Analysis in Brief

March 2010 **Spending and Health Workforce**

Profiling Physicians by Payment Program: A Closer Look at Three Provinces

Executive Summary

In the past 20 years, the introduction of alternative payment programs changed the way physicians in Canada receive their incomes; these payment programs shape remuneration for physicians of both genders in all specialties and age groups.

Using data from the National Physician Database (NPDB), this analysis identified physicians receiving payments from either fee-for-service (FFS) programs or alternative payment programs (APPs) between April 1, 2007, and March 31, 2008. This descriptive analysis looked at physicians' age, sex, specialty and geography in three provinces: Newfoundland and Labrador, Prince Edward Island and New Brunswick.

The analysis found that, while the majority of physicians received payments from both FFS and APPs, more than 70% of physicians still received the vast majority of their payments[i] from only one of these two broad payment programs. Of the three jurisdictions examined, physicians in New Brunswick were the most likely to receive the vast majority of their income from FFS (46.0%), while physicians in Newfoundland and Labrador were the most likely to receive the vast majority of their income through APPs (44.7%). Among APPs, salary was the most frequently used program.

Further, the study also found that certain types of physicians were more likely to be paid through certain payment programs. Overall, younger physicians and female physicians were more likely to receive the vast majority of their payments from APPs. By physician type, medical specialists were the most likely and surgical specialists the least likely to be primarily remunerated by APPs. And within physician types, female medical specialists were more likely than their male counterparts to receive the vast majority of their payments from APPs (69.6% versus 47.1%). For family physicians, there was little difference by sex; however, the difference among age groups was quite pronounced. Approximately two-thirds (67.9%) of those younger than 40 were paid by APPs, compared to 36.2% of those between 40 and 59 and 21.9% of those 60 or older.

i. The analysis used a threshold of 90% to indicate a vast majority of physicians' payments.

Who We Are

Established in 1994, CIHI is an independent, not-for-profit corporation that provides essential information on Canada's health system and the health of Canadians. Funded by federal, provincial and territorial governments, we are guided by a Board of Directors made up of health leaders across the country.

Our Vision

CIHI's vision is to help improve Canada's health system and the well-being of Canadians by being a leading source of unbiased, credible and comparable information that will enable health leaders to make better-informed decisions.

www.cihi.ca

Federal Identity Program

Production of this report is made possible by financial contributions from Health Canada and provincial and territorial governments.
The views expressed herein do not necessarily represent the views of Health Canada or any provincial or territorial government.

Canadian Institute for Health Information

Institut canadien d'information sur la santé

Taking health information further

Introduction

Since the introduction of the public medical care system in Canada in the 1960s, the majority of physicians in Canada have been compensated through FFS. Over time, the use of different payment programs became more prominent. For example, the use of APPs—such as salary, sessional, capitation, block funding, contract and other types of service agreements (see Appendix A)—has grown. Nationally, 24.2% of physicians' clinical earnings were paid through APPs in 2007–2008. This represented an increase from 2003–2004, when APPs represented 19.4% of physicians' clinical earnings (see Table 1).

Table 1 Alternative Payments as a Percentage of Total Clinical Payments, 2003–2004 to 2007–2008

Fiscal Year	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Nun.	Canada
2003–2004	36.3	26.6	35.7	21.9	22.9	15.9	29.8	25.6	9.1	19.5	11.5	97.4		19.4
2004–2005	34.2	29.0	41.4	23.2	23.7	16.7	29.4	26.2	10.8	19.8	16.3	94.4		20.3
2005–2006	31.6	32.0	42.8	24.9	23.9	18.3	28.7	25.7	12.2	20.2	16.0	96.1		21.0
2006–2007	30.0	36.6	45.7	26.2	24.0	20.2	29.2	26.8	11.6	20.6	13.8	94.4		21.8
2007–2008	30.7	39.6	47.0	30.2	25.6	24.4	31.9	27.2	13.4	19.9	13.6	93.8		24.2

Notes
Blank cells for Nunavut indicate years when data was not submitted.
Total clinical payments are the total sum of the physicians' clinical payments from fee-for-service and alternative payments.
Aggregate-level alternative clinical payment information is gathered through provincial and territorial ministries of health.
Sources
National Physician Database, Canadian Institute for Health Information; Provincial and Territorial Ministries of Health.

Why has the use of APPs to compensate physicians increased? The trend towards APPs is intended to better manage health care expenditure, improve quality of care and stabilize physicians' incomes.[1] The number of Canadians reporting unmet needs[ii] increased over the last 10 years. According to the Canadian Community Health Survey, reports of unmet needs rose across the country, from 6% in 1998–1999 to 12% in 2003–2004.[2] Physicians also reported high levels of dissatisfaction with current workloads and working conditions.[3] To better address these issues, a number of APPs were introduced, and they are steadily replacing FFS.[4] Over the years, however, a debate over the benefits of FFS and APPs arose.[5, 6] Is one payment program better than the others? Can payment programs be combined to create a blended remuneration?

These are the types of questions researchers and health human resource planners are trying to answer.

This Analysis in Brief will investigate how physicians in Newfoundland and Labrador, P.E.I. and New Brunswick were paid in 2007–2008, and what types of physicians were more inclined to be paid through APPs or FFS.

ii. An unmet need was determined based on a "yes" response to the following question in the National Population Health Survey and the Canadian Community Health Survey: "During the past 12 months, was there ever a time when you felt that you needed health care but you didn't receive it?"

Data Sources and Methodology

Data Sources

This analysis uses data from the NPDB, which provides information on the demographic characteristics of physicians and their levels of activity within the Canadian medical care system. Data is submitted to CIHI from the provincial and territorial ministries of health. The full data set comes from two separate data submissions to the NPDB. Generally, the NPDB receives quarterly physician-level fee-for-service data files and annual aggregate-level alternative payment data. However, the three jurisdictions in this analysis provided the NPDB with a more detailed data submission for APPs—these jurisdictions currently submit physician-level fee-for-service and alternative payment data.[iii] The data year for this analysis is 2007–2008.

A complete description of NPDB record layouts is available in the *NPDB Data Submission Specifications Manual* at www.cihi.ca.

Methodology

A descriptive analysis was conducted to provide an overview of the different physician characteristics associated with those who are paid through FFS or APPs. The characteristics analyzed were physicians' age, sex, specialty and geography. This information will provide a better understanding of how physicians were paid and which physicians used the various payment structures in their respective jurisdictions. Because this analysis focuses only on three provinces, the results should not be assumed to reflect the situation across the entire country.

In this analysis, the term "physician-level" is mentioned a number of times and should be interpreted as payments that were identified for individual physicians in Newfoundland and Labrador, P.E.I. and New Brunswick. A total of 3,029 physicians were included in this analysis.

The addition of physician-level alternative payment data to the FFS data set increased the total count of physicians from 2,506 to 3,029 (20.9%). The addition of this data also increased the overall money paid to physicians by approximately 55.7%, to $677.3 million for these three jurisdictions.

The age of physicians shown in the analysis was calculated as of March 31, 2008. The urban and rural geography of physicians was defined by using the statistical area classification code.

The results of this analysis will show the different demographics of physicians using FFS and APPs, with the following exclusions:

- Physicians whose total payments were negative in either payment program were excluded from the analysis.
- Due to inconsistencies and incompleteness in reporting, radiology and laboratory services and payments, services provided by radiologists and laboratory specialists and unclassified physicians were excluded from this analysis.
- The analysis focused only on clinical payments; non-clinical payments, such as funding for benefit programs (for example, for medical protective insurance and continuing medical education) and rural incentive programs were, therefore, excluded from the total alternative clinical payments.
- Groupings with a physician count of 1 to 4 were suppressed in this analysis.

Finally, to be consistent in how data was categorized across the jurisdictions, sessional payments reported in the FFS data set were included with alternative payment data.

---

iii. The NPDB is working with all other jurisdictions to receive physician-level alternative payment data. For more information on this project, please refer to the *NPDB Data Submission Specifications Manual, Version 4.0*.

Overview of Total Physician Compensation in Three Jurisdictions

The following analysis examines the distribution of physicians using total clinical compensation in Newfoundland and Labrador, P.E.I. and New Brunswick for 2007–2008.

Table 2 groups physicians into three areas: those who received payments only through APPs, those who received payments from FFS and APPs and those who were paid only by FFS. Generally, in 2007–2008, about one-fifth or fewer of physicians were exclusively paid via APPs or FFS. For example, between 9.6% and 27.6% of each province's physician workforce was paid exclusively through APPs. Conversely, between 6.7% and 33.0% of each province's physician workforce was paid exclusively through FFS.

The majority of physicians in the three provinces were paid through a mix of FFS and APPs, from 51.0% of physicians in P.E.I. to 83.7% of physicians in New Brunswick.

Table 2 Distribution of Physicians by Payment Program, 2007–2008

Payment Program	N.L. (n = 1,187)	P.E.I. (n = 294)	N.B. (n = 1,548)	Total (n = 3,029)
APPs Only	27.6%	16.0%	9.6%	17.3%
Both	55.1%	51.0%	83.7%	69.3%
FFS Only	17.3%	33.0%	6.7%	13.4%
Total	100.0%	100.0%	100.0%	100.0%

Source
National Physician Database, Canadian Institute for Health Information.

Table 3 breaks down the data further using the following categories: physicians receiving 90% or more of their payments through APPs, physicians receiving between 50% and 90% through APPs, physicians receiving between 50% and 90% through FFS and physicians receiving 90% or more through FFS.

While the majority of physicians received payments from both FFS and APPs, 74.3% of physicians still received at least 90% of their payments from only one of these two broad payment programs. However, the proportion of physicians receiving the majority of their payments from either FFS or APPs varied considerably between the provinces. The proportion of physicians receiving 90% of their payments or more through APPs shifted from a high of 44.7% in Newfoundland and Labrador to 33.7% in P.E.I. and 23.0% in New Brunswick.

Table 3 Distribution of Physicians by Main Payment Program, 2007–2008

Payment Program	N.L. (n = 1,187)	P.E.I. (n = 294)	N.B. (n = 1,548)	Total (n = 3,029)
APPs 90%+	44.7%	33.7%	23.0%	32.5%
APPs 50%–90%	6.7%	18.0%	15.1%	12.1%
FFS 50%–90%	12.3%	6.5%	16.0%	13.6%
FFS 90%+	36.3%	41.8%	46.0%	41.8%
Total	100.0%	100.0%	100.0%	100.0%

Source
National Physician Database, Canadian Institute for Health Information.

APPs refer to all payments made for clinical services provided by physicians and not reimbursed on an FFS basis, such as salary, sessional, capitation, block funding, contract and other service agreements.

Salary and sessional payments were the two largest payment sources for physicians who received at least 90% of their payments through APPs (see Table 4). In Newfoundland and Labrador, approximately two-thirds (63.6%) of physicians receiving the vast majority of their payments from APPs were reimbursed by salary. However, in P.E.I. and New Brunswick, a smaller proportion of physicians received salaries (35.4% and 36.2%, respectively).

In P.E.I., salary was still a commonly used APP (35.4%), but the majority of physicians were remunerated by contract payment programs (41.4%). In New Brunswick, the most dominant APP was sessional payments (46.6%). According to New Brunswick's provincial APP general description, "emergency departments in the province's eight regional hospital facilities use sessional compensation on a 24/7 basis," a note which may explain this high proportion.[7]

Table 4 Distribution of Physicians Receiving at Least 90% of Payments Through Alternative Payment Programs, by Payment Type, 2007–2008

Payment Program	N.L. (n = 530)	P.E.I.* (n = 99)	N.B. (n = 356)	Total (n = 985)
Salary 90%+	63.6%	35.4%	36.2%	50.9%
Sessional 90%+	12.8%	0.0%	46.6%	23.8%
Block Funding 90%+	4.0%	0.0%	0.0%	2.1%
Contract 90%+	0.0%	41.4%	0.0%	4.2%
Other Mixes†	19.6%	23.2%	17.1%	19.1%
Total	100.0%	100.0%	100.0%	100.0%

Notes
* Prince Edward Island has a small number of physicians overall; use caution when interpreting results.
† Other mixes were defined as physicians who received less than 90% of their payments from any one of the payment programs.

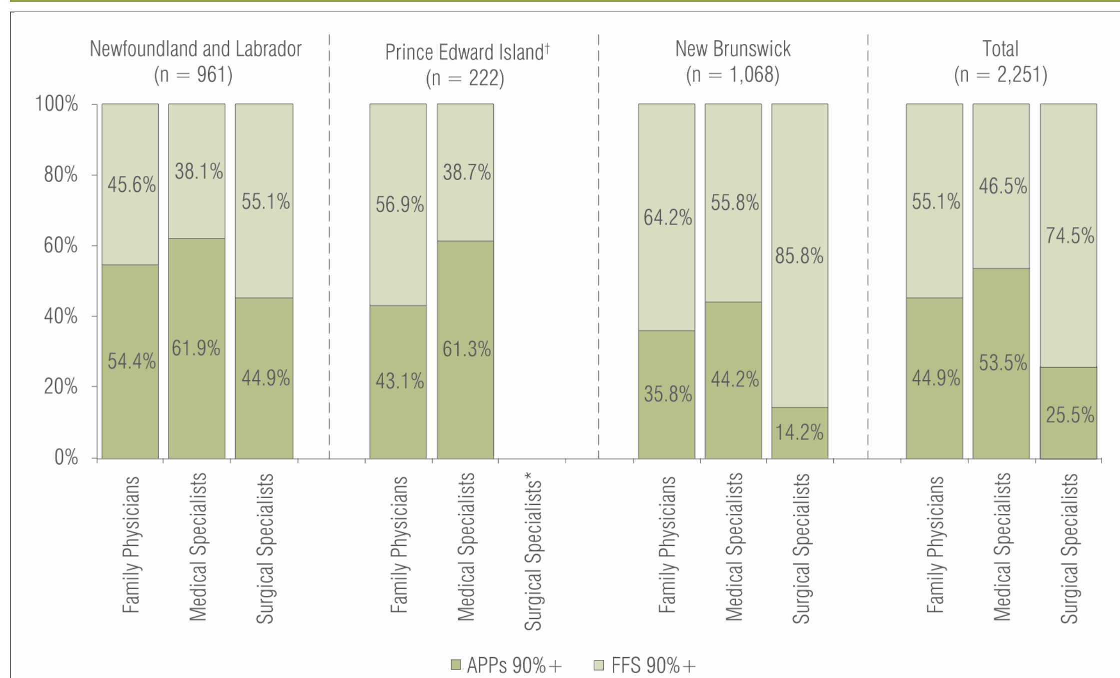
Source
National Physician Database, Canadian Institute for Health Information.

Profiling Physicians Mainly on Alternative Payment Programs Versus Physicians Mainly on Fee-for-Service Programs in Three Provinces

To further investigate how physicians were paid, the following analysis will focus on two categories: those receiving at least 90% of their payments through APPs and those receiving at least 90% of their payments through FFS.

In Figure 1, physicians from these two groups were split into three specialties: family physicians, medical specialists[iv] and surgical specialists. Among the three physician groups, medical specialists were most likely to receive the majority of their income from APPs (61.9% in Newfoundland and Labrador, 61.3% in P.E.I. and 44.2% in New Brunswick). Although the analysis does not attempt to identify any influencing factors, case complexity and lengthy diagnosis processes may make APPs more favourable to this group of physicians.

Figure 1 Distribution of Physicians by Payment Program and Specialty, Comparing Physicians Receiving at Least 90% of Payments Through APPs or FFS, 2007–2008



Notes

* Physician count was from 1 to 4 for this cell. Data was suppressed within the cell.

† Prince Edward Island has a small number of physicians overall; use caution when interpreting results.

Source

National Physician Database, Canadian Institute for Health Information.

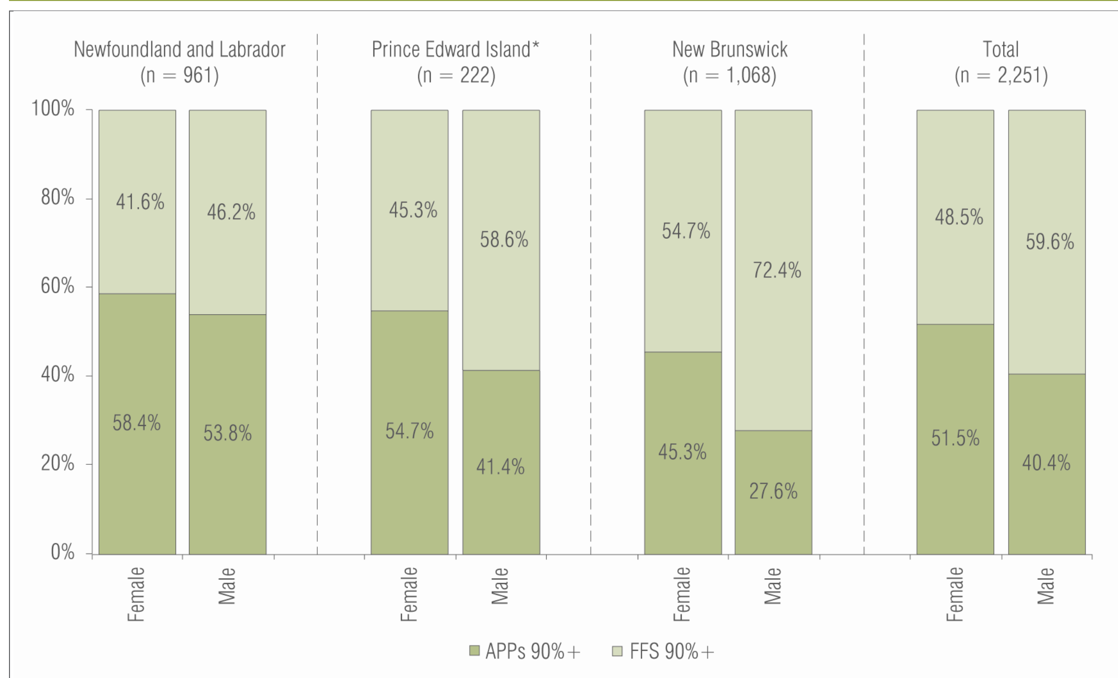
iv. Medical specialists include physicians specializing in the areas of internal medicine, genetics, neurology, psychiatry, pediatrics, dermatology, physical medicine and anesthesia.

As shown in Figure 2, male physicians were more likely than female physicians to receive the vast majority of their payments from FFS in all three provinces. More than half of all female physicians received payments mainly through APPs; in comparison, just fewer than two-thirds (59.6%) of male physicians received their payments mainly through FFS. This mirrors findings from the 2007 National Physician Survey, which found that male physicians were more likely than females to receive the bulk of their income through FFS (50.1% versus 43.2%).[3]

Figure 2 also highlights some provincial variations by gender. In each province, females were more likely than males to receive 90% or more of their payments from APPs; however

- More than half of all male and female physicians in Newfoundland and Labrador were paid mainly through APPs; while
- The majority of male and female physicians in New Brunswick received their payments primarily from FFS.

Figure 2 Distribution of Physicians by Payment Program and Gender, Comparing Physicians Receiving at Least 90% of Payments Through APPs or FFS, 2007–2008



Note

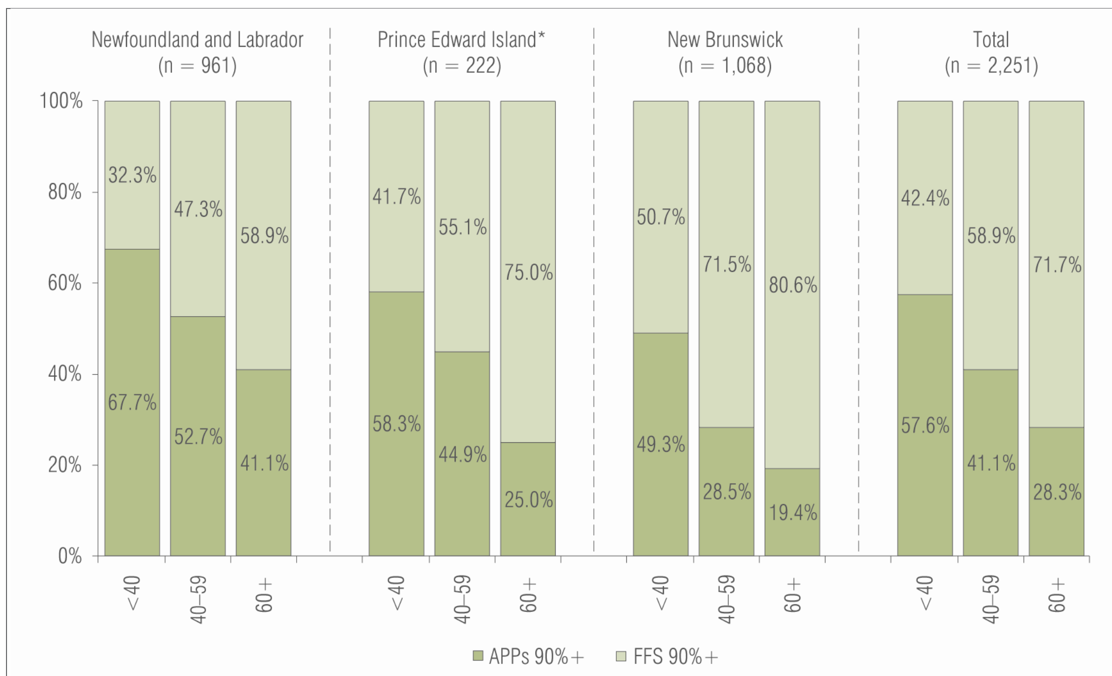
* Prince Edward Island has a small number of physicians overall; use caution when interpreting results.

Source

National Physician Database, Canadian Institute for Health Information.

The proportion of physicians receiving 90% or more of their income from APPs declined with age, from 57.6% among those younger than 40, to 41.1% among those 40 to 59 and 28.3% among those 60 and older (see Figure 3). Even though the age groupings were defined slightly differently, the results from the 2007 National Physician Survey were similar, with younger physicians still being the least likely to receive the majority of their income through FFS (39.9% of those younger than 35 versus 61.7% of those 65 and older).[3]

Figure 3 Distribution of Physicians by Payment Program and Age Group, Comparing Physicians Receiving at Least 90% of Payments Through APPs or FFS, 2007–2008



Note

* Prince Edward Island has a small number of physicians overall; use caution when interpreting results.

Source

National Physician Database, Canadian Institute for Health Information.

Why were some types of physicians more likely to be paid by one type of remuneration program than others? While this study is unable to consider all the factors (such as type of service needed, types of payment programs available and physicians' personal and professional preferences), the analysis looked at some demographic and geographic characteristics of physicians to determine which combination of factors tended to be most prominent among each of the two broad payment programs.

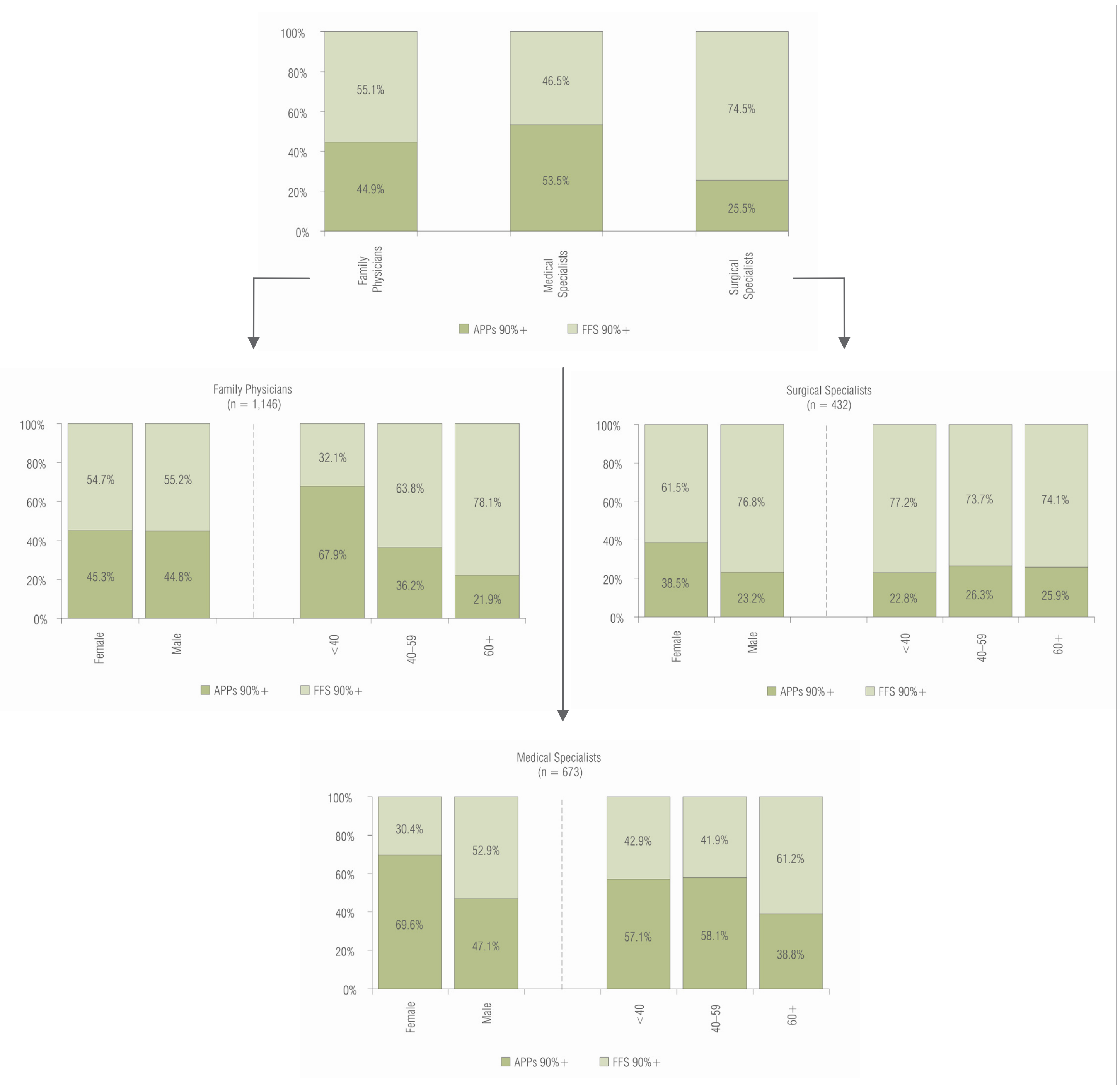
In many cases, analyzing multiple factors together to determine which types of physicians were remunerated by each of the two broad payment types simply confirmed the findings discussed above. For example, as discussed earlier, females and younger physicians were more likely to be remunerated by APPs. When analyzing payment types by gender and age, the same pattern emerged—younger physicians were still more likely to receive the vast majority of their payments from APPs and, within each age group, a higher percentage of females received the vast majority of their payments from APPs (see Appendix B).

Further, when looking at physician type and gender combined, we found that females were more likely to be remunerated by APPs. Looking at different specialties, however, did reveal some differences (see Figure 4). Among family physicians, a similar proportion of male and female physicians was primarily remunerated by APPs (44.8% and 45.3%, respectively). Among specialists, however, there were considerable differences between the percentage of male and female physicians remunerated by APPs. Among surgical specialists, females were more likely to receive payments mainly from APPs (38.5% versus 23.2% for males). The biggest gender differences existed among medical specialists: 69.6% of females received the majority of their income through APPs, compared to 47.1% of males.

An analysis by physician type and age groups revealed that the underlying assumption that younger physicians were more likely to be paid by APPs was not necessarily true for all specialties. For example, the age of surgical specialists did not seem to strongly influence their payment programs. Furthermore, among medical specialists, the results were almost identical for the younger and middle age groups, with 57.1% of physicians younger than 40 and 58.1% of physicians 40 to 59 receiving 90% or more of their payments from APPs.

Finally, while the gender of family physicians did not affect which payment type physicians tended to receive, age seemed to play a role. Two-thirds (67.9%) of family physicians younger than 40 received payments mainly through APPs, compared to 36.2% of physicians 40 to 59 and 21.9% of physicians 60 and older. Other studies have shown that the need for more stability in income is especially important for young family physicians in practice because they seek to balance their income with changes in their own professional and personal lives.[8]

Figure 4 Distribution of Physicians by Payment Program, by Physician Type, Gender and Age Group, Comparing Physicians Receiving at Least 90% of Payments Through APPs or FFS, 2007–2008



Source

National Physician Database, Canadian Institute for Health Information.

Did the prevalence of payment programs vary among urban and rural areas?

As illustrated in Figure 5, the prevalence of APPs for physicians practising in urban or rural areas varied by jurisdiction. In Newfoundland and Labrador, 74.5% of physicians in rural areas received at least 90% of their payments through APPs, compared to 44.6% of physicians in urban areas; in New Brunswick, a higher percentage of physicians in urban areas received 90% or more of their payments from APPs (33.2% versus 27.7% in rural areas).

Figure 5 Distribution of Physicians by Payment Program and Geographic Location, Comparing Physicians Receiving at Least 90% of Payments Through APPs or FFS, 2007–2008

Note

* Prince Edward Island has a small number of physicians overall; use caution when interpreting results.

Source

National Physician Database, Canadian Institute for Health Information.

The study also looked at the different combinations of geographic location and the gender/age/specialty of physicians by payment type. Overall, the results indicated that physicians of any age/gender/specialty who worked in rural and remote areas were more likely to receive the majority of their income through APPs than their colleagues in urban areas (see Appendix B). APPs were perhaps more predominant in rural and remote areas because of recruitment and retention strategies. The difficulty recruiting physicians to and retaining them in rural and remote areas is well documented in the literature;[8–10] physicians are particularly reluctant to work on an FFS basis in a sparsely populated region. Salaries or other types of APPs help to close income gaps by offering adequate and stable income to physicians in under-populated areas. Newfoundland and Labrador was an example of a jurisdiction that used APPs to successfully recruit physicians to and retain them in under-populated areas.[8]

Conclusion

How physicians are paid is an important component of health care reform debates in Canada. The general findings from the three provinces in this study (Newfoundland and Labrador, P.E.I. and New Brunswick) were that a mixture of payment programs was the dominant method of physician payment and that, among APPs, salary was the most frequently used APP.

Physician characteristics influenced the choice of payment methods. Overall, younger physicians and females were more likely to receive 90% or more of their payments from APPs. By physician type, medical specialists were the most likely and surgical specialists the least likely to be primarily remunerated by APPs. Furthermore, by physician type

- Gender differences became more pronounced among medical specialists, with 69.6% of females and 47.1% of males receiving the vast majority of their payments from APPs.
- Differences by age groups were most prevalent among family physicians, with those in the youngest age category being at least twice as likely to be remunerated by APPs as other age categories (67.9% versus 36.2% of those 40 to 59 and 21.9% of those 60 and older).

There are a number of questions worth investigating further in future studies. For example, will the patterns seen here be reflected in other provinces and territories? Do IMGs switch payment methods after they are fully licensed in Canada? How do average payments vary by payment program? How will various health care initiatives influence physician payment programs? What factors play a role in a province's or territory's choice to offer a certain type of payment program? What factors play a role in a physician's choice to choose one type of payment program over another?

CIHI is currently working with all provinces to enhance data collection to have the ability to integrate APP data with FFS data at the physician level across the country. This will provide a more complete measure of physicians' clinical compensation and utilization in the NPDB. CIHI developed an updated data specifications manual for the NPDB in September 2009, which is expected to be adopted by all jurisdictions. The updated manual includes the collection of physician-level information for all payment programs. The data collection process will begin in the fall of 2010.

Acknowledgements

The Canadian Institute for Health Information (CIHI) wishes to acknowledge and thank the following individuals for their contribution to this analysis:

Helen Ke Wei, Senior Analyst, Health Human Resources, CIHI

Walter Feeney, Senior Analyst, Health Human Resources, CIHI

Yvonne Rosehart, Program Lead, Health Human Resources, CIHI

Robert Kyte, Program Lead, Health Human Resources, CIHI

Geoff Ballinger, Manager, Health Human Resources, CIHI

Appendix A: Clinical Alternative Payment Programs

APPs are arrangements to pay physicians directly by methods other than FFS. Classifications vary across jurisdictions. Below are the different APP classifications.

Salary: Physicians are paid based on annual salary scales, either part time or full time. The deduction of income tax at the source and fringe benefits such as vacation are distinguishing features.

Sessional: Payments are based largely on the amount of time a physician spends—daily, weekly or monthly—delivering medical services to a defined group.

Capitation: Medical practices are paid a stipend for each patient registered with the practice. Payment rates may be adjusted based on the age and sex of patients.

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

Contract: Funding is negotiated for physicians providing defined services to a defined population; the compensation arrangement usually specifies services to be provided or time commitments.

Blended: These are mainly instances where physicians are compensated through FFS along with some other form of remuneration. Province-specific variations exist.

Psychiatry: Some jurisdictions pay for psychiatric services by salary, sessional or contract payments.

Northern and under-serviced areas: Most provinces and territories have special programs to ensure care is available in northern or under-serviced areas. These programs include several alternative payment modes, but this data is not broken out in CIHI reports. Along with most emergency and on-call payment programs, they are also counted in alternative clinical payments for comparison purposes. Saskatchewan funds rural on-call and weekend relief coverage payments through FFS.

Emergency and on-call: These alternative payments are to ensure service in emergency departments or for physicians on call in rural areas. They may supplement or replace FFS.

Appendix B: Additional Tables

This section lists the tables used for the analysis that were not included in the document.

Table B1 Distribution of Physicians by Payment Program, by Gender and Age Group, Comparing Physicians Receiving at Least 90% of Payments Through APPs or FFS, 2007–2008

Age	Gender	Payment Program	N.L.	P.E.I.†	N.B.	Total
<40	Female	APPs 90%+	62.9%	59.3%	54.8%	57.9%
<40	Female	FFS 90%+	37.1%	40.7%	45.2%	42.1%
<40	Male	APPs 90%+	70.3%	58.1%	44.0%	57.2%
<40	Male	FFS 90%+	29.7%	41.9%	56.0%	42.8%
40–59	Female	APPs 90%+	55.6%	54.5%	36.8%	46.9%
40–59	Female	FFS 90%+	44.4%	45.5%	63.2%	53.1%
40–59	Male	APPs 90%+	51.6%	43.2%	25.1%	38.9%
40–59	Male	FFS 90%+	48.4%	56.8%	74.9%	61.1%
60+	Female	APPs 90%+	53.8%	*	36.8%	42.9%
60+	Female	FFS 90%+	46.2%	*	63.2%	56.3%
60+	Male	APPs 90%+	40.0%	24.4%	17.7%	27.0%
60+	Male	FFS 90%+	60.0%	75.6%	82.3%	73.0%

Notes
* Physician count was from 1 to 4 for this cell. Data was suppressed within the cell.
† Prince Edward Island has a small number of physicians overall; use caution when interpreting results.

Source
National Physician Database, Canadian Institute for Health Information.

Table B2 Distribution of Physicians by Payment Program, by Gender and Geographic Location, Comparing Physicians Receiving at Least 90% of Payments Through APPs or FFS, 2007–2008

Location	Gender	Payment Program	N.L.	P.E.I.†	N.B.	Total
Rural and Remote Areas	Female	APPs 90%+	82.2%	*	38.8%	64.0%
Rural and Remote Areas	Female	FFS 90%+	17.8%	*	61.2%	36.0%
Rural and Remote Areas	Male	APPs 90%+	72.4%	57.1%	22.2%	58.7%
Rural and Remote Areas	Male	FFS 90%+	27.6%	42.9%	58.8%	41.3%
Urban Areas	Female	APPs 90%+	50.0%	56.4%	45.3%	47.9%
Urban Areas	Female	FFS 90%+	50.0%	43.6%	54.7%	52.1%
Urban Areas	Male	APPs 90%+	41.7%	33.0%	27.4%	33.1%
Urban Areas	Male	FFS 90%+	58.3%	67.0%	72.6%	66.9%

Notes
* Physician count was from 1 to 4 for this cell. Data was suppressed within the cell.
† Prince Edward Island has a small number of physicians overall; use caution when interpreting results.

Source
National Physician Database, Canadian Institute for Health Information.

Table B3 Distribution of Physicians by Payment Program, by Age Group and Geographic Location, Comparing Physicians Receiving at Least 90% of Payments Through APPs or FFS, 2007–2008

Location	Age	Payment Program	N.L.	P.E.I.†	N.B.	Total
Rural and Remote Areas	<40	APPs 90%+	89.0%	*	50.0%	77.2%
		FFS 90%+	11.0%	*	50.0%	22.8%
	40–59	APPs 90%+	72.8%	47.6%	22.7%	56.9%
		FFS 90%+	27.2%	52.4%	77.3%	43.1%
	60+	APPs 90%+	57.4%	*	*	44.3%
		FFS 90%+	42.6%	*	*	55.7%
Urban Areas	<40	APPs 90%+	56.0%	56.4%	48.1%	51.5%
		FFS 90%+	44.0%	43.6%	51.9%	48.5%
	40–59	APPs 90%+	42.6%	41.8%	28.6%	35.5%
		FFS 90%+	57.4%	58.2%	71.4%	64.5%
	60+	APPs 90%+	29.5%	*	18.9%	21.4%
		FFS 90%+	70.5%	*	81.1%	78.6%

Notes

* Physician count was from 1 to 4 for this cell. Data was suppressed within the cell.

† Prince Edward Island has a small number of physicians overall; use caution when interpreting results.

Source

National Physician Database, Canadian Institute for Health Information.

Table B4 Distribution of Physicians by Payment Program, by Physician Type, Gender and Age Group, Comparing Physicians Receiving at Least 90% of Payments Through APPs or FFS, 2007–2008

Location	Specialty	Payment Program	N.L.	P.E.I.†	N.B.	Total
Rural and Remote Areas	Family Physicians	APPs 90%+	71.1%	54.8%	26.4%	55.4%
		FFS 90%+	28.9%	45.2%	73.6%	44.6%
	Medical Specialists	APPs 90%+	83.9%	*	41.7%	77.0%
		FFS 90%+	16.1%	*	58.3%	23.0%
	Surgical Specialists	APPs 90%+	77.8%	*	*	66.7%
		FFS 90%+	22.2%	*	*	33.3%
Urban Areas	Family Physicians	APPs 90%+	41.3%	32.9%	38.1%	38.7%
		FFS 90%+	58.7%	67.1%	61.9%	61.3%
	Medical Specialists	APPs 90%+	56.0%	62.8%	43.0%	49.7%
		FFS 90%+	44.0%	37.2%	57.0%	50.3%
	Surgical Specialists	APPs 90%+	27.5%	19.2%	11.9%	16.9%
		FFS 90%+	72.5%	80.8%	88.1%	83.1%

Notes

* Physician count was from 1 to 4 for this cell. Data was suppressed within the cell.

† Prince Edward Island has a small number of physicians overall; use caution when interpreting results.

Source

National Physician Database, Canadian Institute for Health Information.

References

1. M. Holden and O. Madore, *Remuneration of Primary Care Physicians* (Ottawa, Ont.: Library of Parliament, 2002), accessed on December 10, 2009, from <http://dsp-psd.pwgsc.gc.ca/Collection-R/LoPBdP/PRB-e/PRB0135-e.pdf>.

2. Statistics Canada, *Canadian Community Health Survey, 1998–2004* (Ottawa, Ont.: Statistics Canada, 2009).

3. National Physician Survey 2004 and 2007, *National Results by FP/GP or Other Specialist, Sex, Age, and All Physicians*, last modified 2007, accessed on January 11, 2010, from <http://www.nationalphysiciansurvey.ca/nps/>.

4. R. A. Devlin et al., “Remunerating Primary Care Physicians: Emerging Directions and Policy Options for Canada,” *Healthcare Quarterly* 9, 3 (2006): pp. 34–42.

5. S. Martin, “Fee-for-Service V. Salary: The Debate Is Heating Up,” *Canadian Medical Association Journal* 169, 7 (2003): p. 701, accessed on December 9, 2009, from <http://www.cmaj.ca/cgi/reprint/169/7/701>.

6. R. A. Devlin and S. Sarma, “Do Physician Remuneration Schemes Matter? The Case of Canadian Family Physicians,” *Journal of Health Economics* 27, 5 (2008): pp. 1168–1181.

7. New Brunswick Ministry of Health, *Alternative Payment Program General Description (Internal Document)* (Fredericton, N.B.: Ministry of Health, 2008).

8. D. W. Wranik and M. Durier-Copp, “Physician Remuneration Methods for Family Physicians in Canada: Expected Outcomes and Lessons Learned,” *Health Care Analysis* (January 2009), accessed on December 9, 2009, from <http://toolkit.cfpc.ca/en/files/wranik.pdf>.

9. J. Rourke, “Increasing the Number of Rural Physicians,” *Canadian Medical Association Journal* 178, 3 (2008): pp. 322–325, accessed on December 10, 2009, from <http://www.cmaj.ca/cgi/reprint/178/3/322>.

10. J. T. B. Rourke et al., “Keeping Family Physicians in Rural Practice,” *Canadian Family Physician* 49 (2003): pp. 1142–1149, accessed on December 9, 2009, from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2214284/pdf/14526866.pdf>.