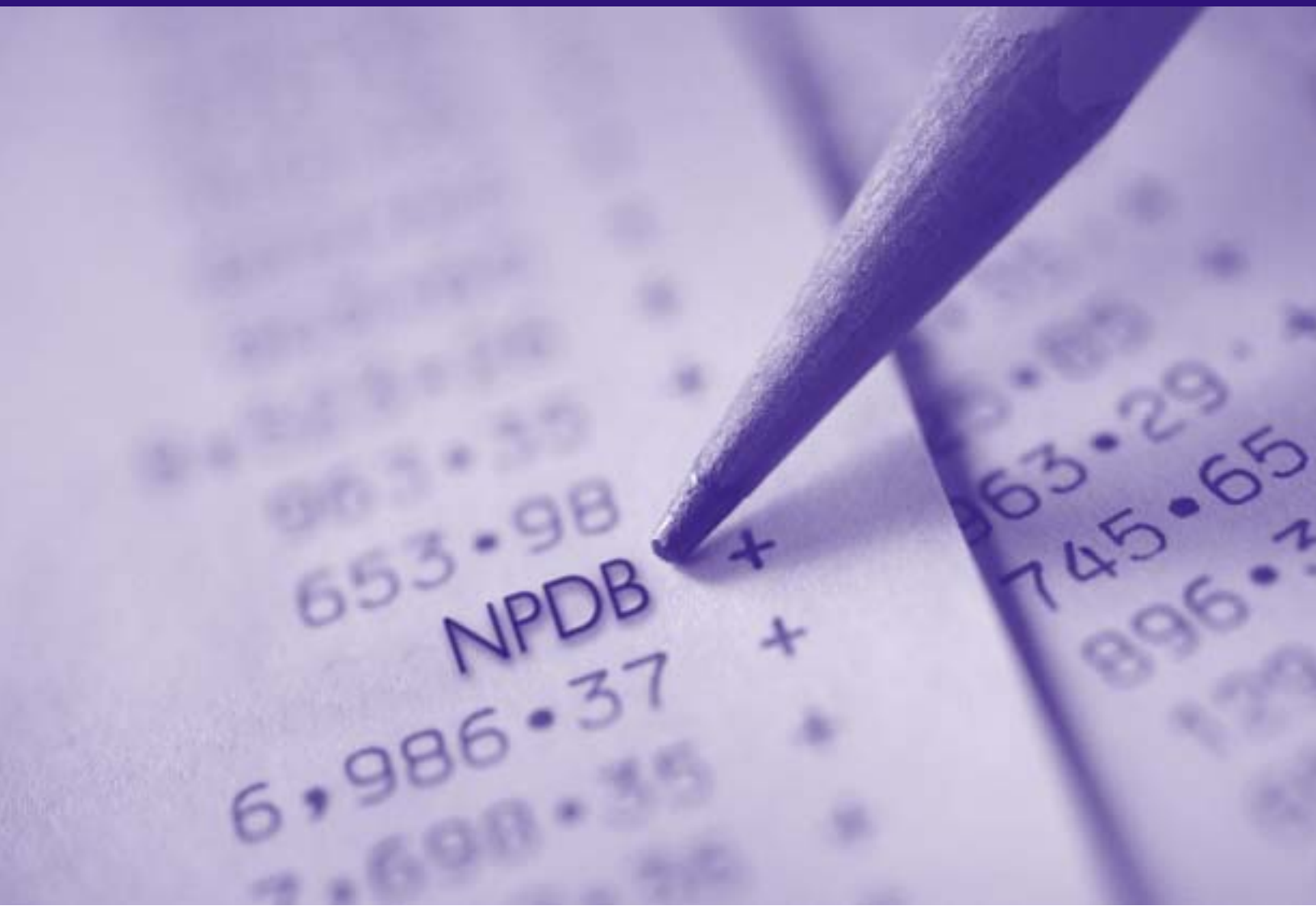
Alternative Payments and the National Physician Database (NPDB)



The Status of Alternative Payment Programs for Physicians in Canada, 2000/2001

Canadian Institute for Health Information
Institut canadien d'information sur la santé

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Alternative Payments and
the National Physician Database (NPDB)

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Foreword

This is the second CIHI report on alternative payments to Physicians in Canada. This year's report updates and, where possible, expands on information presented in the first report, which was published in October 2001[1].

In 1999/2000, as part of the CIHI's activities to improve the availability of information on health human resources, CIHI was requested to provide a report on the status of alternative funding programs and payments in Canada. This report was prepared to assist CIHI in developing plans for collecting data on physicians services insured by the provinces and territories and paid through alternatives to fee-for-service. Specific objectives were:

1. Document alternative physician payment plans (APP) and alternative funding plans in Canada;
2. Quantify expenditures for APPs;
3. Assess impact of APPs on comprehensiveness and data quality in CIHI's National Physician Database (NPDB);
4. Document information collected by each province about utilization and payments in APPs; and
5. Develop strategies and recommendations for incorporating alternative payments in NPDB.

Provincial representatives from CIHI's Expert Group on Physician Databases (see Appendix A) are the main sources of data for this report. Provincial representatives have collaborated with colleagues who have specific responsibilities for alternative payment plans to ensure that statistical and descriptive information are as accurate as possible. Information provided by provincial representatives has been supplemented by personal interviews carried out by CIHI's Department of Health Human Resources.

Data in this report reflect the status of alternative payment plans in 2000/2001. Additional updates are planned for future years.

[1] *Alternative Payments and the National Physician Database. The Status of Alternative Payment Programs for Physicians in Canada, 1999/2000*. CIHI, Ottawa, October 2001.

Definitions

Alternative payment modes are alternatives to fee-for-service used to pay physicians.

Alternative payment plans (APP) refer to actual arrangements to pay physicians by alternative modes. Salaried physicians in underserviced areas would be an example of an alternative payment plan.

Alternative funding refers to methods other than fee-for-service used to fund clinical departments (e.g. practice plans or academic medical centres) or specific programs. The agency that receives the funding is responsible for determining the nature and amount of payment to individual physicians.

Clinical services reported in NPDB include medical care by all specialties except radiology and pathology (these two specialties are not included in NPDB in its present stage of development).

Clinical fee-for-service: Payment of claims submitted for individual services.

Alternative clinical: All payments made for *clinical services* provided by physicians and not reimbursed on a fee-for-service basis. Classifications vary by province.

> *Salary:* Physicians employed on a salary basis.
>
> *Sessional:* Payments on an hourly or daily basis. Used by some provinces to fund services in hospital emergency departments, psychiatry clinics and clinics in rural areas.
>
> *Capitation:* Monthly payments for clients rostered with a physician group.
>
> *Block funding:* Annual budgets negotiated for a group of physicians, usually associated with an academic medical centre.
>
> *Contract and blended:*
>
> 1. Funding to regional boards for clinical services under arrangements in which boards have discretion regarding specific uses of the funds.
> 2. Contractual payments.
> 3. Payment arrangements that incorporate both alternative remuneration and fee-for-service.
>
> *Psychiatry:* Some provinces have programs that provide psychiatric services with funding based on salary, sessional or contract payments.

Northern and underserviced areas: Funding of provincial programs to provide services in northern or underserviced areas. These programs might include a number of alternative modes of payments. Where provinces reported funding for underserviced area programs, no attempt was made to break down individual payment modes.

Emergency and on call: Alternative payments for services in emergency departments or for physicians on call in rural areas. These payments may supplement or replace fee-for-service.

Non-clinical payments—not included in NPDB

Rural incentives: Special incentives in underserviced areas and locum programs. Incentives are paid in addition to payments for clinical services. They would include moving expenses, recruitment or retention bonuses, etc.

Hospital-based physicians: Funding provided to regions or hospitals for radiology and pathology. This category also may include funding for clinical chiefs of staff, medical health officers, cancer and TB programs in some provinces.

Benefits: Contributions by provinces for Canadian Medical Protective Assurance (CMPA) and continuing medical education.

Executive Summary

This report provides an update to information on alternative payments published in October 2001. The 2001 report contains sections of background information, information about NPDB systems development and historical information on payment trends. This year's publication focusses on updating the data presented last year. Readers may wish to consult the previous publication for additional information[2].

Alternative payments increased modestly in 2000/2001, continuing a trend that was evident during the 1990s. Alternative payments in 2000/2001 represented approximately $1.3 billion dollars—10.9% of the value of physicians' clinical services in the ten provinces. The percentage of alternative payments varied considerably across the provinces, ranging from a low of 2.5% in Alberta to a high of 29.0% in Newfoundland.

In 2000/2001, over 28% of Canada's 57,622 physicians received some payments for clinical care from alternative payment modes. The percentage of physicians who receive almost all payments from alternative modes is estimated to be approximately 6.7%. Newfoundland has the highest percentage of physicians who receive almost all payments through alternative modes (27.7%).

Physician Full-time Equivalent s (FTEs) in alternative payment modes account for 9.0% of total FTEs. Nova Scotia has the highest percentage of alternative payment FTEs (26.4%). Quebec, Ontario and Manitoba have the highest ratios of FTEs per 100,000 when both fee-for-service and alternative payment FTEs are combined (171, 169 and 159 per 100,000 population respectively).

[2] *Alternative Payments and the National Physician Database. The Status of Alternative Payment Programs for Physicians in Canada, 1999/2000*. CIHI, Ottawa, October 2001.

Alternative Payments in the Provinces

Nationally, alternative remuneration represents 10.9% of payments for clinical physicians' services reported in NPDB. (Clinical services reported in NPDB include medical care by all specialties except radiology and pathology.) Newfoundland has the highest percentage of alternative payments, followed by Nova Scotia and Manitoba (Figure 1, Table 1). Almost all provinces showed relatively modest increases from 1999 to 2000. Information was obtained directly from the Ontario Ministry of Health and Long-Term Care beginning in 2000 and the data for 1999 may have understated alternative payments.

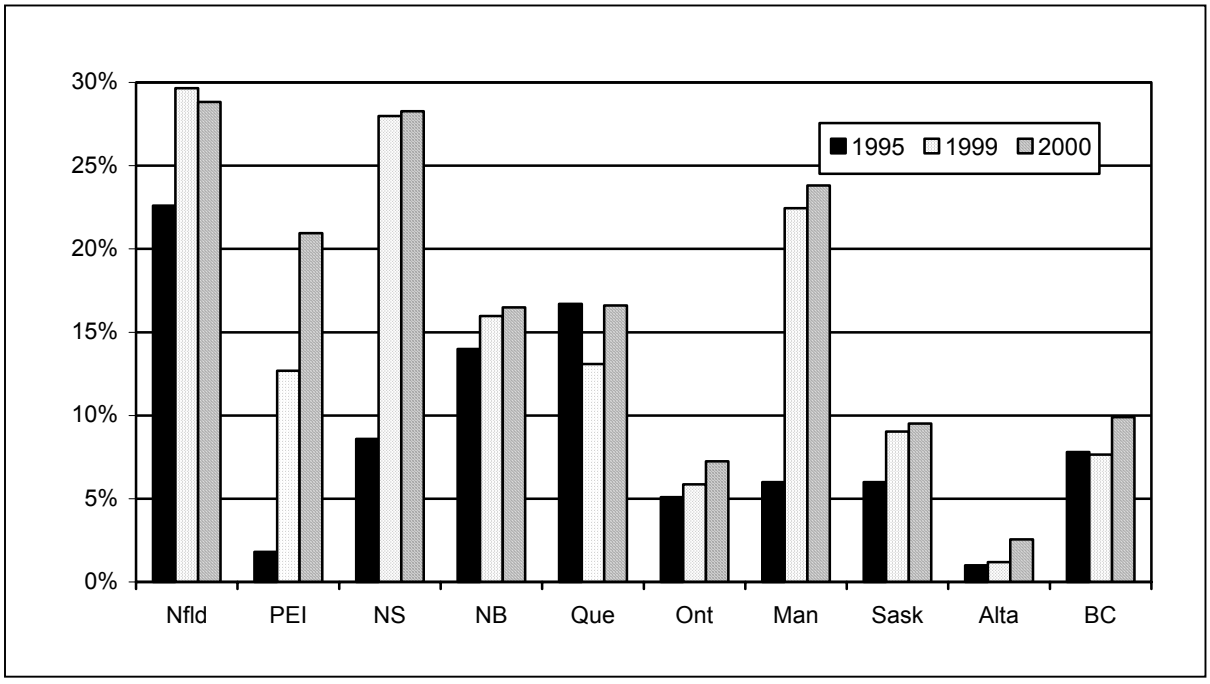

Figure 1. Physicians' Alternative Clinical Payments as a Percentage of Total Clinical Payments, 1995, 1999 and 2000

Table 1 groups alternative forms of funding for clinical services and also shows types of physician payment that are not for clinical services reported in NPDB. In some cases, these other categories may contain relatively small amounts for clinical services. Table 2 provides details of different types of alternative clinical remuneration used in the provinces.

Provincial governments and medical societies adopt different approaches to funding particular programs or medical expenses. Funding approaches also reflect attempts to redress perceived inequities in fee-for-service or new approaches to service delivery. In some cases, provinces take a pragmatic approach to funding specific projects and combine funding for alternative remuneration with an existing budget envelope. For example, funding for regional boards may be increased to include primary care projects.

Box 1—Provincial Notes About Clinical and Non-Clinical Payments

Alternative clinical payments in Table 1 include salary, sessional, capitation, contract services and block funding. (See Table 2 and definitions at the beginning of this report for details). Northern or underserviced area programs and most emergency or on call payments are also included with clinical payments to enhance comparability.

A number of provinces have enhanced alternative payments for services in emergency departments or for physicians on call in rural areas. Enhanced payments have been grouped with clinical payments where they are tied to service provision. Arrangements vary—for example, in Manitoba alternative payments are made to top-up fee-for-service emergency room billings in the Winnipeg teaching hospitals while they substitute for fee-for-service in rural areas and urban community hospitals. In New Brunswick, special on call premiums supplement normal remuneration for emergency services (which is made through alternative remuneration). In Saskatchewan, general practice rural on call and weekend relief coverage payments are billed on a fee-for-service basis.

Rural incentives refer to special incentives in underserviced areas and locum programs. In Saskatchewan, rural and remote incentives are distributed by the Saskatchewan Medical Association. British Columbia has subsidiary agreements for enhanced payments in certain rural areas.

Hospital-based physicians consist mainly of payments to regions or hospitals for hospital-based radiology and pathology. The category may also include relatively small amounts of funding for salaried FTE positions in Prince Edward Island and Saskatchewan (i.e. block funding to the Saskatchewan College of Medicine for the departments of geriatrics and family medicine paid through the Clinical Services Fund and for university-based obstetrical anaesthetists and neurosurgeons). In this respect, it might include some clinical care transferred from fee-for-service remuneration.

Benefits include contributions by provinces for Canadian Medical Protective Assurance (CMPA) and continuing medical education. In British Columbia, this category also includes disability insurance and provincial contributions to physicians' retirement fund. This information was not included in the request to provinces for this report but it has been included for provinces that were able to provide the data.

Table 1. Summary of Physician Payments by Type of Payment and Province, Fiscal 2000/2001, ($'000)

1. Clinical (NPDB)

	Nfld.	P.E.I	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	All Provinces
Fee-for-service	116,490	28,689	225,492	168,619	1,999,591	4,558,401	324,230	275,950	963,780	1,650,553	10,311,796
	71.2%	*79.1%*	*71.7%*	*83.5%*	*83.4%*	*92.8%*	*76.2%*	*90.5%*	*97.5%*	*90.1%*	*89.1%*
Alternative Clinical	47,201	7,600	88,855	33,314	398,162	355,674	101,320	29,024	25,214	181,122	1,267,486
	28.8%	*20.9%*	*28.3%*	*16.5%*	*16.6%*	*7.2%*	*23.8%*	*9.5%*	*2.5%*	*9.9%*	*10.9%*
Sub-total Clinical	163,691	36,289	314,348	201,933	2,397,753	4,914,076	425,550	304,974	988,994	1,831,675	11,579,283

2. Non-clinical

	Nfld.	P.E.I	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	All Provinces
Rural Incentives								1,640	1,496	5,792	8,927
Hospital-based Physicians	5,924		30,485	28,403		6,500	18,363	53,706	21,208		164,589
Benefits	1,548	797	8,849	4,345		66,689		7,030	21,718	65,886	176,862
Sub-total Non-clinical	7,471	797	39,334	32,747		73,189	18,363	62,376	44,422	71,678	350,378
Total Payments	**171,162**	**37,086**	**353,682**	**234,680**	**2,397,753**	**4,987,264**	**443,913**	**367,350**	**1,033,416**	**1,903,353**	**11,929,660**

Note: Missing values indicate either no payments or insufficient detail to break down payments to certain categories.

Sources: Estimates for all provinces were reported by provincial representatives on the NPDB Expert Group on Physician Databases.

Table 2. Estimated Alternative Clinical Payments by Type of Payment and Province, Fiscal 2000/2001, ($'000)

	Nfld.	P.E.I	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	All Provinces
Salary	42,517		9,633	13,255	64,865		3,193			8,830	142,294
Sessional	1,561		1,543	15,805	175,362		3,350			47,380	245,002
Capitation							0			3,093	3,093
Block Funding	3,122		41,657				0	4,658			49,437
Psychiatry			13,764				6,587	6,762			27,113
Contracted/Blended/ Unspecified		7,600		1,902	157,935	341,441	36,279	14,759	13,614	82,269	655,798
Northern and Underserviced Areas						14,234	26,762	2,844		31,233	75,073
Emergency and On Call			22,258	2,352			25,149		11,600	8,317	69,676
Total	**47,201**	**7,600**	**88,855**	**33,314**	**398,162**	**355,674**	**101,320**	**29,024**	**25,214**	**181,122**	**1,267,486**

Note: Contract and Blended includes:

- A special program of blended remuneration in Quebec for specialists introduced at the end of 1999. Funding to regional boards for hospital-based programs (including emergency services) in Prince Edward Island, Manitoba and Saskatchewan.
- Contract payments in New Brunswick and Saskatchewan.
- Service Agreements in British Columbia.
- Unspecified includes some payments that were not broken down, e.g. Ontario, which has block funding and other forms of alternative remuneration.

Missing values indicate either no payments or insufficient detail to break down payments to certain categories.

Sources: Estimates for all provinces were reported by provincial representatives on the NPDB Expert Group on Physician Databases.

Physicians in Alternative Payment Plans

Over 28% of physicians in Canada received some remuneration for insured services in the form of alternative payments in 2000–2001. The percentage ranges from less than 3% in Alberta to 70% in Manitoba (Table 3). Many physicians who received one form of alternative payment also received fee-for-service payments and/or other types of alternative payment.

The number of physicians who receive payments mainly through alternative payment modes was estimated for each province using a variety of methods, depending on the extent of information available from the province. The intent was to estimate the number for whom *almost all* clinical income from provincial sources was obtained from alternative funding[3]. When interpreting these data it is important to note that it was not possible to apply a single criterion to all provinces.

[3] Alternative funding refers to the way in which clinical services were funded by provincial governments, not the way in which physicians were paid individually.

Nationally, almost seven percent of physicians receive payments mainly through alternative payment modes (Table 3). Newfoundland had the highest percent, reflecting the tendency for rural family practitioners to be paid through salaried arrangements. Nova Scotia and Prince Edward Island ranked second and third. In Nova Scotia a relatively large number of physicians practice in block funding arrangements, while in PEI a number of specialists practice on a salaried basis. In the other provinces, physicians who receive mainly alternative payments represented less than 10% of total physicians.

Table 3. Total Physicians and Physicians Who Received Alternative Payments, by Province, Fiscal 2000/2001

	Total physicians	Number of physicians paid through alternative modes	Percent of total physicians paid through alternative modes	Number of physicians paid mainly through alternative modes	Percent of total physicians paid mainly through alternative modes
Nfld.	941	448	47.6%	261	27.7%
P.E.I.	223	103	46.0%	36	16.1%
N.S.	1,988	1,205	60.6%	336	16.9%
N.B.	1,355	673	49.7%	80	5.9%
Que.	14,670	6,220	42.4%	1,053	7.2%
Ont.	21,730	3,527	16.2%	1,057	4.9%
Man.	2,193	1,535	70.0%	173	7.9%
Sask.	1,565	199	12.7%	92	5.9%
Alta.	5,014	140	2.8%	75	1.5%
B.C.	7,943	2,165	27.3%	683	8.6%
All Provinces	57,622	16,215	28.1%	3,846	6.7%

Note: Total physicians are reported to CIHI annually by the provinces. The number reported usually reflects those registered with provincial medicare plans and may exceed the number actually paid. Physicians receiving alternative payments were estimated from these annual reports (total physicians less the percentage who receive only fee-for-service payments) in Prince Edward Island, New Brunswick and Manitoba. In other provinces information collected for this report allowed for more specific estimates.

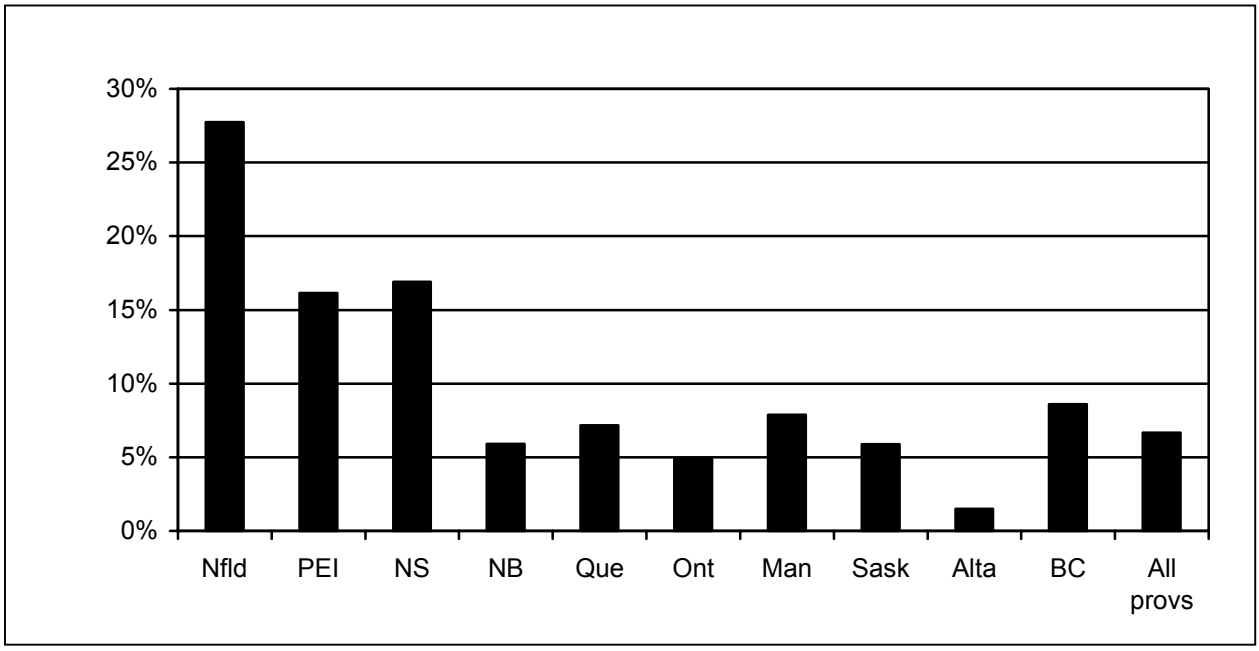

Figure 2. Percent of Clinical Physicians Paid Mainly Through Alternative Modes, by Province, 2000/2001

Estimated Full-time Equivalents

Approximate estimates of FTEs in alternative payment modes are shown in Table 4. Overall, physician activities in alternative payment modes represent approximately 4,400 FTEs. Alternative payment FTEs are equivalent to 9.0% of estimated total FTEs in Canada. Alternative payment FTEs range from just over one percent of total FTEs in Alberta to approximately 26% in Nova Scotia. Newfoundland, Quebec and Manitoba have 16% to 18% of physician FTEs in alternative payment modes.

When FTEs from fee-for-service and alternative payment modes are combined, the distribution of physicians per 100,000 population is different from the distribution when only fee-for-service physicians are included (Table 5, Figure 3). Quebec and Ontario have 171 and 169 fee-for-service FTEs per 100,000 population, followed by Manitoba with 159. Newfoundland, Nova Scotia and British Columbia form a second tier in provincial rankings with 148–154 FTEs per 100,000 population. The four remaining provinces have 131–141 FTEs per 100,000 population.

Table 4. Estimated FTEs in Alternative Payment, by Province, Fiscal 2000/2001

	Full-time Equivalent Physicians			Distribution	
	FFS	APP	Total	FFS	APP
Nfld.	662	134	796	83.2%	16.8%
P.E.I.	162	21	183	88.3%	11.7%
N.S.	1,060	380	1,440	73.6%	26.4%
N.B.	903	83	985	91.6%	8.4%
Que.	10,561	2,027	12,589	83.9%	16.1%
Ont.	19,058	744	19,802	96.2%	3.8%
Man.	1,485	329	1,814	81.9%	18.1%
Sask.	1,314	124	1,439	91.4%	8.6%
Alta.	4,118	54	4,172	98.7%	1.3%
B.C.	5,716	536	6,252	91.4%	8.6%
All Provinces	45,039	4,432	49,470	91.0%	9.0%

Note: As described in Box 2, FTE estimates use CIHI's "Full-time Equivalent Physicians Report, Canada, 1999/2000 and 2000/2001" and "Average Payment Per Physician Report, Canada, 1999/2000 and 2000/2001". The relevant data series from these reports are presented in Appendix B, Tables B1 and B2.
APP FTEs are estimated from data supplied by the provinces for this report.

Table 5. Estimated Total FTE Physicians per 100,000 Population, by Type of Payment and Province, Fiscal 2000/2001

	FTEs per 100,000 Population			Population per FTE Physician
	FFS	APP	Total	
Nfld.	123	25	148	674
P.E.I.	117	16	133	754
N.S.	114	41	154	649
N.B.	120	11	131	762
Que.	143	27	171	586
Ont.	162	6	169	592
Man.	130	29	159	630
Sask.	129	12	141	708
Alta.	137	2	139	722
B.C.	141	13	154	649
All Provinces	147	14	161	621

Note: Estimates of FTE physicians per 100,000 population were derived using Statistics Canada's Net Population Estimates for Canada, by Provinces, 2000 (see Appendix B, Table B3).

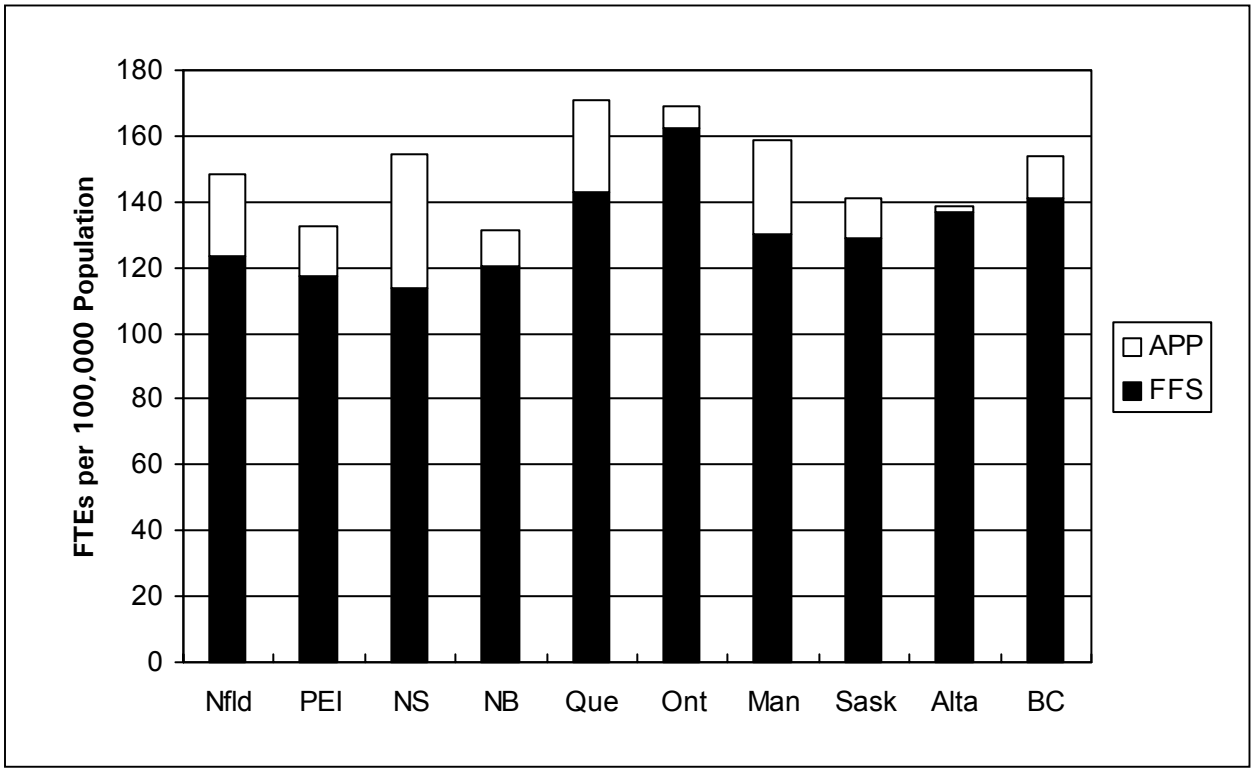

Figure 3. Total FTE Physicians per 100,000 Population, by Type of Payment and Province, Fiscal 2000/2001

Box 2—Estimating FTEs in Fee-for-service and in Alternative Payment Plans

Fee-for-service

CIHI's FTE methodology calculates benchmark payment levels for physicians in each of 18 specialties in a base year. Physicians below the lower benchmark are assigned a proportion of one FTE, those between the lower and upper benchmarks are assigned a count of one and those above the benchmark are counted by a log-linear methodology. Approximately 40% of physicians are below the benchmarks, 20% are within the benchmarks and 40% are above during the base year. In subsequent years the benchmarks are indexed to fee changes and FTE counts are recalculated.

Alternative payments

Three criteria were used to estimate FTEs in alternative payment plans, with the choice of criteria depending on the availability of information:

1. Actual counts of funded FTEs for specific programs were used where these data were available. In Nova Scotia, the majority of alternative FTEs are in block funding arrangements and FTE status is based on the CIHI methodology. Manitoba and Saskatchewan provide FTEs funding in northern locations and certain programs administered by regional boards.
2. Where physicians received most of their remuneration through alternative funding, amounts paid were divided by average paid per FTE GP/FP or medical specialist physician. The denominators for this calculation were taken from CIHI's "Average Payment Per Physician Report, Canada, 1999/2000 and 2000/2001" (see Appendix B, Table B2). This method was used in Nova Scotia for institutional psychiatry, for Quebec physicians who receive the majority of their remuneration from alternative funding and for British Columbia physicians who receive payments through blended/unspecified APPs.
3. A proportional estimate was used for all other programs. Proportions, calculated by dividing alternative payments by fee-for-service payments using the figures given in Table 1, were applied to FFS FTE physician counts in order to estimate alternative payment FTEs. FFS FTE physician counts were taken from CIHI's "Full-time Equivalent Physicians Report, Canada, 1999/2000 and 2000/2001" (see Appendix B, Table B1). The resulting estimates were reduced by one half due to an assumption that at least half of alternative payments would go to physicians who already exceed the FTE lower benchmarks of fee-for-service payments.

Precise estimates are not possible using aggregate data as FTEs are calculated from individual physician level data. A precise count would require individual level data from all payment modes to be combined as FTEs from different payment modes are not additive due to the fact that physicians with payments anywhere in between the benchmarks are counted as one and those above are counted by a log-linear methodology. The aggregate estimates are useful, however, in order to appreciate the effects of alternative FTE estimates on overall physician supply.

Provincial Administrative Information About Alternative Payment

Provinces have not followed consistent approaches to reporting services provided under alternative payment programs. Shadow billing (using the entire set of codes in provincial fee schedules) is used for all services in Quebec. Shadow billing is prevalent in Nova Scotia although the extent of reporting varies, especially in rural emergency care. Saskatchewan uses shadow billing in certain programs and has developed a set of information codes designed to capture related information from family physicians practising under alternate payment. New Brunswick physicians who have moved from fee-for-service to alternative payment contracts now shadow bill. There is some shadow billing in Prince Edward Island and its extension is being considered as part of provincial fee negotiations. In Quebec and the Atlantic Provinces, responsibility for both fee-for-service and alternative payments tends to be centralized within Ministries of Health, a situation that can facilitate common policies within a province for information collection from fee-for-service and different forms of alternative payment.

Ontario and the western provinces use shadow billing in some form for some programs, but none of these provinces have policies requiring information collection from alternative payment plans in standard formats. Responsibility for individual APPs tends to be spread across different units within health ministries and in most provinces each administrative unit is responsible for setting its own information requirements.

Alternative Reimbursement in Each Province

This section contains details of alternative reimbursement in each province. It is a revised version of a section in the 1996 report: *Alternative Payment Programs and Data Collection.*

Newfoundland and Labrador

Salary: Approximately 40% of salaried physicians are GPs and the remaining 60% are specialist physicians. GPs affiliated with rural community hospitals, largely outside of the Avalon Peninsula, commonly practice on a salaried basis. Salaried physicians are employed by regional health boards and funded by the Medical Care Plan (MCP). Although movement between fee-for-service and alternative payment modes is unrestricted, the most recent agreement between MCP and the Newfoundland Medical Association (NMA) recognizes that physicians can convert to salaried status with regional boards if they wish to do so. A number of academic physicians have taken advantage of this option.

Salary has been the predominant model for rural physicians for two reasons: (1) relatively small practice populations make alternative payment modes more desirable, particularly for specialist physicians; and (2) many physicians in rural areas are international medical graduates (IMGs) who are not fully licensed in Canada, and therefore not able to practice on a fee-for-service basis. IMGs practising under alternative plans may switch to fee-for-service once they have fully established their medical credentials in Canada.

Sessional: Sessional payments are an option for fee-for-service physicians who staff hospital emergency departments. Sessional tends to be favoured during the midnight to eight shifts. Sessional payments are also related to the provision of specialized care, such as diabetes clinics, cystic fibrosis clinics and genetic counselling.

Block Funding: Block funding arrangements exist for cardiac surgery, some anaesthesia services and paediatic surgery. These arrangements define set dollar amounts for prescribed services within physician specialty groups.

Population-based Funding and Primary Care: Capitation is not used as a form of remuneration at present.

Information Collection: Alternative payments to individual physician are not reported in the provincial database.

Prince Edward Island

Salary: Prince Edward Island has hospital-based salaried physicians in the specialties of internal medicine, paediatrics, physical medicine, oncology, radiation oncology and laboratory.

Sessional: Sessional reimbursement is used in emergency medicine.

Block Funding: Block funding is used in PEI's two largest facilities to pay emergency room physicians on an hourly basis.

Population-based Funding and Primary Care: Capitation is not used to fund primary care.

Information Collection: Shadow billing is used with some salaried physicians.

Nova Scotia

Salary: Approximately 30 psychiatrists practice on a salaried basis in provincial mental health hospitals or centres. However, most physicians in these centres practice on a sessional basis. Salary arrangements are available to general practitioners in certain rural areas. Income guarantees are also available as part of an incentive package for GPs in designated underserviced areas. About 35-40 GPs practice under one or the other of the rural arrangements.

Rural Emergency and On Call Payments: During the late 1990s the province agreed to provide lump sum payments to physicians who staff emergency departments in rural areas or provide on call services where emergency departments do not exist. Based on a 1/3 call these programs provide up to $145,000 per year to physicians who qualify. In most cases there are more than three physicians in each call group. Almost all physicians who receive payments have fee-for-service practices in the communities where they are located.

Sessional: Most physicians who provide services in provincial mental health centres are on a contract arrangement that incorporates hourly payments. Many of these physicians also have fee-for-service practices in their local communities.

Block Funding: The Department of Pediatrics at Dalhousie University (approximately 45 physicians) has been block funding since July, 1994. The entire Department of Medicine became block funded in January 1999 (120 physicians). A number of smaller arrangements also exist. In total, 256 physicians were funded exclusively through this payment mode in 1999–2000.

Population-based Funding and Primary Care: Capitation is not used.

Information Collection: Shadow billing is used to collect information on services provided under block funding and GP salaried services in rural areas. An activity reporting system, which is not based on encounters, is used in mental health centres.

New Brunswick

Salary/Contract: A number of physicians in the provincial psychiatric facilities are salaried. Also, many physicians in the province have restricted licenses, which do not permit a fee-for-service practice. More physicians are interested in a salaried arrangement. Currently, some physicians in the following specialties have salaried arrangements: anaesthesia, diagnostic radiology, geriatrics, hematology, infectious diseases, rheumatology, medical oncology, pathology, medical microbiology, obstetrics/gynecology, pediatrics, neonatology, physical medicine, psychiatry, radiation oncology, general surgery, neurosurgery and general practice.

Sessional: Emergency departments in the eight regional hospital facilities use sessional compensation on a 24/7 basis. Community hospital facilities operate their emergency departments on a fee-for-service basis with some who have sessional arrangements for evenings, weekends and holidays. Sessional fees are also used in nursing homes, jails, detox, DVA and some clinics.

Block Funding: Three physicians at the University of New Brunswick campus are block funded but payments are identified for each physician in the group.

Population-based Funding and Primary Care: Capitation is not used. As the Community Health Centres are set to open in June 2003, there will be some arrangements created for the primary care physicians who establish a practice in those facilities.

Alternative Payment Contract: General surgeons and general practitioners were initially contracted for certain rural areas where recruitment was unachievable. Other specialties are moving to this arrangement.

Information Collection: Information is collected through shadow billing for physicians who have moved from fee-for-service to an alternative payment contract. New Brunswick is currently working with the Regional Health Authorities to implement a process to collect patient data for all non-FFS physicians.

Quebec

Salary: Most physicians employed in Local Community Service Centres (CLSC) are salaried. Public health physicians are also salaried. Almost half of payments for care by psychiatrists are made in the form of salary.

Sessional: Sessional payments are used to reimburse physicians in community health programs, long term geriatric care and some psychiatric institutions.

Blended: This is a new program introduced in late 1999, as an alternative form of remuneration for specialists. Physicians who participate receive a flat daily rate plus a percentage of the fee-for-service rates for insured services. Approximately 2,200

specialists received alternative remuneration through this program in fiscal 2000/2001. Blended payments accounted for 80% of alternative and 14% of total payments to specialists that year.

Block Funding: This form of reimbursement is not used. Physicians in academic health sciences centres bill fee-for-service.

Population-based Funding and Primary Care: Capitation is not used.

Information Collection: All programs are administered by the Regie d'Assurance Maladie. Reporting systems incorporate encounter level data.

Ontario

Salary: Community Health Centres in Ontario have community boards and compensate physicians on salary. Some of the other AFPs may pay physicians on salary once they receive funding from the Ministry.

Sessional: Sessional payments are generally provided to fee-for-service physicians who provide psychiatry, anaesthesia and non-billable geriatric physician services to underserviced areas and high-risk populations. This type of payment compensates physicians at an hourly or sessional rate of several hours for time spent treating patients. This time is often outside their normal office practice. There are still a few hospitals paying physicians through the "Scott Sessional" for emergency room payments.

Block Funding: The majority of APPs funding emergency room (ER), neonatal intensive care units, paediatric and gynaecological oncology physician services receive block funding. The block funding is paid to a physician group or association which is required to set up an internal governance structure which outlines how the physicians will be paid for the services negotiated under the APP contract.

Population-based Funding and Primary Care: There are two main types of models that are funded through population-based funding. Both are primary care service providers. The first is physicians practicing within Health Service Organizations (HSOs). These are multi-disciplinary group practices, which are funded according to a purely population-based payment model. The second is physicians practicing within the Ontario Family Health Network framework. This is a blended funding model that uses a capitation payment for a base number of codes, but allows fee-for-service billing for any codes outside the basket.

Contractual: All Ontario alternate payment programs are arranged through a contractual agreement. The current preference for the Ministry is to first centrally negotiate a template agreement with the Ontario Medical Association and offer it to eligible physician groups. Where this is not possible, contracts are usually negotiated with physician groups, the Ontario Medical Association and the Ministry of Health and Long Term Care. Participating physicians receive a pre-determined amount of funding to provide the list of in-scope services outlined in the negotiated contract. There is on going monitoring and evaluation of all contracts in order to ensure adequate service levels and expectations are met.

Information Collection: All APPs have reporting expectations clearly outlined in the contracts. The most common form, "shadow billing", parallels the fee-for-service system. However, payments for services covered by the contract are assigned at no value. In agreements where there is no shadow billing, other reporting methods are instituted, in order to ensure adequate service levels and accountability. In addition, some contracts require shadow billing and other forms of reporting depending on the deliverables. For example, the Emergency Department AFAs report on CTAS scores, volumes, shadow billing and hours of coverage.

Manitoba

Salary: Physicians in Winnipeg Community Hospitals are compensated on salary. Physicians in the Winnipeg teaching hospitals (Health Sciences Centre and St. Boniface General Hospital) are compensated through a blend of fee-for-service and alternate funding. Emergency services provided outside of Winnipeg are compensated entirely through Alternate Funding. Physicians in mental health centres in Brandon and Selkirk are compensated on a salaried basis as are hospital-based pathologists in Winnipeg and Brandon. Some physicians (primariliy Family Practitioners) in remote areas receive salary through the medicare plan or the Northern Medical Unit.

Sessional: Sessional reimbursement is used in special circumstances, such as itinerant physicians who service rural areas and personal care homes, some psychiatry and specialist diagnostic services in hospital.

Blended Funding Arrangements: A combination of fee-for-service and alternate fundng used to remunerate the oncologists at Cancer Care Manitoba. Oncologists compensated under this arrangement are required to bill a minimum amount of fee-for-service in order to qualify for the alternate funding top-up.

Population-based Funding and Primary Care: Capitation is not used by Manitoba Health, but has not been ruled it out as an option.

Information Collection: Encoutner level data is collected by the medicare program for salaried GPs in rural and northern areas. Each paying agency is responsible for information from other modalities. Encounter level data is not available from these paying agencies.

Saskatchewan

Salary: A relatively small percentage of Saskatchewan physicians are compensated through salaried arrangements. District Health Boards provide options for salaried employment in some areas (emergency, mental health services, house officers), but the predominant arrangements are service contracts or sessional arrangements. The majority, but not all, physicians working in Saskatchewan's four Community Clinics work on a salaried basis. A Northern Medical Services agreement with the University of Saskatchewan provides salaried reimbursement for family physicians working in remote northern communities. The

Student Health Centre at the University of Saskatchewan also employs family physicians to provide services on campus. Block funding provided to the Saskatchewan Cancer Agency provides salaried reimbursement for physicians working in the cancer clinics.

Sessional: District Health Boards contract a number of physicians to provide services on a sessional basis, including (but not limited to) contract psychiatrists, some emergency physicians and geriatricians at the provincial geriatric assessment unit.

Service Contracts: The large majority of physicians compensated on a non-fee-for-service basis are compensated through service agreements. These include most physicians contracted by District Health Boards, including emergency physicians, pathologists and primary care physicians. Some physicians working at the College of Medicine do so on a service contract or clinical stipend basis.

District Health Board Administered Fee-for-service: Some districts contract physicians to provide clinical services on a district administered fee-for-service basis using a fee schedule that mirrors the Medical Services Branch Payment Schedule. This is the predominant model for hospital-based radiology.

Blended: Anaesthetists in Saskatoon for the most part are paid on a fee-for-service basis. However the provision of obstetrical anaesthesia is funded through an alternate payment service contract. Transplant nephrologists are paid on a fee-for-service basis but they receive an additional stipend for administration, donor search and family consultation associated with each renal implant. Most alternate payment contracts allow fee-for-service billing of services provided to out-of-province beneficiaries. At least one family practice alternate payment contract applies to a defined list of services only and all other services rendered are paid on a fee-for-service basis.

General Practice Rural Emergency and On Call Payments: A Weekend On Call Relief Program implemented in February 1997 and the Emergency Room Coverage Program implemented in December 1997 are administered through the Medical Services Branch using the claims processing system with fee codes defined as time-based items.

Specialist Emergency Coverage Program: Implemented July 2001, this program is jointly administered by District Health Boards, the Department and the Saskatchewan Medical Association. Specialists on prescribed call rotation receive a daily stipend for being available for new emergency (unassigned) patients.

Funding Source: From the Department of Health's perspective, most of the above compensation arrangements are funded through global (block), service agreement or population-based funding models. Two family physician group practices are funded directly by the Department through a population-based/hybrid capitation type model.

Information Collection: Submission of encounter level data is a requirement of all alternative payment contracts but compliance varies. Claims are typically submitted through a shadow billing process that uses provincial fee schedule codes. Encounter level data is submitted through this manner from the Community Clinics.

Encounter data are not available on services provided through the Clinical Services Fund, services provided by most hospital-based physicians (emergency, critical care associates, house officers, radiologists), by Northern Medical Services physicians, contract psychiatrists, salaried cancer clinic physicians and by pathologists.

Alberta

Salary/Contract: A variety of Alberta physicians are paid through salary/contractual arrangements administered through Regional Health Authorities.

Sessional: There are two sessional funding projects operating in Alberta, both of which are part of regional health authority programs dedicated to the treatment of chronic pain, and others in development.

Block Funding: No block funding payment plans have been implemented in Alberta as yet, however a model for future use is in development.

Population-based Funding and Primary Care: There are four capitation projects currently operating in Alberta. Three of them have geographically or "virtually" rostered populations, and one is an urban medical practice which requires its patients to enroll. Capitation payments are calculated on the basis of patient age, gender, and the set of services offered by the practice.

Contractual: The first contractual payment project, which is within a community health centre, is expected to become operational within the next few months. Participating physicians will receive a pre-set amount for a pre-determined volume of services over a year.

Information Collection: Alternative payment service information is currently being collected for two of the above modes of payment using the existing fee-for-service codes (but without service counts or dollar amounts). In addition, evaluation activities for all operational projects are ongoing. They include personal interviews and monitoring. A new information system is being developed to facilitate alternative payment data reporting.

British Columbia

British Columbia's alternative payments program is administered primarily through the Ministry of Health Services' Clinical Services Contracts (CSC) branch. The CSC branch allocates funds to the province's health authorities, which in turn contract with physicians to deliver programs of health care services. The CSC branch funds physicians' services, but does not pay physicians directly.

Salary: Few salaried payment arrangements remain within the CSC program. Those remaining are being phased-out or replaced with sessional or service agreements. A new Provincial Salary Agreement, between the provincial government and the British Columbia Medical Association (BCMA), outlines the terms and conditions of employment that apply to salary agreements established for the provision of government-funded medical services.

Sessions: Health authorities may apply to the CSC for funding for their payment of sessional physicians. The health authority determines the amount of time it will require of physicians to deliver a particular health program, where 3.5 hours equals one session of physician time and where a session may be broken into quarter-hour increments. The CSC branch commits a maximum number of sessions to the health authority, and the health authority submits a claim with supporting records of physician services to the CSC for release of funding equal to the number of sessions used. Sessional payment rates and conditions are defined in the Provincial Sessional Agreement between the provincial government and the BCMA. The agreement applies to all government-funded sessional physician arrangements.

Service contracts: Health authorities may apply to the CSC branch for funding dedicated to the delivery of a specific program of health care services. The health authority and CSC establish a service agreement between them, and the health authority uses its CSC allocation to contract with physicians to deliver services within its envelop of program-specific funding. Service deliverables and physician payments are defined within local physician contracts and must be aligned with the terms and conditions of the authority's funding agreement with the CSC and with the Provincial Services Agreement between the province and the BCMA.

Population-based Primary Health Care: A population-based, blended funding model for primary health care is administered through the Ministry of Health Planning's Strategic Initiatives program and its Primary Health Care Organization model (PHCO). The PHCO funds a core of services comprising those normally provided in family practices. Compensation for participating physicians is 'blended', being a combination of capitation-based and fee-for-service payments. A PHCO physician receives a capitation payment for the core services provided to patients registered with the PHCO practice, but also fee-for-service payments for core services provided to patients, who are not registered with the practice, or for non-core services regardless of registration. PHCO physicians receive approximately 90 percent of their income for payment of registered patients' core services and 10 percent from fee-for-service income.

Information Provision: The CSC branch is redesigning its business and payment systems to align with the reporting and data collection efficiencies of the Ministry's fee-for-service claims system. New program reporting and payment codes are being developed to allow electronic submission of encounter data and provide the health ministries and health authorities with the information they require to manage the health system. Reporting is a condition of funding, as well as an expectation of the accountability defined within health service plans and performance agreements between the health authorities and the ministries of health.

Appendix A

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Appendix B

Table B1: Full-time Equivalent Fee-for-service Physicians, Canada and the Provinces, 2000/2001

Nfld.	P.E.I	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	All Prov
661.71	161.90	1,060.47	902.52	10,561.38	19,058.26	1,484.98	1,314.27	4,117.70	5,715.57	45,039

Notes: Based on gross payments; Alternative payment physicians are excluded.

Source: Full-time Equivalent Physicians Report, Canada, 1999/2000 and 2000/2001, CIHI, 2002

Table B2: Average Payment per Full-time Equivalent Fee-for-service Physician, by Province, 2000/2001

	Nfld.	P.E.I	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.
FP/GPs	134,616	156,657	177,134	159,639	142,095	176,689	150,155	164,049	185,028	196,403
Medical Specialists	178,994	196,407	216,329	195,182	161,082	219,224	189,670	207,014	213,073	227,038

Notes: Based on gross payments; Alternative payment physicians are excluded.

Source: Average Payment Per Physician Report, Canada, 1999/2000 and 2000/2001, CIHI, 2002

Table B3: Updated Post-censal Net Population Estimates, Canada and the Provinces, 2000

Nfld.	P.E.I	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	All Prov
536,200	138,200	934,100	750,500	7,377,400	11,732,300	1,142,900	1,018,400	3,011,500	4,058,700	30,700,200

Notes: Canada totals are ten province totals, the Yukon and Northwest Territories are excluded.
Net population estimates are produced by excluding from total estimates the members of the Royal Canadian Mounted Police, the Canadian Armed Forces personnel and the number of inmates in Federal and Provincial institutions.
Figures are updated post-censal estimates, based on 1996 census counts, adjusted for net census undercoverage.
Figures have been rounded independently to the nearest hundred.

Source: Statistics Canada