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Foreword

This is the third CIHI report on alternative payments to physicians in Canada. This year’s report updates and, where possible, expands on information presented in previous years’ reports. Data from Yukon were provided for the first time in 2001–2002.

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.

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

Data in this report reflect the status of alternative payment plans in fiscal year 2001–2002. Preliminary data are presented for payments during 2002–2003 for jurisdictions that have reported it as of March 31, 2004. Additional updates are planned for future years.

Revised Estimates

Fee-for-service payments used in this report have been revised to reflect clinical fee-for-service totals (see Definitions section) from the National Physician Database (NPDB). These totals consist of fee-for-service payments to all physicians except the technical specialties of radiology and laboratory. Revisions were made for 1999–2000 and for 2000–2001. In previous reports the fee-for-service data have been supplied by Expert Group representatives and in some cases they included payments to radiology and laboratory specialists. The revised data provides a more appropriate base for comparisons to alternative payments.
Definitions

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

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

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

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

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

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

Salary: Physicians employed on a salary basis.

Sessional: Payments on an hourly or daily basis. Used by some jurisdictions to fund services in hospital emergency departments, psychiatry clinics and clinics in rural areas.

Capitation: Monthly payments for clients rostered with a physician group.

Block funding: Annual budgets negotiated for a group of physicians, usually associated with an academic medical centre.

Contract and blended:
1. Funding to regional boards for clinical services under arrangements in which boards have discretion regarding specific uses of the funds.
2. Contractual payments.
3. Payment arrangements that incorporate both alternative remuneration and fee-for-service.

Psychiatry: Some jurisdictions have programs that provide psychiatric services with funding based on salary, sessional or contract payments.
Northern and underserviced areas: Funding of provincial/territorial programs to provide services in northern or underserviced areas. These programs might include a number of alternative modes of payments. When funding for underserviced area programs was reported, no attempt was made to break down individual payment modes.

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

Non-clinical payments—not included in NPDB

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

Hospital-based physicians: Funding provided to regions or hospitals for radiology and pathology, as well as other physicians employed by hospitals and paid through hospital budgets. This category also may include funding for clinical chiefs of staff, medical health officers, cancer and TB programs in some jurisdictions.

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

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

This report provides an update to information on alternative payments published in 2001 and 2002. The 2001 report, which was the first in this series, contains sections of background information, information about NPDB systems development and historical information on payment trends.¹ Readers who wish to have additional information are referred to the 2001 publication. This year’s publication focuses on updating the data presented in the 2002 report.

Alternative payments increased by approximately 40% in 2001–2002. Alternative payments in 2001–2002 represented approximately $1.8 billion dollars—16.2% of the value of physicians’ clinical services in the eleven provinces/territories. The percentage of alternative payments varied considerably across jurisdictions, ranging from a low of 4.7% in the Yukon to a high of 38.9% in Newfoundland and Labrador.

In 2001–2002, the percentage of physicians who received any alternative payments ranged from 4.4% in Alberta to 53.5% in Quebec. Quebec has the highest percentage of physicians who receive almost all payments through alternative modes (23.4%).

Physician Full-Time Equivalents (FTEs) in alternative payment modes account for 11.3% of total FTEs. Nova Scotia has the highest percentage of alternative payment FTEs (28.5%). Quebec, Ontario and Manitoba have the highest ratios of FTEs per 100,000 when both fee-for-service and alternative payment FTEs are combined (178, 165 and 167 per 100,000 population respectively).

Alternative Payments in Canada

Alternative payments for clinical services reached $1.77 billion in 2001–2002 and represented 16.3% of total clinical payments (Figure 1). Alternative payments increased by approximately 40% (from $1.27 billion in 2000–2001). Newfoundland and Labrador has the highest percentage of alternative payments, followed by Manitoba and Nova Scotia (Figure 2, Table 1).

Figure 1. Physicians’ Alternative Clinical Payments, 1999–2000, to 2001–2002

Note: Results for 1999 and 2000 are based on the 10 provinces. Results for 2001 are based on the 10 provinces and the Yukon.
Source: Information is gathered through provincial/territorial representatives of CIHI’s Expert Group on Physician Databases.

Figure 2. Physicians’ Alternative Clinical Payments as a Percentage of Total Clinical Payments, 1999, 2000 and 2001

Note: Results for 1999 and 2000 are based on the 10 provinces. Results for 2001 are based on the 10 provinces and the Yukon.
Source: Information is gathered through provincial/territorial representatives of CIHI’s Expert Group on Physician Databases.
Alternative clinical payments in Table 1 include salary, sessional, capitation, contract services and block funding. (See Table 3 and definitions at the beginning of this report for details). Northern or underserviced area programs and most emergency or on call payments are also included with alternative clinical payments to enhance comparability.

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

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

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

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

Benefits include contributions by provinces/territories for Canadian Medical Protective Assurance (CMPA) and continuing medical education. In British Columbia, this category also includes disability insurance and provincial contributions to physicians’ retirement fund. This information was not requested for the purposes of this publication, but it has been reported for provinces/territories that were able to provide the data.
Table 1 shows a three year comparison of fee-for-service and alternative payments. Preliminary data for 2002–2003 are also shown. Newfoundland and Labrador, Ontario and Manitoba did not submit alternative payment data for 2001–2002 and 2002–2003. Estimates for these provinces were obtained from public accounts and provincial reports. These estimates were considered important in order to define national trends, but they are subject to review and possible change in future. The fee-for-service amounts in Table 1 have been revised for former years. They now show total fee-for-service payments for clinical services from the National Physician Database.

Table 2 shows types of physician payment that are not for clinical services reported in NPDB. In some cases, these other categories may contain relatively small amounts for clinical services. It is important to note that the information in Table 2 reflects both payment arrangements and reporting arrangements in provinces. In some jurisdictions no data are reported for benefits, for example. The category titled, “Hospital based physicians” represents payments to radiologists, pathologists and other physicians employed in hospitals. In some jurisdictions part or all of these payments are made through hospital budgets and are not reported as physician payments. The information is not complete 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/territories. Provincial/territorial governments and medical societies adopt different approaches to funding particular programs or medical expenses. Funding approaches also reflect attempts to redress perceived inequities in fee-for-service or new approaches to service delivery. Programs for emergency and on call reimbursement are notable examples. On call payments account for significant proportions of alternative payments in Nova Scotia, Saskatchewan, Alberta and British Columbia. Manitoba and New Brunswick reported significant amounts in 2000–2001 but did not provide data for 2001–2002.
### Table 1. Summary of Physician Payments by Type of Payment and Province/Territory, Fiscal 1999–2000 to 2002–2003 ($’000)

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</tr>
<tr>
<td>Fee-for-Service¹</td>
<td>100,430</td>
<td>26,163</td>
<td>224,907</td>
<td>170,264</td>
<td>3,733,473</td>
<td>241,444</td>
<td>244,093</td>
<td>829,127</td>
<td>1,248,857</td>
<td>8,529,521</td>
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<td>Alternative Clinical</td>
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<td>5,780</td>
<td>84,280</td>
<td>33,798</td>
<td>298,624</td>
<td>277,824</td>
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<td>Sub-Total Clinical</td>
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<td>31,943</td>
<td>309,187</td>
<td>204,062</td>
<td>401,129</td>
<td>327,070</td>
<td>269,889</td>
<td>840,027</td>
<td>1,380,057</td>
<td>9,532,145</td>
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<tr>
<td><strong>2000–2001</strong></td>
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</tr>
<tr>
<td>Fee-for-Service¹</td>
<td>98,768</td>
<td>26,079</td>
<td>229,387</td>
<td>168,520</td>
<td>3,829,225</td>
<td>272,815</td>
<td>248,969</td>
<td>881,313</td>
<td>1,269,594</td>
<td>8,774,619</td>
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<tr>
<td>Alternative Clinical</td>
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<td>5,761</td>
<td>88,855</td>
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<td>398,162</td>
<td>355,674</td>
<td>101,320</td>
<td>29,024</td>
<td>25,214</td>
<td>181,122</td>
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<tr>
<td>Sub-Total Clinical</td>
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<td>31,840</td>
<td>318,243</td>
<td>201,834</td>
<td>396,087</td>
<td>325,993</td>
<td>224,583</td>
<td>113,348</td>
<td>1,050,716</td>
<td>10,042,105</td>
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<td><strong>2001–2002</strong></td>
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<td></td>
</tr>
<tr>
<td>Fee-for-Service¹</td>
<td>96,776</td>
<td>26,711</td>
<td>230,082</td>
<td>185,818</td>
<td>3,911,314</td>
<td>289,705</td>
<td>266,775</td>
<td>975,426</td>
<td>1,303,825</td>
<td>7,687</td>
<td>9,133,109</td>
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<tr>
<td>Alternative Clinical</td>
<td>61,498</td>
<td>5,901</td>
<td>99,514</td>
<td>40,813</td>
<td>482,322</td>
<td>530,484</td>
<td>150,523</td>
<td>34,665</td>
<td>30,712</td>
<td>379</td>
<td>1,771,101</td>
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<tr>
<td>Sub-Total Clinical</td>
<td>158,274</td>
<td>32,612</td>
<td>329,595</td>
<td>226,631</td>
<td>4,411,798</td>
<td>440,228</td>
<td>301,441</td>
<td>1,046,297</td>
<td>1,597,957</td>
<td>8,066</td>
<td>10,904,209</td>
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Please see footnotes at end of table.
### Table 1. Summary of Physician Payments by Type of Payment and Province/Territory, Fiscal 1999–2000 to 2002–2003 ($’000) (cont’d)

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</thead>
<tbody>
<tr>
<td>Alternative Clinical</td>
<td>64,617</td>
<td>8,705</td>
<td>113,798</td>
<td>46,816</td>
<td>528,424</td>
<td>550,442</td>
<td>167,687</td>
<td>42,321</td>
<td>105,287</td>
<td>345,880</td>
<td>771</td>
<td>1,978,942</td>
</tr>
</tbody>
</table>

1 Fee-for-service payments for 1999–2001 and 2000–2001 presented in this report update fee-for-service payment information presented in previous Alternative Payments and the National Physician Database reports.

2 Preliminary fee-for-service payment estimates based on the NPDB are not available for 2002–2003 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/territorial representatives of CIHI’s Expert Group on Physician Databases, with the exception of Newfoundland and Labrador, Manitoba and Ontario in 2001–2002 and 2002–2003. Alternative clinical payment information for Newfoundland and Labrador, Manitoba and Ontario were obtained from public accounts and estimates compiled in the CIHI National Health Expenditures Database for 2001–2002 and 2002–2003. The data are preliminary and subject to change.

### Table 2. Summary of Non-Clinical Physician Payments by Type of Payment and Province, Fiscal 2001–2002 ($’000)

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<tr>
<td>Rural Incentives</td>
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<td>478</td>
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<td></td>
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<td>11,209</td>
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<tr>
<td>Hospital-Based Physicians</td>
<td>3,132</td>
<td>32,149</td>
<td>35,202</td>
<td>6,800</td>
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<td>141,122</td>
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<td>Benefits</td>
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<td>672</td>
<td>8,081</td>
<td>4,116</td>
<td>70,984</td>
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<td>183,062</td>
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<tr>
<td>Sub-Total Non-Clinical</td>
<td>1,838</td>
<td>4,282</td>
<td>40,230</td>
<td>39,318</td>
<td>77,784</td>
<td>4,532</td>
<td>77,038</td>
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<td>335,393</td>
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</table>

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

Sources: Information is gathered through provincial/territorial representatives of CIHI’s Expert Group on Physician Databases. CIHI’s National Health Expenditures Database was used as a secondary source of information for Newfoundland and Labrador, Manitoba and Ontario. The data are preliminary and subject to change.
Table 3. Estimated Alternative Clinical Payments by Type of Payment and Province/Territory, Fiscal 2001–2002 ($’000)

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<tr>
<td>Salary</td>
<td>52,282</td>
<td>3,868</td>
<td>10,967</td>
<td>16,541</td>
<td>68,496</td>
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<td>8,769</td>
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<td>160,923</td>
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<td>Sessional</td>
<td>9,216</td>
<td>1,561</td>
<td>22,225</td>
<td>184,494</td>
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<td>50,977</td>
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<td>4,857</td>
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<td>53,407</td>
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<td>Psychiatry</td>
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<td>14,534</td>
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<tr>
<td>Blended</td>
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<td>229,331</td>
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<td>Northern and Underserviced Areas</td>
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<td>33,523</td>
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<td>58,530</td>
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<td>Emergency and On Call</td>
<td>23,901</td>
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<td>10,233</td>
<td>110,454</td>
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<td>194,765</td>
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<td>Contracted/Unspecified</td>
<td>491,110</td>
<td>150,523</td>
<td>16,562</td>
<td>20,694</td>
<td>85,385</td>
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<td></td>
<td>379</td>
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<td>764,653</td>
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<tr>
<td>Total</td>
<td>61,498</td>
<td>5,901</td>
<td>99,514</td>
<td>40,813</td>
<td>482,322</td>
<td>530,484</td>
<td>150,523</td>
<td>34,665</td>
<td>70,871</td>
<td>294,132</td>
<td>379</td>
<td>1,771,101</td>
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</table>

Notes: Blended includes a special program of blended remuneration in Quebec for specialists introduced at the end of 1999. Funding to regional boards for hospital-based programs (including emergency services) in Prince Edward Island, Manitoba and Saskatchewan.
Contract and Unspecified includes:
- Service Agreements in British Columbia.
- Payments that were not broken down, e.g. Ontario, which has block funding and other forms of alternative remuneration.
Missing values indicate either no payments or insufficient detail to break down payments to certain categories.

Sources: Information is gathered through provincial/territorial representatives of CIHI’s Expert Group on Physician Databases. CIHI’s National Health Expenditures Database was used as a secondary source of information for Newfoundland and Labrador, Manitoba and Ontario. The data are preliminary and subject to change.
Physicians in Alternative Payment Plans

The proportion of physicians who receive some remuneration for insured services in the form of alternative payments varies across jurisdictions. In 2001–2002 the percentages ranged from 4.4% in Alberta to 53.5% in Quebec (Table 4). Many physicians who received one form of alternative payment also received fee-for-service payments and/or other types of alternative payment.

The number of physicians who receive payments mainly through alternative payment modes was provided by some jurisdictions and estimated for others using a variety of methods, depending on the extent of information available (Figure 3). The intent was to estimate the number for whom at least 50% of all clinical income from provincial sources was obtained from alternative funding.2

The proportion of physicians who receive at least half of their clinical income from alternative sources, again, varies across jurisdictions (Table 4). Prince Edward Island (30.0%), Nova Scotia (21.1%) and Quebec (23.4%) had the highest percentages. In most other jurisdictions, physicians who receive mainly alternative payments represented less than 10% of total physicians.

Table 4. Total Physicians and Physicians Who Received Alternative Payments, by Province, Fiscal 2001–2002

<table>
<thead>
<tr>
<th>Province</th>
<th>Total number of physicians</th>
<th>Number of physicians paid through alternative modes</th>
<th>Percent of total physicians paid through alternative modes</th>
<th>Number of physicians paid mainly through alternative modes</th>
<th>Percent of total physicians paid mainly through alternative modes</th>
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<tr>
<td>N.L.</td>
<td>945</td>
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<tr>
<td>P.E.I.</td>
<td>190</td>
<td>57</td>
<td>30.0%</td>
<td>57</td>
<td>30.0%</td>
</tr>
<tr>
<td>N.S.</td>
<td>2,003</td>
<td>1,287</td>
<td>64.3%</td>
<td>423</td>
<td>21.1%</td>
</tr>
<tr>
<td>N.B.</td>
<td>1,488</td>
<td>583</td>
<td>39.2%</td>
<td>100</td>
<td>6.7%</td>
</tr>
<tr>
<td>Que.</td>
<td>14,752</td>
<td>7,896</td>
<td>53.5%</td>
<td>3,452</td>
<td>23.4%</td>
</tr>
<tr>
<td>Ont.</td>
<td>22,030</td>
<td>3,013</td>
<td>13.7%</td>
<td>387</td>
<td>1.8%</td>
</tr>
<tr>
<td>Man.</td>
<td>2,093</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sask.</td>
<td>1,622</td>
<td>260</td>
<td>16.0%</td>
<td>96</td>
<td>5.9%</td>
</tr>
<tr>
<td>Alta.</td>
<td>5,151</td>
<td>227</td>
<td>4.4%</td>
<td>75</td>
<td>1.5%</td>
</tr>
<tr>
<td>B.C.</td>
<td>8,234</td>
<td>2,337</td>
<td>28.4%</td>
<td>835</td>
<td>10.1%</td>
</tr>
</tbody>
</table>

Note: 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.

Sources: Information is gathered through provincial/territorial representatives of CIHI’s Expert Group on Physician Databases. Newfoundland and Labrador, Prince Edward Island and Manitoba did not submit 2001–2002 physician count data. CIHI’s Southam Medical Database was used to estimate the total number of physicians in Newfoundland and Labrador, Prince Edward Island and Manitoba. Prince Edward Island physician count data for 2002–2003 was used to estimate alternative payment physician counts for 2001–2002. The data are preliminary and subject to change.

2 Alternative funding refers to the way in which clinical services were funded by provincial governments, not the way in which physicians were paid individually.
Overall, physician activities in alternative payment modes represent an estimated 5,695 FTEs (Table 5). Alternative payment FTEs are equivalent to 11.3% of total FTEs in Canada. Alternative payment FTEs range from 3.5% of total FTEs in Alberta to 28.5% in Nova Scotia.

Table 5. Estimated FTEs in Alternative Payment

<table>
<thead>
<tr>
<th>Province</th>
<th>FFS</th>
<th>APP</th>
<th>Total</th>
<th>FFS %</th>
<th>APP %</th>
</tr>
</thead>
<tbody>
<tr>
<td>N.L.</td>
<td>631</td>
<td>200</td>
<td>831</td>
<td>75.9%</td>
<td>24.1%</td>
</tr>
<tr>
<td>P.E.I.</td>
<td>162</td>
<td>63</td>
<td>226</td>
<td>72.0%</td>
<td>28.0%</td>
</tr>
<tr>
<td>N.S.</td>
<td>1,044</td>
<td>416</td>
<td>1,460</td>
<td>71.5%</td>
<td>28.5%</td>
</tr>
<tr>
<td>N.B.</td>
<td>844</td>
<td>238</td>
<td>1,081</td>
<td>78.0%</td>
<td>22.0%</td>
</tr>
<tr>
<td>Que.</td>
<td>10,952</td>
<td>2,239</td>
<td>13,192</td>
<td>83.0%</td>
<td>17.0%</td>
</tr>
<tr>
<td>Ont.</td>
<td>18,440</td>
<td>1,250</td>
<td>19,690</td>
<td>93.6%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Man.</td>
<td>1,515</td>
<td>394</td>
<td>1,909</td>
<td>79.4%</td>
<td>20.6%</td>
</tr>
<tr>
<td>Sask.</td>
<td>1,325</td>
<td>123</td>
<td>1,447</td>
<td>91.5%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Alta.</td>
<td>4,207</td>
<td>153</td>
<td>4,360</td>
<td>96.5%</td>
<td>3.5%</td>
</tr>
<tr>
<td>B.C.²</td>
<td>5,480</td>
<td>618</td>
<td>6,098</td>
<td>89.9%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Total</td>
<td>44,600</td>
<td>5,695</td>
<td>50,295</td>
<td>88.7%</td>
<td>11.3%</td>
</tr>
</tbody>
</table>

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

1 As described in Box 2, FTE estimates use CIHI’s “Full-Time Equivalent Physicians Report, Canada, 2001–2002” and “Average Payment Per Physician Report, Canada, 2001–2002”. The relevant data series from these reports are presented in Appendix B, Tables B1 and B2. APP FTEs are estimated from data supplied by the provinces for this report.

2 British Columbia’s 2001–2002 FFS FTE physician estimates are preliminary. These estimates may be updated if British Columbia provides CIHI with retroactive payment information pertaining to services provided in 2001–2002.
When FTEs from fee-for-service and alternative payment modes are combined, the
distribution of physicians per 100,000 population is different from the distribution when
only fee-for-service physicians are included (Table 6, Figure 4). Quebec, Manitoba and
Ontario have 178 to 165 FTEs per 100,000 population, followed by Prince Edward Island,
Nova Scotia and Newfoundland and Labrador with 162, 156 and 156 respectively.

Table 6. Estimated Total FTE Physicians Per 100,000 Population\(^1\), by Type of
Payment and Province, Fiscal 2001–2002

<table>
<thead>
<tr>
<th>Province</th>
<th>FTEs Per 100,000 Population</th>
<th>Population Per FTE Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FFS</td>
<td>APP</td>
</tr>
<tr>
<td>N.L.</td>
<td>118</td>
<td>38</td>
</tr>
<tr>
<td>P.E.I.</td>
<td>117</td>
<td>45</td>
</tr>
<tr>
<td>N.S.</td>
<td>112</td>
<td>45</td>
</tr>
<tr>
<td>N.B.</td>
<td>112</td>
<td>32</td>
</tr>
<tr>
<td>Que.</td>
<td>148</td>
<td>30</td>
</tr>
<tr>
<td>Ont.</td>
<td>155</td>
<td>10</td>
</tr>
<tr>
<td>Man.</td>
<td>132</td>
<td>34</td>
</tr>
<tr>
<td>Sask.</td>
<td>131</td>
<td>12</td>
</tr>
<tr>
<td>Alta.</td>
<td>137</td>
<td>5</td>
</tr>
<tr>
<td>B.C.(^2)</td>
<td>134</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>144</td>
<td>18</td>
</tr>
</tbody>
</table>

Note: Fee-for-service is abbreviated as “FFS”; Alternative physician payment programs is abbreviated as “APP”.
\(^1\) Estimates of FTE physicians per 100,000 population were derived using Statistics Canada’s Net Population Estimates
for Canada, by Provinces, 2001 (see Appendix B, Table B3).
\(^2\) British Columbia’s 2001–2002 FFS FTEs per 100,000 population estimates are preliminary. These estimates may be
updated if BC provides CIHI with retroactive payment information pertaining to services provided in 2001–2002.

Figure 4. Total FTE Physicians Per 100,000 Population, by Type of Payment
and Province, Fiscal 2001–2002

Note: Fee-for-service is abbreviated as “FFS”; Alternative physician payment programs is abbreviated as “APP”.
Sources: Information is gathered through provincial/territorial representatives of CIHI’s Expert Group on
Physician Databases.
Box 2—Estimating FTEs in Fee-for-Service and in Alternative Payment Plans

Fee-for-service

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

Alternative payments

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

1. Actual counts of funded FTEs for specific programs were used where these data were available. In Nova Scotia, the majority of alternative FTEs are in block funding arrangements and FTE status is based on the CIHI methodology. Manitoba and Saskatchewan provide FTEs funding in northern locations and certain programs administered by regional boards.

2. Where physicians received most of their remuneration through alternative funding, amounts paid were divided by average paid per FTE. The denominators for this calculation were taken from CIHI’s “Average Payment Per Physician Report, Canada, 2001–2002” (see Appendix B, Table B2). This method was used in Nova Scotia for institutional psychiatry, and for Quebec physicians who receive the majority of their remuneration from alternative funding.

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, 2001–2002” (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 physician are not reported in the provincial database.
Prince Edward Island
Salary: Prince Edward Island has hospital-based salaried physicians in the specialties of internal medicine, paediatrics, physical medicine, oncology, radiation oncology, laboratory, psychiatry, anaesthesia, otolaryngology and obstetrics/gynecology. Also Prince Edward Island has salaried physicians in the area of family medicine that work primarily in collaborative family health centres.

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

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

All sessional and some blended payments are administered through FFS systems and are reported in NPDB.

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

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

Sessional: Most physicians who provide services in provincial mental health centres are on a contract arrangement that incorporates hourly payments. Many of these physicians also have fee-for-service practices in their local communities.
Block Funding: The Department of Pediatrics at Dalhousie University (approximately 45 physicians) has been block funding since July, 1994. The entire Department of Medicine became block funded in January 1999 (120 physicians). A number of smaller arrangements also exist. In total, 256 physicians were funded exclusively through this payment mode in 1999–2000.

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

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

New Brunswick

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

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

Block Funding: There is no block funding in New Brunswick.

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

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

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

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

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

Blended: This is a new program introduced in late 1999, as an alternative form of remuneration for specialists. Physicians who participate receive a flat daily rate plus a percentage of the fee-for-service rates for insured services. Approximately 2,700 specialists received alternative remuneration through this program in fiscal 2001–2002. Blended payments accounted for 80% of alternative and 14% of total payments to specialists that year.

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

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

Information Collection: All programs are administered by the Régie d’assurance maladie du Québec. Reporting systems incorporate encounter level data.

Ontario

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

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

Block Funding: The majority of APPs funding emergency room (ER), neonatal intensive care units, 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 ongoing monitoring and evaluation of all contracts in order to ensure adequate service levels and expectations are met.

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

Manitoba

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

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

Blended Funding Arrangements: A combination of fee-for-service and alternate funding used to remunerate the oncologists at Cancer Care Manitoba. Oncologists compensated under this arrangement are required to bill a minimum amount of fee-for-service in order to qualify for the alternate funding top-up.
Population-Based Funding and Primary Care: Capitation is not used by Manitoba Health, but has not been ruled it out as an option.

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

Saskatchewan

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

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

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

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

Blended: Anaesthetists in Saskatoon for the most part are paid on a fee-for-service basis. However the provision of obstetrical anaesthesia is funded through an alternate payment service contract. Transplant nephrologists are paid on a fee-for-service basis but they receive an additional stipend for administration, donor search and family consultation associated with each renal implant. Most alternate payment contracts allow fee-for-service billing of services provided to out-of-province beneficiaries. At least one family practice alternate payment contract applies to a defined list of services only and all other services rendered are paid on a fee-for-service basis.
General Practice Rural Emergency and On Call Payments: A Weekend On Call Relief Program implemented in February 1997 and the Emergency Room Coverage Program implemented in December 1997 are administered through the Medical Services Branch using the claims processing system with fee codes defined as time-based items.

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

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

Information Collection: Submission of encounter level data is a requirement of all alternative payment contracts but compliance varies. Claims are typically submitted through a shadow billing process that uses provincial fee schedule codes. Encounter level data is submitted through this manner from the Community Clinics. Encounter data are not available on services provided through the Clinical Services Fund, services provided by most hospital-based physicians (emergency, critical care associates, house officers, radiologists), by Northern Medical Services physicians, contract psychiatrists, salaried cancer clinic physicians and by pathologists.

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

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

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

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

Contractual: There is one contractual payment project within a community health centre (information as of 2000–2001).
Information Collection: Alternative payment service information is currently being collected for two of the above modes of payment using the existing fee-for-service codes (but without service counts or dollar amounts). In addition, evaluation activities for all operational projects are ongoing. They include personal interviews and monitoring. A new information system is being developed to facilitate alternative payment data reporting.

British Columbia

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

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

Sessions: Health authorities may apply to the APP for funding to pay sessional physicians. The health authority determines the amount of time it will require of physicians to deliver a particular health program, where 3.5 hours equals one session of physician time and where a session may be broken into quarter-hour increments. The APP commits a maximum number of sessions to the health authority, and the health authority submits a claim, with supporting records of physician services, to the APP for release of funding equal to the number of sessions used. Sessional payment rates and conditions are defined in the 2002 Provincial Sessional Agreement between government and the BCMA. The agreement applies to all government-funded sessional physician arrangements.

Population-Based Primary Health Care: A population-based, blended funding model for primary health care is administered through the Ministry of Health Planning’s Strategic Initiatives program and its Primary Health Care Organization (PHCO) model. The Ministry provides funds through a contractual arrangement for “core” family practice services for patients registered at a PHCO. Core services are those normally provided in family practices. Funding for the services is “blended”, being a combination of capitation-based and fee-for-service payments. Population-based funding (capitation) usually provides the contractor with approximately 90 percent of the revenue for the services delivered to registered patients. Fee-for-service payment provides approximately 10 percent of the revenues. Contracts for funding are normally negotiated between the Ministry and regional health authorities. Compensation of individual physicians is determined within the health authority and may be based on a salary, sessional or service agreements or capitation basis.
On Call Program: The Medical On-Call/Availability Program (MOCAP) is a provincial program established by the 2001 Working Agreement between the British Columbia Medical Association (BCMA) and the Government of British Columbia to ensure citizens reliable access to emergency medical services. Specialist and GP call groups provide on-call medical availability for emergency medical services for unassigned or orphaned patients at acute care hospitals, D&T centres, and specified emergency treatment rooms, as designated by each regional health authority.

Information Provision: The information compiled within the APP payment system is not easily reported along side the Ministry’s fee-for-service data. The APP is planning to redesign its systems to improve reporting to and from the health authorities, capture patient encounter information, and overall support the data collection necessary for health service planning and program evaluation.
Appendix A
Expert Group on Physician Databases
Ministry of Health Representatives

NEWFOUNDLAND AND LABRADOR
Barry Stanley
Manager, Finance and Statistics
Newfoundland and Labrador and
Labrador Department of Health and
Community Services
Confederation Building
West Block, 1st Floor
P.O. Box 8700
St. John’s, NF
A1B 4J6
Phone: (709) 729-2304
Fax: (709) 729-3151
E-mail: barrystanley@mail.gov.nf.ca

PRINCE EDWARD ISLAND
Johanne Irwin
Physician Services Manager
Prince Edward Island Health and Social
Services
16 Garfield Street
P.O. Box 2000
Charlottetown, PE
C1A 7N8
Phone: (902) 368-6736
Fax: (902) 368-6186
E-mail: jcirwin@ihis.org

NOVA SCOTIA
Mike Joyce
Economist
Nova Scotia Department of Health
Joseph Howe Building
1690 Hollis Street, 12th Floor
P.O. Box 488
Halifax, NS
B3J 2R8
Phone: (902) 424-6879
Fax: (902) 424-0605
E-mail: joycems@gov.ns.ca

NEW BRUNSWICK
James Ayles
Health Information Consultant
New Brunswick Health and Wellness
520 King Street
P.O. Box 5100, 2nd Floor
Carleton Place - Medicare/PDP
Fredericton, NB
E3B 5G8
Phone: (506) 457-3591
Fax: (506) 453-3983
E-mail: james.ayles@gnb.ca

ONTARIO
Julian Young
Manager, Information and Project
Management
Ontario Ministry of Health and Long-
Term Care
49 Place d’Armes
2nd Floor
P.O. Box 48
Kingston, ON
K7L 5J3
Phone: (613) 548-6323
Fax: (613) 548-6309
E-mail: julian.young@moh.gov.on.ca

QUEBEC
Harold Côté
Direction de la main-d’œuvre médicale
Ministère de la Santé et des
Services Sociaux
Gouvernement du Québec
1075, chemin Ste-Foy, 8e étage
Québec (Québec)
G1S 2M1
Phone: (418) 266-6987
E-mail: harold.cote@msss.gouv.qc.ca
Expert Group on Physician Databases
Ministry of Health Representatives

MANITOBA
Ted Tomchak
Economist
Manitoba Health
1030 - 300 Carlton Street
Winnipeg, MB
R3B 3M9
Phone: (204) 782-7206
Fax: (204) 775-7536
E-mail: ttomchak@gov.mb.ca

SASKATCHEWAN
Carmelle Mondor
Program Manager, Data & Statistical Services
Saskatchewan Health
T.C. Douglas Building
3475 Albert Street
Regina, SK
S4S 6X6
Phone: (306) 787-3450
Fax: (306) 787-3761
E-mail: cmondor@health.gov.sk.ca

ALBERTA
Serena Humphries
Business Solutions Lead
Alberta Health and Wellness
17th Floor, Telus Plaza, North Tower
10025 Jasper Avenue
P.O. Box 1360 , Station Main
Edmonton, AB
T5J 2N3
Phone: (780) 415-2782
Fax: (780) 415-1094
E-mail: Serena.Humphries@gov.ab.ca

BRITISH COLUMBIA
Ms. Mei Wong
Senior Economist, Economic Analysis and Negotiations Support
Ministry of Health
1-2, 1515 Blanshard St.
Victoria, British Columbia
V8W 3C8
Phone: (250) 952-3216
Fax: (250) 952-1414
E-mail: mei.wong@moh.hnet.bc.ca

YUKON
Sherri Wright
Manager, Systems and Insured Services
Yukon Department of Health and Social Services
204 Lambert Street
P.O. Box 2703
Whitehorse, YT
Y1A 2C6
Phone: (867) 667-5706
Fax: (867) 393-6486
E-mail: sherri.wright@gov.yk.ca
Appendix B
Table B1. Full-Time Equivalent Fee-for-Service Physicians, Canada and the Provinces, 2001–2002

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<tbody>
<tr>
<td>630.75</td>
<td>162.44</td>
<td>1,043.96</td>
<td>843.61</td>
<td>10,952.18</td>
<td>18,439.54</td>
<td>1,515.20</td>
<td>1,324.53</td>
<td>4,207.43</td>
<td>5,480.33</td>
<td>44,599.97</td>
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¹-British Columbia’s 2001–2002 FFS FTE physician estimates are preliminary. These estimates may be updated if British Columbia provides CIHI with retroactive payment information pertaining to services provided in 2001–2002.


Table B2. Average Payment Per Full-Time Equivalent Fee-for-Service Physicians, by Province, 2001–2002

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<tbody>
<tr>
<td>FP/GPs</td>
<td>140,445</td>
<td>160,474</td>
<td>180,378</td>
<td>193,173</td>
<td>150,304</td>
<td>181,781</td>
<td>156,343</td>
<td>173,336</td>
<td>202,743</td>
<td>208,301</td>
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<tr>
<td>Medical Specialists</td>
<td>190,183</td>
<td>207,059</td>
<td>219,047</td>
<td>223,957</td>
<td>165,151</td>
<td>221,753</td>
<td>196,682</td>
<td>219,312</td>
<td>227,916</td>
<td>245,082</td>
</tr>
<tr>
<td>All Physicians</td>
<td>175,855</td>
<td>192,714</td>
<td>220,595</td>
<td>227,706</td>
<td>169,352</td>
<td>213,026</td>
<td>191,772</td>
<td>203,371</td>
<td>232,064</td>
<td>240,016</td>
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<tbody>
<tr>
<td>532,400</td>
<td>139,100</td>
<td>934,800</td>
<td>750,700</td>
<td>7,416,800</td>
<td>11,924,600</td>
<td>1,144,400</td>
<td>1,012,700</td>
<td>3,065,500</td>
<td>4,102,800</td>
<td>29,900</td>
<td>31,053,700</td>
</tr>
</tbody>
</table>

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