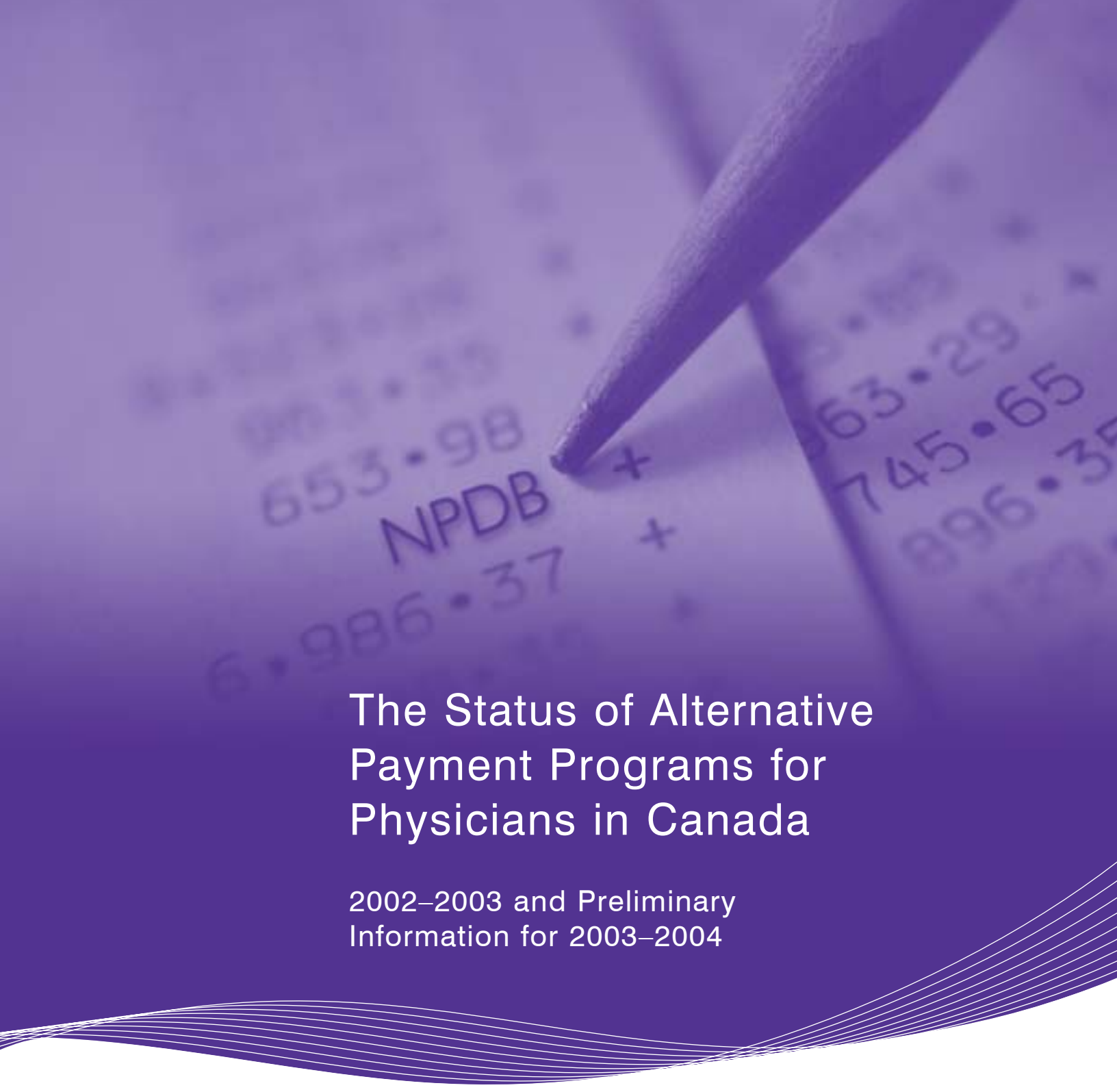

The Status of Alternative Payment Programs for Physicians in Canada

2002–2003 and Preliminary Information for 2003–2004

Alternative Payments and the National Physician Database

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

Canadian Institute for Health Information
377 Dalhousie Street
Suite 200
Ottawa, Ontario
K1N 9N8

Telephone: (613) 241-7860
Fax: (613) 241-8120
www.cihi.ca

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The Status of Alternative Payment Programs for Physicians in Canada, 2002–2003 and Preliminary Information for 2003–2004

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Foreword

This is the fourth report by CIHI on alternative payments to physicians in Canada. This year's report updates and, where possible, expands on information presented in previous years' reports.

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 to:

1. Document alternative physician payment plans (APP) and alternative funding plans (AFP) 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/territory about utilization and payments in APPs, and
5. Develop strategies and recommendations for incorporating alternative payments in NPDB.

Provincial and territorial ministries of health are the main sources of data for this report. CIHI worked closely with provincial/territorial Ministry of Health representatives on CIHI's Expert Group on Physician Databases (see Appendix A).

Data in this report reflect the status of alternative payment plans in fiscal year 2002–2003. Preliminary data are presented for payments during 2003–2004 for jurisdictions that have reported it as of March, 2005. Additional updates are planned for future years.

Revised Estimates

Fee-for-service payments used in this report are derived from the Canadian Institute for Health Information (CIHI) National Physician Database (NPDB). These totals consist of fee-for-service payments, selected for comparability across jurisdictions and for all physicians, except the technical specialties of radiology and laboratory. Fee-for-service payment information, published in predecessors[1] of the current report, has been updated in this report using NPDB payment information. The use of NPDB data, including the application of payment source selection criteria and exclusion of radiology and laboratory specialists, is intended to provide a more appropriate base for comparisons to alternative payments.

1. Alternative Payments and the National Physician Database (NPDB). The Status of Alternative Payment Programs, for Physicians in Canada, 1999/2000 (Ottawa: CIHI, 2001), and Alternative Payments and the National Physician Database (NPDB). The Status of Alternative Payment Programs, for Physicians in Canada, 2000/2001 (Ottawa: CIHI, 2002).

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. Data submission to the NPDB for radiology and pathology specialists is variable across jurisdictions. As such, NPDB data for these two specialties are not included in published reports.

Clinical fee-for-service refers to payment of claims submitted for individual services.

Alternative clinical refers to all payments made for *clinical services* provided by physicians and not reimbursed on a fee-for-service basis. Classifications vary across jurisdictions.

Salary: Physicians employed on a salary basis.

Sessional: Payments on an hourly or daily basis. Used by some jurisdictions 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 jurisdictions have programs that provide psychiatric services with funding based on salary, sessional or contract payments.

Northern and underserviced areas: Funding of provincial/territorial programs to provide services in northern or underserviced areas. These programs might include a number of alternative modes of payments. When funding for underserviced area programs was reported, 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, as well as other physicians employed by hospitals and paid through hospital budgets. This category also may include funding for clinical chiefs of staff, medical health officers, cancer and TB programs in some jurisdictions.

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

Shadow billing is an administrative process whereby physicians submit service provision information using provincial/territorial fee codes, however payment is not directly linked to the services reported. Shadow billing data can be used to maintain historical measures of service provision based on fee-for-service claims data.

Executive Summary

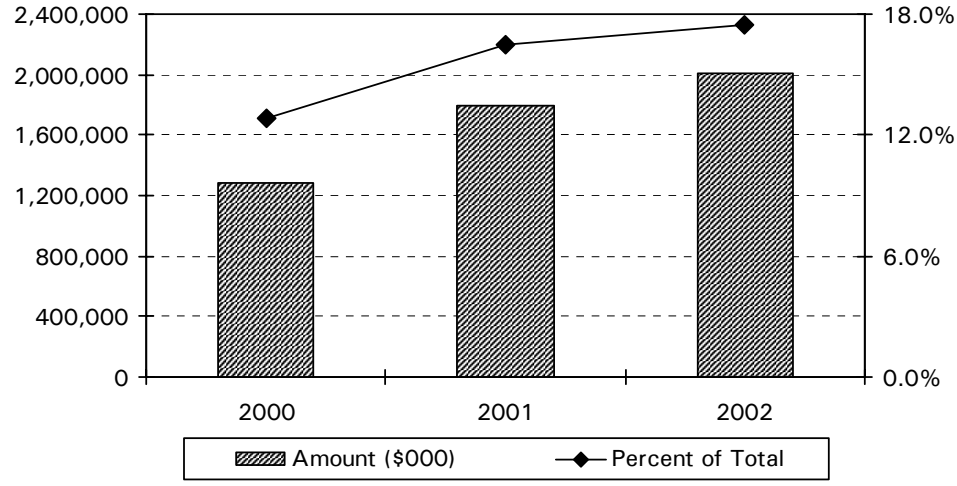
This report provides an update to information on alternative payments published in 2004.[2] Alternative payments increased by approximately 12% in 2002–2003, compared to 2001–2002. Alternative payments in 2002–2003 represented approximately $2.01 billion dollars—17.5% of the value of physicians' clinical payments in the provinces and Yukon. The percentage of alternative payments varied considerably across jurisdictions, ranging from lows of 8.0% and 8.7% in Yukon and Alberta to a high of 42.2% in Newfoundland and Labrador.

In 2002–2003, the percentage of physicians who received any alternative payments ranged from 5.1% in Alberta to 62.9% in Nova Scotia. Physician Full-Time Equivalents (FTEs) in alternative payment modes account for 11.7% of total FTEs. Nova Scotia has the highest percentage of alternative payment FTEs (29.1%).

2. Alternative Payments and the National Physician Database (NPDB). The Status of Alternative Payment Programs for Physicians in Canada, 2001–2002 and Preliminary Information for 2002–2003 (Ottawa: CIHI, 2004).

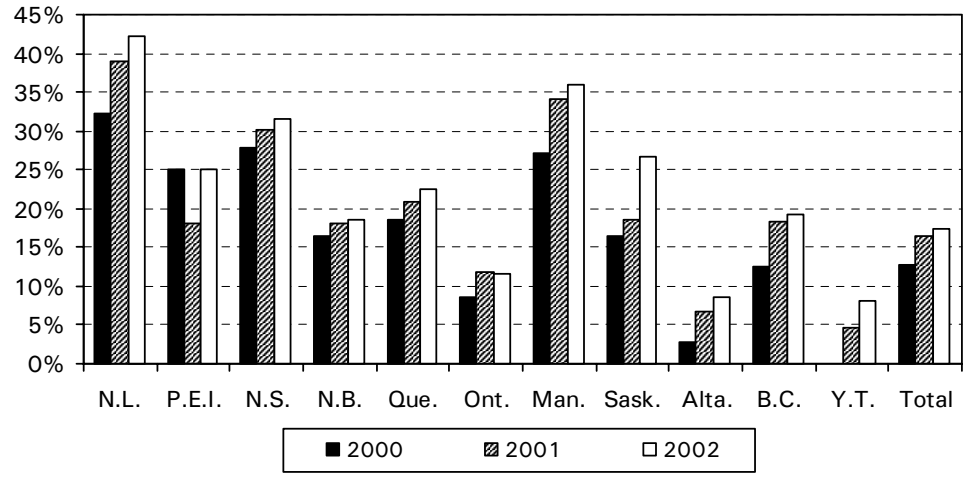
Alternative Payments in Canada

Alternative payments for clinical services reached $2.01 billion in 2002–2003 and represented 17.5% of total clinical payments (Figure 1). Alternative payments increased by 11.7% (from $1.80 billion in 2001–2002). Newfoundland and Labrador had the highest percentage of alternative payments, followed by Manitoba and Nova Scotia (Figure 2, Table 1).



Note: Results for 2000 are based on the 10 provinces. Subsequent years include the 10 provinces and the Yukon.
Sources: Provincial/Territorial Ministries of Health. CIHI National Health Expenditures Database for Ontario 2001 and Manitoba 2001 and 2002.

Figure 1. Physicians' Alternative Clinical Payments, 2000–2001 to 2002–2003



Note: Data for 2000 are based on the 10 provinces. Data for 2001 and 2002 include the 10 provinces and the Yukon.
Sources: Provincial/Territorial Ministries of Health. CIHI National Health Expenditures Database for Ontario 2001 and Manitoba 2001 and 2002.

Figure 2. Physicians' Alternative Clinical Payments as a Percentage of Total Clinical Payments, 2000–2001 to 2002–2003

Box 1—Notes About Clinical and Non-Clinical Payments

Alternative clinical payments in Table 1 include salary, sessional, capitation, contract services and block funding. (See Table 3 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 alternative clinical payments to enhance comparability.

A number of jurisdictions 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.

In this report payments related to rural incentives, hospital-based physicians and benefits are classified as **non-clinical alternative payments**.

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, pathology and medical officers. The category may also include relatively small amounts of funding for salaried FTE positions. In this respect, it might include some clinical care transferred from fee-for-service remuneration.

Benefits include contributions by provinces and territories 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 requested for the purposes of this publication, but it has been reported for provinces and territories that were able to provide the data.

Table 1 shows a three year comparison of fee-for-service and alternative payments. Preliminary data for 2003–2004 are also shown. Ontario did not submit alternative payment data for 2001–2002 and Manitoba did not submit alternative payment data for 2001–2002 and subsequent years. Estimates for these provinces and years were obtained from public accounts and provincial reports using CIHI's National Health Expenditures Database. These estimates were considered important in order to define national trends, but they are subject to review and possible change in future. The fee-for-service amounts in Table 1 have been revised for former years. As noted previously, they now show total fee-for-service payments for clinical services from the National Physician Database.[3]

Table 2 shows types of physician payment that are defined as non-clinical alternative payments for the purposes of this report. In some cases, these other categories may contain relatively small amounts for clinical services. It is important to note that the information in Table 2 reflects both payment arrangements and reporting arrangements in provinces. In some jurisdictions no data are reported for benefits, for example. The category titled, "Hospital-based physicians", represents payments to radiologists, pathologists and other physicians employed in hospitals. In some jurisdictions part or all of these payments are made through hospital budgets and are not reported as physician payments. The information is considered to be incomplete, but is included here for jurisdictions that identified these payments.

Table 3 provides details of different types of alternative clinical remuneration used in the provinces and territories. Provincial and territorial 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. Programs for emergency and on call reimbursement are notable examples. On call payments account for significant proportions of alternative payments in Nova Scotia, Saskatchewan, Alberta and British Columbia.

3. Saskatchewan data shown in Table 1 updates information published in earlier alternative payment reports. The update is due to a reclassification of approximately 55% of payments from a category known as Medical Remuneration that is paid to regional health authorities. Additional information from Saskatchewan this year made it possible to extract the amounts for clinical care as defined in this report.

Table 1. Summary of Physician Payments by Type of Payment and Province/Territory, Fiscal 2000–2001 to 2003–2004 ($'000)

2000–2001

	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Total
Fee-for-Service[1]	98,768	26,079	229,387	168,520	1,749,950	3,829,225	272,815	248,969	881,313	1,269,594	8,774,619
	67.7%	81.9%	72.1%	83.5%	81.5%	91.5%	72.9%	83.6%	97.2%	87.5%	87.2%
Alternative Clinical	47,201	5,761	88,855	33,314	398,162	355,674	101,320	48,894	25,214	181,122	1,288,442
	32.3%	18.1%	27.9%	16.5%	18.5%	8.5%	27.1%	16.4%	2.8%	12.5%	12.8%
Sub-Total Clinical	145,968	31,840	318,243	201,834	2,148,112	4,184,900	374,135	297,863	906,527	1,450,716	10,063,062

2001–2002

	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	Total
Fee-for-Service	96,776	26,711	230,082	185,818	1,838,989	3,911,314	289,705	266,775	975,426	1,303,825	7,687	9,133,109
	61.1%	81.9%	69.8%	82.0%	79.2%	88.1%	65.8%	81.6%	93.2%	81.6%	95.3%	83.6%
Alternative Clinical	62,526	5,901	99,514	40,813	482,322	530,484	150,523	60,320	70,871	294,132	379	1,797,784
	38.9%	18.1%	30.2%	18.0%	20.8%	11.9%	34.2%	18.4%	6.8%	18.4%	4.7%	16.4%
Sub-Total Clinical	159,302	32,612	329,595	226,631	2,321,311	4,441,798	440,228	327,096	1,046,297	1,597,957	8,066	10,930,893

2002–2003

	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	Total
Fee-for-Service	97,128	26,892	246,080	205,993	1,826,785	3,936,651	299,510	274,459	1,117,028	1,449,169	8,807	9,488,501
	57.8%	75.0%	68.4%	81.5%	77.5%	*88.4%*	64.1%	73.3%	91.3%	80.7%	92.0%	82.5%
Alternative Clinical	70,788	8,957	113,798	46,816	531,291	516,399	167,687	99,839	105,996	345,881	771	2,008,223
	42.2%	25.0%	31.6%	18.5%	22.5%	11.1%	35.9%	26.7%	8.7%	19.3%	8.0%	17.5%
Sub-Total Clinical	167,916	35,849	359,878	252,809	2,358,076	4,453,050	467,196	374,298	1,223,025	1,795,050	9,578	11,496,724

Please see footnotes at end of table.

Table 1. Summary of Physician Payments by Type of Payment and Province/Territory, Fiscal 2000–2001 to 2003–2004 ($'000) (cont'd)

2003–2004 (preliminary estimates)[2]												
	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.[3]	Sask.	Alta.	B.C.	Y.T.	Total
Alternative Clinical	79,647	11,691	144,172	61,660	611,504	775,549		107,839	115,127	362,891	1,228	2,271,308

1. Fee-for-service payments for 2000–2001 presented in this report update fee-for-service payment information presented in previous Alternative Payments and the National Physician Database reports.
2. Preliminary fee-for-service payment estimates based on the NPDB are not available for 2003–2004 at the time of writing.
3. 2003–2004 alternative clinical payment estimates are not available for Manitoba at the time of writing.

Sources : Fee-for-service NPDB payments are based on data submitted to the National Physician Database, CIHI; Alternative clinical payment information is gathered through provincial and territorial Ministries of Health, with the exception of Ontario for 2001–2002 and of Manitoba for 2001–2002 and 2002–2003 data. CIHI's National Health Expenditures Database is used to derive alternative payment estimates when data is not available from provincial and territorial sources for this report. In these cases, the data are estimates and subject to change.

Table 2. Summary of Non-Clinical Physician Payments by Type of Payment and Province/Territory, Fiscal 2002–2003 ($'000)

	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	Total
Rural Incentives		521					4,303		996	5,239		11,058
Hospital-Based Physicians		3,321	34,060	36,570		832,229		35,063				941,243
Benefits	1,346	1,004	8,073	5,121				15,356	22,170	65,234		118,304
Sub-Total Non-Clinical	1,346	4,846	42,133	41,691		832,229	4,303	50,419	23,166	70,473		1,070,606

Notes: Missing values indicate either no payments or insufficient detail to break down payments to certain categories.
Ontario payments for hospital-based physicians are from hospital budget data prepared according to the MIS Guidelines and include benefits.

Sources: Provincial/Territorial Ministries of Health. CIHI's National Health Expenditures Database was used as a secondary source of information when data was not available from provincial or territorial sources for the purposes of this report. In these cases, the data are estimates and subject to change.

Table 3. Estimated Alternative Clinical Payments by Type of Payment and Province/Territory, Fiscal 2002–2003 ($'000)

	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	Total
Salary	60,848	6,664	12,825	19,614	72,641	22,365			21,166	12,853		223,935
Sessional	1,788		1,303	24,171	201,617	650			1,706	54,739		285,975
Capitation									4,537			4,537
Block Funding	8,152		53,365			181,985		4,875				248,376
Psychiatry			16,371			955						17,326
Blended		2,293			257,032	9,748				6,576		275,649
Northern and Underserviced Areas				3,031		59,718		2,960		36,374		102,083
Emergency and On Call			29,933			157,260		20,147	62,463	127,011		396,815
Contracted/Unspecified						83,718	167,687	71,858	21,166	108,328	771	453,528
Total	70,788	8,957	113,798	46,816	531,291	516,399	167,687	99,839	105,996	345,881	771	2,008,223

Notes: 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 and Unspecified includes:

- Service Agreements in British Columbia.
- 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: Provincial/Territorial Ministries of Health. CIHI's National Health Expenditures Database was used as a secondary source of information when data was not available from provincial or territorial sources for the purposes of this report. In these cases, the data are estimates and subject to change.

Physicians in Alternative Payment Plans

The proportion of physicians who receive some remuneration for insured services in the form of alternative payments varies across jurisdictions. In 2002–2003 the percentages ranged from 5.1% in Alberta to over 50% in Quebec, New Brunswick and Nova Scotia (Table 4). Many physicians who received one form of alternative payment also received fee-for-service payments and/or other types of alternative payment.

Some jurisdictions provided the number of physicians who receive *at least 50%* of all clinical income from provincial sources through alternative funding.[4] Nova Scotia, New Brunswick and British Columbia reported that over 10% of physicians receive mainly alternative payments.

Table 4. Total Physicians and Physicians Who Received Alternative Payments, by Province and Territory, Fiscal 2002–2003

	Total number of 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
N.L.	983	443	45.1%	18	1.8%
P.E.I.	182				
N.S.	2,030	1,277	62.9%	330	16.3%
N.B.	1,406	723	51.4%	328	23.3%
Que.	15,016	7,889	52.5%		
Ont.	22,032	4,052	18.4%	2,001	9.1%
Man.	2,063				
Sask.	1,629	342	21.0%		
Alta.	5,318	269	5.1%		
B.C.	8,368	2,319	27.7%	870	10.4%
Y.T.	60	*	*	*	*

Notes: The number of physicians reported usually reflects the total number of physicians registered with provincial/territorial medicare plans and may exceed the number actually paid.

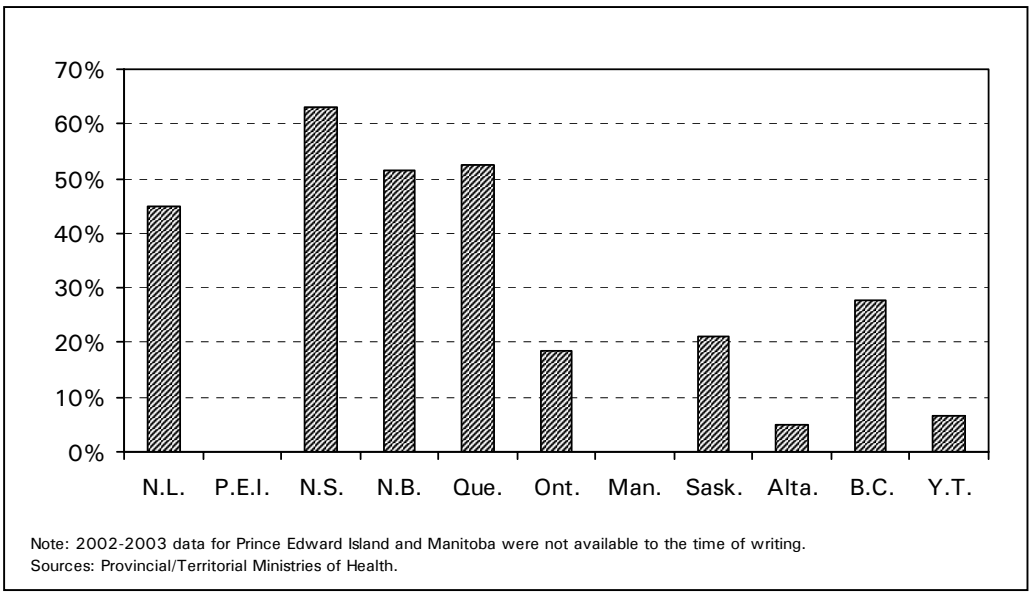
The number of physicians paid through alternative modes may double count physicians in some jurisdictions who participate in more than one form of alternative payment.

2002–2003 data for Prince Edward Island and Manitoba were not available at the time of writing.

* Value suppressed in accordance with CIHI privacy policy.

Sources: Provincial/Territorial Ministries of Health.

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



Note: 2002-2003 data for Prince Edward Island and Manitoba were not available to the time of writing.
Sources: Provincial/Territorial Ministries of Health.

Figure 3. Percent of Clinical Physicians Who Received Payments Through Alternative Modes, by Province/Territory, 2002–2003

Estimated Full-Time Equivalents

Overall, physician activities in alternative payment modes represent an estimated 5,872 FTEs (Table 5). Alternative payment FTEs are equivalent to 11.7% of total FTEs in Canada. Alternative payment FTEs range from 4.5% of total FTEs in Alberta to 29.1% in Nova Scotia.

Table 5. Estimated FTEs in Alternative Payment[1], by Province, Fiscal 2002–2003

	Estimated Full-Time Equivalent Physicians			Distribution	
	FFS	APP	Total	FFS	APP
N.L.	585	213	798	73.3%	26.7%
P.E.I.	162	27	189	85.7%	14.3%
N.S.	1,043	427	1,470	70.9%	29.1%
N.B.	852	97	949	89.8%	10.2%
Que.	10,607	2,299	12,906	82.2%	17.8%
Ont.	18,416	1,302	19,717	93.4%	6.6%
Man.	1,454	407	1,861	78.1%	21.9%
Sask.	1,293	235	1,528	84.6%	15.4%
Alta.	4,103	195	4,298	95.5%	4.5%
B.C.	5,620	671	6,290	89.3%	10.7%
Total	44,134	5,872	50,006	88.3%	11.7%

Note: Fee-for-service is abbreviated as "FFS"; Alternative physician payment programs is abbreviated as "APP".

1. As described in Box 2, FTE estimates use CIHI's "Full-Time Equivalent Physicians Report, Canada, 2002–2003" and "Average Payment Per Physician Report, Canada, 2002–2003". 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.

When FTEs from fee-for-service and alternative payment modes are considered, the distribution of physicians per 100,000 population may cluster more closely around the national average than when only fee-for-service physicians are included (Table 6). In 2002–2003, the number of alternative payment FTEs ranged from 6 per 100,000 population in Alberta to 46 per 100,000 population in Nova Scotia.

Table 6. Estimated FTE Physicians Per 100,000 Population[1], by Type of Payment and Province, Fiscal 2002–2003

	Estimated FTEs Per 100,000 Population	
	FFS	**APP**
N.L.	113	41
P.E.I.	118	20
N.S.	113	46
N.B.	114	13
Que.	143	31
Ont.	152	11
Man.	126	35
Sask.	130	24
Alta.	132	6
B.C.	137	16
Total	141	19

Note: Fee-for-service is abbreviated as "FFS"; Alternative physician payment programs is abbreviated as "APP".

1. Estimates of FTE physicians per 100,000 population were derived using Statistics Canada's Net Population Estimates for Canada, by Provinces, 2002 (see Appendix B, Table B3).

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 estimates 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. The denominators for this calculation were taken from CIHI's *Average Payment Per Physician Report, Canada, 2002–2003* (see Appendix B, Table B2). This method was used in Nova Scotia for institutional psychiatry, and for Quebec physicians who receive remuneration from blended payments.
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 fee-for-service (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, 2002–2003* (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. However, the aggregate estimates provide useful information on the possible overall supply of physicians using FTE estimates that include both FFS and APP physicians.

Administrative Information About Alternative Payment

Provinces/territories have not followed consistent approaches to reporting services provided under alternative payment programs. Shadow billing (using the entire set of codes in physician services 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. 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 jurisdiction 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 jurisdictions each administrative unit is responsible for setting its own information requirements.

Alternative Reimbursement in Each Jurisdiction

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 and Labrador 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 shift. 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 pediatric 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 physicians 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, pediatrics, physical medicine, oncology, radiation oncology, laboratory, psychiatry, anaesthesia, otolaryngology and obstetrics/gynecology. Also Prince Edward Island has salaried physicians in the area of family medicine that work primarily in collaborative family health centres.

Sessional ER: Sessional reimbursement is used in emergency medicine in urban (on-site) and rural facilities (on-call).

Blended Funding: Blended funding provides for physicians opting for remuneration based on a "all inclusive" hourly rate modality in lieu of salaried modality that would offer other entitlements such as pension, long term disability coverage, paid leave for vacations, continuing medical education, sick days and the like. Blended funding also includes the on-call stipends paid to specialists on-call at Prince Edward Island's two largest facilities and per bed stipends paid to House Physicians serving long-term care facilities.

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

Information Collection: Shadow billing is used with most salaried and sessional physicians.

Updated March, 2005.

Nova Scotia

Salary: The number of physicians on salary/alternative payment plans continues to increase. There are several contract options available at the present time and the Department of Health is receptive to other proposals that enhance patient care within the province. Currently there are regional specialist contracts for anaesthesiology, geriatrics, neonatology, pediatrics, obstetrics/gynecology, palliative care and psychiatry. There are salary arrangements available to general practitioners in certain rural areas and General Practitioner/Nurse Practitioner contract that support collaborative practice teams in designated areas.

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. The Emergency funding is based on the Murray Formula (for Levels 1 and 2) and data is submitted annually. Additionally, there is designated money available for specialist on call services and family physician on call services.

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. Sessional arrangements are made for the provision of care in jails, detox, youth facilities and some health centres.

Block Funding: The block funding arrangements are associated with academic centres. The Department of Pediatrics at Dalhousie University has been block funding since July, 1994. Additional contracts within the IWK Health Sciences Centre include diagnostic imaging and surgery. The entire Department of Medicine became block funded in January 1999. A number of other arrangements also exist within the Capital District Health Authority (neurosurgery, family medicine, otolaryngology, radiation oncology, pathology, gyne-oncology).

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 other salaried/contract positions. Current initiatives within the Department of Health are focused on developing frameworks for deliverables (beginning with the GP contracts and the Department of Medicine contract).

Updated March, 2005.

New Brunswick

Salary/Contract: Some general physicians and specialists doing clinical work in New Brunswick are remunerated through a salary based on the Medical Pay Plan (MPP) and some clauses under Parts I and III of the Public Service.

The MPP has four levels: general physician, uncertified specialists, specialists and department head. In some instances certain GPs and specialists can only be paid through a salary. For example, Community Health Centre physicians can only be remunerated through salary. Similarly physicians working with a restricted licence, which does not permit a fee-for-service practice, are salaried.

Salaried physicians can be found in specialties such as: anaesthesia, geriatrics, infectious diseases, internal medicine, rheumatology, neonatology, pediatrics, physical medicine, psychiatry, radiation and medical oncology, general surgery and general practice.

Sessional: Emergency departments in the provinces' eight regional hospital facilities use sessional compensation on a 24/7 basis. Non-regional hospital facilities operate their emergency departments using a variety of payment options including fee-for-service, availability stipends, a sessional rate or a combination of the three.

Sessional funding arrangements are also created to remunerate physicians for services provided in nursing homes, jails, detox centres, mental health centres, pediatric clinics, and reproductive health clinics.

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

Contracts/Alternate payments: Some physicians have an all inclusive contract with remuneration which is outside the scales of the Medical Pay Plan. It can include the possibility to do some fee-for-service.

Guaranteed Income: A few physicians have a guaranteed yearly income based on fee-for-service earnings. The physicians bill fee-for-service and the department pays them the balance if they haven't reached their guaranteed income.

Information Collection: Information is collected through shadow billing for some 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.

Updated March, 2005.

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 2,700 specialists received alternative remuneration through this program in fiscal 2001–2002. 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 Régie d'assurance maladie du Québec. 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, pediatric 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 Alternative Funding Agreements report on Canadian Triage Acuity Scale 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 (primarily 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 funding 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: Encounter 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: In a Contractual model funding is based on a pre-negotiated amount, for a pre-determined volume of services over a specified period of time. There were four contractual funding projects in Alberta in 2003–2004.

Contractual Academic Funding Plans (AFP): An AFP provides a means of amalgamating and integrating the various sources of funding that are used to compensate physicians within an academic department for the variety of services that they provide. These services may include teaching, research, clinical services and administration. There were three academic funding plans in Alberta in 2003–2003 .

Sessional: Under the sessional model the physician is paid a predetermined rate (usually an hourly amount) for work during a set period of time for the provision of defined insured medical services within an organized program. There were nine sessional projects in Alberta in 2003–2004.

Block Funding: Block funding resembles contractual funding, but differs in scope and scale. In block funding, all physicians in a given geographic area (e.g. regional, provincial) and within a single recognized discipline agree to provide all their medical services for a major period of time at one or more specified sites in exchange for a negotiated amount. There was one block funding project in Alberta in 2003–2004.

Population-Based Funding and Primary Care: The Capitation model is used for the provision of family medicine or primary care. A medical practice is paid a predetermined annual amount for each of its patients. The funding allotment covers a basket of insured medical services. There were two capitation projects in Alberta in 2003–2004.

Information Collection: Alternative payment service information is currently being collected using the existing fee-for-service codes (but without service counts or dollar amounts).

Updated March, 2005.

British Columbia

British Columbia's Alternative Payments Program (APP) is administered through the Ministry of Health Services' Medical and Pharmaceutical Services Division. The APP allocates funds to the province's health authorities, which in turn contract with physicians to deliver programs of health care services. The APP funds physicians' services, but does not pay physicians directly.

Service contracts: The health authorities may apply to the APP for funding dedicated to the delivery of a specific program of health care services. The health authority and APP establish a funding contract between them, and the health authority subsequently contracts with or employs physicians to deliver services within an APP envelope of program-specific funding. Service deliverables and physician payments are defined within local-level physician contracts, which must be aligned with the terms and conditions of the health authority's funding agreement with the APP and with the 2002 *Provincial Service* and *Provincial Salary Agreements* between government and the British Columbia Medical Association (BCMA).

Sessions: Health authorities may apply to the APP for funding to pay 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 APP 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 APP for release of funding equal to the number of sessions used. Sessional payment rates and conditions are defined in the 2002 *Provincial Sessional Agreement* between government and the BCMA. The agreement applies to all government-funded sessional physician arrangements.

Population-based Primary Health Care: A population-based, blended funding model for primary health care is administered through the Chronic Disease Management and Primary Health Care program of the Ministry of Health. Contracts for services are negotiated between the Ministry and regional health authorities for delivery of a fixed basket of "core" services to a defined population. Health authorities then provide the service directly or contract with private practices for delivery of the care. Compensation of individual physicians is determined entirely within the health authority and/or private practice. Funding for the services is "blended", being a combination of population-based funding for core services to the defined population plus fee-for-service for all other services. The

population-based component of service funding uses a risk adjusted capitation model which recognizes the impact of comorbidity upon the utilization of resources. Funding and payment under the model are directly linked to timely and accurate submission of encounter and claims data so that compliance with reporting requirements under the model is high.

Information Provision: The information compiled within the APP payment system is not easily reported along side the Ministry's fee-for-service data. The APP is planning to redesign its systems to improve reporting to and from the health authorities, capture patient encounter information, and overall support the data collection necessary for health service planning and program evaluation.

Reporting is a condition of APP's funding of the health authorities and is required to meet expectations for accountability and the service delivery defined within the Ministries' health service plans and performance agreements.

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Yukon

Yukon has the majority of its physicians billing fee-for-service. Also billing fee-for-service are a number of visiting specialists (Yukon does not have the population that warrants a host of specialty practitioners) and a number of locum physicians who are in and out of Yukon in a matter of weeks (but who still bill fee-for-service). There are a limited number of physicians (visiting) who are paid a "sessional", but these numbers are too small to report (less than 5). There are a "few" who are on contract and shadow bill the plan.

Appendix A

Expert Group on Physician Databases
Ministry of Health Representatives

Newfoundland and Labrador

Barry Stanley
Manager, Finance and Statistics
Newfoundland and Labrador
Department of Health and Community Services
Confederation Building
West Block, 1st Floor
P.O. Box 8700
St. John's, N.L.
A1B 4J6

Prince Edward Island

Johanne Irwin
Physician Services Manager
Prince Edward Island Health and Social Services
16 Garfield Street
P.O. Box 2000
Charlottetown, P.E.I.
C1A 7N8

Nova Scotia

Mike Joyce
Economist
Nova Scotia Department of Health
Joseph Howe Building
1690 Hollis Street, 12th Floor
P.O. Box 488
Halifax, N.S.
B3J 2R8

New Brunswick

James Ayles
Health Information Consultant
New Brunswick Health and Wellness
520 King Street
P.O. Box 5100, 2nd Floor
Carleton Place - Medicare/PDP
Fredericton, N.B.
E3B 5G8

Ontario

Julian Young
Manager,
Information and Project Management
Ontario Ministry of Health and Long-Term Care
49 Place d'Armes
2nd Floor
P.O. Box 48
Kingston, Ont.
K7L 5J3

Quebec

Philippe Joncas
Direction Générale du personnel réseau
Ministère de la Santé et des Services sociaux
1005 chemin Ste-Foy
3ième étage
Québec, Que.
G1S 4N4

Expert Group on Physician Databases
Ministry of Health Representatives

Manitoba

Sean Brygidyr
Health Labour Relations Officer
Manitoba Health
300 Carlton Street
Room 1024
Winnipeg, Man.
R3B 3M9

Saskatchewan

Carmelle Mondor
Program Manager,
Data and Statistical Services
Saskatchewan Health
T.C. Douglas Building
3475 Albert Street
Regina, Sask.
S4S 6X6

Alberta

David Onyschuk
Consultant
Alberta Health and Wellness
Telus Plaza North Tower
10025 Jasper Avenue
17th Floor
Edmonton, Alta.
T5J 2N3

British Columbia

Mei Wong
Manager,
Information Resource Management
Knowledge Management and
Technology Division
Ministry of Health Services
7–1, 1515 Blanshard St.
Victoria, B.C.
V8W 3C8

Yukon

Gregor Gabb
Health Information Specialist
Yukon Department of Health and
Social Services
2071—2nd Avenue
P.O. Box 2703
Whitehorse, Y.T.
Y1A 2C6

Appendix B

Table B1. Full-Time Equivalent Fee-for-Service Physicians, by Province, 2002–2003

N.L.	P.E.I	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Total
585.18	161.77	1,042.75	851.82	10,607.24	18,415.79	1,453.61	1,292.81	4,103.14	5,619.72	44,133.83

Source: *Full-Time Equivalent Physicians Report, Canada, 2002–2003*, CIHI 2004.

Table B2. Average Payment Per Full-Time Equivalent Fee-for-Service Physicians, by Province, 2002–2003

	N.L.	P.E.I	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.
FP/GPs	155,174	150,779	191,164	207,506	153,739	183,448	177,212	181,845	238,182	227,245
Medical Specialists	209,072	221,111	237,740	240,864	163,592	225,357	194,650	226,864	269,569	259,833
All Physicians	190,026	187,287	235,923	244,618	171,033	217,945	206,536	214,636	272,381	260,918

Source: *Average Payment Per Physician Report, Canada, 2002–2003,* CIHI, 2004.

Table B3. Updated Post-Censal Net Population Estimates, Canada and the Provinces/Territories, 2002–2003 ('000s)

N.L.	P.E.I	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	Total
518.6	137.1	925.7	745.0	7,443.1	12,117.9	1,152.9	992.3	3,114.4	4,111.1		31,258.2

Notes: 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/territorial 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.