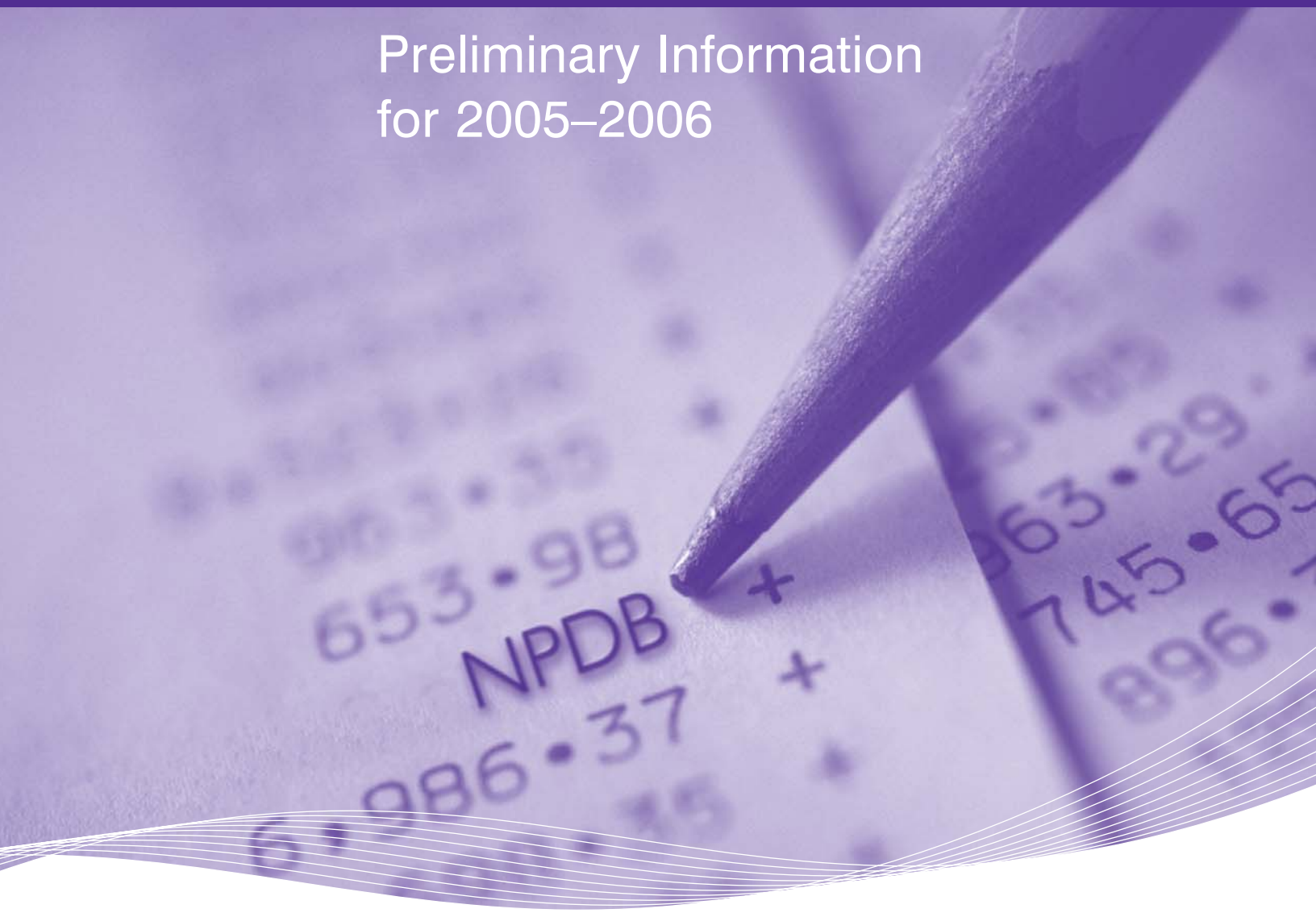
The Status of Alternative Payment Programs for Physicians in Canada, 2004–2005, and

Preliminary Information for 2005–2006



Alternative Payments and the National Physician Database (NPDB)

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The Status of Alternative Payment Programs for Physicians, 2004–2005 and Preliminary Information for 2005–2006

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Executive Summary

This is the first year that CIHI's *The Status of Alternative Payment Programs for Physicians, 2004–2005 and Preliminary Information for 2005–2006* reflects information received from all ten provincial Ministries of Health as well as two of the three territorial Ministries of Health. Previously, for missing provincial data, estimates from CIHI's National Health Expenditures Database were used.

Alternative payments in 2004–2005 were approximately 2.65 billion dollars—20.5% of the value of physicians' clinical payments. The percentage of alternative payments varied considerably across jurisdictions in 2004–2005, ranging from 10.8% in Alberta to 41.5% in Nova Scotia and 97.3% in the Northwest Territories. Between 2003–2004 and 2004–2005, alternative payments increased by 9.8%. While the proportion of alternative payments is still increasing, this is less than the increase of 24.1% reported between 2002–2003 and 2003–2004.

Over the past five years (2000–2001 to 2004–2005), total alternative payments in Canada doubled from 1.31 billion dollars to 2.65 billion dollars. The share of alternative payments has increased during that time in all jurisdictions. Preliminary 2005–2006 data indicate that alternative payments increased by approximately 10%.

Provincial and territorial governments adopt different approaches to funding particular alternative payment programs. On-call payments account for significant funding in most of the jurisdictions that report them. Other commonly funded alternative payment programs reported by jurisdictions include block funding, sessional and salary payments. Provinces and territories also make non-clinical payments, such as funding for benefit programs (such as for medical protective assurance and for continuing medical education) and rural incentive programs.

The prevalence of alternative remuneration can also be illustrated by looking at the proportion of physicians receiving at least some of their clinical income through alternative funding. Over half of physicians in Canada (55.0%) received some remuneration for insured services in the form of alternative payments in 2004–2005. Variation was found across jurisdictions. The percentage of physicians who received any alternative payments ranged from 9.7% in the Yukon and Alberta to approximately 75% in Nova Scotia and Manitoba and 96.1% in the Northwest Territories.

Based on the jurisdictions that provided information about the number of physicians who receive *at least 50%* of all clinical income through alternative funding for their jurisdiction, it is evident that only a minority of physicians rely on alternative remuneration as their main source of income under provincial and territorial Medicare plans. For example, about 12% of physicians in British Columbia and Ontario and approximately one quarter of physicians in Nova Scotia, New Brunswick, and Quebec receive *at least 50%* of all clinical income through alternative modes. Conversely, almost all the physicians in the Northwest Territories (96.8%) receive *at least 50%* of all clinical payments from alternative funding schemes.

Physician Full-Time Equivalents (FTEs) in alternative payment modes account for 11.8% of total FTEs. Alternative payment FTEs range from less than 10% of total FTEs in Alberta and Ontario to approximately 25% in New Brunswick, Newfoundland and Labrador, and Nova Scotia.

When FTEs from both fee-for-service (FFS) and alternative payment modes are considered, FTEs per 100,000 population show less variability among the provinces than when only FFS physicians are included. Based on total payments there were 158 FTEs per 100,000 population in Canada. Newfoundland and Labrador ranked highest (an estimated 172 FTEs per 100,000 population), while Quebec and Ontario ranked second, with each province having an almost identical number of FTEs per 100,000 population (164 versus 163 respectively).

As of early 2007, CIHI receives complete physician-level data on alternative payments from the provinces of New Brunswick and Newfoundland and Labrador, as well as partial physician-level data on alternative payments from Nova Scotia. Physician-level alternative physician payment plan (APP) data is important in that it allows expenditures to be itemized by specialty in order to understand what proportion of payments are FFS versus APP, as well as the similarities and differences across jurisdictions. Physician-level APP data also allows for an understanding of what proportion of physicians are paid from FFS and what proportion are paid from APP, useful information to continuously improve the quality of physician information in Canada and CIHI's National Physician Database (NPDB). Physician-level APP data also allows improved analysis of the number of FTE physicians as well as of the average payment per physician.

Introduction

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 (FFS). Specific objectives were to:

1. Document alternative physician payment plans (APP) and alternative funding plans (AFP) in Canada;
2. Document information collected by each province and territory about utilization and payments in APPs;
3. Quantify expenditures for APPs;
4. Assess impact of APPs on comprehensiveness and data quality in CIHI's National Physician Database (NPDB); and
5. Develop strategies and recommendations for incorporating alternative payments in NPDB.

Data in this report reflect the status of alternative payment plans in fiscal year 2004–2005. Preliminary data are presented for payments during 2005–2006.

To date, this report documents aggregate-level APPs and AFPs in Canada and quantifies expenditures for APPs at the national and jurisdictional level. From this information, the impact of APPs on the comprehensiveness of CIHI's NPDB can start to be addressed. For example, NPDB FFS data accounts for 79.5% of clinical payments across Canada in 2004–2005. The comprehensiveness varies by jurisdiction (please refer to Figure 2).

Over the past few years, considerable progress has been made to accumulate a national picture of utilization and payment information from APPs, as well as to work with jurisdictions to gather more detailed APP data. The following discussion illustrates the enhancements over the last year.

Collecting APP Data at the Aggregate Level from all Jurisdictions

CIHI has been working with all Canadian jurisdictions to collect aggregate-level APP data as a minimum, with a preference for collecting detailed information for each physician from all jurisdictions. The latest developments include:

Manitoba: CIHI's *The Status of Alternative Payment Programs for Physicians, 2004–2005 and Preliminary Information for 2005–2006* reflects information received from the Manitoba Ministry of Health in place of information that was estimated for the last three years from CIHI's National Health Expenditures Database.

Northwest Territories: Information on alternative payment programs in the Northwest Territories were also submitted to CIHI for the first time this year and are included in this year's report. *CIHI now receives alternative payment data from two of the three territories.*

Yukon: Has historically provided aggregate-level APP data since fiscal year 2001–2002 to this report.

Quebec: Has historically provided aggregate-level APP data. In addition, data at the specialty level is now provided.

The collection of APP data at the aggregate level from all jurisdictions is important in that it provides a more complete description of the APPs that exist in the various jurisdictions. All provinces now contribute data to this annual report, greatly improving our understanding of how alternative payment programs vary by province. Furthermore, now that the majority of territories provide CIHI with alternative payments data, we are getting closer to a complete national picture.

Collecting APP Data at the Physician Level

CIHI is working with the jurisdictions that already provide aggregate-level APP data in order to receive physician-level APP data. The latest developments include:

Newfoundland and Labrador: CIHI has received complete physician-level data on alternative payments this year for the first time.

PEI: Submits shadow-billing services for both salary and session on-call programs in its quarterly NPDB data submissions.

Nova Scotia: CIHI receives some physician-level data on alternative payments.

New Brunswick: Salary, sessional, and capitation data is identified in its quarterly NPDB data submissions. CIHI also receives complete physician-level data on alternative payments.

Ontario: Submits shadow-billing services for block funding programs in its quarterly NPDB data submissions.

British Columbia: Submits northern and isolation allowances in its quarterly NPDB data submissions.

In the absence of complete physician-level data on alternative payments in a given jurisdiction, partial APP data submissions must be carefully analyzed. This ensures that FFS and APP portions are not double-counted in cases where funding is joint, and in cases where the degree of partial reporting for a given APP is unknown. One of the ways in which CIHI is addressing this data quality issue is by supplementing the current aggregate information being received with more detailed summaries of the alternative payments made to Canadian physicians. Such information goes beyond totals to report by payment program and specialty.

With the collection of physician-level FFS and APP data, new analysis can be undertaken. For example, collecting APP data allows expenditures to be itemized by specialty in order to understand what proportion of payments are FFS versus APP, as well as the similarities or differences across jurisdictions. Analyzing physician-level APP data also allows for an understanding of what proportions of physicians are paid from FFS and what proportions are paid from APP. This level of information is useful to the continuous improvement of physician information in Canada and CIHI's NPDB.

Methodology

Data Sources

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

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

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

Summary of Alternative Payment Definitions

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

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

Alternative funding refers to methods other than FFS 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. In many provinces payment to radiology and pathology specialists are made through regional health authorities or hospitals and detailed payment data are not submitted to NPDB.

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

The various forms of **Alternative clinical payments** and **Alternative non-clinical payments** vary across jurisdictions and are defined in Appendix A.

Estimating Physician Full-Time Equivalents (FTEs) in 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 upper benchmark are counted by a log-linear methodology. Approximately 40% of physicians are below the benchmarks, 20% are within the benchmarks and 40% are above during the base year. In subsequent years the benchmarks are indexed to fee changes and FTE estimates are recalculated.

Estimating Physician Full-Time Equivalents (FTEs) in Alternative Payment Plans

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

1. Actual counts of funded FTEs for specific programs were used where these data were available. In Nova Scotia, FTEs in block funding are based on the number of physicians who receive all payments from block funding. Saskatchewan provides FTEs funded in northern locations and certain programs administered by regional boards.
2. For New Brunswick, each physician's total alternative payments are summed and compared to CIHI's FFS FTE benchmarks in order to calculate alternative payment FTE values using the FFS FTE methodology described above. This methodology can be applied as the province of New Brunswick reports alternative payment information to CIHI at the level of the individual physician.
3. A proportional estimate was used for all other jurisdictions. Proportions, calculated by dividing alternative payments by FFS payments using the figures given in Table 1, were applied to FFS FTE physician counts in order to estimate alternative payment FTEs[i]. The resulting estimates were reduced by one half due to an assumption that at least half of alternative payments would go to physicians who already exceed the FTE lower benchmarks of FFS payments.

Limitations

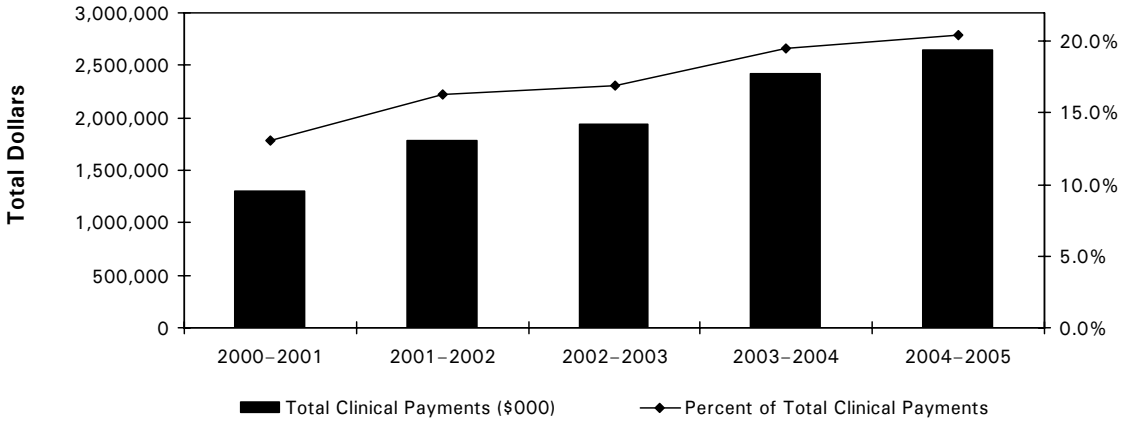
1. In estimating Physician FTEs in APPs, precise estimates are not possible using aggregate data, as FTEs are calculated from individual physician-level data. FTEs from different payment modes are not additive due to the fact that physicians with payments anywhere in between the benchmarks are counted as one and those above are counted by a log-linear methodology. However, the aggregate estimates provide useful information on the overall supply of physicians using FTE estimates that include both FFS and APP physicians.

i. FFS FTE physician counts were taken from CIHI's Full-Time Equivalent Physicians Report, Canada, 2004–2005 (see Appendix C, Table C1)

2. Radiology and laboratory specialists and services are excluded from FFS and APP analyses. This is done in order to provide a more appropriate base for comparisons across the different forms of physician payments.
3. Alternative payments are estimated from CIHI's National Health Expenditures Database for Ontario 2001–2002 and Manitoba 2001–2002 to 2003–2004.
4. Non-clinical payment information is incomplete as some payments identified as non-clinical may contain relatively small amounts for clinical services. Also, in some jurisdictions, part or all of these payments are made through hospital budgets and are not reported as physician payments. Therefore, the information on non-clinical payments is considered to be incomplete.

Alternative Payments in Canada: Findings and Analysis

Alternative payments in 2004–2005 were approximately 2.65 billion dollars—20.5% of the value of physicians' clinical payments (Figure 1). Between 2003–2004 and 2004–2005, alternative payments increased by 9.8%. While the proportion of alternative payments is still increasing, this is less than the increase of 24.1% reported between 2002–2003 and 2003–2004. Over the past five years (2000–2001 to 2004–2005), total alternative payments in Canada doubled.

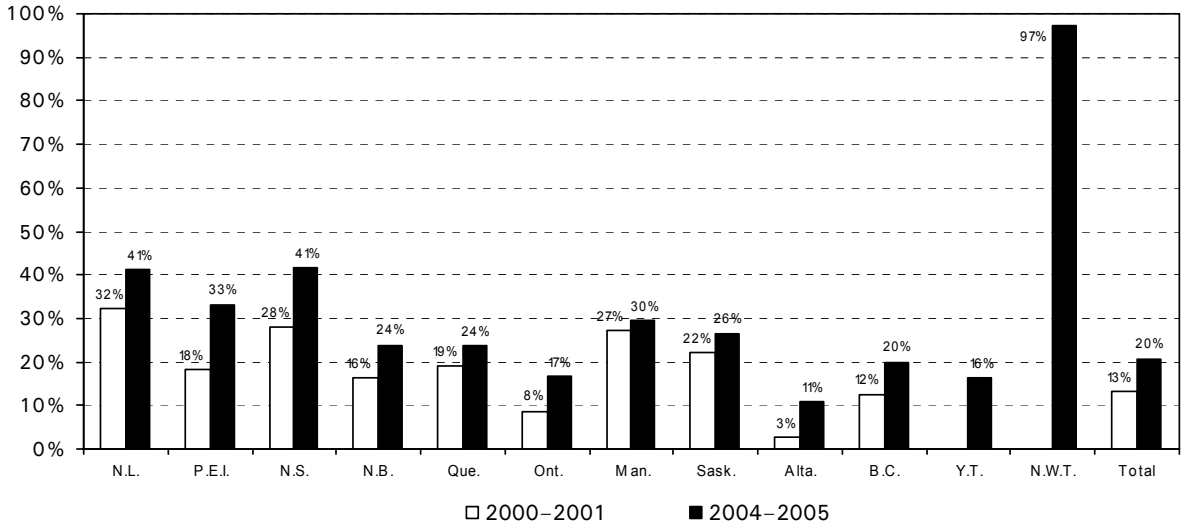


Notes: Data submissions were first received and are included as of 2001–2002 for the Yukon and as of 2003–2004 for the Northwest Territories. Data excludes Nunavut.

Sources: Provincial/Territorial Ministries of Health. CIHI National Health Expenditures Database for Ontario 2001–2002 and Manitoba 2001–2002 to 2003–2004.

Figure 1. Physicians' Alternative Clinical Payments in Canada, 2000–2001 to 2004–2005

This year's first data submission from the Northwest Territories indicated that almost all physicians are paid through salary or sessional arrangements, and therefore the Northwest Territories had the highest percentage of alternative payments (97%). Among the other jurisdictions, Newfoundland and Labrador and Nova Scotia were highest, at approximately 41% (Figure 2). All jurisdictions have increased the share of alternative payments since 2000–2001.



Notes: Alternative payments in the Northwest Territories were 97.3% of total payments.
Data for 2000–2001 were not available for the Northwest Territories and the Yukon. Data were not available for Nunavut.

Sources: Provincial/Territorial Ministries of Health.

Figure 2. Physicians' Alternative Clinical Payments as a Percentage of Total Clinical Payments, 2000–2001 and 2004–2005

Table 1 shows a five-year comparison of FFS and alternative payments by jurisdiction. This table documents the growth and prevalence of alternative payments in all jurisdictions. For example, the trends shown in Table 1 indicate an increase in the percentage of alternative payments each year for the provinces of Prince Edward Island, Nova Scotia, New Brunswick, Quebec, Ontario, and Alberta.

While the percentage of alternative payments increased in the early 2000s, the percentage of alternative payments has remained constant for the last few years for Newfoundland and Labrador, Manitoba, and British Columbia. Saskatchewan has shown increases and decreases in the percentage of alternative payments and the current level is below that of the 2002–2003 level.

Preliminary data for 2005–2006 are also shown and these estimates indicate that alternative payments increased by approximately 10% that year. FFS payments are not yet available from the NPDB for the 2005–2006 fiscal year and only the alternative payment components are presented.

Table 1. Physician Payments by Type of Payment in Thousands of Dollars and Percentage of Total Payments by Province/Territory, Fiscal 2000–2001 to 2004–2005

2000–2001

	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Total
Fee-for-Service	98,761	26,078	229,386	168,718	1,690,019	3,829,183	272,791	248,882	881,311	1,269,502	**8,714,633**
	67.7%	81.9%	72.1%	83.5%	80.9%	91.5%	72.9%	78.0%	97.2%	87.5%	**87.0%**
Alternative Clinical	47,201	5,761	88,855	33,314	398,162	355,674	101,320	70,233	25,214	181,122	**1,306,856**
	32.3%	18.1%	27.9%	16.5%	19.1%	8.5%	27.1%	22.0%	2.8%	12.5%	**13.0%**
Sub-Total Clinical	**145,962**	**31,839**	**318,242**	**202,032**	**2,088,181**	**4,184,858**	**374,111**	**319,115**	**906,525**	**1,450,625**	**10,021,490**

2001–2002

	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	Total
Fee-for-Service	96,769	26,711	230,079	185,966	1,779,976	3,911,634	289,680	266,680	975,423	1,386,455	7,671	**9,157,043**
	60.7%	81.9%	69.8%	82.0%	78.7%	88.1%	72.0%	75.8%	93.2%	82.5%	95.3%	**83.7%**
Alternative Clinical	62,526	5,901	99,514	40,813	482,322	530,484	112,892	85,153	70,871	294,132	379	**1,784,986**
	39.3%	18.1%	30.2%	18.0%	21.3%	11.9%	28.0%	24.2%	6.8%	17.5%	4.7%	**16.3%**
Sub-Total Clinical	**159,295**	**32,612**	**329,592**	**226,779**	**2,262,298**	**4,442,118**	**402,572**	**351,833**	**1,046,294**	**1,680,587**	**8,050**	**10,942,029**

2002–2003

	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	Total
Fee-for-Service	97,128	26,892	245,907	205,959	1,816,097	3,985,029	299,510	274,480	1,117,541	1,452,927	8,807	**9,530,276**
	57.8%	75.0%	68.4%	81.5%	78.1%	88.5%	70.5%	72.9%	91.3%	80.8%	92.0%	**83.1%**
Alternative Clinical	70,788	8,957	113,798	46,816	508,511	516,399	125,252	101,841	105,996	345,881	771	**1,945,011**
	42.2%	25.0%	31.6%	18.5%	21.9%	11.5%	29.5%	27.1%	8.7%	19.2%	8.0%	**16.9%**
Sub-Total Clinical	**167,916**	**35,849**	**359,705**	**252,775**	**2,324,608**	**4,501,428**	**424,762**	**376,321**	**1,223,537**	**1,798,808**	**9,578**	**11,475,287**

Please see footnotes at end of table.

Table 1. Physician Payments by Type of Payment in Thousands of Dollars and Percentage of Total Payments by Province/Territory, Fiscal 2000–2001 to 2004–2005 (cont'd)

2003–2004													
	N.L.	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**Y.T.**	**N.W.T.**	**Total**
Fee-for-Service	117,055	26,682	259,711	217,879	1,964,977	4,090,409	314,927	288,021	1,154,919	1,481,887	9,416	805	**9,926,687**
	58.2%	69.5%	64.3%	77.9%	77.0%	84.0%	70.1%	74.1%	90.9%	80.3%	88.5%	2.6%	**80.4%**
Alternative Clinical	83,933	11,691	144,194	61,660	587,590	780,111	134,250	100,415	115,416	362,891	1,228	30,341	**2,413,721**
	41.8%	30.5%	35.7%	22.1%	23.0%	16.0%	29.9%	25.9%	9.1%	19.7%	11.5%	97.4%	**19.6%**
Sub-Total Clinical	**200,988**	**38,373**	**403,905**	**279,539**	**2,552,567**	**4,870,520**	**449,177**	**388,436**	**1,270,335**	**1,844,778**	**10,644**	**31,146**	**12,340,408**

2004–2005													
	N.L.	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**Y.T.**	**N.W.T.**	**Total**
Fee-for-Service	128,376	26,805	250,352	227,301	1,989,857	4,272,005	340,255	319,633	1,215,567	1,505,269	10,064	829	**10,286,312**
	58.8%	66.9%	58.5%	76.4%	76.1%	83.2%	70.4%	73.6%	89.2%	80.1%	83.7%	2.7%	**79.5%**
Alternative Clinical	90,109	13,239	177,239	70,136	624,141	864,973	142,738	114,498	146,950	375,008	1,959	30,315	**2,651,305**
	41.2%	33.1%	41.5%	23.6%	23.9%	16.8%	29.6%	26.4%	10.8%	19.9%	16.3%	97.3%	**20.5%**
Sub-Total Clinical	**218,485**	**40,044**	**427,590**	**297,437**	**2,613,999**	**5,136,978**	**482,993**	**434,131**	**1,362,517**	**1,880,277**	**12,023**	**31,144**	**12,937,617**

2005–2006 (Preliminary Estimates)													
	N.L.	**P.E.I.**	**N.S.**	**N.B.**	**Que.**	**Ont.**	**Man.**	**Sask.**	**Alta.**	**B.C.**	**Y.T.**	**N.W.T.**	**Total**
Alternative Clinical	85,192	14,780	192,812	81,369	651,814	1,056,499	165,450	120,048	184,637	400,408	2,018	30,315	2,985,341

Notes: Data submissions from the Yukon have been received as far back as 2001–2002. Data submissions from the Northwest Territories have been received as far back as 2003–2004. Preliminary fee-for-service payment estimates based on the NPDB are not available for 2005–2006 at the time of writing. Columns may not add to total due to rounding. Data were not available for Nunavut.

Sources: Fee-for-service payments are based on data submitted to the National Physician Database, CIHI; Alternative clinical payment information is gathered through provincial and territorial Ministries of Health, with the exception of Ontario for 2001–2002 and Manitoba for 2001–2002 to 2003–2004. CIHI's National Health Expenditures Database was used as a source of estimates in those instances.

Table 2 shows types of physician payment that are defined as non-clinical alternative payments. In some cases, these other categories may contain relatively small amounts for clinical services. It is important to note that the information in Table 2 reflects both payment arrangements and reporting arrangements in provinces. For example, all jurisdictions have negotiated benefit packages for physicians but some jurisdictions do not report data for benefits. The category titled "Hospital-based physicians" primarily represents payments to radiologists and pathologists. In some jurisdictions part or all of these payments are made through hospital budgets and are not reported as physician payments. The information on non-clinical payments is considered to be incomplete, but is included here for jurisdictions that identified these payments.

Table 3 details the different types of alternative clinical remuneration used in the provinces and territories. On call payments account for significant proportions of alternative payment in all but one of the six provinces that report them. The results presented in Table 3 also indicate that provincial and territorial governments and medical societies adopt different approaches to funding particular programs or medical expenses. For example, while eight out of twelve reporting jurisdictions indicate salary payments, only two out of twelve reporting jurisdictions indicate capitation payments. Funding approaches also reflect attempts to redress perceived inequities in FFS or new approaches to service delivery; programs for emergency and on call reimbursement are notable examples.

Table 2. Summary of Non-Clinical Physician Payments by Type of Payment and Province/Territory, Fiscal 2004–2005 ($'000)

	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Total
Rural Incentives		441			18,652		11,625			8,618	1,292		**40,627**
Hospital-Based Physicians		4,253	38,350	42,858			41,751	47,080					**174,292**
Benefits	1,178	874	8,418	9,364	10,327			19,432	25,958	65,300	500		**141,351**
Sub-Total Non-Clinical	**1,178**	**5,568**	**46,768**	**52,222**	**28,979**		**53,375**	**66,512**	**25,958**	**73,918**	**1,792**		**356,269**

Notes: Missing values indicate that no payments were reported for a given category. Data were not available for Nunavut.

Sources: Provincial/Territorial Ministries of Health.

Table 3. Estimated Alternative Clinical Payments by Type of Payment and Province/Territory, Fiscal 2004–2005 ($'000)

	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Total
Salary	71,692	9,996	18,305	37,799	74,427	29,951				12,104		30,315	**284,589**
Sessional	1,948		1,454	28,458	222,242	680			5,243	54,833			**314,858**
Capitation						48,297			3,560				**51,857**
Block Funding	10,022		109,837			347,193		12,703					**479,754**
Psychiatry			11,023			1,076							**12,099**
Blended		3,243			327,472	141,261				8,459			**480,435**
Northern and Underserviced Areas						108,158		3,630		49,608			**161,396**
Emergency and On Call	6,447		36,620			188,357		20,083	71,400	124,400			**447,307**
Contracted/Unspecified				3,879			142,738	78,082	66,747	125,604	1,959		**419,009**
Total	**90,109**	**13,239**	**177,239**	**70,136**	**624,141**	**864,973**	**142,738**	**114,498**	**146,950**	**375,008**	**1,959**	**30,315**	**2,651,305**

Notes: Blended payments in Quebec consist of payments under a special program that combines daily payments and fee-for-service. Only the daily payments portion is shown in the above table.

Contract and Unspecified include:

i. Service Agreements in British Columbia.

ii. Payments that were not broken down by program.

Missing values indicate that no payments were reported for a given category.

Data were not available for Nunavut.

Sources: Provincial/Territorial Ministries of Health.

Physicians in Alternative Payment Plans: Findings and Analysis

As can be seen in Table 4, 55.0% of physicians in Canada received some remuneration for insured services in the form of alternative payments (including both clinical and non-clinical payments). The proportion of physicians who received alternative payments varied across jurisdictions. Table 4 details the *number of physicians* receiving alternative payments, as opposed to the jurisdictional payment amounts shown in Table 1. As shown in Table 4, in 2004–2005 both Alberta and the Yukon recorded the lowest percentage of total physicians paid through alternative modes (9.7%), while the Northwest Territories recorded the highest percentage (96.1%). Among the provinces, the percentages ranged from 9.7% of physicians in Alberta to approximately 75% of physicians in Nova Scotia and Manitoba.

Table 4 also shows that many physicians who received one form of alternative payment also received FFS payments and/or other types of alternative payment. Some jurisdictions provided the number of physicians who receive *at least 50%* of all clinical income from provincial sources through alternative funding,[ii] as indicated in the last two columns of Table 4. Although the data are incomplete, it seems evident from jurisdictions that do report this statistic that only a minority of physicians rely on alternative remuneration as their main source of income under provincial and territorial Medicare plans. The Northwest Territories is the exception.

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

Table 4. Total Physicians and Physicians Who Received Alternative Payments, by Province and Territory, Fiscal 2004–2005

	Total number of physicians	Number of physicians paid through alternative modes	Percent of total physicians paid through alternative modes	Number of physicians who receive at least 50% of all clinical income through alternative modes	Percent of total physicians who receive at least 50% of all clinical income through alternative modes
N.L.	1,013	443	43.7%	NA	NA
P.E.I.	239	122	51.0%	85	35.6%
N.S.	2,167	1,612	74.4%	522	24.1%
N.B.	1,527	873	57.2%	434	28.4%
Que.	14,403	8,718	60.5%	3,452	24.0%
Ont.	21,750	5,151	23.7%	2,600	12.0%
Man.	2,223	1,678	75.5%	NA	NA
Sask.	1,680	454	27.0%	NA	NA
Alta.	5,690	552	9.7%	NA	NA
B.C.	8,823	2,561	29.0%	1,043	11.8%
Y.T.	62	6	9.7%	6	9.7%
N.W.T.	78	75	96.1%	75	96.1%
Total	59,655	32,790	55.0%	NA	NA

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

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

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

NA = Not available

Data were not available for Nunavut.

Sources: Provincial/Territorial Ministries of Health.

Estimated Full-Time Equivalents

Overall, physician activities in alternative payment modes represent an estimated 5,955 FTEs (Table 5). Alternative payment FTEs are equivalent to 11.8% of total FTEs in Canada. Alternative payment FTEs range from less than 10% of total FTEs in Alberta and Ontario to approximately 25% in New Brunswick, Newfoundland and Labrador, and Nova Scotia[iii].

Table 5. Estimated FTEs in Alternative Payment, by Province, Fiscal 2004–2005

	Estimated Full-Time Equivalent Physicians			Distribution	
	FFS	APP	Total	FFS	APP
N.L.	656	230	887	74.0%	26.0%
P.E.I.	157	39	196	80.2%	19.8%
N.S.	1,014	359	1,372	73.9%	26.1%
N.B.	846	272	1,117	75.7%	24.3%
Que.	10,684	1,676	12,359	86.4%	13.6%
Ont.	18,338	1,857	20,195	90.8%	9.2%
Man.	1,477	310	1,787	82.7%	17.3%
Sask.	1,255	236	1,491	84.2%	15.8%
Alta.	4,217	255	4,471	94.3%	5.7%
B.C.	5,803	723	6,526	88.9%	11.1%
Total	**44,447**	**5,955**	**50,402**	**88.2%**	**11.8%**

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

The Territories are not included due to low numbers in either the FFS or APP cells.

Sources: As described in the *Methodology* section of this report, FFS FTE estimates are from CIHI's *Full-Time Equivalent Physicians Report, Canada, 2004–2005* (see Appendix C, Table C1). APP FTEs are estimated from data supplied by provincial Ministries of Health for this report.

The inclusion of alternative payments data leads to a more complete picture of FTE physician counts in Canadian jurisdictions. This additional information indicates that when FTEs from both FFS and alternative payment modes are considered, FTEs per 100,000 population show less variability among the provinces than when only FFS physicians are included. As can be seen in Table 6 and Figure 3, based on total payments there were 158 FTEs per 100,000 population in Canada. Newfoundland and Labrador ranked highest (172), while Quebec and Ontario ranked second, with each province having an almost identical number of FTEs per 100,000 (164 versus 163 respectively).

As can be seen in Table 6, provinces that are below the median in FFS FTEs tend to be above the median in alternative payment FTEs.[iv]

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

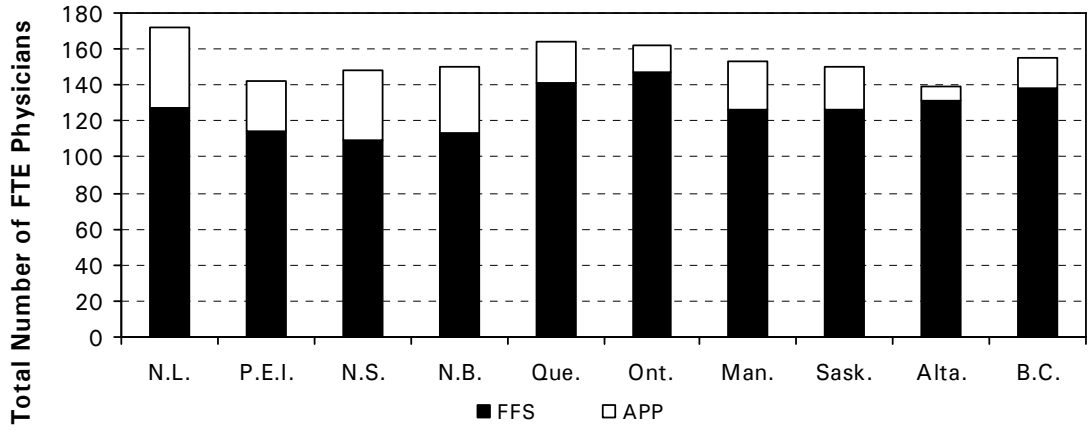
iv. Statistically, the coefficient of variation (defined as the standard deviation divided by the mean) across provinces drops from approximately 10% to 5%.

Table 6. Estimated FTE Physicians per 100,000 Population, by Type of Payment and Province, Fiscal 2004–2005

	Estimated FTEs Per 100,000 Population		
	FFS	**APP**	**Total**
N.L.	127	45	172
P.E.I.	114	25	139
N.S.	109	39	148
N.B.	113	38	151
Que.	142	22	164
Ont.	148	15	163
Man.	126	27	153
Sask.	126	24	150
Alta.	132	8	140
B.C.	138	17	155
Total	139	19	158
Median	127	24	152

Notes: Fee-for-service is abbreviated as "FFS"; Alternative physician payment programs are abbreviated as "APP". The Territories are not included due to low numbers in either the FFS or APP cells.

Sources: Estimates of FTE physicians per 100,000 population were derived using Statistics Canada's Net Population Estimates for Canada, by Jurisdiction, 2004–2005 (see Appendix C, Table C2). APP FTEs are estimated from data supplied by provincial Ministries of Health for this report.



Notes: Fee-for-service is abbreviated as "FFS"; Alternative physician payment programs are abbreviated as "APP". The Territories are not included due to low numbers in either the FFS or APP cells.

Sources: Estimates of FTE physicians per 100,000 population were derived using Statistics Canada's Net Population Estimates for Canada, by Jurisdiction, 2004–2005 (see Appendix C, Table C2). APP FTEs are estimated from data supplied by provincial Ministries of Health for this report.

Figure 3. FTE Physicians per 100,000 Population by Type of Payment, 2004–2005

Alternative Reimbursement in Each Jurisdiction

The provinces and territories have not followed consistent approaches to reporting services provided under alternative payment programs. Shadow billing[v] describes the process whereby physicians submit service provision information using fee codes, but payment is not directly linked to the services provided. 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.

This section contains details of alternative reimbursement in each province, using categories reported in the NPDB alternative payment series. The provincial and territorial ministries of Health have updated and/or reviewed the following descriptions during the preparation of this report.

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.

v. Further information regarding *Shadow billing* can be found in Appendix A.

Newfoundland and Labrador (cont'd)

Sessional: Sessional payments are an option for fee-for-service physicians who staff hospital emergency departments. Sessional tends to be favoured during the night shift. Sessional payments are also related to the provision of specialized care, such as diabetes clinics, cystic fibrosis clinics and genetic counselling.

Block Funding: Block funding arrangements exist for cardiac surgery, some 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.

Prince Edward Island

Salary: Prince Edward Island has hospital-based salaried physicians in the specialties of internal medicine, paediatrics, physical medicine, oncology, radiation oncology, laboratory, and anaesthesia. Prince Edward Island also has salaried physicians in the area of family medicine that work primarily in collaborative family health centres.

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

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

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

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

Nova Scotia

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

Nova Scotia (cont'd)

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. Emergency funding for the most severe triage levels 1 and 2 is based on the Murray Formula, which uses patient volume to determine the number of funded hours, and data are submitted annually. Additionally, there is designated money available for specialist on call services and family physician on call services.

Sessional: Most physicians who provide services in provincial mental health centres are on a contract arrangement that incorporates hourly payments. Many of these physicians also have fee-for-service practices in their local communities. Sessional arrangements are made for the provision of care in jails, detox centres, well women's clinics, teen health centres and for the provision of care to hospital inpatients that do not have a regular family physician.

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

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

Information Collection: Shadow billing is used to collect information on services provided under block funding and other salaried/contract positions.

New Brunswick

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

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

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

New Brunswick (cont'd)

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

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

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

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

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

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

Quebec

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

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

Blended: This is a program introduced in late 1999, as an alternative form of remuneration for specialists. Physicians who participate receive a flat daily rate plus a percentage of the fee-for-service rates for insured services. Approximately 3,300 specialists received alternative remuneration through this program in fiscal 2003–2004. The flat benefit of Blended payments accounted for 85% of alternative payments and about 30% of total payments paid to specialists in that year were under a Blended contract.

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

Quebec (cont'd)

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

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

Ontario

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

Sessional: Sessional payments are generally provided to fee-for-service physicians who provide psychiatry, 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. For emergency room payments, there are still a few hospitals paying physicians by "Scott Sessional", sessional payments in lieu of FFS payments recommended by the 1995 Scott report[vi] on physician services in small and/or rural hospital emergency departments.

Block Funding: The majority of APPs funding emergency room (ER), neonatal intensive care units, paediatric and gynaecological oncology physician services receive block funding. The block funding is paid to a physician group or association which is required to set up an internal governance structure which outlines how the physicians will be paid for the services negotiated under the APP contract.

Population-Based Funding and Primary Care: There are two main types of models that are funded through population-based funding. Both are primary care service providers. The first is physicians practicing within Health Service Organizations (HSOs). These are multi-disciplinary group practices, which are funded according to a purely population-based payment model. The second is physicians practicing within the Ontario Family Health Network framework. This is a blended funding model that uses a capitation payment for a base number of codes, but allows fee-for-service billing for any codes outside the basket.

Contractual: All Ontario alternate payment programs are arranged through a contractual agreement. The current preference for the Ministry is to first centrally negotiate a template agreement with the Ontario Medical Association and offer it to eligible physician groups. Where this is not possible, contracts are usually negotiated with physician groups, the Ontario Medical Association and the Ministry of Health and Long-Term Care. Participating physicians receive a pre-determined amount of funding to provide the list of in-scope services outlined in the negotiated contract. There is on going monitoring and evaluation of all contracts in order to ensure adequate service levels and expectations are met.

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

Ontario (cont'd)

Information Collection: All APPs have reporting expectations clearly outlined in the contracts. The most common form, "shadow billing", parallels the fee-for-service system. However, payments for services covered by the contract are assigned 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 is used to remunerate the oncologists at Cancer Care Manitoba. Oncologists compensated under this arrangement are required to bill a minimum amount of fee-for-service in order to qualify for the alternate funding top-up.

Population-Based Funding and Primary Care: Capitation is not used by Manitoba Health, but has not been ruled out as an option.

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

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

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

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

Blended: Anaesthetists in Regina and Saskatoon for the most part are paid on a fee-for-service basis. However the provision of obstetrical anaesthesia is funded through an alternate payment service contract. Transplant nephrologists are paid on a fee-for-service basis but they receive an additional stipend for administration, donor search and family consultation associated with each renal implant. Most alternate payment contracts allow fee-for-service billing of services provided to out-of-province beneficiaries.

General Practice Rural Emergency and On Call Payments: A Weekend On Call Relief Program implemented in February 1997 and the Emergency Room Coverage Program implemented in December 1997 are administered through the Medical Services Branch using the claims processing system with fee codes defined as time-based items.

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

Saskatchewan (cont'd)

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

Alberta

Salary/Contract: In a Contractual model, funding is based on a pre-negotiated amount, for a pre-determined volume of services over a specified period of time. There were thirteen contractual funding projects in Alberta in 2005–2006.

Contractual Academic Funding Plans (AFP): An AFP provides a means of amalgamating and integrating the various sources of funding that are used to compensate physicians within an academic department for the variety of services that they provide. These services may include teaching, research, clinical services and administration. There were seven academic funding plans in Alberta in 2005–2006.

Sessional: Under the sessional model the physician is paid a predetermined rate (usually an hourly amount) for work during a set period of time for the provision of defined insured medical services within an organized program. There were thirteen sessional projects in Alberta in 2005–2006.

Block Funding: Block funding resembles contractual funding, but differs in scope and scale. In block funding, all physicians in a given geographic area (e.g. regional, provincial) and within a single recognized discipline agree to provide all their medical services for a major period of time at one or more specified sites in exchange for a negotiated amount. There are no block funding projects in Alberta in 2005–2006.

Population-Based Funding and Primary Care: The Capitation model is used for the provision of family medicine or primary care. A medical practice is paid a predetermined annual amount for each of its patients. The funding allotment covers a basket of insured medical services. There were two capitation projects in Alberta in 2005–2006.

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

British Columbia

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

British Columbia (cont'd)

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 2004 *Provincial Service* and *Provincial Salary Agreements* between government, the Medical Services Commission and the British Columbia Medical Association (BCMA). A 2006 Agreement was signed between the three parties revising compensation rates stated within the 2004 Provincial Salary and Service Agreements.

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 claims, with supporting records of physician services, to the APP for release of funding equal to the number of sessions used. The 2004 Provincial Sessional Agreement outlines terms and conditions for sessional payments. Sessional payment rates were revised in the 2006 Agreement. The Provincial Sessional Agreement applies to all government-funded sessional physician arrangements.

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

Blended Funding Program: Population-based Primary Health Care: A population-based, blended funding model for primary health care is also administered through the MSD. Contracts for services are negotiated between the Ministry and health authorities for delivery of a fixed basket of 'core' services to a defined population. Health authorities then provide the service directly or contract with private practices for delivery of the care. Compensation of individual physicians is determined entirely within the health authority and/or private practice. Funding for the services is 'blended', being a combination of population-based funding for core services to the defined population plus fee-for-service for all other services. The population-based component of service funding uses a risk adjusted capitation model, which recognizes the impact of comorbidity upon the utilization of resources. Funding and payment under the model are directly linked to timely and accurate submission of encounter and claims data so compliance with reporting requirements under the model is high.

Yukon

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

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

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

Northwest Territories

Salary: Northwest Territories has hospital-based salaried physicians in the specialties of anaesthesiology, general surgery, internal medicine, obstetrics/gynaecology, orthopaedics, otolaryngology, psychiatry and pediatrics. As well, Norwest Territories has salaried physicians in the area of family medicine who work in clinics, emergency rooms and as hospitalists.

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

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

Appendix A

Alternative Payment Modes: Definitions

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 and 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. Northern or underserviced area programs and most emergency or on call payments are also included with alternative clinical payments to enhance comparability. In Saskatchewan, general practice rural on call and weekend relief coverage payments are billed on a fee-for-service basis.

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

Non-clinical payments—not included in 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, relocation allowances and locum programs, etc.

Hospital-based physicians: Funding provided to regions or hospitals for radiology and pathology, as well as other physicians employed by hospitals and paid through hospital budgets. This category also may include funding for clinical chiefs of staff, medical health officers, cancer and TB programs in some jurisdictions. The category may also include relatively small amounts of funding for salaried FTE positions. In this respect, it might include some clinical care transferred from fee-for-service remuneration.

Benefits: Contributions by the provinces and territories for Canadian Medical Protective Assurance (CMPA) and continuing medical education. In some provinces, this category also includes disability insurance and provincial contributions to physicians' retirement funds or maternity benefits.

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

Appendix B

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Appendix C

Table C1. Full-Time Equivalent Fee-for-Service Physicians, by Province, 2004–2005

N.L.	P.E.I	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Total
656.40	157.18	1,013.61	845.66	10,683.64	18,338.13	1,477.46	1,255.28	4,216.59	5,802.81	44,446.76

Source: *Full-Time Equivalent Physicians Report, Canada, 2004–2005*, CIHI 2006.

Table C2. Updated Post-Censal Net Population Estimates, Canada and the Provinces/Territories, 2004–2005 (000s)

N.L.	P.E.I	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Total
516.0	137.6	928.7	746.4	7,549.7	12,424.3	1,168.5	992.5	3,203.6	4,201.7	29.5	42.6	31,971.8

Notes: Net population estimates are produced by excluding from total estimates the members of the Royal Canadian Mounted Police, the Canadian Armed Forces personnel and the number of inmates in federal and provincial/territorial institutions.

Figures are updated post-censal estimates, based on 2001 census counts, adjusted for net census undercoverage.

Figures have been rounded independently to the nearest hundred.

Total includes Nunavut.

Source: Statistics Canada.