

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

Preliminary Information for 2004–2005

Alternative Payments and the
National Physician Database (NPDB)



Canadian Institute
for Health Information

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**The Status of Alternative Payment Programs for Physicians in Canada,
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Foreword

This is the fifth annual report by CIHI on alternative payments to physicians in Canada. This year's report updates and, where possible, expands on information presented in past 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.

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

Data Sources

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. 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.

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

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 CIHI's National Health Expenditures database, and are based on provincial public accounts and annual reports.

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 underserved 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

Alternative payments increased by approximately 22.4% in 2003–2004 compared to 2002–2003. Alternative payments in 2003–2004 were approximately 2.38 billion dollars—19.5% of the value of physicians’ clinical payments. The percentage of alternative payments varied considerably across jurisdictions, ranging from 9.7% in Alberta to 41.8% in Newfoundland and Labrador.

In 2003–2004, the percentage of physicians who received any alternative payments ranged from 6.6% in Alberta to approximately 73% in Prince Edward Island and Nova Scotia. Physician Full-Time Equivalents (FTEs) in alternative payment modes account for 11.5% of total FTEs. Newfoundland and Labrador and Nova Scotia have the highest percentage of alternative payment FTEs (26.4% and 25.7% respectively).

Alternative Payments in Canada

Alternative payments for clinical services reached \$2.38 billion in 2003–2004 and represented 19.5% of total clinical payments (Figure 1). Alternative payments increased by 22.4% in 2003–2004 (from \$1.95 billion in 2002–2003). Newfoundland and Labrador had the highest percentage of alternative payments, followed by Nova Scotia and Manitoba (Figure 2).

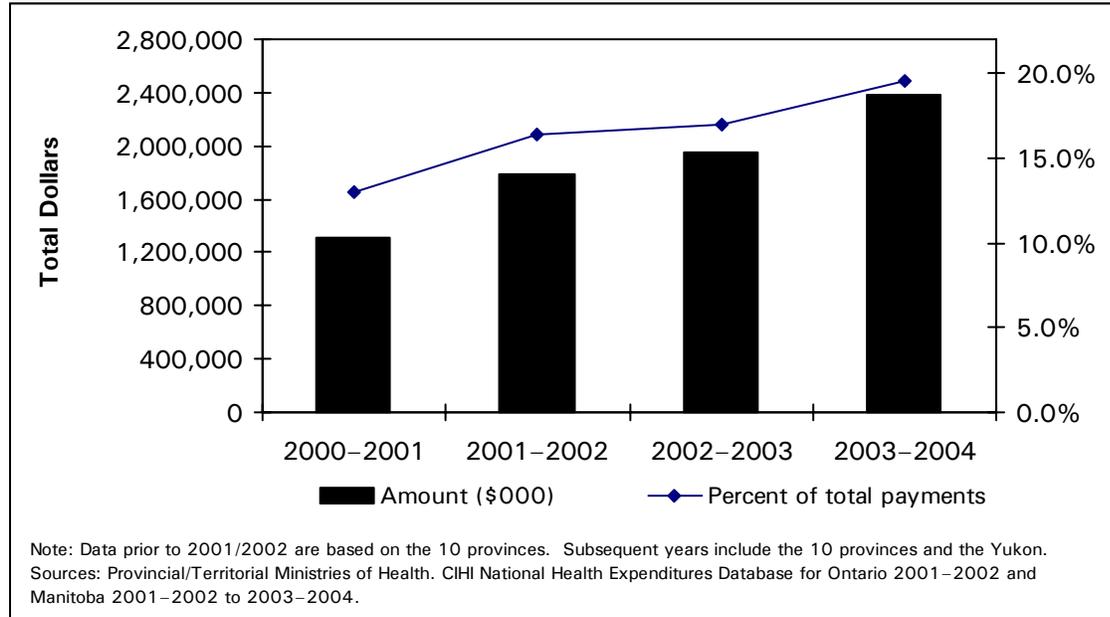


Figure 1. Physicians' Alternative Clinical Payments, 2000-2001 to 2003–2004

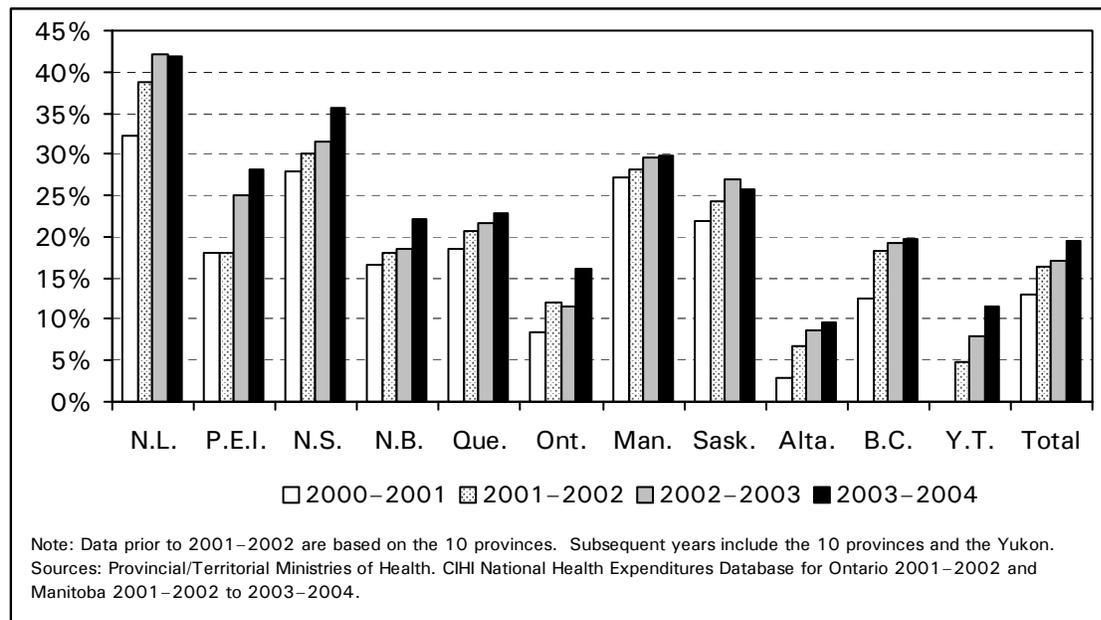


Figure 2. Physicians' Alternative Clinical Payments as a Percentage of Total Clinical Payments, 2000–2001 to 2003–2004

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 underserved area programs and most emergency or on call payments are also included with alternative clinical payments to enhance comparability. 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 underserved areas, such as relocation allowances and locum programs.

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 some provinces, this category also includes disability insurance and provincial contributions to physicians' retirement funds or maternity benefits.

Table 1 shows a four-year comparison of fee-for-service and alternative payments by jurisdiction. Preliminary data for 2004–2005 are also shown, meaning that for the 2004–2005 fiscal year, fee-for-service payments are not yet available and thus only the alternative payment components are presented. Alternative payments have been increasing as a percentage of total clinical payments in all jurisdictions.

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” primarily represents payments to radiologists and pathologists. 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 six of the seven provinces that report them.

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	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%	78.0%	97.2%	87.5%	87.0%	
Alternative Clinical	47,201	5,761	88,855	33,314	398,162	355,674	101,320	70,233	25,214	181,122	1,306,856	
	32.3%	18.1%	27.9%	16.5%	18.5%	8.5%	27.1%	22.0%	2.8%	12.5%	13.0%	
Sub-Total Clinical	145,968	31,840	318,243	201,834	2,148,112	4,184,900	374,135	319,202	906,527	1,450,716	10,081,475	
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%	72.0%	75.8%	93.2%	81.6%	95.3%	83.7%
Alternative Clinical	62,526	5,901	99,514	40,813	482,322	530,484	112,892	85,153	70,871	294,132	379	1,784,986
	38.9%	18.1%	30.2%	18.0%	20.8%	11.9%	28.0%	24.2%	6.8%	18.4%	4.7%	16.3%
Sub-Total Clinical	159,302	32,612	329,595	226,631	2,321,311	4,441,798	402,597	351,928	1,046,297	1,597,957	8,066	10,918,095
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%	78.2%	88.4%	70.5%	72.9%	91.3%	80.7%	92.0%	83.0%
Alternative Clinical	70,788	8,957	113,798	46,816	508,511	516,399	125,252	101,841	105,996	345,881	771	1,945,011
	42.2%	25.0%	31.6%	18.5%	21.8%	11.6%	29.5%	27.1%	8.7%	19.3%	8.0%	17.0%
Sub-Total Clinical	167,916	35,849	359,878	252,809	2,335,296	4,453,050	424,762	376,300	1,223,025	1,795,050	9,578	11,433,512

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												
	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	Total
Fee-for-Service	117,055	29,865	259,708	217,901	1,964,955	4,040,282	314,935	288,132	1,080,032	1,481,961	9,427	9,804,253
	58.2%	71.9%	64.3%	77.9%	77.1%	83.8%	70.1%	74.2%	90.3%	80.3%	88.5%	80.5%
Alternative Clinical	83,933	11,691	144,194	61,660	584,714	780,111	134,250	100,415	115,416	362,891	1,228	2,380,503
	41.8%	28.1%	35.7%	22.1%	22.9%	16.2%	29.9%	25.8%	9.7%	19.7%	11.5%	19.5%
Sub-Total Clinical	200,988	41,556	403,902	279,561	2,549,669	4,820,393	449,185	388,548	1,195,448	1,844,852	10,655	12,184,756

2004–2005 (preliminary estimates) ¹												
	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man. ³	Sask.	Alta.	B.C.	Y.T.	Total
Alternative Clinical	90,109	13,239	177,602	70,136	621,470	864,973	135,213	114,498	139,164	375,008	1,959	2,603,371

Notes

Yukon data was not collected in 2000–2001.

¹ Preliminary fee-for-service payment estimates based on the NPDB are not available for 2004–2005 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 Manitoba for 2001–2002 and subsequent years. CIHI's National Health Expenditures Database was used as a source of estimates in those instances.

Table 2. Summary of Non-Clinical Physician Payments by Type of Payment and Province/Territory, Fiscal 2003–2004 (\$'000)

	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	Total
Rural Incentives		487			18,900		10,421			6,829		36,637
Hospital-Based Physicians		3,897	26,776	39,690		907,143	41,751	45,357			136	1,064,749
Benefits	1,354	942	8,073	7,121	14,229			16,344	23,175	57,949	416	129,603
Sub-Total Non-Clinical	1,354	5,326	34,849	46,811	33,129	907,143	52,172	61,701	23,175	64,778	552	1,230,990

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

Table 3. Estimated Alternative Clinical Payments by Type of Payment and Province/Territory, Fiscal 2003–2004 (\$'000)

	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	Total
Salary	69,164	8,857	16,500	31,843	75,089	26,927				12,860		241,240
Sessional	1,904		1,461	26,701	214,653	650			3,110	54,542		303,021
Capitation									3,812			3,812
Block Funding	9,519		79,707			375,858		4,976	7,171			477,231
Psychiatry			11,220			975						12,195
Blended		2,834			294,971	17,201				6,822		321,828
Northern and Underserved Areas						60,097		3,133		46,251		109,481
Emergency and On Call	3,346		35,306			182,268		20,376	64,569	127,190		433,055
Contracted/Unspecified				3,116		116,135	134,250	71,930	36,754	115,226	1,228	478,639
Total	83,933	11,691	144,194	61,660	584,714	780,111	134,250	100,415	115,416	362,891	1,228	2,380,503

Notes: Blended payments in Quebec consist of daily payments under a special program that combines daily payments and fee-for-service.

Contract and Unspecified includes:

- i. Service Agreements in British Columbia.
- ii. Payments that were not broken down by program.

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

Sources: Provincial/Territorial Ministries of Health. CIHI's National Health Expenditures Database was used as a source for Manitoba estimates.

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 2003–2004 the percentages ranged from 6.6% of physicians in Alberta to approximately 73% of physicians in Prince Edward Island 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,¹ as indicated in the last two columns of Table 4 below. Percentages ranged from 9.4% in the Yukon to 44.4% in Prince Edward Island.

Table 4. Total Physicians and Physicians Who Received Alternative Payments, by Province and Territory, Fiscal 2003–2004

	Total number of physicians	Number of physicians paid through alternative modes	Percent of total physicians paid through alternative modes	Number of physicians who receive at least 50% of all clinical income through alternative modes	Percent of total physicians who receive at least 50% of all clinical income through alternative modes
N.L.	1,013	451	44.5%	NA	NA
P.E.I.	180	132	73.3%	80	44.4%
N.S.	2,116	1,535	72.5%	482	22.8%
N.B.	1,496	770	51.5%	407	27.2%
Que.	15,267	8,258	54.1%	NA	NA
Ont.	21,402	4,188	19.6%	2,444	11.4%
Man.	NA	NA	NA	NA	NA
Sask.	1,654	359	21.7%	NA	NA
Alta.	5,481	364	6.6%	NA	NA
B.C.	8,545	2,409	28.2%	873	10.2%
Y.T.	64	6	9.4%	6	9.4%

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.

Data was not provided by Manitoba in 2003–2004.

NA = Not available

Source: Provincial/Territorial Ministries of Health.

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

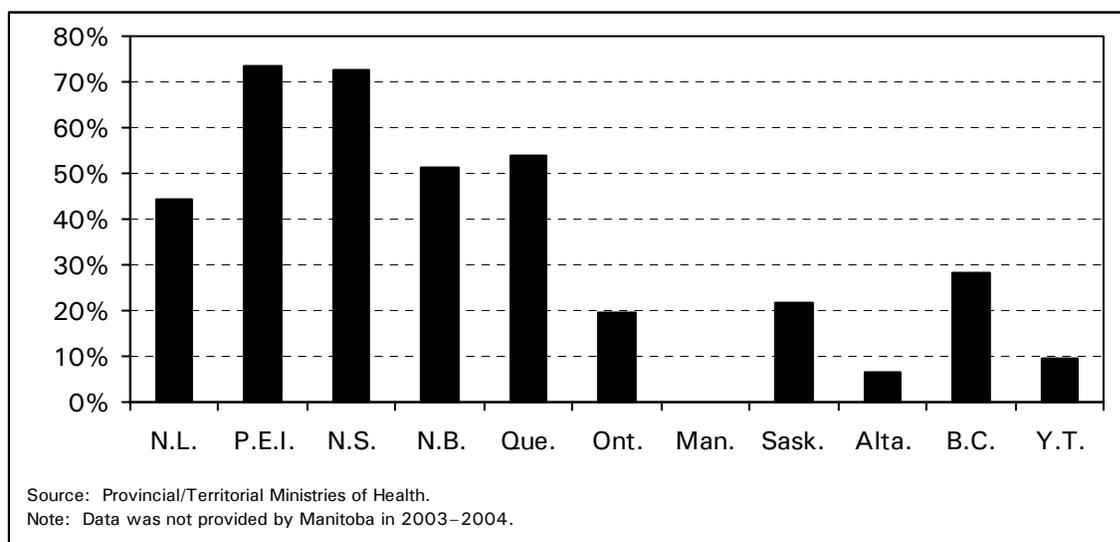


Figure 3. Percent of Clinical Physicians Who Received Payments Through Alternative Modes, by Province/Territory, 2003–2004

Estimated Full-Time Equivalents

Overall, physician activities in alternative payment modes represent an estimated 5,699 FTEs (Table 5). Alternative payment FTEs are equivalent to 11.5% of total FTEs in Canada. Alternative payment FTEs range from 5.1% of total FTEs in Alberta to 26.4% in Newfoundland and Labrador. Refer to Box 2 for a description of the FTE methodology.

Table 5. Estimated FTEs in Alternative Payment,¹ by Province, Fiscal 2003–2004

	Estimated Full-Time Equivalent Physicians			Distribution	
	FFS	APP	Total	FFS	APP
N.L.	607	218	825	73.6%	26.4%
P.E.I.	161	31	192	83.6%	16.4%
N.S.	1,054	365	1,419	74.3%	25.7%
N.B.	854	251	1,105	77.3%	22.7%
Que.	10,724	1,596	12,319	87.0%	13.0%
Ont.	18,086	1,746	19,832	91.2%	8.8%
Man.	1,431	305	1,736	82.4%	17.6%
Sask.	1,229	279	1,508	81.5%	18.5%
Alta.	3,895	208	4,104	94.9%	5.1%
B.C.	5,720	700	6,420	89.1%	10.9%
Total	43,760	5,699	49,460	88.5%	11.5%

Note:

Fee-for-service is abbreviated as “FFS”; Alternative physician payment programs is abbreviated as “APP”.

¹ As described in Box 2, FFS FTE estimates are from CIHI’s *Full-Time Equivalent Physicians Report, Canada, 2003–2004* (see Appendix B, Table B1). APP FTEs are estimated from data supplied by provincial/territorial Ministries of Health for this report. Manitoba APP FTEs are estimated from alternative payment information from CIHI’s National Health Expenditure Database.

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, Figure 4). In 2003–2004, the number of alternative payment FTEs ranged from 7 per 100,000 population in Alberta to 42 per 100,000 population in Newfoundland and Labrador.

Table 6. Estimated FTE Physicians Per 100,000 Population,¹ by Type of Payment and Province, Fiscal 2003–2004

	Estimated FTEs Per 100,000 Population		
	FFS	APP	Total
N.L.	117	42	159
P.E.I.	117	23	139
N.S.	114	39	153
N.B.	115	34	148
Que.	143	21	164
Ont.	148	14	162
Man.	123	26	150
Sask.	124	28	152
Alta.	124	7	130
B.C.	138	17	155
Total	139	18	157

Notes:

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, 2003–2004 (see Appendix B, Table B2). APP FTEs are estimated from data supplied by provincial/territorial Ministries of Health for this report. Manitoba APP FTEs are estimated from alternative payment information from CIHI’s National Health Expenditure Database.

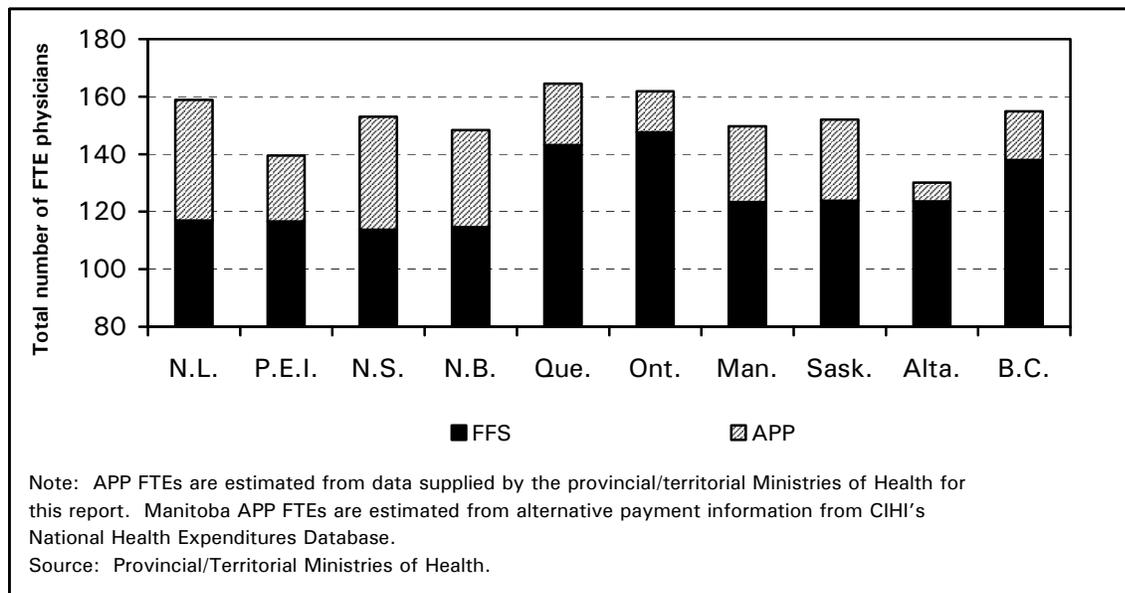


Figure 4. FTE Physicians Per 100,000 Population by Type of Payment, 2003–2004

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, FTEs in block funding are based on the number of physicians who receive all payments from block funding. Saskatchewan provides FTEs funded in northern locations and certain programs administered by regional boards.
2. The province of New Brunswick reports alternative payment information to CIHI at the level of the individual physician. Each physician's total alternative payments are summed and compared to CIHI's fee-for-service FTE benchmarks in order to calculate alternative payment FTE values. For New Brunswick, alternative payment FTE values are calculated using the fee-for-service FTE methodology described above.
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, 2003–2004* (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 paediatric 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.

Updated November 2005.

Prince Edward Island

Salary: Prince Edward Island has hospital-based salaried physicians in the specialties of internal medicine, paediatrics, physical medicine, oncology, radiation oncology, laboratory, and anaesthesia. 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 February 2006.

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, well women’s clinics, teen health centres and for the provision of care to hospital inpatients that do not have a regular family physician.

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 (surgery, neurosurgery, family medicine, otolaryngology, radiation oncology, pathology, gyne-oncology, critical care, psychiatry, anaesthesiology).

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 December 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 of New Brunswick.

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, paediatrics, 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, paediatric 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 November 2005.

Quebec

Salary: As the sessional payments (GPs) and blended mode (Specialists) has gained popularity, salary is less and less popular. Still about 40% of earnings paid to GPs employed in Local Community Service Centres (CLSC) and 30% of earnings paid to GPs working in psychiatric care are paid as salary.

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

Blended: This is a 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 3,300 specialists received alternative remuneration through this program in fiscal 2003–2004. The flat benefit of Blended payments accounted for 85% of alternative payments and about 30% of total payments paid to specialists in that year were under a Blended contract.

Block Funding: This form of reimbursement is not used. Physicians in academic health sciences centres often bill Blended payments.

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 for FFS.

Updated February 2006.

Ontario

Salary: Community Health Centres in Ontario have community boards and compensate physicians on salary. Some of the other APPs 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 underserved 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 Alternative Funding Agreements report on Canadian Triage Acuity Scale scores, volumes, shadow billing and hours of coverage.

Updated November 2005.

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 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.

Updated February 2006.

Saskatchewan

Salary: A relatively small percentage of Saskatchewan physicians are compensated through salaried arrangements. Regional Health Authorities 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: Regional Health Authorities 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 Regional Health Authorities, 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.

Regional Health Authority Administered Fee-for-Service: Some regions contract physicians to provide clinical services on a regionally-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 Regina and 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.

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 Regional Health Authorities, the Department and the Saskatchewan Medical Association. Specialists on prescribed call rotation receive a daily stipend for being available for new emergency (unassigned) patients.

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.

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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 eight contractual funding projects in Alberta in 2004–2005.

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 six academic funding plans in Alberta in 2004–2005.

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 thirteen sessional projects in Alberta in 2004–2005.

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 are no block funding projects in Alberta in 2004–2005. A group of neurosurgeons moved from a block funding model in 2003–2004 to an AFP model in 2004–2005.

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 2004–2005.

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

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British Columbia

British Columbia's Alternative Payments Program (APP) is administered through the Ministry of Health's 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.

Information Provision: 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 Ministry's health service plans and performance agreements.

Along with reporting captured within the APP payment system, reporting from health authorities includes patient encounter information to support the data collection necessary for health service planning and program evaluation.

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.

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Yukon

Yukon has the majority of its resident physicians billing fee for service. Due to the small population of Yukon, which does not warrant a host of resident specialty practitioners, there are a number of visiting specialists and locum physicians who are in and out of Yukon in a matter of weeks. These visiting specialists and locum physicians mostly bill fee for service to the Yukon Health Care Insurance Plan. There are a limited number of visiting physicians who are paid a sessional rate but these numbers are too small to report (i.e. less than 5).

Alternative Payment Plans (APP): There are a small number of resident physicians who are on contract with the Health Services Branch and shadow bill the Yukon Health Care Insurance Plan. Alternate Payment Plan contracts are negotiated by each physician and are subject to the provisions outlined in the Yukon Medical Associations memorandum of understanding with the Health Services Branch.

Information Collection: Shadow Billing is done to collect information on the number and dollar amount of services provided by contract physicians.

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Appendix A

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Appendix B

Table B1. Full-Time Equivalent Fee-for-Service Physicians, by Province, 2003–2004

N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Total
607.08	160.70	1,054.15	853.79	10,723.52	18,085.63	1,430.86	1,229.01	3,895.37	5,720.01	43,760.12

Source: *Full-Time Equivalent Physicians Report, Canada, 2003–2004*, CIHI 2006.

Table B2. Updated Post-Censal Net Population Estimates, Canada and the Provinces/Territories, 2003–2004 (000s)

N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	Total
519.1	137.8	927.1	744.7	7,489.0	12,253.0	1,159.8	992.4	3,153.4	4,145.8	31.2	31,522.2

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.

