The Introduction of APPs in Alberta

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In 1995, the Government of Alberta signed a Letter of Understanding with the Alberta Medical Association. As part of the agreement, the Government and the Association gave formal recognition to a new method for reimbursing physicians in the province. In this case, we examine why Alberta chose in 1995 to introduce an Alternative Payment Plan (APP) for reimbursing physicians based on a plurality of potential funding models, governed by common guiding principles. The choice has facilitated a gradual movement towards shifting physicians from fee-for-service to other methods of reimbursement for services.

The case study is one of six developed in Alberta as part of a cross-provincial study on the determinants of health reform in Canada. These cases collectively cover four policy categories: setting out governance and accountability arrangements, establishing financing arrangements, making program delivery arrangements, and defining program content¹. The introduction of Alternative Payment Plans (APPs) is an example of the second category, where the policy issue relates to changes in how health care is financed.

Pertinent documents and public records (e.g., media, Hansard) were reviewed to establish the background for the case study. These information sources were complemented by 21 semi-structured interviews with key informants. The data were analyzed using a coding framework developed from the public policy literature that focused on key institutional, idea, and interest group concepts, as well as important

By mid-1992, the Minister of Health was busy delivering the fiscal message that became a hallmark of the Government after the 1993 election:

"expenditures since 1981 to the present fiscal have increased by 178 per cent [15 per cent/annum] although population and prices during the same 12 year period increased by 17 per cent and 66 per cent respectively...To meet the historical expenditures of the social sector and balance the budget on the current revenue base, virtually all of the remaining government departments would have to be closed."

As the Government moved closer to a provincial election in 1993, substantial focus was placed on a mounting provincial debt of \$ 32 billion that had accumulated during the 1980s, because of deficit budgeting, in part, directed towards economic diversification. Getty's term as Premier had been punctuated by the collapse of a number of major firms, such as the Principal Group, that had developed as a result of government largesse. The Government had also accumulated financial losses from the support of Novatel, a failed attempt to enter the cellular telephone manufacturing industry. In addition, the Getty Government faced a major plunge in oil revenues. Although the government responded by cutting expenditures and raising taxes, it remained unable to overcome the mounting financial problems. The net result was a loss of confidence in the strong state presence in the marketplace initiated by Lougheed.⁵

In addition to these internal problems, the provincial Progressive Conservatives faced a significant challenge from the federal Reform Party. With a platform of fiscal austerity and smaller government, and its political base in Alberta, the Reform Party was a threat to move into the provincial political arena, if the Progressive Conservatives did not fill the political vacuum. This set the stage for the emergence of a political agenda of radical expenditure reduction. Not surprisingly, provincial conservative political strategists perceived that failure to address this issue could have serious electoral consequences.

were well crafted exercises in public relations. When Government released its report about the Roundtables on Health Care, the conclusions were consistent with the larger political agenda.⁸

Government-Physician Relations

Traditionally, the Government of Alberta and the Alberta Medical Association have been ideologically aligned on major issues affecting the practice of medicine. Alberta resisted entry into national Medicare during the early 1960s and also sought to protect the rights of physicians to extra-bill during the debate surrounding the introduction of the Canada Health Act. Although this has been the case, the AMA only received official recognition as the sole representative of physicians in the province in 2003. Prior to this, the role of the AMA as primary representative of the collective interests of physicians in Alberta was an informal convention that existed on a contract-by-contract basis.

Within this conventional role, the AMA has negotiated a multi-year, collective (Master) agreement encompassing the reimbursement of physicians and since the introduction of capped budgets has determined the distribution of the funding within the collective agreement across medical specialties. The 1986 master agreement contained provisions for bilateral consultation on matters relating to capped budgets.

A cap on the overall physician budget was achieved through negotiations leading to a seven-year agreement beginning in April 1992. The agreement, which included a 5.5 per cent increase at 85% of the previous year CPI (year one of the agreement), marked the first time that the government had placed any limits (a hard cap) on the overall physician budget. Under the agreement, individual physicians earning above a set dollar limit could have their income reduced during the next quarter. In essence, if doctors



case of physicians, the government called for a 5% roll-back of salaries for physicians and other health care workers with a November response deadline. In November, the AMA responded indicating a willingness to take a pay cut, but only within the context of negotiations for a greater say in health reforms. In the ensuing negotiations, the AMA agreed to a 6.8% rollback during 1994/95, including a recognition that an additional 10% reduction found in the Alberta Health business plan would be required. In total, \$200 million was to be slashed from the physician services budget in the following two-year period. Included in the agreement was a plan to consolidate private lab services to save \$56 million, de-insure \$5 million in services annually and place a temporary limit on the number of new doctors who could establish practices in the province. What the AMA did not achieve was recognition as the sole representative of physicians in the province or physician representation on regional health boards. In a follow-up vote in June of 1994, 56% of members ratified the deal.

In January of 1995, negotiations between the two parties began again. The objective of the negotiations was to find \$100 million in savings from the physician services budget. During the negotiation, the AMA proposed the introduction of a managed care model, Fee-for-Comprehensive Care, as an alternative method of payment to fee-for-service. The proposed model was to be optional and would involve either individual physicians or groups of physicians who would "be prepaid a set amount to provide a defined set of primary care services to a defined population for a defined period of time." ¹⁴ While preliminary consensus was reached on the Fee-for-Comprehensive Care proposal, the idea was subsequently rejected by Alberta Health. In light of the continued government insistence on an additional \$100 million in savings from the physician

With a committee of six with equal representation from Alberta Health and the medical association, achieving consensus was often very difficult:

Direct quote removed to protect identity of source



Second, the devolution of responsibility for service delivery to health regions and the subsequent significant reduction or elimination of staffing in many program areas left the Ministry with little capacity or expertise about the day-to-day workings of the health system. Between 1994 and 2004 a total of eight Deputy Ministers were rotated through the department. Several reorganizations of the department also ensued. Observers concluded that after such tumult, here was little policy capacity left inside the department anyway.

Further complicating the capacity issue was the tendency within the department to





from rural constituencies, the new government forged a consensus around the necessity of significant change to eliminate a growing deficit and debt. In this policy environment, the luxury of being able to arrive at a stalemate in medical negotiations ended. Alberta Health received clear instructions from Treasury Board to cut physician costs by 20 per cent in three years. Although politicians were committed to this larger objective, they were less certain about s



was a primary consideration for politicians, although the political homogeneity of the province ultimately gave government the upper hand.

Regional Health Authorities

In general, RHAs were interested in APPs because of the competition for scarce resources, such as rural physicians. Thus, they tended to watch each other closely for the impact of new physician initiatives. Since they were in competition with each other for doctors and nurses, coming to the table and speaking with one collective voice was



Alberta Medical Association

In contrast to the organizational turmoil experienced by Alberta Health bureaucrats, the AMA was a well-organized and relatively stable organization that was responsive to its membership. When it came to negotiations with government, the AMA always came well prepared, having consulted both the existing body of academic evidence and policy learning from other associations across the country. Thus, for all intents and purposes, the AMA drove negotiations around the Master Agreement, especially during the 1990s. Although it has developed a cooperative stance in negotiations with government since the early 1990s, the AMA has argued consistently for physician-led (centred) primary care reform through a variety of reimbursement options. The maintenance of FFS as a reimbursement option and physician choice have continued to be priorities.

A number of issues relative to these negotiations emerged in the early 1990s. Although through convention, the AMA played the role of bargaining agent for its members, the role was not legislated and was thus subject to being reaffirmed at the beginning of each negotiation. With the advent of health reforms, this role was potentially threatened both from within the ranks of the profession and from other political actors. For example, in the wake of the negotiated fee cap in 1992, the Calgary-based Multidisciplinary Association of Medicine challenged in Court of Queen's Bench the right of the AMA to negotiate an agreement with government that was binding on all Alberta physicians. ³⁷As previously discussed, by the early 1990s there were a number of APP arrangements in place of which the AMA had little or no knowledge.

In the general policy discourse, fee-for-service as a method of payment for medical services was seen as encouraging undesirable behavior including: volume-driven care or "churning" rather than service provided based on need; lack of focus on promotion and prevention or chronic disease management; and a lack of fairness in the distribution of financial resources across medical specialties (relative value). For these



such as the shortage of rural doctors or the need to pursue more promotion and prevention as best practice.

Alberta Health had been working on developing a general accountability framework since the Getty era. As early as 1989, the Department of Health (as it was then called) developed an internal discussion paper "to provide a common basis of understanding to facilitate a discussion of 'accountability' and 'accountability mechanisms' among a variety of players within the Department of Health." ⁴⁵ Some of this preliminary internal thinking was shared with other jurisdictions through the Minister's speech at the F/P/T Conference of Health Ministers in September 1989. ² As an idea in good currency,

the whole discussion around accountability I think was politically attractive too and aligned with the conservative philosophy that if you give people an amount of money they have to be responsible for what happens to it and be able to account for what happened to it.

In 1991, the way to achieve accountability included:

"planning for health services based on identified needs, goals and outcomes; enhancing health information that will assist in monitoring and evaluating the health system; increasing provider responsibility and accountability in managing resources [our emphasis]; and facilitating consumer choice and responsibility in health resource utilization." ³

By 1993, Alberta Health was contemplating defining accountability relationships among health providers, the Department and Government and drew heavily on the earlier concepts of accountability mechanisms and measurement:

Conference of Deputy Ministers of Health. Among, other things, the Barer-Stoddart Report suggested that there was an oversupply of physicians and current approaches to determining medical human resource needs would not likely resolve persistent problems, such as the shortage of physicians in rural areas. In the early to mid-1990s, all provinces responded to this logic by reducing funding for medical schools. Again, as an idea in good currency, this meshed with the political imperative to reduce expenditures in health care.⁴⁷

Because of the significant financial and power implications of the reforms for physicians, the AMA was pro-active in developing APP options. In preparation for the 1995 negotiations, the AMA produced a discussion paper on Fee for Comprehensive Care, an APP option for primary care. The paper became the foundation for the development of APPs in Alberta. As described:

The proposed F C C (FCC) is a strictly optional, alternative mechanism – in addition to $FEE\ F$ E CE [original emphasis] – for payment of Alberta physicians. It is remuneration for prepaid medical care based on dollars per patient rather than dollars per service. The generic equivalent would be capitation.⁴⁹

In providing a rationale for the new payment mechanism, the AMA noted that:

The status quo is no more. Major changes are happening in Alberta and restructuring means both opportunities and risks. There is risk in embracing and fashioning change. There is also risk in trying to avoid, delay or subvert change...Payment mechanisms other than fee for service are becoming more comng i 1 Tfeao a.2 -0.2T1.0 1 T(e) 0.2 (c) 0.2(ha) 0.2 (nT 5(e) ha)o 0.2 (om)d0 1 T(e) (c.2 (ha)T

Establish an overall provincial context under which primary health care alliances can be established. To overcome physician fatigue with health reform, Alberta Health, AMA and the health regions collectively would need to reach agreement on common goals and working relationships, develop a clear workplan, develop clear principles for pilot projects, and generate joint discussion papers on alternative financing and de92cm BT 3.76 30 TT 3.76(fSc) 0.2 (i) 0.2 (ng a)00aat on



 Formation of Physician Groups and Physician Acceptance of Payment Alternatives

This deals with how local physicians form practice groups using alternative payment methods. To make this happen, Tripartite would need to effectively communicate remuneration options, encourage the use of pilot projects, and develop support tools to assist physicians to determine which payment option was best suited for their local circumstances.

4. Alliances

Alliances of communities, physicians and other providers could be encouraged through the Tripartite Process, including pilot projects to assess the cost-benefit impact of alliances. To accomplish this, opportunities for new relationships between providers through APPs needed to be considered; APPs needed to be directly managed through Tripartite; appropriate inducements fpr those considering pilot projects needed to be developed; and, a process for public involvement needed to be developed.

5 Flow of Resources from RHA budgets

If, and how, the RHAs flow funds and resources to local communities will partly drive the alliances that are possible. The AMA committed some time ago to

depending on the circumstances. This also began the process of bringing the variety of existing APPs into greater alignment with the Physician Services Budget.



