

## How family physicians are funded in Canada

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Family physicians (FPs) in Canada undergo specialised training, often in a Family Medicine Residency, and complete the College of Family Physicians of Canada (CFPC) national certification examination. Their payment is negotiated and administered separately by the 10 provincial governments and three territorial governments, using different funding arrangements in different settings. Under the Canada Health Act, provinces will be financially penalised if they permit private billing by physicians or copayments by provincially insured patients other than for certain services funded by third parties, such as insurance medical examinations, reports and travel services.

In 2001, FPs reported practising in private offices/clinics (73.1%), community health centres (7.1%), emergency departments (6.7%), hospital in-patient units (3.3%), walk-in clinics (3.1%), and family medicine teaching units (2.5%).<sup>1</sup> National surveys confirm that fee-for-service continues to be the main form

of remuneration for physician services (Box), with little apparent change between 1997 and 2001.<sup>1</sup>

### The drive towards alternative payment methods

Under the current healthcare system, 12% of Canadians (with considerable geographical variation) report having unmet healthcare needs.<sup>2</sup> Millions do not have access to an FP, and emergency department waiting times are long. FPs have identified high levels of dissatisfaction with current workloads and working conditions.<sup>1</sup> Governments appear to believe that alternative funding arrangements will address these problems and are the key to involving FPs in primary healthcare reforms.<sup>2,3</sup> Alternative payment approaches combine fee-for-service, capitation (lump sum payment per patient managed over a given period), salary, sessional and other funding arrangements.<sup>4</sup> Other, less common funding arrange-

ments include block funding and service agreements. In block funding, annual budgets are negotiated for a group of physicians, usually associated with an academic medical centre. Service agreements are often used to recruit and retain physicians in rural areas and take the form of:

- funding to regional boards for clinical services under arrangements by which boards have discretion regarding specific uses of the funds;
- contractual payments; and
- payment arrangements that incorporate both alternative remuneration and fee-for-service.

Both the Canadian Medical Association and the CFPC advocate that all FPs should be able to choose the practice model that best meets their patients', their co-workers' and their own needs.<sup>5</sup> In Canada's largest province, Ontario, both the Ontario College of Family Physicians and the Ontario Medical Association (OMA) support FPs working in practice networks (Family Health Networks) funded through a blended payment model (which combines different methods), but recommend physicians have a choice. The remuneration model for Family Health Networks (FHN) preferred by the Ontario Ministry of Health is based on:

- a capitated rate for all registered patients;
- fee-for-service payments at a rate of 10% of the provincial schedule for most services;
- bonuses for targeted preventive care (theoretically up to C\$8800/FP);
- payment for taking new patients;
- continuing medical education allowances;
- practice management fees; and
- some access to nurse practitioners paid by the government.

This model encompasses on-call arrangements 24 hours a day, 7 days a week, and evening and weekend clinic access. Working in such networks with blended capitation payment is thought to provide incentives for promoting preventive healthcare and chronic disease management, and to improve professional satisfaction.<sup>1</sup> However, uptake of the FHN model has been slow, prompting the Ontario government, in conjunction with the OMA, to introduce a simpler model, the Family Health Group. This model,

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### Remuneration\* among Canadian family physicians, 2001<sup>1</sup>

	Physicians receiving remuneration type <sup>†</sup>	Mean (SD) proportion of total income accounted for by remuneration type
Fee-for-service	23 070 (90.8%)	85.4% (24.9)
Salary	3 775 (15.0%)	50.5% (37.4)
Sessional	8 171 (32.5%)	35.0% (33.7)
Capitation	469 (1.9%)	69.9% (31.0)
Other	4 567 (18.2%)	14.1% (20.9)

\* Remuneration for clinical services other than on-call services. Based on a census survey of Canadian family doctors (n = 13 088) weighted to estimate the total population of Canadian family doctors. † The combined percentage may exceed 100% as some respondents checked off more than one answer.

based on virtual patient populations (either from the ministry health insurance database or patient registration), is paid on a fee-for-service model, with requirements to provide on-call arrangements 24 hours a day, 7 days a week, and after-hours clinic access.

The Primary Health Care Transition Fund<sup>3</sup> policy to shift physicians to a blended capitation model aims to improve access to care, quality, integration, health outcomes and cost-effectiveness. There is a strong desire that the most appropriate (least expensive) person deliver the service to the patient, invoking passionate debate about whether this means substituting for or supplementing FPs. The current policy position is that a collaboration of FPs with nurse practitioners, pharmacists and other professionals is more feasible with blended and capitation models than with the current fee-for-service arrangements. However, it is yet to be seen if blended payments and new models, with their additional administrative burdens on the FP and the practice, will add costs to the healthcare payer or improve health outcomes.

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