some facilities and not others, or make facilities eligible that should not be, and vice versa; and

- Regions could skim monies from the fund to deal with other issues they see as more pressing.

Input from Designated Facilities

Although the information request from the facilities did not directly ask about the possible transference of program administration, a number of facilities provide unprompted comments. All those who raised the question of program authority requested that the program remain with Alberta Health and Wellness.

Interview with the Alberta Medical Association

The Alberta Medical Association felt that a key issue for physicians was independence, and that any move that was seen to make physicians subservient to or "work for" a region would be problematic for most physicians. Alberta Health and Wellness is seen as a neutral body that pays physicians for services, without influencing practice patterns. Thus, the program should stay with Alberta Health and Wellness.

The Alberta Medical Association did feel that with the new agreement, there was beginning to be a proliferation of small programs (Rural On-Call, Specialist On-Call, Acute Care coverage) with different payment mechanisms. Rather than give the Rural On-Call Remuneration Program to the regions, perhaps there could be some consideration given to including in the fee-for-service schedule and treat it like any other physician service.

Survey Responses from Rural Physicians

Question 38 on the survey addressed this issue of transfer in some detail, with regard to how this might change the day-to-day life of a rural physician.

38. The Consensus statement that established the Rural On-Call Remuneration Program proposed that, starting April 1, 2001, the program be managed directly by each RHA, who would also make payments to the participating physicians. What impact do you think this would have on the following aspects of the program?

Table 15 - Impact on Practice - Transfers to the Regions

	Much Better		Better		No change		Worse		Much Worse		No Response	
	#	%	#	%	#	%	#	%	#	%	#	%
Accuracy of Payment Amounts	4	1.2	22	6.7	178	54.5	55	16.8	17	5.2	51	15.6
Responsiveness to questions and queries	5	1.5	50	15.3	130	39.8	64	19.6	27	8.2	51	15.6
Responsiveness to complaints and concerns	6	1.8	48	14.7	122	37.3	73	22.3	27	8.3	51	15.6
Speed of receiving Payments	4	1.2	26	8.0	152	46.5	66	20.2	25	7.6	54	16.5
Scheduling of on-call responsibilities	3	0.9	19	5.8	212	64.8	25	7.6	18	5.5	50	15.3
Relationship with the local hospital	5	1.5	16	4.9	200	61.2	41	12.5	11	3.4	54	16.5
Relationship with other local physicians	3	0.9	15	4.4	225	68.8	22	6.7	9	2.8	53	16.2
Relationship with the Regional Health Authority	5	1.5	25	7.6	133	40.7	85	26.0	26	8.0	53	16.2

Unfortunately, a question regarding equity was not asked specifically on the survey. However, 22 physicians felt strongly enough about this issue to raise it in Question 29 (If there are any other issues regarding the Rural On-call program that have not been addressed by this survey, we would appreciate it if you would identify them). A sample of the responses include:

- "I definitely want arms-length from any Regional Health Authority payment to me. If they pay me, they would feel they could control me. I vehemently oppose giving them this right."

- "Do not let the Regional Health Authority run this. We are not their employees, but if they get to dispense the funds and run the program, they will expect us to work like their employees and dictate to us what we can and can't do."

- "If the Regional Health Authority took over management, I would be afraid they would slash budgets and be remiss in payments. Why change an infrastructure that works? New committees would be struck and the administration costs would increase."

- "I don't like the idea of the Regional Health Authority administrating the fund. They may feel it is their money to distribute to another area in the region."

- "I'm terribly worried that the region will skim off more from the pool, may restrict MD numbers, etc. - keep it in the hands of a neutral body."

- "Why change a system that is working? Our Regional Health Authority is hopeless - they can barely manage their present responsibilities."

- "Keep the Regional Health Authority out of it! Billings could/should occur directly between AHCIP and MD providing service using current technology options."

- "Regionalization has been very tough on rural physicians - frustrations with privileges, turf wars, constant threat of "centralization" of services. The fear is that regions will/may manipulate the on-call payments."

Only three physicians felt that the transfer would be acceptable, with most feeling that there was no need to change a program that was clearly working well.

Overall Reaction to Proposed Transfer

The proposed transfer of responsibility to the regions is not seen to be beneficial to rural physicians or to retention and recruitment of rural physicians by any group. The only rationale that was provided in any of our discussions was that "the Consensus Statement requires it". Alberta Health and Wellness supported the transfer on the grounds that it placed decision-making closer to the local level, and that in line with current government policy direction, Alberta Health and Wellness does not undertake direct delivery of services. It seems that this is a philosophical, rather than a practical, rationale.

A key concern that the transfer issue has highlighted is the significant lack of trust between many regions and their local physicians. Physicians do not appear to trust their respective regions, and RHAs do not seem to trust the physicians practising within the region. The survey responses indicate that of the 264 physicians who responded to Question 38, 108 physicians, or 41%, expect that their relationship with the region will worsen if responsibilities are transferred. Only 29 physicians thought the relationship might improve (11%), and 127, or 48%, felt that it would not change.

Recent Developments

In late March, Alberta Health and Wellness informed the regional health authorities of the effective transfer of administration for the Rural On-Call Remuneration Program, effective April 1, 2001. The primary change that this transfer creates is the source of payments for physicians for services provided. In the future, instead of forwarding the payment information to Alberta Health and Wellness and Alberta Health and Wellness paying the physician, each regional health authority will make payments to physicians providing emergency on-call services within approved facilities from the monthly per facility block of funds provided. The responsibilities and authorities of the regional health authorities include:

- obtaining the information required from physicians to support the payment process;
- determining, in consultation with physicians, the preferred payment frequency (i.e., weekly, bi-weekly, or monthly) and other specifics of payment (e.g., electronic funds transfer versus manual cheque, and payments to individual physicians or to an entire clinic); and
- determining whether the regional health authority will collect regional on-call data centrally or will administer the program at each facility.

Alberta Health and Wellness confirms that the Rural On-Call Remuneration Program continues to be a provincial program. The RPAP retains responsibility for determining facility eligibility for inclusion in the program.

It is thus too late for the evaluators to recommend, based on evidence from the field, that Alberta Health and Wellness retain their role of providing payments directly to physicians.

Recommendation 3 - To ensure continued equity in program delivery, it is critical that Alberta Health and Wellness retain overall policy direction, program design, and setting of program parameters, with advice and input from the RPAP Coordinating Committee. The RPAP Coordinating Committee should work closely with Alberta Health & Wellness to design a monitoring mechanism to ensure that program integrity continues.

Other Program Monitoring

Facility eligibility for emergency on-call payments for physicians was originally determined by the Regional Health Authorities, in consultation with physicians and Alberta Health and Wellness and listed on a schedule. Subsequent changes to this schedule of eligible facilities requires the recommendation of the RPAP Coordinating Committee and the approval of the Minister of Health and Wellness (Consensus Statement).

The funding for emergency on-call services is provided to eligible facilities that meet these criteria:

- acute care facilities which offer to the general public emergency on-call coverage 24 hours per day, 365 days per year;
- facilities where the emergency department is not staffed by geographic full-time physicians practising emergency medicine; and
- facilities where there are 25,000 or fewer unscheduled visits annually to the emergency department.

The Consensus Statement establishing the program states “It is understood that any deletions of eligible facilities from the schedule will occur as a result of a Regional Health Authority’s strategies for delivering effective and efficient services, and not due to the implementation of this new program. It is also understood that physician input into the process of changing the schedule of eligible facilities will be based on considerations of patient needs, as well as the adequacy, effectiveness and efficiency of on-call service delivery. The final determination of eligible facilities lies with the Regional Health Authorities and requires approval by the Minister of Health.”

Processes related to the monitoring of the program were not specifically addressed in the Consensus Statement. While it is clear that the number of unscheduled emergency visits is not the only issue to be considered in determining initial and continuing eligibility (24-hour/365 day coverage and fulltime emergency staff being other issues), now that there are a few facilities that are reaching that plateau, a process must be established to deal with issues of continuing eligibility.

Of the 73 facilities that provided information through the facility information request, there are eight emergency facilities that have over 20,000 unscheduled annual emergency visits. The following table identifies the busiest rural emergency facilities.

Table 16 - Emergency Visits, 1999 - 2000

Facility	1999		2000	
	Unscheduled Visits	Total Visits	Unscheduled Visits	Total Visits
Rocky Mountain House General Hospital	N/A	27,688	N/A	13,129**
Stony Plain Municipal Hospital	N/A	26,438	N/A	29,970
Bonnyville Health Centre	21,568	27,092	23,117	28,387
High River General Hospital	19,757	24,071	21,500	26,495
Lacombe Community Health Care Centre	N/A	24,063	N/A	24,731
Leduc Community Hospital and Health Centre	20,627	21,335	22,596	24,492
Fort Saskatchewan Health Centre	16,954	20,879	19,557	22,640
Cold Lake Health Centre	14,556	18,806	15,264	20,012

N/A = information not available
** First two quarters only

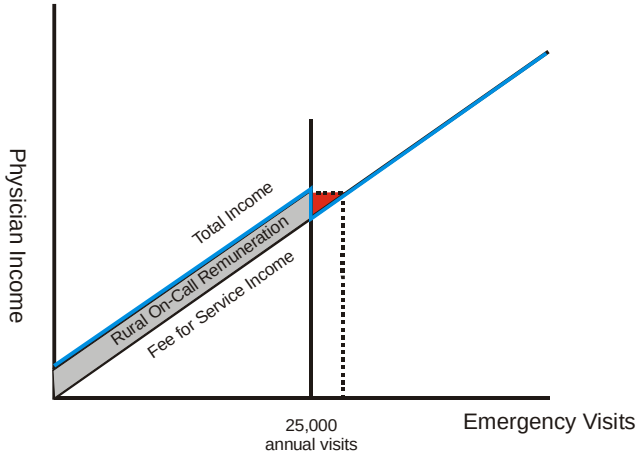
Although neither Rocky Mountain House General Hospital nor Stony Plain Municipal Hospital record unscheduled versus scheduled emergency room visits, there is a likelihood that, if they have not already exceeded the eligibility limit, they could do so at any time.

To date, there is no on-going monitoring of the number of unscheduled emergency room visits by the Rural On-Call Remuneration Program administration. Thus, there is no easy way to ensure that facilities are accountable and remain eligible for the Rural On-Call Remuneration Program.

As a key eligibility criterion, and given that at least two facilities are approaching the eligibility limit, the following recommendation is proposed:

> **Recommendation 4 - The RPAP Coordinating Committee should implement annual monitoring of the approved facilities considering items such as coverage, staffing and the number of unscheduled emergency room visits in rural hospitals, and tightly defining what is meant by "unscheduled" visits.**

The limit of 25,000 was initially selected for the Rural On-Call Remuneration Program on the grounds that, once a hospital had more than this number of annual visits, there was sufficient funding from fee-for-service payments to adequately compensate physicians providing on-call services. Theoretically, when a rural hospital exceeds the 25,000 limit, funding through the Rural On-Call Remuneration Program should cease. The graphic on the next page illustrates the impact of this "de-listing" on the income of physicians providing on-call services.



As the number of emergency room visits rises, so does the fee-for-service income of physicians providing on-call services. However, the remuneration received from the Rural On-Call Remuneration Program is constant regardless of the number of emergency visits in the facility. Thus, the income from the Rural On-Call Remuneration Program provides a fixed supplement to the variable income from fee-for-service. If a facility becomes "de-listed", at the point at which the number of visits exceeds 25,000, there is an actual drop in physician income. This "notch" effect is likely to be a significant disincentive for physicians to continue their on-call responsibilities unless it can be mitigated is some manner. The graph illustrates that as unscheduled emergency visits continue to rise above 25,000, physicians will, in effect, be working for free until the income derived strictly from fee-for-service exceeds the previous total of fee-for-service plus Rural On-Call Remuneration provided to the physicians at 25,000 emergency room visits.

Almost all physicians and regional medical directors that were interviewed raised extreme concerns regarding the impact of de-listing a currently eligible facility, terminating Rural On-Call Remuneration Program payments to physicians providing on-call services to that facility. Regions feared that physicians would remove services if payments were suddenly stopped.

There would seem to be basically four options when a facility reaches 25,000 visits:

1. **De-list the facility** - This will result in a drop in income for physicians participating in on-call responsibilities. This could result in a "vicious circle", whereby physicians reduce their willingness to undertake on-call responsibilities. Facilities may react by changing their delivery approach through recruitment of full-time emergency room physicians. Physician income in the community thus reduces even further because of the loss of the fee-for-service income from emergency room practice. Lastly, this could result in a loss of physicians to the community as the income pool to support the community practices reduces significantly.

2. **Increase the cut-off point** - In a sense, this may only be delaying the inevitable, since, as population increases, emergency visits in all facilities will continue to climb. Immediately, however, the disincentive effect for facilities approaching the 25,000 mark will be avoided. Depending on the level to which the new cut-off is raised, new facilities may become eligible (e.g., Wetaskiwin).

3. **Establish a sliding scale for payments** - Once a facility passes the 25,000 mark, a sliding scale for hourly reimbursement could be established for physicians providing on-call

services, which would lessen the impact of complete de-listing of the facility. One option, for example, could be to reduce the hourly payments in 10% increments for each additional 1,000 visits to the emergency room.

4. **Remove all limits** - this would entail changing the program eligibility rules such that once a facility is designated as "rural", it remains eligible for Rural On-Call Remuneration Program payments in perpetuity. This would require re-assessment of all facilities, and consideration of whether the "near-urban" facilities should continue to be covered, as well as whether high-volume rural facilities (such as Wetaskiwin) should be included.

Recommendation 5 - The RPAP Coordinating Committee should monitor the number of unscheduled emergency room visits for at least one year. After more accurate information is obtained, consideration should be given to adjusting the 25,000 parameter.

Other Issues Arising from the Evaluation

Coverage for GP Specialists

The most pressing issue raised during this evaluation of the Rural On-Call Remuneration Program was the lack of coverage for general practitioners with special skills training. Unlike Royal College specialists, who will now receive additional recognition and remuneration under the new Specialist On-Call Program, the GP specialists are not recognized eligible under any program. These physicians are, in many cases, on-call at all times, and face more onerous on-call requirements than most physicians covered under the Rural On-Call Remuneration Program. Serious cases of inequity will arise when GP specialists alternate on-call requirements with Royal College specialists. Most GP specialists do a regular on-call rotation for which they are compensated. However, they are also on call the rest of the time in their area of special skills. Having these individuals with special training in rural locations provides a real saving to the health system, since people can be treated quickly, close to home, without having to be transported to a regional centre.

Some regions feared that, unless some way of reimbursing these physicians is found, the GP specialists would start to remove these specialist services from the region. The incentive for taking specialist training would be seriously undermined if these physicians were the only physicians left in Alberta who were not compensated for emergency on-call responsibilities.

Recommendation 6 - If the issue of remuneration for rural general practitioners with special skills is not addressed by the new Specialist On-Call Program, then the RPAP Coordinating Committee should promote the recognition of and remuneration for the on-call responsibilities of general practitioners with special skills.

There were a number of suggestions as to how this remuneration might be accomplished, including:

1. **Lump sum annual payment** - for physicians designated by their regional medical director as required to be on-call for special skills, an annual stipend would be provided.

Suggestions were that this should approximate the amount that non-specialist physicians get annually (approximately $20,000 to $25,000 was suggested).

2. **Augmenting the fee code** - this would require establishing new fee-for-service codes specifically for those rural physicians with special skills who are called in to undertake these specialist procedures.

Coverage for Acute Care On-Call

Many physicians pointed out through open-ended comments in the survey, and during the interviewing process that they are actually on-call for emergencies during the day as well as on weekends and evenings. This "day-time on-call" can be extremely disruptive to physicians (as well as their patients) who are trying to offer regular clinic/office hours but are suddenly called out to the local facility to deal with an emergency situation or to treat a patient admitted to the local facility without a family physician. Many physicians and regional medical directors felt strongly that these requirements should be recompensed for the rural regions in the same way as evening and weekend on-call responsibilities. In addition, the last agreement between the Alberta Medical Association and the Alberta Government institutes a new program for urban physicians for Acute Care Coverage. This has highlighted the perceived inequities in the minds of the rural physicians.

> **Recommendation 7 - The RPAP Coordinating Committee should consider mechanisms for extending the coverage for emergency on-call services to 24 hours per day, 7 days per week to provide coverage for physicians called from their clinic during the day to attend the emergency department. Full-time emergency room staff would not be eligible for this payment.**

Several physicians mentioned that were this to come into effect, it would allow them to lighten their clinic schedule on days that they were on-call without losing money. This would require a budget increase to the Rural On-Call Remuneration Program of approximately 30% or approximately $3,500,000.

Impact on the Rural Locum Program

The Rural Locum Program funded through Alberta Health and Wellness has the mandate of providing replacement physicians in communities with fewer than five physicians. The Weekend Initiative for planned relief, in place since 1996 and funded by RPAP, provides weekend hospital emergency coverage in communities with fewer than four physicians enabling on-call frequency of no more than one-in-four weekends. Respondents to the physician survey indicated the following usage of the Rural Locum Program:

Table 17 - Use of the Rural Locum Program

	Number	%
Frequent Use	19	5.8%
Occasional Use	32	9.8%
Do not Use	262	80.1%
No Response	14	4.3%
Total	327	100%

The Chair of the Rural Locum Program Steering Committee, in the Rural Locum Program Annual Report for 1998/1999, stated that "the introduction of the On-call Remuneration Program (ORP) in October 1998 has not appreciably affected the weekend program. Eligible communities that accessed the program prior to the ORP continue to access the RLP which, clearly demonstrates the value rural physicians place on time off."

In the 1999/2000 Rural Locum Program Annual Report, the Chair noted that there was a small decrease in access of both weekend and short-term locum coverage. This is attributed to the current stability of rural physician resources. In 1999/2000, thirty communities representing 12 regional health authorities accessed the weekend initiative. Three eligible regions have not accessed the weekend initiative.

A pilot project, funded by RPAP for 2000-2001, permitted senior physicians the option to reduce hospital weekend on-call. This project covered senior physicians who have worked more than nine years in rural Alberta and practice in communities with fewer than 16 physicians. The program only replaces the senior physician if the local physicians agree that they do not want to pick up the extra on-call. Of the 15 eligible physicians who registered initially, eight physicians in eight communities accessed this initiative in 2000, to cover a total of 44 weekends. The evaluation of the initiative found than among the factors which were listed as deterrents to participation were attractiveness of on-call payments and availability of a colleague to take the senior physician's on-call and concerns about funding leaving the community. The need for some overhead payment component to participating physicians was mentioned in the evaluation findings.

Specific Facility Issues

Wetaskiwin

A number of rural physicians from Wetaskiwin raised concerns that their local facility was deemed not to be eligible for Rural On-Call Remuneration Program funding since the number of unscheduled emergency room visits exceeded the 25,000 limit, even though the community is designated under Section 5 as a community with a shortage of physicians. A review of the illustration on page 25 will quickly demonstrate the potential inequity. It is possible that the total income (Rural On-Call Remuneration Program plus fee for service) of physicians operating out of a facility with 23,000 unscheduled visits may be higher than the income of physicians providing emergency on-call services in a facility with 27,000 visits (fee- for-service only). Basically, this reflects more work for less pay. However, once a facility exceeds the break-even point, the participating physicians will have access to significantly more income through fee for service than any physician working in a Rural On-Call Remuneration Program eligible facility does.

Wetaskiwin was not surveyed to provide data on emergency room visits. However, the evaluators understand that Wetaskiwin is significantly over the 25,000 limit, and that it is unlikely that an inequity such as noted above exists.

Banff

Several physicians from the Banff area raised concerns that the Rural On-Call Remuneration Program was being used to fund full-time emergency room physicians who do not offer any office/clinic services to the community. If this is occurring, it should be examined in more depth than is possible through this evaluation.

Summary and Conclusions

This evaluation of the Rural On-Call Remuneration Program has four primary objectives:

1. To evaluate the extent to which this program is meeting its stated goals and the goals of RPAP (i.e., to aid rural physician recruitment and retention);

2. To assess stakeholder participation and satisfaction with these two programs;

3. To recommend improvements to the on-going monitoring of the program by the RPAP Coordinating Committee and Alberta Health and Wellness; and

4. To assess whether administration of the program should be transferred to the Regional Health Authorities effective April 1, 2001.

The evaluators confirm that:

1. The Rural On-Call Remuneration Program is a crucial component of the overall Rural Physician Action Plan. The majority of rural physicians and regional medical directors confirm that the program is having a positive effect on recruitment and retention of rural physicians.

2. Over two-thirds of Alberta rural physicians are participating in the Rural On-Call Remuneration Program. This proportion seems to be fairly consistent across the regions. The largest group of non-participants are general practitioners with special skills. The remaining physicians who do not participate in the program tend to be close to retirement age. Satisfaction levels with the design and operation of the program are very high amongst both rural physicians and regional medical directors.

3. Since several facilities are approaching the current limit of 25,000 unscheduled emergency room visits, the Rural On-Call Remuneration Program should begin monitoring of unscheduled emergency room visits on an annual basis. This will increase facility accountability to the program.

4. All respondents felt that the administration of the Rural On-Call Remuneration Program and payments to physicians should not be transferred to the regional health authorities. However, Alberta Health and Wellness transferred administration effective April 1, 2001.

The complete set of recommendations made by this evaluation follows:

APPENDIX 1 - CONSENSUS STATEMENT

Recommendations for a new rural on-call remuneration program

-Consensus Statement-

Preamble

Whereas the provision of emergency on-call services in rural locations poses significant lifestyle and economic challenges for the physicians providing this important service, and

Whereas the recognition of and compensation for the provision of emergency on-call services is a significant measure to enhance the recruitment and retention of physicians in rural Alberta, and

Whereas such a new on-call program represents an important component of a broad array of measures to address rural physician issues as contained in the Rural Physician Action Plan,

Therefore, the Minister of Health has committed to the development and implementation of a new rural emergency on-call remuneration.

To ensure an effective and efficient program design, implementation and administration, Alberta Health and Wellness and the Alberta Section of Rural Medicine (ASRM) of the Alberta Medical Association (AMA) formed a working group mandated to develop, on a consensus basis, recommendations to the Minister on such a new program. The following represents the consensus recommendations achieved by the working group on how the new program will achieve specific objectives. It is understood that this program is an initiative of the Minister of Health, and that he is exclusively responsible for setting the terms and conditions of the program.

Objectives

- To give recognition to and compensate physicians for the unique lifestyle and economic circumstances of providing emergency on-call in rural areas and to provide an incentive to increase the number of physicians who provide rural emergency on-call services.

- To ensure that Albertans living in rural and remote locations of the province receive comprehensive and continuous emergency on-call services.

- To provide opportunities for physicians and Regional Health Authorities to work together more closely on issues concerning the delivery of medical and physician services to their populations.

Recommendation 1

- That the emergency on-call remuneration be paid in addition to income earned by a physician during an on-call shift, either through fee-for-service or alternative payment arrangements, without affecting the fee schedule or governing rules.

Recommendation 2

- That the Minister of Health provide funding at a fixed hourly rate per eligible facility to cover the following annual emergency on-call hours:

    - All annual hours with the exception of the hours of Monday to Friday, 8 a.m. to 5 p.m.

    - Where a statutory holiday falls on a weekday (Monday to Friday), the hours from 8 a.m. to 5 p.m. of that statutory holiday are also eligible for this program.

- The hourly rate will be $17 from the date of implementation to March 31, 2000. As of April 1, 2000, the hourly rate will increase to $21.

- The on-call funding per facility is to be shared among the physicians who provide on-call services at each eligible facility, based on the number of hours of on-call service provided by each physician. Where two or more physicians share on-call hours at the same eligible facility, only one payment covering the hours provided at that facility will be made.

- To provide a meaningful lifestyle improvement, it is recommended that, where possible, a physician should be on call not more than one day in four as long as this does not compromise the objective of providing full on-call coverage.

- To avoid excessive on-call provision by individual physicians, it is recommended that the Chiefs of Staff of the Regional Health Authorities review on-call schedules with the physicians providing this service in their jurisdiction.

Recommendation 3

- That the funding be provided for emergency on-call services provided in eligible which meet the following criteria:

    - Acute care facilities, which offer to the general public emergency on-call coverage 24 hours per day, 365 days per year,

    - Where the emergency department is not staffed by geographic full-time physicians practicing emergency medicine, and

    - Where there are 25,000 or fewer unscheduled visits annually to the emergency department.

- A Regional Health Authority may apply to have included in the schedule of eligible facilities non-hospital facilities, which hold themselves out to the general public as

providing emergency on-call coverage 24 hours per day, 365 days per year, or, where appropriate, for a specified period of time in a year. The Regional Health Authority will need to demonstrate how such a non-hospital facility fits into its overall service delivery plan, be satisfied that the facility has the necessary equipment to provide emergency services, and ensure that full on-call coverage is provided by the facility.

- The eligible facilities will be determined by the Regional Health Authorities, in consultation with physicians, and listed on a schedule. Any change to this schedule of eligible facilities will require the approval of the Minister of Health.

Recommendation 4

- The administration of the program budget will be with Alberta Health until March 31, 2001. Effective April 1, 2001, the administration of the program budget will be transferred to the Regional Health Authorities. The program funds will be transferred to the Regional Health Authorities and their use will be limited to the rural on-call program, which will remain a provincial program.

Recommendation 5

- That, as a transition from the terminated Incentive Payment Program (IPP) to the new rural on-call program, physicians who applied for IPP payments for the first quarter of 1998 will make a choice between joining the new rural on-call program upon the implementation date, or continuing to apply for IPP payments up to and including the first quarter of 1999, ending March 31, 1999.

- Where a physician does not make an explicit choice to continue to receive payments based on the former IPP, he will be deemed by Alberta Health to have chosen participation in the new rural on-call program.

Recommendation 6

- That the program be evaluated two years after implementation. The Rural Physician Action Plan Coordinating Committee will present an evaluation report to the Minister of Health no later than March 31, 2001.

Recommendation 7

- That the program be implemented effective October 1, 1998.

Undertakings and common understandings

- The AMA and the ASRM agree that this program is designed to facilitate the recruitment and retention of rural physicians, and to address the lifestyle issues caused by rural on-call service provision. It is recognized that the valuable on-call services provided by rural physicians during the hours of 8 a.m. to 5 p.m. Monday to Friday are not included in the rural on-call remuneration program at this time. This is not intended to diminish the recognition of the value of these services.

- The AMA, ASRM, and rural physicians will make their best efforts to work with the Regional Health Authorities to ensure full and adequate rural on-call coverage in eligible facilities throughout Alberta.

- Between the implementation date of this program and March 31, 2001, the rural physicians, supported by the AMA and the ASRM, will make every effort to work with the Regional Health Authorities to identify and resolve issues, which present barriers to integrated and cooperative service delivery.

- It is understood that any deletions of eligible facilities from the schedule will occur as a result of a Regional Health Authority's strategies for delivering effective and efficient services, and not due to the implementation of this new program.

- It is also understood that physician input into the process of changing the schedule of eligible facilities will be based on consideration of patient needs, as well as the adequacy, effectiveness and efficiency of on-call service delivery, and that the final determination of eligible facilities lies with the Regional Health Authorities and requires approval by the Minister of Health.

- The Minister of Health will establish the features, terms and conditions of the rural on-call remuneration program as of April 1, 2001 in consultation with the AMA and the ASRM.

APPENDIX 2 - LIST OF ELIGIBLE FACILITIES

Region	Facilities
Region 1 - Chinook	000009 Crowsnest Pass Health Care Centre 000023 Cardston Municipal Hospital 000028 Coaldale Hospital 000050 Fort MacLeod Health Care Centre 000075 Magrath General Hospital 000080 Milk River, Border Counties Hospital 000086 Picture Butte Hospital 000087 Pincher Creek Municipal Hospital 000091 Raymond General Hospital 000100 Taber & District Health Care Complex
Region 2 - Palliser	000005 Bassano General Hospital 000011 Bow Island Health Centre 000014 Brooks General & Auxiliary Hospital 000084 Oyen, Big Country Hospital
Region 3 - Headwaters	000002 Banff Mineral Springs Hospital 000022 Canmore General Hospital 000027 Claresholm General Hospital 000060 High River General Hospital 000111 Vulcan Community Health Centre 000139 Black Diamond, Oilfields General Hospital 760600 Lake Louise Clinic Health Centre
Region 5	000034 Didsbury District Health Services 000036 Drumheller District Health Services 000057 Hanna District Health Services 000101 Three Hills District Health Services 000134 Strathmore District Health Services
Region 6 - David Thompson	000063 Innisfail Health Care Centre 000068 Lacombe Community Health Care 000083 Olds General Hospital 000088 Ponoka General Hospital 000093 Rimbey General Hospital 000094 Rocky Mountain House General Hospital 000119 Sundre General Hospital 214500 Sylvan Lake Medical Clinic
Region 7 - East Central	000021 Camrose, St. Mary's Hospital 000025 Castor, Our Lady of the Rosary Hospital 000030 Consort Municipal 000031 Coronation Municipal Hospital 000032 Daysland General Hospital

Region	Facilities
	000058 Hardisty General Hospital 000066 Killam General Hospital 000089 Provost Municipal Health Care Centre 000097 Stettler General Hospital 000102 Tofield Health Centre 000108 Vermilion Health Care Complex 000109 Viking General Hospital 000112 Wainwright & District Health Care Centre
Region 8 - Westview	000033 Devon General Hospital 000045 Edson & District Health Care Centre 000061 Hinton General Hospital 000065 Jasper, Seton General Hospital 000098 Stony Plain Municipal Hospital
Region 9 - Crossroads	000035 Drayton Valley General Hospital
Region 10 - Capital	000070 Leduc General Hospital
Region 11 - Aspen	000001 Athabasca General Hospital 000003 Barrhead General Hospital 000012 Boyle Health Care Centre 000078 Mayerthorpe Health Centre 000113 Westlock Health Care Centre 000116 Whitecourt Health Centre 000133 Fox Creek Health Centre 000136 Swan Hills Health Centre
Region 12 - Lakeland	000029 Cold Lake Health Centre 000046 Elk Point Health Centre 000052 Fort Saskatchewan Health Centre 000067 Redwater 000095 Lac La Biche, W.J. Cadzow Health Centre 000099 St. Paul, St.Therese Health Centre 000105 Two Hills Health Centre 000107 Vegreville, St. Joseph's General Hospital 000141 Bonnyville Health Centre
Region 13 - Mistahia	000006 Beaverlodge Municipal Hospital 000049 Fairview General Hospital 000096 Central Peace General Hospital 000106 Valleyview Health Centre 000121 Grande Cache General Hospital 000132 Grimshaw Berwyn District Hospital
Region 14 - Peace	000074 McLennan, Sacred Heart Community Health Centre 000076 Manning Community Health Centre 000085 Peace River Community Health Centre

Region	Facilities
Region 15 - Keeweetinok	000059 High Prairie Health Complex 000118 Slave Lake General Hospital 000144 Wabasca Desmarais General Hospital
Region 17 - Northwestern	000053 St.Theresa General Hospital 000123 High Level General Hospital

APPENDIX 3 - RURAL PHYSICIAN SURVEY

January 17, 2001

Dear Rural Physician:

Re: Evaluation of the Rural On-call Evaluation Report

The Rural Physician Action Plan Coordinating Committee (RPAP CC) is undertaking an evaluation of the Rural On-Call Remuneration Program. An evaluation of RPAP conducted in 1996 identified that the lack of coverage for on-call in rural communities was a huge issue for rural physicians. In September 1998, the newly designed Rural On-Call Remuneration Program was established through negotiations between the AMA Section of Rural Medicine and Alberta Health and Wellness. During the establishment of the program, it was agreed that the RPAP CC would evaluate the program two years after its inception. Therefore, the RPAP CC has contracted with C. A. MacDonald and Associates to conduct the evaluation.

This evaluation will incorporate, through the use of surveys and interviews, the views of all key stakeholders in the Rural On-Call Remuneration Program, including rural physicians and representatives from all rural health authorities and participating facilities. This will be supplemented by expert informant interviews with representatives of the College of Physicians and Surgeons, the Alberta Medical Association, and Alberta Health and Wellness.

A project Steering Committee comprised of four members, representing the RPAP CC, the AMA Section of Rural Medicine, Alberta Health and Wellness, and the Council of Medical Directors, are advising the working team throughout this project. The final report will be completed by March 31, 2001 and presented to the RPAP CC for consideration.

As part of this process, the information that you provide through this brief (15 minutes) survey will provide valuable information to determine whether further changes are required to the Rural On-Call Remuneration Program. If you have any questions about this survey, please call Duncan MacDonald at (780) 487-8943, or contact him by e-mail at duncan@camacdonald.com.

I would appreciate it if you would take the time to complete the attached survey. Your feedback is important to us. The results of this important evaluation will be made available to you at the end of the project, in April 2001. Thank you for your assistance.

Sincerely,

David Kay, CHE
Program Manager
Rural Physician Action Plan

SURVEY – RURAL ON-CALL REMUNERATION PROGRAM

You do not need to put your name on this survey. All information provided is strictly confidential and will NOT be attributed to the individual that provides it.

You and your practice

1. Gender: ☐ Male ☐ Female
2. Practice: ☐ Full-time ☐ Part-time
3. In what health region(s) do you practice? (Please specify RHA # and name)

   _____
4. Age:

   ☐ Under 30 years old
   ☐ 30 - 39 years old
   ☐ 40 - 54 years old
   ☐ 55 -69 years old
   ☐ 70 years or older
5. Area of speciality:
   ☐ Family physician/general practitioner
   ☐ Obstetrics-gynaecology
   ☐ General Surgery
   ☐ Speciality (please specify): _____
   ☐ Special areas of training (please specify)_____
6. Type of practice:
   ☐ Single proprietorship
   ☐ Small Group Practice (2 or 3 physicians)
   ☐ Large Group Practice (4 or more physicians)
   ☐ Locum
   ☐ Employed by Hospital or University
   ☐ Employed by Regional Health Authority
7. Do you have privileges at the local hospital? ☐ Yes ☐ No
8. Do you provide emergency room on-call? ☐ Yes ☐ No
9. If you do **not** provide on-call services, what might encourage you to do so?

   _____

   _____

If you do not have privileges or do not provide emergency room on-call services, you do not need to complete the remainder of this survey. However, it is important that we also know what proportion of physicians do not provide on-call services. Please return this page no later than February 23, 2001 to:

Duncan MacDonald
C. A. MacDonald & Associates, Inc.
15407 - 75 Avenue
Edmonton, Alberta T5R 2Y9

Alternatively, you can also return this page of the survey by fax to (780) 481-0923.

Thank you for taking the time to provide this information.

Your Community

10. Has your community added a new physician in the past six months?
    - Yes
    - No

11. Is your community actively recruiting for another physician?
    - Yes
    - No

Your Practice

12. How long have you been in rural practice?
    - Less than one year
    - 1 - 2 years
    - 3 - 4 years
    - 5 - 6 years
    - 7 - 10 years
    - More than 10 years

13. How many patients do you see, on average, on a daily basis?
    - Under 10
    - 11 – 25
    - 26 – 50
    - Over 50

14. How many days per week do you have office/clinic hours?
    - 1
    - 2
    - 3
    - 4
    - 5
    - 6
    - 7

15. How many days per week do you work on average?
    - 1
    - 2
    - 3
    - 4
    - 5
    - 6
    - 7

16. Would you like to change the number of patient visits you provide on a daily basis?
    - Increase significantly
    - Increase slightly
    - Stay the same
    - Decrease slightly
    - Decrease significantly

17. Do you access the Rural Local Program weekend program?
    - Yes, frequently
    - Yes, occasionally
    - No

18. What was your emergency on-call schedule prior to the introduction of the Rural On-Call Remuneration Program in October 1998?
    - Did not have any on-call commitments
    - 1:1 (every night)
    - 1:2 (every second night)
    - 1:3 (one night in three)
    - 1:4 (one night in four)
    - 1:5 (one night in five)
    - 1:6 (one night in six)
    - 1:7 (once a week)
    - Don't remember

19. How frequently do you provide emergency on-call services now?

- Do not have on-call commitments
- 1:1 (every night)
- 1:2 (every second night)
- 1:3 (one night in three)
- 1:4 (one night in four)
- 1:5 (one night in five)
- 1:6 (one night in six)
- 1:7 (once a week)

20. How frequently would you **like to be** on-call in the future?

- No on-call commitments
- 1:1 (every night)
- 1:2 (every second night)
- 1:3 (one night in three)
- 1:4 (one night in four)
- 1:5 (one night in five)
- 1:6 (one night in six)
- 1:7 (once a week)

Please explain why, if different from your actual on-call circumstances: _____

_____

_____

21. Are you planning to change your emergency on-call commitments?

- No
- Yes (please explain what actions you intend to take): _____

_____

_____

22. Do you intend to change the location of your practice in the next five years?

- Yes
- No (if no, please go to question 26)
- Don't know/unsure

23. How long do you intend to continue practice in your current location?

- 1 more year
- 1 - 2 more years
- 3 - 5 years
- More than 5 years
- Don't know/unsure

24. Where will your next practice be located?

- Plan to retire
- Rural practice in Alberta
- Rural practice outside Alberta
- Urban practice in Alberta
- Urban practice outside Alberta

25. How much is your decision to leave your current practice a result of your emergency on-call commitments? Please select the most appropriate response from the list below.

- My decision to leave is a direct result of my on-call commitments.
- My decision to leave my current practice has been influenced by my on-call commitments, among other things.
- My decision to leave my current practice is not related to my on-call commitments.

Impact of the Rural On-Call Remuneration Program

26. Are you eligible for payments under the Rural On-Call Remuneration Program (i.e. your local hospital facility is a designated facility under the program)?

- Yes
- No

27. Please indicate how the introduction of the Rural On-Call Remuneration Program changed your satisfaction with your on-call commitments?

- I am much more satisfied with my emergency on-call commitments.
- I am marginally more satisfied with my emergency on-call commitments.
- There has been no change in my level of satisfaction with my emergency on-call commitments.
- I am marginally less satisfied with my emergency on-call commitments.
- I am much less satisfied with my emergency on-call commitments.

28. Does the Rural On-Call Remuneration Program adequately compensate you for the demands of emergency on-call services?

- Yes
- No

Why or why not? _____

_____

Design of the Rural On-Call Remuneration Program

Eligibility for Rural On-Call Remuneration Program payments is a function of two design elements. The volume of visits to the emergency department of the facility (less than 25,000 unscheduled visits per year) determines whether a facility can be designated as eligible. Payment to individual physicians is determined by the number of hours between 5:00 p.m. and 8:00 a.m. on weekdays, and 5:00 p.m. Friday until 8:00 a.m. Monday on weekends that a physician is on call at a designated facility.

29. Do you think that 25,000 unscheduled visits per year is an appropriate cut-off to designate a "low-volume" rural emergency department? Please select the appropriate response below.

- 25,000 unscheduled visits is appropriate.
- 25,000 unscheduled visits is too high.
- 25,000 unscheduled visits is too low.

30. Do you think that hourly payments for the time that physicians are on-call to a designated facility is an appropriate way to reimburse rural physicians for emergency on-call responsibilities?

    ☐ Yes ☐ No (if No, please explain what you would prefer)

    _____

31. Would you suggest any changes to the design of the Rural On-Call Remuneration Program to more adequately compensate you for your emergency on-call responsibilities?

    _____

    _____

    _____

    _____

    _____

32. Would you suggest any changes to the design of the Rural On-Call Remuneration Program to increase the level of participation in the provision of emergency on-call services from physicians in your local area? _____

    _____

    _____

    _____

    _____

    _____

Operation of the Rural On-Call Remuneration Program

The Rural On-Call Remuneration Program is currently overseen by the RPAP CC, and managed and administered by Alberta Health and Wellness. Each eligible facility submits payment requests to Alberta Health and Wellness, and physicians receive their payments directly from Alberta Health and Wellness.

33. Please indicate your overall level of satisfaction with the following aspects of the Rural On-Call Remuneration Program.

	Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied
Overall Program Design					
Overall Program Operation					
Level of Hourly Payments					
Accuracy of Payment Amounts					
Responsiveness to questions and queries					
Responsiveness to complaints and					

	Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied
Overall Program Design					
Overall Program Operation					
concerns					
Speed of receiving Payments					

34. To what degree has the implementation of the Rural On-Call Remuneration Program changed the following aspects of your practice?

	Much Better	Better	No change	Worse	Much Worse
Scheduling of on-call responsibilities					
Relationship with the local hospital					
Relationship with other local physicians					
Relationship with the Regional Health Authority					

35. How would you suggest that the management or operation of the Rural On-Call Remuneration Program could be improved? _____
_____
_____

36. How effective do you think that the Rural On-Call Remuneration Program is in <u>recruiting</u> rural physicians?

- Very effective
- Somewhat effective
- Not effective
- No opinion

37. How effective do you think that the Rural On-Call Remuneration Program is in <u>retaining</u> rural physicians?

- Very effective
- Somewhat effective
- Not effective
- No opinion

38. The Consensus statement that established the Rural On-Call Remuneration Program proposed that, starting April 1, 2001, the program be managed directly by each RHA, who would also make payments to the participating physicians. What impact do you think this would have on the following aspects of the program?

	Much Better	Better	No change	Worse	Much Worse
Accuracy of Payment Amounts					
Responsiveness to questions and queries					
Responsiveness to complaints and concerns					
Speed of receiving Payments					
Scheduling of on-call responsibilities					
Relationship with the local hospital					
Relationship with other local physicians					
Relationship with the Regional Health Authority					

39. If there are any other issues regarding the Rural On-call Remuneration Program that have not been addressed by this survey, we would appreciate it if you would identify them in the remaining space. _____

_____

_____

_____

Please return this survey no later than February 23, 2001. A self-addressed envelope is enclosed. The return address is:

C. A. MacDonald & Associates, Inc.
15407-75 Avenue
Edmonton, Alberta T5R 2Y9

Alternatively, you can also return this survey by fax to (780) 481-0923, remembering to fax both sides of your survey responses.

Thank you for taking the time to provide this information.

APPENDIX 4 - SURVEY RESPONDENT DEMOGRAPHICS

Table 18 - Survey Respondents - Gender

	Number	%
Male	273	78.8%
Female	71	20.6%
No Response	2	0.6%
Total	345	100%

Table 19 - Survey Respondents - Practice

	Number	%
Full-time	282	81.7%
Part-time	33	9.6%
Retired	29	8.4%
No Response	1	0.3%
Total	345	100%

Table 20 - Survey Respondents - Regional Distribution

Region	Number	%
Region 1 - Chinook	34	9.9%
Region 2 - Palliser	14	4.1%
Region 3 - Headwaters	29	8.4%
Region 4 - Calgary	1	0.3%
Region 5	21	6.1%
Region 6 - David Thompson	40	11.6%
Region 7 - East Central	33	9.6%
Region 8 - Westview	29	8.4%
Region 9 - Crossroads	16	4.6%
Region 10 - Capital	13	3.8%
Region 11 - Aspen	22	6.4%
Region 12 - Lakeland	33	9.6%
Region 13 - Mistahia	13	3.8%
Region 14 - Peace	12	3.5%
Region 15 - Keeweetinok	12	3.5%
Region 17 - Northwestern	7	2.0%
No Response	17	4.9%
TOTAL	345	100%

Table 21 - Survey Respondents - Age Distribution

Age Group	Number	%
Under 30	12	3.5%
30 - 39	103	29.9%
40 - 54	181	52.5%
55 - 69	40	11.6%
70 or older	6	1.7%
No Response	3	0.8%
TOTAL	345	100%

Table 22 - Survey Respondents - Area of Speciality

Area of Speciality		Number
Family Practice/General Practitioner		320
Obstetrics-gynaecology		1
General Surgery		6
Other Board-certified Specialists		13
GP Specialists	Anaesthesiology	31
	Obstetrics	24
	General Surgery	20
	Other	11
No Response		18

Table 23 - Type of Practice

Type of Practice	Number	%
Single Proprietorship	43	12.5%
Small Group Practice (2 or 3)	87	25.2%
Large Group Practice (4 or more)	198	57.4%
Locum	5	1.4%
Employed by RHA	4	1.2%
No Response	8	2.3%
TOTAL		100%

Table 24 - Survey Respondents - Privileges and On-Call Behaviour

	Have Privileges		Provide On-Call	
	Number	%	Number	%
Yes	332	96.2%	304	88.1%
No	11	3.2%	38	11.0%
No Response	2	0.6%	3	0.9%
Total	345	100%	345	100%

NOTE: One physician who provides on-call does NOT have privileges at the local facility.

All remaining tables are based on 327 responses, since if a physician did not have privileges and did not provide on-call services, they were not required to complete the rest of the survey.

Table 25 - Physician Resources

Has/Is your community:	**Yes**
Added a new physician in the past six months	144
Actively recruiting a physician	152
Added a new physician **AND** is actively recruiting a physician	73
Has added a physician **AND** is **NOT** actively recruiting	70
Has **NOT** added a new physician **AND IS** actively recruiting	79
Has **NOT** added a new physician **AND** is **NOT** actively recruiting	86

Table 26 - Length of Time in Practice

	Number	**%**
Less then 1 year	8	2.4%
1 - 2 years	30	9.1%
3 - 4 years	43	13.2%
5 - 6 years	23	7.0%
7 - 10 years	43	13.2%
More than 10 years	168	51.4%
Total	327	100%

Table 27 - Physician Workload - Patients per Day

	Number	**%**
Under 10	3	0.9%
11 - 25	65	19.9%
26 - 50	229	70.0%
Over 50	16	4.9%
No response	14	4.3%
Total	327	100.0%

Table 28 - Physician Workload - Days Per Week

	Office/Clinic Days Per Week		Working Days Per Week	
	Number	**%**	**Number**	**%**
1	0	0	1	0.3%
2	16	4.9%	7	2.1%
3	22	6.7%	9	2.8%
4	49	15.0%	23	7.0%
5	199	60.9%	171	52.3%
6	23	7.0%	88	26.9%
7	0	0	15	4.6%
No Response	17	5.5%	13	4.0%
Total	327	100%	327	100%

Table 29 - Desired Change in Patient Load

	Number	**%**
Increase significantly	13	4.0%
Increase slightly	28	8.6%
Stay the same	164	50.1%
Decrease slightly	90	27.5%
Decrease significantly	16	4.9%
No Response	16	4.9%
Total	327	100%