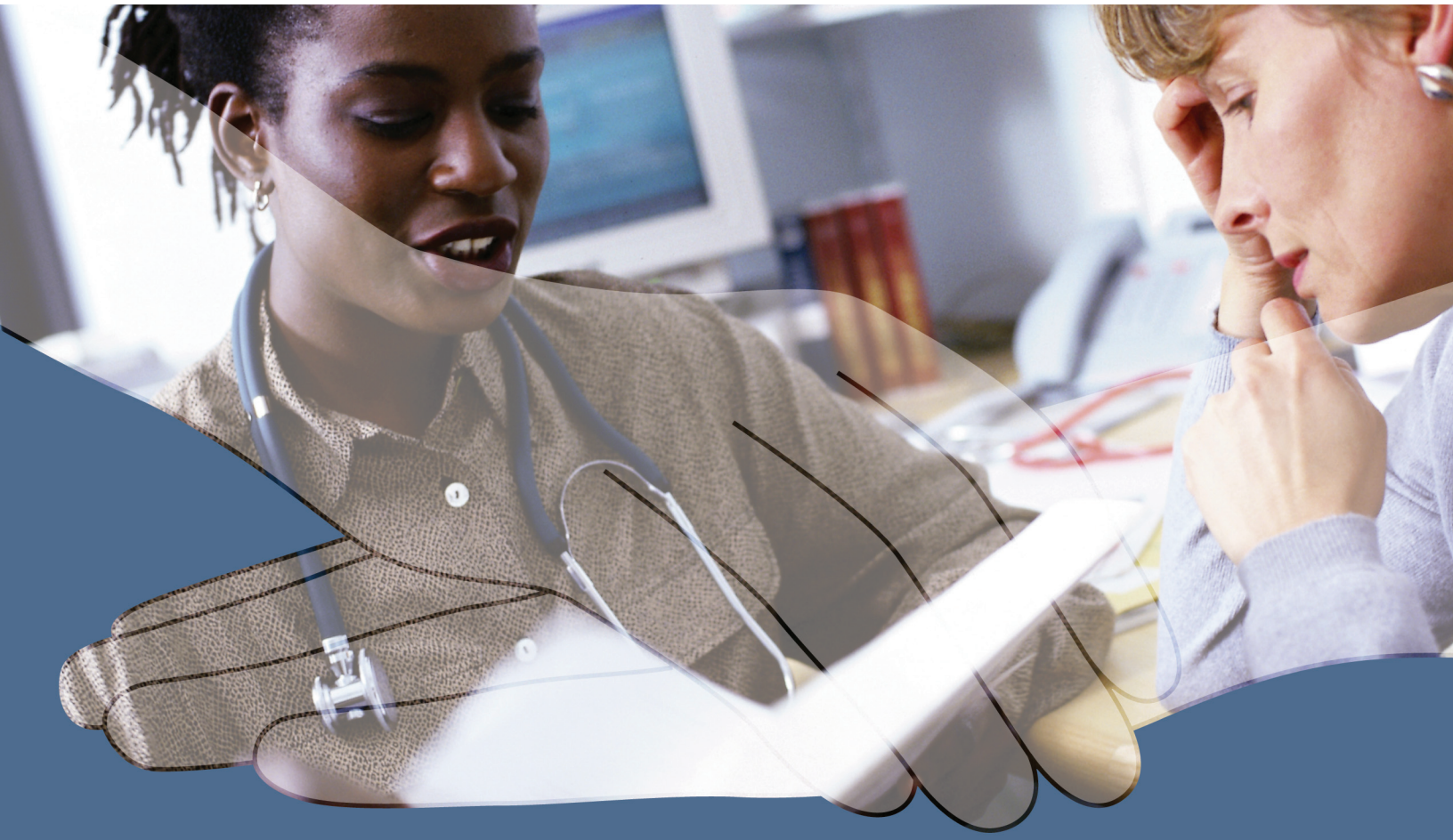
PHYSICIANS



Physicians in Canada: The Status of Alternative Payment Programs 2005–2006

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Physicians in Canada: The Status of Alternative Payment Programs, 2005–2006

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Preface

The Canadian Institute for Health Information (CIHI) collects and analyzes information on health and health care in Canada and makes it publicly available. Canada's federal, provincial and territorial governments created CIHI as a not-for-profit, independent organization dedicated to forging a common approach to Canadian health information. CIHI's goal: to provide timely, accurate and comparable information. CIHI's data and reports inform health policies, support the effective delivery of health services and raise awareness among Canadians of the factors that contribute to good health.

To meet this mandate, CIHI's core functions include the coordination and promotion of national health information standards and health indicators, the development and management of health databases and registries, the funding and facilitation of population health research and analysis, the coordination and development of education sessions and conferences and the production and dissemination of health information research and analysis.

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Executive Summary

This is the seventh annual report in a series of publications on the status of alternative physician payment programs in Canada. In addition to including information on programs in each province and territory, a more in-depth look into programs at the specialty level has been included for seven jurisdictions.

Over the past few years, considerable progress has been made in forming a national picture of utilization and payment information from alternative physician programs (APP), as well as in working with jurisdictions to gather more detailed APP data. This year, seven jurisdictions were able to submit physician-level or specialty-level data. As a result, CIHI is pleased to report a new table this year, presenting the distribution of alternative payment dollars among the physician specialties in these seven jurisdictions. CIHI is encouraged by this new level of analysis and anticipates working more with the jurisdictions to increase the data provided over time.

Payments made to physicians through alternative clinical payment programs in 2005–2006 totalled approximately $2.98 billion, representing 21.3% of all the payments made to physicians for clinical services in Canada. Over six years, the value of total alternative clinical payments more than doubled, from $1.31 billion in 2000–2001 to $2.98 billion in 2005–2006.

In 2005–2006, the proportion of payments made through alternative clinical payment programs varied considerably across jurisdictions, ranging from 12.3% in Alberta to 42.8% in Nova Scotia and 96.1% in the Northwest Territories. At the national level, between 2004–2005 and 2005–2006, alternative clinical payments increased by 12.6%. While the proportion of alternative clinical payments is still increasing, this is less than the increase of 24.1% reported between 2002–2003 and 2003–2004.

Provincial and territorial governments adopt different approaches to funding particular alternative payment programs. Emergency and on-call payments account for significant funding in most of the jurisdictions that report them. Other commonly funded alternative clinical payment programs reported by jurisdictions include block funding and sessional and salary payments. Provinces and territories also make non-clinical payments, such as funding for benefit programs (for example, for medical protective assurance and for continuing medical education) and rural incentive programs. These payments, however, are excluded from the total alternative clinical payments. At the national level, the non-clinical alternative payments represented 9.6% of total alternative payments in 2005–2006.

The prevalence of alternative payment programs can also be illustrated by looking at the proportion of physicians receiving at least some of their clinical income through alternative funding. Almost 40% of physicians in Canada received some remuneration for insured services in the form of alternative payments in 2005–2006, which represents a 5% increase from the previous year. Over six years (2000–2001 to 2005–2006), the proportion of physicians receiving at least some of their clinical income through alternative funding increased from 28.1% to 39.1%. In addition, variation was found across jurisdictions. The percentage of physicians who received any alternative payments ranged from 10.3% in Alberta to approximately 96.1% in the Northwest Territories.

Physician full-time equivalents (FTEs) in alternative clinical payment modes accounted for 12.4% of total FTEs. Alternative clinical payment FTEs ranged from less than 10% of total FTEs in Alberta to over 25% in Nova Scotia and New Brunswick.

When FTEs from both fee-for-service (FFS) and alternative clinical payment modes are considered, FTEs per 100,000 population show less variability among the provinces than when only FFS physicians are included. Based on total clinical payments, there were 162 FTEs per 100,000 population in Canada. This number increased by 3% from 2004–2005 to 2005–2006. Newfoundland and Labrador ranked highest (an estimated 170 FTEs per 100,000 population), while Quebec and Ontario ranked second, with each province having an almost identical number of FTEs per 100,000 population (167 versus 166, respectively).

This year, new tables have been added presenting 2005–2006 specialty-level alternative payment data for seven jurisdictions: Newfoundland and Labrador, New Brunswick, Quebec, Manitoba, Saskatchewan, British Columbia and the Northwest Territories. This is important as it allows expenditures to be itemized by specialty in order to understand what proportion of payments are fee-for-service versus alternative clinical payment programs, as well as to examine the similarities and differences across jurisdictions. We look forward to working with all the jurisdictions to increase the availability of this type of data in the future.

Introduction

The Health Human Resources team of the Canadian Institute for Health Information is pleased to present *Physicians in Canada: Alternative Payment Programs, 2005–2006.* This is the seventh in a series of publications on the status of alternative payment programs to physicians in Canada.

The preceding reports in this series have documented aggregate-level alternative physician payment programs (APP) and alternative funding programs (AFP) in Canada and quantified expenditures for APP at the national and jurisdictional levels (see Appendix A for a description of definitions). From this information, the impact of APP on the comprehensiveness of CIHI's National Physician Database (NPDB) can start to be addressed.

Over the past few years, considerable progress has been made in forming a national picture of utilization and payment information from APP, as well as in working with jurisdictions to gather more detailed APP data. This year, seven jurisdictions were able to submit physician-level or specialty-level data. As a result, CIHI is pleased to report a new table this year, presenting the distribution of alternative payment dollars among the physician specialties in Newfoundland and Labrador, New Brunswick, Quebec, Manitoba, Saskatchewan, British Columbia and the Northwest Territories. CIHI is encouraged by this new level of analysis and anticipates working more with the jurisdictions to increase the data provided over time.

Further, with the collection of physician-level FFS and APP data, new analysis can be undertaken. For example, itemizing expenditures by specialty will enable a more in-depth understanding of the similarities and differences across jurisdictions. Analyzing physician-level APP data also offers a better understanding of what proportion of physicians is paid from FFS and what proportion is paid from APP. This level of information is useful to the continuous improvement of physician information in Canada and CIHI's NPDB.

We hope that this report provides a solid foundation for the work of those with an interest in physician supply and utilization in Canada.

Data Analysis

Methodological Overview

Provincial and territorial ministries of health are the main sources of data on alternative payments. CIHI works closely with the provincial and territorial ministry of health representatives on CIHI's Advisory Group on Physician Databases (see Appendix B).

For jurisdictions that have not provided data on alternative payments in past years, their alternative payments were estimated from CIHI's National Health Expenditures Database (NHEX). To date, this methodology cannot be applied to Nunavut as there is not the level of detail required for this jurisdiction within NHEX.

Fee-for-service payments used in this report are derived from CIHI's 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 and services, is intended to provide a more appropriate base for comparisons to alternative payments.

Physician specialty designations in this report are derived from those in the NPDB, which are assigned by the provincial medical care plans and grouped within the NPDB to a national equivalent. In most instances, two types of designations are provided: the latest acquired certified specialty and the plan-payment specialty. The latter is used for the purposes of this report. For further information on physician specialty designations in the NPDB, please see CIHI's *Physicians in Canada: Average Gross Fee-for-Service Payments, 2005–2006,* available at www.cihi.ca.

Estimating Physician Full-Time Equivalents in Fee for Service

CIHI's full-time equivalent (FTE) methodology calculates benchmark payment levels for physicians in each of 17 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 upper 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. For more detailed information on the FTE calculation using the NPDB data and definitions, please refer to CIHI's *Physicians in Canada: Average Gross Fee-for-Service Payments, 2005–2006*, available at www.cihi.ca.

Estimating Physician Full-Time Equivalents in Alternative Payment Programs

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. Saskatchewan provides FTEs funded in northern locations and certain programs administered by regional boards.
2. Where physician-level alternative payment information was provided, each physician's total alternative payments were summed and compared to CIHI's FFS FTE benchmarks in order to calculate alternative payment FTE values using the FFS FTE methodology described above. This methodology was applied only to New Brunswick's data.
3. If either of the above two criteria were not met, a proportional estimate was used. Proportions, calculated by dividing alternative payments by FFS payments using the figures given in Table 1, were applied to FFS FTE physician counts in order to estimate alternative payment FTEs.[i] 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 FFS payments.

Notes to Readers

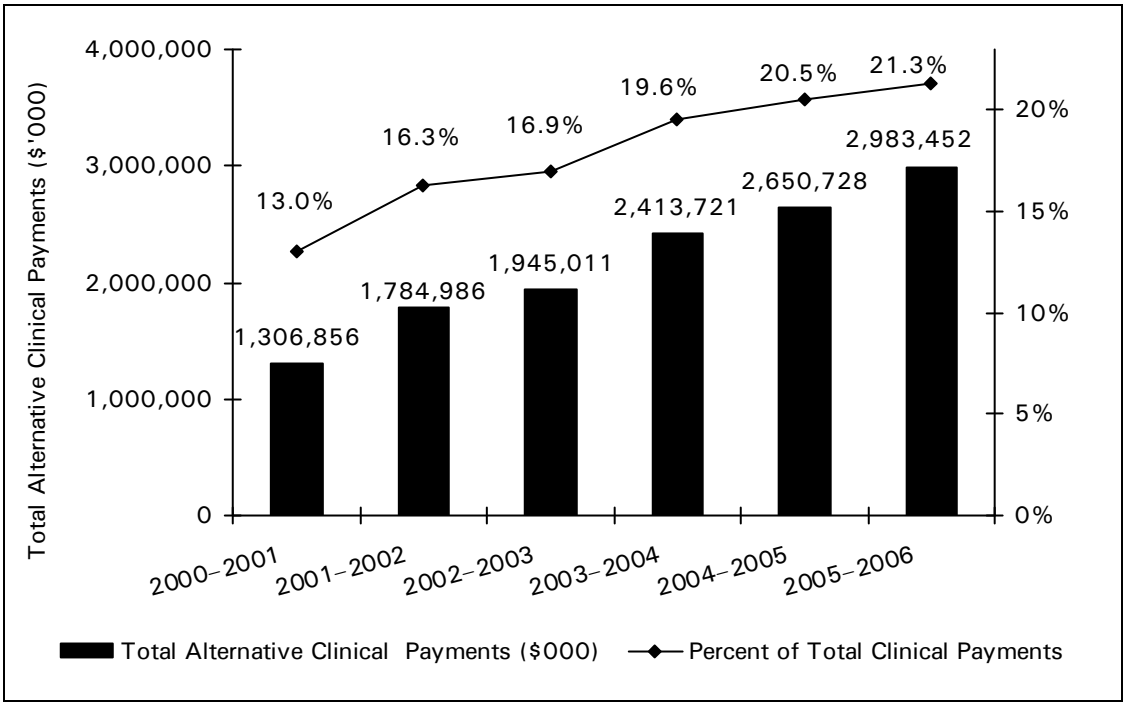
1. In estimating physician FTEs in alternative payment programs, precise estimates are not possible using aggregate data, as FTEs are normally calculated from individual physician-level data.
2. FTEs from different payment modes are not additive due to the fact that physicians with payments anywhere 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 overall supply of physicians using FTE estimates that include both FFS and APP physicians.
3. Non-clinical payment information is incomplete as some payments identified as non-clinical may contain relatively small amounts for clinical services. Also, in some jurisdictions, part or all of these payments are made through hospital budgets and are not reported as physician payments. Therefore, the information on non-clinical payments is considered to be incomplete. These payments are excluded from the total alternative clinical payments.

i FFS FTE physician counts were taken from CIHI's *Physicians in Canada: Average Gross Fee-for-Service Payments, 2005–2006* (see Appendix C, Table C1).

Physician Payments Through Alternative Payment Programs in Canada

Alternative clinical payments in 2005–2006 were approximately $2.98 billion—21.3% of the value of physicians' total clinical payments[ii] (Figure 1). Between 2004–2005 and 2005–2006, alternative clinical payments increased by 12.6%. While the proportion of alternative clinical payments is still increasing, this is less than the increase of 24.1% reported between 2002–2003 and 2003–2004. Over six years (2000–2001 to 2005–2006) the trend was steadily upward and total alternative clinical payments in Canada more than doubled in this time period.

Figure 1 Physicians' Alternative Clinical Payments in Canada, 2000–2001 to 2005–2006



Notes

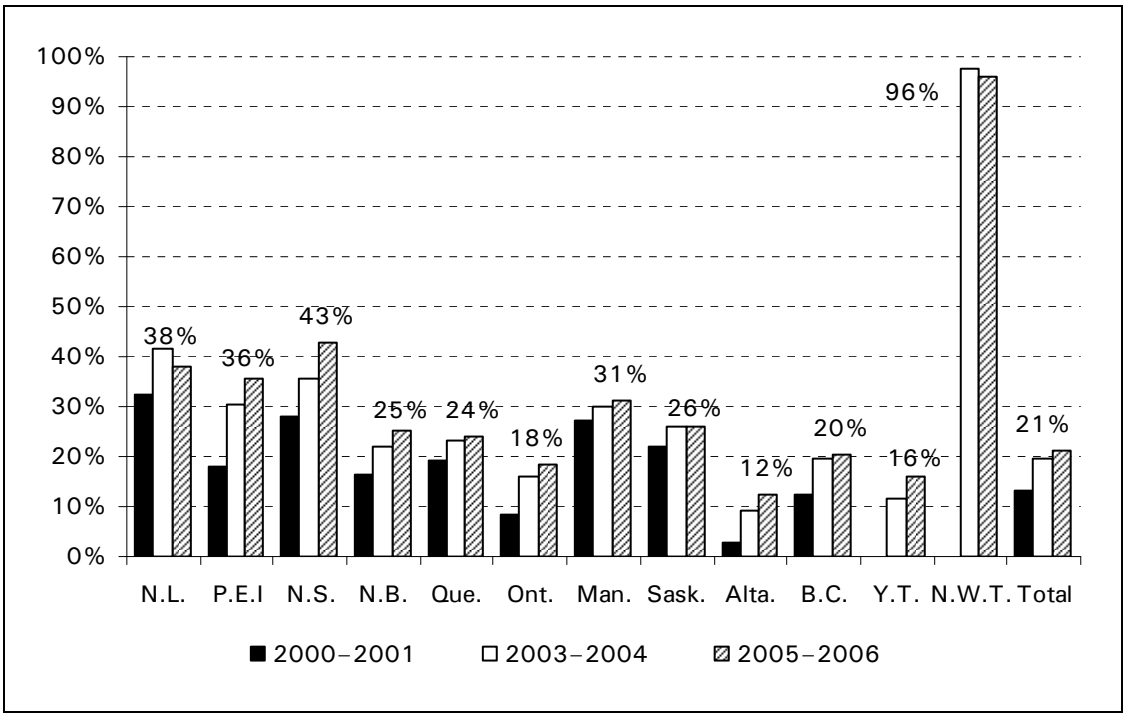
Data submissions were first received and are included as of 2001–2002 for the Yukon and as of 2003–2004 for the Northwest Territories. Data exclude alternative non-clinical payments. Data exclude Nunavut.

Sources

Provincial/territorial ministries of health; National Health Expenditures Database for Ontario 2001–2002 and Manitoba 2001–2002 to 2003–2004, Canadian Institute for Health Information.

ii Total clinical payments are the total sum of the physicians' clinical payments from fee-for-service and alternative payments.

Figure 2 Physicians' Alternative Clinical Payments as a Percentage of Total Clinical Payments by Jurisdiction, 2000–2001, 2003–2004 and 2005–2006



Notes

Alternative clinical payments in the Northwest Territories were 96.1% of total clinical payments.

Data for 2000–2001 were not available for the Northwest Territories and the Yukon. Data were not available for Nunavut.

Sources

Provincial/territorial ministries of health.

The Northwest Territories is a unique jurisdiction in that almost all physicians are paid through salary or sessional arrangements, at the highest percentage of alternative clinical payments (96%). Among the other jurisdictions, Newfoundland and Labrador and Nova Scotia were highest, at approximately 40% (Figure 2). All jurisdictions have increased the share of alternative clinical payments since 2000–2001 (data not available for Nunavut).

Table 1 shows a six-year comparison of FFS and alternative clinical payments by jurisdiction. This table documents the growth and prevalence of alternative clinical payments in all jurisdictions. For example, the trends shown in Table 1 indicate an increase in the proportion of alternative clinical payments each year for the provinces of Prince Edward Island, Nova Scotia, New Brunswick, Quebec, Ontario and Alberta. Jurisdictions that have shown a decrease in some years still show an overall increase from 2001 to 2006.

While the percentage of alternative clinical payments increased in the early 2000s, the percentage of alternative clinical payments remained constant for the last few years for Manitoba and British Columbia.

Table 1 Physician Clinical Payments by Type of Payment in Thousands of Dollars and Percentage of Total Clinical Payments by Province/Territory, 2000–2001 to 2005–2006

Table 1.1

Physicians' Fee-for-Service Clinical Payments, by Province/Territory and Canada 2000–2001 to 2005–2006

	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Nun.	Canada
Fiscal Year							('000)							
2000–2001	98,761	26,078	229,386	168,718	1,690,019	3,829,183	272,791	248,882	881,311	1,269,502				8,714,631
2001–2002	96,769	26,711	230,079	185,966	1,779,976	3,911,634	289,680	266,680	975,423	1,386,455	7,671			9,157,044
2002–2003	97,128	26,892	245,907	205,959	1,816,097	3,985,029	299,510	274,480	1,117,541	1,452,927	8,807			9,530,277
2003–2004	117,055	26,682	259,711	217,879	1,964,977	4,090,409	314,927	288,021	1,154,919	1,481,887	9,416	805		9,926,688
2004–2005	128,376	26,805	250,352	227,301	1,989,857	4,272,005	340,255	319,633	1,215,567	1,505,269	10,064	1,760		10,287,244
2005–2006	139,084	26,527	257,921	235,346	2,058,341	4,674,829	363,853	343,180	1,314,850	1,565,288	10,561	1,222		10,991,002
							(Annual Percentage Change)							
2000–2001	---	---	---	---	---	---	---	---	---	---	---	---	---	---
2001–2002	-2.0	2.4	0.3	10.2	5.3	2.2	6.2	7.2	10.7	9.2	---	---	---	5.1
2002–2003	0.4	0.7	6.9	10.8	2.0	1.9	3.4	2.9	14.6	4.8	14.8	---	---	4.1
2003–2004	20.5	-0.8	5.6	5.8	8.2	2.6	5.1	4.9	3.3	2.0	6.9	---	---	4.2
2004–2005	9.7	0.5	-3.6	4.3	1.3	4.4	8.0	11.0	5.3	1.6	6.9	118.6	---	3.6
2005–2006	8.3	-1.0	3.0	3.5	3.4	9.4	6.9	7.4	8.2	4.0	4.9	-30.6	---	6.8

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Table 1.2

Physicians' Fee-for-Service Payments as a Percentage of Total Clinical Payments, by Province/Territory and Canada 2000–2001 to 2005–2006

	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Nun.	Canada
Fiscal Year							(Percentage Distribution)							
2000–2001	67.7	81.9	72.1	83.5	80.9	91.5	72.9	78.0	97.2	87.5				87.0
2001–2002	60.7	81.9	69.8	82.0	78.7	88.1	72.0	75.8	93.2	82.5	95.3			83.7
2002–2003	57.8	75.0	68.4	81.5	78.1	88.5	70.5	72.9	91.3	80.8	92.0			83.1
2003–2004	58.2	69.5	64.3	77.9	77.0	84.0	70.1	74.1	90.9	80.3	88.5	2.6		80.4
2004–2005	58.8	66.9	58.5	76.3	76.1	83.2	70.4	73.6	89.2	80.1	83.7	5.6		79.5
2005–2006	62.0	64.2	57.2	74.7	75.9	81.6	68.7	74.1	87.7	79.6	84.0	3.9		78.7
							(Annual Percentage Change)							
2000–2001	---	---	---	---	---	---	---	---	---	---	---	---	---	---
2001–2002	-10.2	0.0	-3.2	-1.8	-2.8	-3.8	-1.3	-2.8	-4.1	-5.7	---	---	---	-3.8
2002–2003	-4.8	-8.4	-2.1	-0.6	-0.7	0.5	-2.0	-3.8	-2.0	-2.1	-3.5	---	---	-0.8
2003–2004	0.7	-7.3	-5.9	-4.3	-1.5	-5.1	-0.6	1.7	-0.5	-0.5	-3.8	---	---	-3.1
2004–2005	0.9	-3.7	-8.9	-2.1	-1.1	-1.0	0.5	-0.7	-1.9	-0.3	-5.4	118.4	---	-1.2
2005–2006	5.5	-4.1	-2.3	-2.2	-0.2	-1.9	-2.4	0.6	-1.7	-0.5	0.3	-30.6	---	-1.1

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Table 1 Physician Clinical Payments by Type of Payment in Thousands of Dollars and Percentage of Total Clinical Payments by Province/Territory, 2000–2001 to 2005–2006 (cont'd)

Table 1.3

Physicians' Alternative Clinical Payments, by Province/Territory and Canada 2000–2001 to 2005–2006

	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Nun.	Canada
Fiscal Year							('000)							
2000–2001	47,201	5,761	88,855	33,314	398,162	355,674	101,320	70,233	25,214	181,122				1,306,856
2001–2002	62,526	5,901	99,514	40,813	482,322	530,484	112,892	85,153	70,871	294,132	379			1,784,987
2002–2003	70,788	8,957	113,798	46,816	508,511	516,399	125,252	101,841	105,996	345,881	771			1,945,010
2003–2004	83,933	11,691	144,194	61,660	587,590	780,111	134,250	100,415	115,416	362,891	1,228	30,341		2,413,720
2004–2005	90,109	13,239	177,239	70,449	624,141	864,973	142,738	114,498	146,950	375,008	1,959	29,425		2,650,728
2005–2006	85,192	14,780	192,812	79,726	651,814	1,056,499	165,556	120,048	184,637	400,408	2,018	29,963		2,983,453
							(Annual Percentage Change)							
2000–2001	---	---	---	---	---	---	---	---	---	---	---	---	---	---
2001–2002	32.5	2.4	12.0	22.5	21.1	49.1	11.4	21.2	181.1	62.4	---	---	---	36.6
2002–2003	13.2	51.8	14.4	14.7	5.4	-2.7	10.9	19.6	49.6	17.6	103.4	---	---	9.0
2003–2004	18.6	30.5	26.7	31.7	15.6	51.1	7.2	-1.4	8.9	4.9	59.3	---	---	24.1
2004–2005	7.4	13.2	22.9	14.3	6.2	10.9	6.3	14.0	27.3	3.3	59.5	-3.0	---	9.8
2005–2006	-5.5	11.6	8.8	13.2	4.4	22.1	16.0	4.8	25.6	6.8	3.0	1.8	---	12.6

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Table 1.4

Physicians' Alternative Clinical Payments as a Percentage of Total Clinical Payments, by Province/Territory and Canada, 2000–2001 to 2005–2006

	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Nun.	Canada
Fiscal Year							(Percentage Distribution)							
2000–2001	32.3	18.1	27.9	16.5	19.1	8.5	27.1	22.0	2.8	12.5				13.0
2001–2002	39.3	18.1	30.2	18.0	21.3	11.9	28.0	24.2	6.8	17.5	4.7			16.3
2002–2003	42.2	25.0	31.6	18.5	21.9	11.5	29.5	27.1	8.7	19.2	8.0			16.9
2003–2004	41.8	30.5	35.7	22.1	23.0	16.0	29.9	25.9	9.1	19.7	11.5	97.4		19.6
2004–2005	41.2	33.1	41.5	23.7	23.9	16.8	29.6	26.4	10.8	19.9	16.3	94.4		20.5
2005–2006	38.0	35.8	42.8	25.3	24.1	18.4	31.3	25.9	12.3	20.4	16.0	96.1		21.3
							(Annual Percentage Change)							
2000–2001	---	---	---	---	---	---	---	---	---	---	---	---	---	---
2001–2002	21.4	0.0	8.1	9.1	11.8	40.5	3.5	10.0	143.5	40.2	---	---	---	25.1
2002–2003	7.4	38.1	4.8	2.9	2.6	-3.9	5.2	11.8	27.9	9.9	71.0	---	---	3.9
2003–2004	-0.9	21.9	12.8	19.1	5.2	39.6	1.4	-4.5	4.9	2.3	43.3	---	---	15.4
2004–2005	-1.2	8.5	16.1	7.3	3.7	5.1	-1.1	2.0	18.7	1.4	41.2	-3.1	---	4.7
2005–2006	-7.9	8.2	3.2	6.9	0.7	9.5	5.8	-1.7	14.2	2.1	-1.5	1.8	---	4.2

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Notes

--- Indicate that data were not applicable for a given category.

Blank cells for the Yukon, Northwest and Nunavut territories indicate years when data were not submitted. Columns may not add to total due to rounding. Total clinical payments are the total sum of the physicians' clinical payments from fee-for-service and alternative payments.

Sources

Fee-for-service payments are based on data submitted to the National Physician Database, with the exception of the Northwest Territories, which submitted fee-for-service information with alternative clinical payment data collection. 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 to 2003–2004. CIHI's National Health Expenditures Database was used as a source of estimates in those instances.

Physician Payments by Specialty Through Alternative Payment Programs in Seven Jurisdictions

This year, CIHI received aggregate-level physician payment data by specialty from seven jurisdictions: Newfoundland and Labrador, New Brunswick, Quebec, Manitoba, Saskatchewan, British Columbia and the Northwest Territories. The remaining jurisdictions were unable to provide the data to CIHI as they do not collect the alternative payment data at this level. CIHI is hoping to expand this table to include more jurisdictions next year.

Table 2 shows for the first time specialty-level physician payments in 2005–2006 for these seven jurisdictions. Variation was found across specialties. In Newfoundland and Labrador, the proportions of alternative clinical payment range from approximately 3% of total physician clinical payments in dermatology, plastic surgery and neurosurgery to approximately 70% in pediatrics. In New Brunswick, there is no alternative clinical payment in dermatology and otolaryngology, but the proportion of alternative clinical payment in neurosurgery is approximately 93% of total physician clinical payments. In Quebec, the proportions of alternative clinical payment range from approximately 3% of total physician clinical payments in ophthalmology and plastic surgery to approximately 50% in psychiatry and neurosurgery. In Manitoba, the proportions range from less than 5% of total physician clinical payments in neurology, ophthalmology and otolaryngology to 88.7% in neurosurgery. In Saskatchewan, there is no alternative clinical payment in dermatology and physical medicine, but the proportions of alternative clinical payment in psychiatry and pediatrics are approximately 60% of total physician clinical payments. This additional information allows expenditures to be itemized by specialty in order to understand what proportion of payments is fee-for-service versus alternative clinical payments across the different types of specialty, useful information to continuously improve the quality of physician information in Canada and CIHI's NPDB.

Table 2 Fee-for-Service and Alternative Physician Clinical Payments by Specialty and Selected Provinces in Thousands of Dollars, 2005–2006

	N.L.			N.B.			Que.			Man.			Sask.			B.C.		N.W.T.
	FFS	ACPP	Percent*	FFS	ACPP	Percent*	FFS	ACPP	Percent*	FFS	ACPP	Percent*	FFS	ACPP	Percent*	FFS	ACPP	ACPP
Family Medicine	**61,285**	**32,106**	**34.4%**	**107,799**	**39,009**	**26.6%**	**927,792**	**302,128**	**24.6%**	**156,805**	**83,070**	**34.6%**	**173,809**	**53,587**	**23.6%**	**774,364**	**60,789**	**19,200**
Medical Specialties	**40,638**	**31,892**	**44.0%**	**57,844**	**32,300**	**35.8%**	**675,705**	**280,398**	**29.3%**	**122,982**	**51,731**	**29.6%**	**85,794**	**50,553**	**37.1%**	**447,729**	**NA**	**4,537**
Internal Medicine	20,234	8,872	30.5%	28,372	9,820	25.7%	341,643	61,604	15.3%	49,812	29,554	37.2%	44,337	20,009	31.1%	188,067	NA	1,702
Neurology	1,203	1,841	60.5%	2,259	1,101	32.8%	34,798	6,711	16.2%	4,703		0.0%	3,892	509	11.6%	20,431	NA	
Psychiatry	4,819	8,217	63.0%	4,876	11,759	70.7%	81,665	109,701	57.3%	19,927	11,477	36.5%	7,970	12,906	61.8%	88,499	NA	1,087
Pediatrics	2,905	6,890	70.3%	6,356	5,089	44.5%	69,124	38,873	36.0%	16,081	8,170	33.7%	6,082	9,423	60.8%	36,941	NA	1,271
Dermatology	2,145	52	2.4%	2,690		0.0%	42,568	3,216	7.0%	3,819	211	5.2%	1,892		0.0%	18,199	NA	
Physical Medicine				547	1,533	73.7%	9,669	5,344	35.6%	2,005	507	20.2%	588		0.0%	5,514	NA	
Anesthesia	9,332	6,020	39.2%	12,744	2,998	19.0%	96,238	54,948	36.3%	26,635	1,812	6.4%	21,033	7,706	26.8%	90,078	NA	477
Surgical Specialties	**37,161**	**13,545**	**26.7%**	**69,703**	**7,562**	**9.8%**	**454,844**	**69,287**	**13.2%**	**84,066**	**15,600**	**15.7%**	**83,577**	**16,916**	16.8%	**343,194**	NA	**5,257**
General Surgery	8,018	4,513	36.0%	12,246	2,111	14.7%	99,273	28,931	22.6%	20,454	4,265	17.3%	21,087	4,945	19.0%	57,276	NA	1,305
Thoracic/ Cardio. Surgery	1,071	1,706	61.4%	4,127	231	5.3%	16,971	3,352	16.5%	6,077	882	12.7%	5,131	726	12.4%	21,488	NA	
Urology	3,223	147	4.4%	7,119	516	6.8%	39,744	3,292	7.6%	4,810	1,179	19.7%	4,695	1,041	18.1%	26,826	NA	
Orthopedic Surgery	6,007	1,993	24.9%	10,829	4	0.0%	53,177	9,873	15.7%	12,758	1,640	11.4%	11,131	2,333	17.3%	47,423	NA	1,133
Plastic Surgery	1,769	48	2.6%	3,971	83	2.0%	14,936	531	3.4%	4,374	453	9.4%	4,493	195	4.2%	14,960	NA	
Neurosurgery	1,724	47	2.7%	174	2,194	92.7%	7,518	6,891	47.8%	547	4,301	88.7%	1,698	2,417	58.7%	11,684	NA	
Ophthalmology	6,479	398	5.8%	14,839	85	0.6%	83,211	2,468	2.9%	13,650	310	2.2%	17,939	810	4.3%	90,303	NA	446
Otolaryngology	5,106	355	6.5%	6,105		0.0%	44,949	5,033	10.1%	4,936	257	4.9%	5,582	257	4.4%	24,715	NA	971
Obstetrics/ Gynecology	3,764	4,338	53.5%	10,293	2,338	18.5%	95,065	8,916	8.6%	16,460	2,313	12.3%	11,821	4,192	26.2%	48,519	NA	1,402
Other Specialties	NA	**8,354**	NA	NA	**856**	NA	NA	NA	NA	NA	**15,156**	NA	NA	NA	NA	NA	NA	**969**
Total Specialties	**77,799**	**53,791**	**40.9%**	**127,547**	**40,718**	**24.2%**	**1,130,549**	**349,686**	**23.6%**	**207,048**	**82,487**	**28.5%**	**169,371**	**67,469**	**28.5%**	**790,923**	**161,700**	**10,763**
Total Physicians	**139,084**	**85,897**	**38.2%**	**235,346**	**79,727**	**25.3%**	**2,058,341**	**651,814**	**24.1%**	**363,853**	**165,557**	**31.3%**	**343,180**	**121,056**	**26.1%**	**1,565,287**	**222,489**	**29,963**

Notes

NA = Not available.

* Percentage that alternative clinical payment programs are of total physician clinical payments.

Fee-for-service is abbreviated as "FFS;" alternative clinical physician payments are abbreviated as "ACPP."

Other specialties include radiology and pathology. Those payments were included in their respective jurisdictional aggregated clinical totals, thus they are included here. Blank cells indicate that no payments were reported for a given category.

The B.C. Rural Retention program and on-call payments are not included in Table 2 as the breakdown of payments by specialty was not available for this year. Contract payments ($143 million in 2005–2006) are assigned to a specialty based on the nature of the majority of the services of the contract, and not the specialty of the practitioner(s) performing the work. Percentages have not been shown for these reasons.

Fee-for-service payments data were not available for the Northwest Territories.

There are minor differences between Saskatchewan and Newfoundland and Labrador totals reported in this table and in Table 3 due to revisions incorporated in the specialty-level data.

Sources

Fee-for-service payments are based on data submitted to the National Physician Database, Canadian Institute for Health Information; alternative clinical payment information is gathered through provincial and territorial ministries of health.

Alternative Clinical Payments by Type of Program

Table 3 details the different types of alternative clinical remuneration used in the provinces and territories. On-call payments account for significant proportions of alternative clinical payment in all but two of the seven provinces that report them. The results presented in Table 3 also indicate that provincial and territorial governments and medical societies adopt different approaches to funding particular programs or medical expenses. For example, while 8 out of 12 reporting jurisdictions indicate salary payments, only 2 out of 12 reporting jurisdictions indicate capitation payments. Please see Appendix A and the section entitled Alternative Payment Programs in Each Jurisdiction for a description of specific programs in each jurisdiction.

Non-Clinical Payments to Physicians

Table 4 shows types of physician payment that are defined as non-clinical alternative payments. In some cases, these other categories may contain relatively small amounts for clinical services. It is important to note that the information in Table 4 reflects both payment arrangements and reporting arrangements in the provinces and territories. For example, all jurisdictions have negotiated benefit packages for physicians but some jurisdictions do not report data for benefits. 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 on non-clinical payments is considered to be incomplete, but is included here for jurisdictions that identified these payments.

Table 3 Estimated Alternative Clinical Payments by Type of Payment and Province/Territory, 2005–2006 ($'000)

	N.L.	P.E.I	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Total
Salary	70,593	11,014	19,098	41,741	73,799	36,220				10,053		29,963	**262,518**
Sessional	1,923		1,278	31,200	226,019	765			6,003	58,474			**325,662**
Capitation						45,887			3,855				**49,742**
Block Funding	6,766		121,880			314,460		12,401					**455,507**
Psychiatry			10,988			986							**11,974**
Blended		3,766			351,996	372,715				12,576			**741,053**
Northern and Underserviced Areas						71,669		5,394		51,771			**128,834**
Emergency and On Call	5,910		39,568	5,579		213,797		20,801	75,300	126,148			**487,103**
Contracted/Unspecified				1,206			165,556	81,452	99,479	141,386	2,018		**491,097**
Total	**85,192**	**14,780**	**192,812**	**79,726**	**651,814**	**1,056,499**	**165,556**	**120,048**	**184,637**	**400,408**	**2,018**	**29,963**	**2,983,452**

Notes

Only the daily payments portion is shown in the above table.

Contract and unspecified include:

i. Service agreements in British Columbia.

ii. Payments that were not broken down by program.

Blank cells indicate that no payments were reported for a given category.

Data were not available for Nunavut.

Sources

Provincial/territorial ministries of health.

Table 4 Summary of Non-Clinical Physician Payments by Type of Payment and Province/Territory, 2005–2006 ($'000)

	N.L.	P.E.I	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Total
Rural Incentives		260			18,749					11,864	277		31,150
Hospital-Based Physicians		4,993	43,534	45,990				51,315					145,832
Benefits	1,120	952	8,566	10,044	6,805			18,831	28,242	65,300	500		140,360
Sub-Total Non-Clinical	**1,120**	**6,205**	**52,099**	**56,034**	**25,554**			**70,146**	**28,242**	**77,164**	**777**		**317,342**

Notes

Blank cells indicate that no payments were reported for a given category.

Data were not available for Nunavut.

Sources

Provincial/territorial ministries of health.

Physician Workforce and Alternative Payments in Canada

As can be seen in Table 5, 39.1% of physicians in Canada received some remuneration for insured services in the form of alternative payments (including clinical payments and non-clinical payments). The proportion of physicians who received alternative payments varied across jurisdictions. Table 5 details the number of physicians receiving alternative payments, as opposed to the jurisdictional payment amounts shown in Table 1. As shown in Table 5, the percentage of physicians who received any alternative payments ranged from 10.3% in Alberta to approximately 96.1% in the Northwest Territories. Over six years (2000–2001 to 2005–2006), the proportion of physicians receiving at least some of their clinical income through an alternative mode of funding increased from 28.1% to 39.1%.

Based on the jurisdictions that provided information about the number of physicians who receive at least 50% of all clinical income through alternative funding, it is evident that only a minority of physicians rely on alternative remuneration as their main source of income under provincial and territorial medicare plans. For example, about 11% of physicians in British Columbia and approximately one-third of physicians in Prince Edward Island and New Brunswick receive at least 50% of all clinical income through alternative modes. Conversely, almost all the physicians in the Northwest Territories (96.1%) receive at least 50% of all clinical payments from alternative funding schemes.

Table 5 Total Physicians and Physicians Who Received Alternative Payments, by Province and Territory, 2005–2006

	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.	1,049	397	37.8%	21	2.0%
P.E.I.	233	128	54.9%	86	36.9%
N.S.	2,220	1,689	76.1%	525	23.6%
N.B.	1,444	844	58.4%	495	34.3%
Que.	14,605	8,918	61.1%	NA	NA
Ont.	22,555	6,495	28.8%	3,100	13.7%
Man.	2,317	1,732	74.8%	418	18.0%
Sask.	1,708	404	23.7%	NA	NA
Alta.	5,912	608	10.3%	NA	NA
B.C.	8,998	2,633	29.3%	1,013	11.3%
Y.T.	64	8	12.5%	8	12.5%
N.W.	78	75	96.1%	75	96.1%
Total	**61,183**	**23,931**	**39.1%**	**NA**	**NA**

Notes

NA = Not available.

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 in N.B. excluded radiology and laboratory specialists.

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.

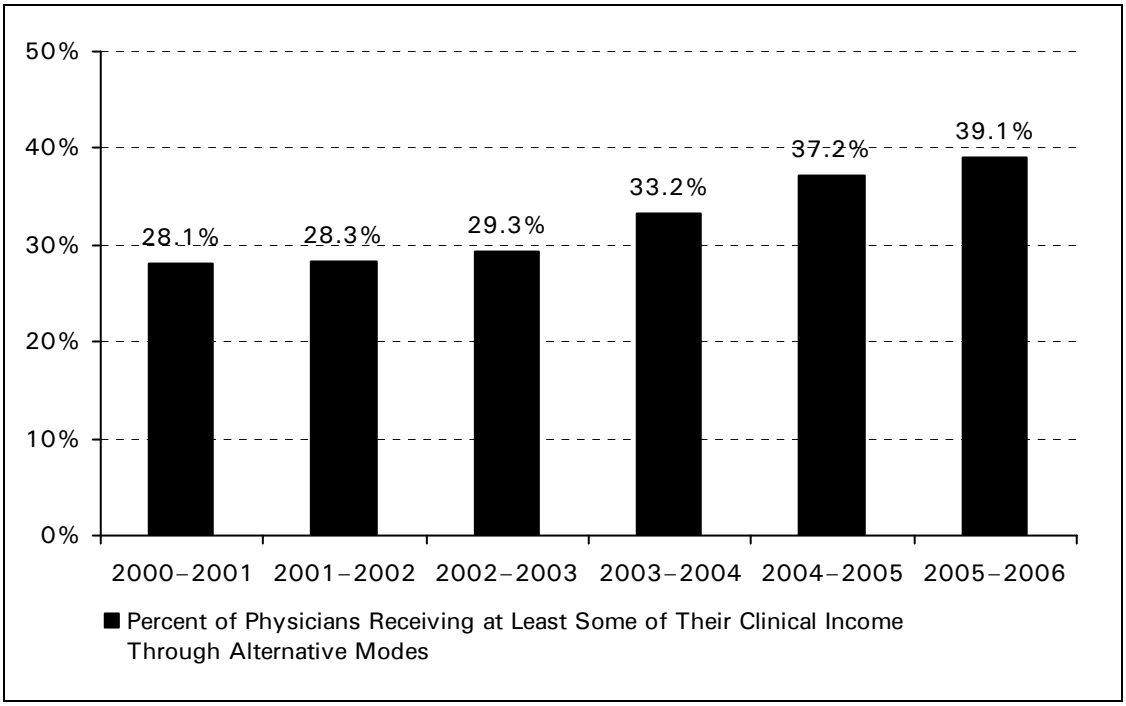
The number of physicians who receive 50% or more of income through alternative modes was not reported by some provinces.

Data were not available for Nunavut.

Sources

Provincial/territorial ministries of health.

Figure 3 Percent of Physicians Receiving at Least Some of Their Clinical Income Through Alternative Modes in Canada, 2000–2001 to 2005–2006



Notes
Data submissions were first received and are included as of 2001–2002 for the Yukon and as of 2003–2004 for the Northwest Territories. Data exclude Nunavut.

Sources
Provincial/territorial ministries of health.

This is the first year that we are presenting trend information on the proportion of physicians who received alternative payments in Canada. As can be seen in Figure 3, the proportion of physicians receiving at least some of their clinical income through alternative funding increased from 28.1% to 39.1% over the six years (2000–2001 to 2005–2006). Between 2004–2005 and 2005–2006, the proportion of physicians receiving alternative payments increased by 5%; this is less than the increase of 13% reported between 2003–2004 and 2004–2005. Although physicians can receive payments from multiple sources, there is no evidence that fewer physicians are being paid on an FFS basis. However, the popularity of alternative funding programs is on the rise.

Estimated Full-Time Equivalents

Overall, physician activities in alternative clinical payment modes represent an estimated 6,407 FTEs (Table 6). Alternative clinical payment FTEs are equivalent to 12.4% of total FTEs in Canada. Alternative clinical payment FTEs range from less than 10% of total FTEs in Alberta to approximately 25% in New Brunswick, Newfoundland and Labrador and Nova Scotia.[iii]

Table 6 Estimated FTEs in Fee-for-Service and Alternative Clinical Payments, by Province, 2005–2006

	Estimated Full-Time Equivalent Physicians			Distribution	
	FFS	ACPP	Total	FFS	ACPP
N.L.	671	205	876	76.6%	23.4%
P.E.I.	135	38	173	78.2%	21.8%
N.S.	1,013	379	1,391	72.8%	27.2%
N.B.	868	304	1,173	74.0%	26.0%
Que.	10,923	1,730	12,653	86.3%	13.7%
Ont.	18,692	2,112	20,804	89.8%	10.2%
Man.	1,504	342	1,846	81.5%	18.5%
Sask.	1,256	228	1,483	84.6%	15.4%
Alta.	4,353	306	4,658	93.4%	6.6%
B.C.	5,973	764	6,736	88.7%	11.3%
Total	**45,387**	**6,407**	**51,794**	**87.6%**	**12.4%**

Notes

Fee-for-service is abbreviated as "FFS;" alternative clinical physician payment programs are abbreviated as "ACPP."

Columns may not add to total due to rounding. The territories are not included due to low numbers in either the FFS or ACPP cells.

Sources

As described in the Methodology section of this report, FFS FTE estimates are from *Physicians in Canada: Average Gross Fee-for-Service Payments, 2005–2006* (see Appendix C, Table C1). ACPP FTEs are estimated from data supplied by provincial ministries of health for this report.

iii. A description of the FTE methodology used can be found in the Methodology section at the beginning of this report.

The inclusion of alternative clinical payments data leads to a more complete picture of FTE physician counts in Canadian jurisdictions. This additional information indicates that when FTEs from both FFS and alternative clinical payment modes are considered, FTEs per 100,000 population show less variability among the provinces than when only FFS physicians are included. As can be seen in Table 7 and Figure 4, based on total clinical payments there were 162 FTEs per 100,000 population in Canada. Newfoundland and Labrador ranked highest (170), while Quebec and Ontario ranked second, with each province having an almost identical number of FTEs per 100,000 (167 versus 166, respectively). As can be seen in Table 7, provinces that are below the median in FFS FTEs tend to be above the median in alternative clinical payment FTEs.[iv]

Table 7 Estimated FTE per 100,000 Population, by Type of Payment and Province, 2005–2006

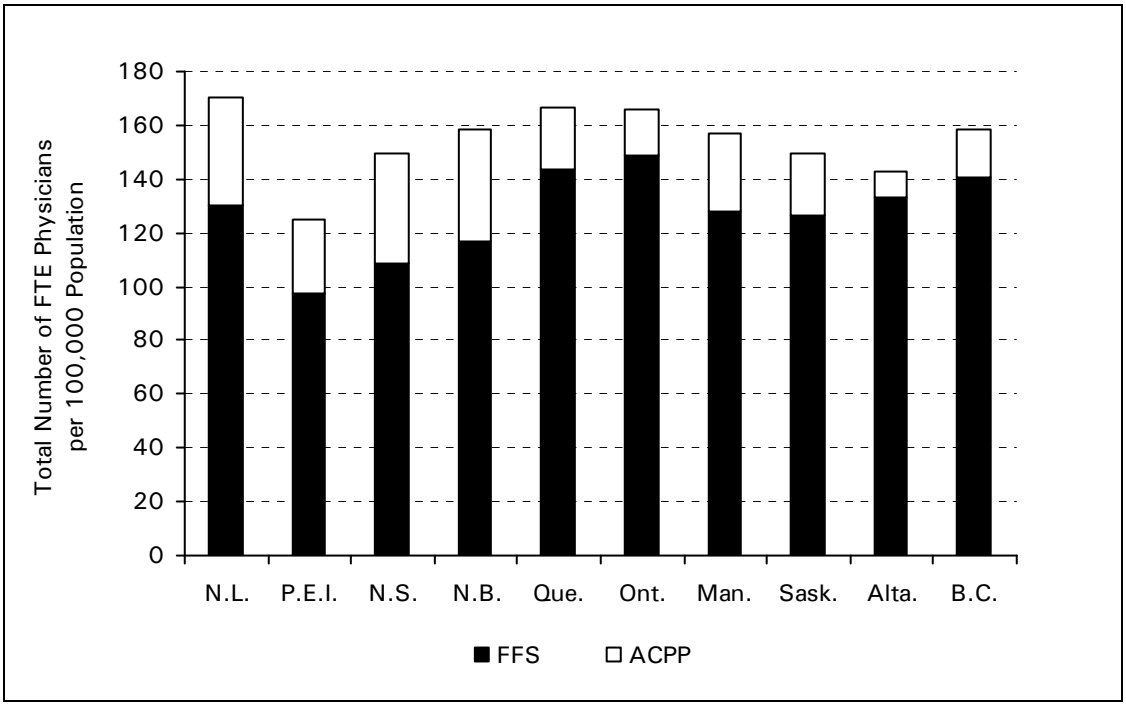
	Estimated FTEs per 100,000 Population		
	FFS	ACPP	Total
N.L.	130	40	170
P.E.I.	98	27	125
N.S.	109	41	149
N.B.	117	41	158
Que.	144	23	166
Ont.	149	17	166
Man.	128	29	157
Sask.	127	23	150
Alta.	133	9	142
B.C.	140	18	158
Total	**142**	**20**	**162**

Notes
Fee-for-service is abbreviated as "FFS;" alternative clinical physician payment programs are abbreviated as "ACPP." The territories are not included due to low numbers in either the FFS or ACPP cells.

Sources
Estimates of FTE physicians per 100,000 population were derived using Statistics Canada's *Net Population Estimates for Canada, by Jurisdiction, 2005–2006* (see Appendix C, Table C2). ACPP FTEs are estimated from data supplied by provincial ministries of health for this report.

iv. Statistically, the coefficient of variation (defined as the standard deviation divided by the mean) across provinces drops from approximately 10% to 5%.

Figure 4 Estimated FTE per 100,000 Population by Type of Payment and Province, 2005–2006



Notes

Fee-for-service is abbreviated as "FFS;" alternative clinical physician payment programs are abbreviated as "ACPP." The territories are not included due to low numbers in either the FFS or ACPP cells.

Sources

Estimates of FTE physicians per 100,000 population were derived using Statistics Canada's Net *Population Estimates for Canada, by Jurisdiction, 2004–2005* (see Appendix C, Table C2).

ACPP FTEs are estimated from data supplied by provincial ministries of health for this report.

Alternative Payment Programs in Each Jurisdiction

This section contains details of alternative payment programs provided by each jurisdiction, using categories reported in the NPDB alternative payment series. The provinces and territories have unique approaches to reporting services provided under alternative payment programs based on their individual needs. This information has been provided and reviewed by each jurisdiction in the preparation of this report, and is considered current as of October 2007.

Newfoundland and Labrador

Salary: Approximately 40% of salaried physicians are general practitioners (GPs) and the remaining 60% are specialist physicians. GPs affiliated with rural community hospitals, largely outside of the Avalon Peninsula, commonly practise 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) acknowledges 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 practise 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 night 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 anesthesia 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.

Prince Edward Island

Salary: P.E.I. has hospital-based salaried physicians in the specialties of internal medicine, pediatrics, physical medicine, oncology, radiation oncology, laboratory and anesthesia. P.E.I. also 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).

Prince Edward Island (cont'd)

Blended Funding: Blended funding provides for physicians opting for remuneration based on an "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 P.E.I.'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.

Nova Scotia

Alternative Funding Contracts: The number of physicians who receive remuneration for insured services through alternatives to fee for service 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 anesthesiology, geriatrics, neonatology, pediatrics, obstetrics/gynecology and palliative care. There are also contract arrangements available to general practitioners in certain rural areas and general practitioner/nurse practitioner contracts that support collaborative practice teams in designated areas. All physicians on contract are considered independent contractors and not employees. There are few physicians remunerated through salary.

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 are submitted annually. Additionally, there is designated money available for specialty on-call services and family physician on-call services.

Sessional: Sessional arrangements are available for pre-approved services of a physician engaged on a time basis. 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, detoxification centres, well women's clinics, teen health centres and for the provision of care to hospital inpatients who do not have a regular family physician.

Nova Scotia (continued)

Block Funding: The block funding arrangements are typically associated with academic centres and include the following Academic Funding Plans within the Capital District Health Authority and the IWK Health Sciences Centre (surgery, family medicine, otolaryngology, radiation oncology, pathology, gyne-oncology, critical care, psychiatry and diagnostic imaging). In 2006, a new AFP/APP framework was developed that represents a blended model of remuneration. At the present time, the Department of Medicine, the Department of Anaesthesia, the Division of Neurosurgery and the Department of Emergency Medicine have been converted to this new framework, which incorporates deliverables as well as billing targets.

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 contract payment arrangements.

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 specialist, specialist 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: anesthesia, 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 province's 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, detoxification 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.

New Brunswick (continued)

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.

Quebec

Salary: As the sessional payments (GPs) and blended mode (specialists) have 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, for administrative work in family health clinics, long-term geriatric care and some psychiatric institutions, and in 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 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.

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, anesthesia 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. For emergency room payments, there are still a few hospitals paying physicians by "Scott Sessional," sessional payments in lieu of FFS payments recommended by the 1995 Scott report[v] on physician services in small and/or rural hospital emergency departments.

Block Funding: The majority of APPs funding emergency department, neonatal intensive care units, pediatric and gynecological 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 that 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 practising within health service organizations (HSOs). These are multidisciplinary group practices, which are funded according to a purely population-based payment model. The second is physicians practising 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 ongoing monitoring and evaluation of all contracts in order to ensure that adequate service levels and expectations are met.

v. G. W. S. Scott, *Report of the Fact Finder on the Issue of Small/Rural Hospital Emergency Department Physician Service*, Final Report to the Ontario Ministry of Health, Ontario Hospital Association and Ontario Medical Association (March 22, 1995).

Ontario (cont'd)

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 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 is 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 are 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 are not available from these paying agencies.

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: Anesthetists in Regina and Saskatoon for the most part are paid on a fee-for-service basis. However, the provision of obstetrical anesthesia 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: The 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 the 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.

Saskatchewan (cont'd)

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 are 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 predetermined volume of services over a specified period of time. There were 13 contractual funding projects in Alberta in 2006–2007.

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 seven academic funding plans in Alberta in 2006–2007.

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 16 sessional projects in Alberta in 2006–2007.

Block Funding: Block funding resembles contractual funding, but differs in scope and scale. In block funding, all physicians in a given geographic area (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 were no block funding projects in Alberta in 2006–2007.

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 2006–2007.

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

British Columbia

B.C.'s alternative payments program (APP) is administered through the Ministry of Health's Medical Services Division (MSD). The APP provides funds to the five regional health authorities and the provincial health authority, which in turn contract with physicians to deliver health care services.

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 with each other, 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 specified in the physician contracts and these are aligned with the terms and conditions of the health authority's funding agreement with the APP and with the newly signed Physician Master Agreement. The agreement incorporates and replaces previous physician agreements between government, the Medical Services Commission and the British Columbia Medical Association (BCMA).

Sessions: In addition to service contract arrangements, health authorities may apply to the APP for funding to pay physicians on a sessional arrangement, where a session equals 3.5 hours of physician time and may be broken into quarter-hour increments. The health authority and APP negotiate the number of sessions required to deliver a particular health program and APP commits these sessions to the health authority. As sessions are provided the health authority submits claims, with supporting records of physician services, to the APP for release of funding equal to the number of sessions used. The newly signed Physician Master Agreement outlines the terms and conditions for sessional payments.

Information Provision: Reporting is a condition of APP funding and is required to meet expectations for accountability. Along with reporting captured within the APP payment system, reporting from health authorities includes patient encounter information to support the data collection necessary for contract monitoring and evaluation and health service planning.

Blended Funding Program: Population-Based Primary Health Care: A population-based, blended funding model for primary health care is also administered through the MSD. Contracts for services are negotiated between the ministry and health authorities for the 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, 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 that recognizes the impact of comorbidity on the utilization of resources. Funding and payment under the model are directly linked to timely and accurate submission of encounter and claims data so compliance with reporting requirements under this model is high.

Yukon Territory

The Yukon has the majority of its resident physicians billing fee for service. Due to the small population of the 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 the 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 (that is, less than five).

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 Association's 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.

Northwest Territories

Salary: The Northwest Territories has hospital-based salaried physicians in the specialties of anesthesiology, general surgery, internal medicine, obstetrics/gynecology, orthopedics, otolaryngology, psychiatry and pediatrics. In addition, the Norwest Territories has salaried physicians in the area of family medicine who work in clinics, emergency rooms and as hospitalists.

Sessional: Sessionals are used to fill vacancies in specialties and general practice. They are employed as independent contractors and remuneration is based on a daily rate for services. In addition, travel costs are reimbursed and accommodations are provided.

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

Appendix A

Definitions

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

Alternative payment programs (APP) refer to actual arrangements to pay physicians by alternative modes. Salaried physicians would be an example of an alternative payment program.

Alternative funding refers to methods other than FFS used to fund clinical departments (for example, 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 the NPDB include medical care by all specialties except radiology and pathology. In many provinces payments to radiology and pathology specialists are made through regional health authorities or hospitals and detailed payment data are not submitted to the NPDB.

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

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 the NPDB

Rural Incentives: Special incentives in under-serviced areas and locum programs. Incentives are paid in addition to payments for clinical services. They would include moving expenses, recruitment or retention bonuses, relocation allowances and locum programs, 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 may also include funding for clinical chiefs of staff, medical health officers, cancer and tuberculosis programs in some jurisdictions. 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: Contributions by the 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.

Shadow billing is an administrative process whereby physicians submit service provision information using provincial and 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.

Total clinical payments are the total sum of the physicians' clinical payments from fee-for-service and alternative payments.

Appendix B

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Appendix C

Table C1 Full-Time Equivalent Fee-for-Service Physicians, by Province, 2005–2006

N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Total
670.51	135.05	1,012.84	868.33	10,923.45	18,691.70	1,503.98	1,255.66	4,352.83	5,972.53	45,386.88

Source
Physicians in Canada: Average Gross Fee-for-Service Payments, 2005–2006, 2008, Canadian Institute for Health Information.

Table C2 Updated Post-Censal Net Population Estimates, Canada and the Provinces/Territories, 2005–2006 ('000s)

N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Total
514.6	138.1	932.8	741.5	7,602.4	12,562.0	1,173.6	990.4	3,270.0	4,258.4	31.1	42.7	32,287.7

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 2001 census counts, adjusted for net census undercoverage.

Figures have been rounded independently to the nearest hundred.

Total includes Nunavut.

Source
Statistics Canada.