Alternative Payment Plans in Saskatchewan

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of payment, there has not been significant movement away from the fee-for-service payment system in the province. Beginning in 1992 as part of a large-scale health system restructuring, the Government of Saskatchewan set up a branch of Saskatchewan Health dedicated to alternative payments (the Alternative Payments Unit) and began a number of pilot projects in various communities across the province. The physicians were paid using a capitated payment plan and were part of primary health care teams consisting of a diverse group of health care practitioners. This approach included service delivery and performance expectations that focused on team rather than individual results for individual patients and the population being addressed by the team. The projects were viewed as unsuccessful and did not create a large following for alternate payments. That was until the 2002 Action Plan sought a greater role for primary health care teams as part

It must be noted that payments to physicians other than using a fee-for-service plan is not a new phenomenon in the province. With the introduction of medicare in 1962, a number of clinics sprung up around the province called *community clinics*. These rural clinics, which are still functioning today, have as few as a single physician paid for the most part through a n divT1 0-Cr

Even though the option, either through the projects set up in 1994 or through community clinics, has been around for quite some time, there is still not see a large-scale move to non-fee-for-service payment a decade later. As of the 2003 fiscal year, fee-for-service paid physicians totaled 69% of total spending of the Medical Services Branch of Saskatchewan Health[2] whereas non-fee-for-service paid physicians accounted for 1.5%.[3] This project has attempted to answer the question of why the government decided to examine a voluntary alternate payment scheme through pilot projects set up throughout the early 1990s though not until 2002 with the *Saskatchewan Action Plan for Primary Health Care* were alternate payment plans viewed as a possible solution to delivery problems and supplemental to that, why has the voluntary program has not seen much growth in its decade of being. The Primary Care Network teams set up under the *Action Plan* are

College of Physicians and Surgeons were not made available for interview on this subject.

Definitions/Context

area. The National Health System in the United Kingdom has established an incentive based capitated system which includes a number of patient health related factors in determining some physician s salaries.

Salary, fee-for-service and capitation are the three main ways of paying physicians. There are other, less often used, methods and any number of permutations of blended payments. The pilot projects in Saskatchewan used largely the capitated form of payment, with one project specifically using the principle of *negation*. Negation is the process of taking away payment whenever a patient decides to venture outside of the capitation area for treatment. Patients are placed on a *roster* for a particular physician or clinic and anytime a rostered patient seeks care outside of that clinic, payment is reduced

work more easily in a rural area where there is not limited choice when it comes to the patient seeking out another physician, unlike urban areas where there are more clinics from which the patient can choose.

The Saskatchewan Story

The debate over physician payment in Saskatchewan dates back to the inception

ion of

there would be a reduction in clinical autonomy. Prior to medicare, physicians were paid by individual patients based on services provided: a fee-for-service system. Under medicare, the government agreed to keep a fee-for-service system, but each service would have a standard billable amount which would be paid by the government instead of the individual patient. This was the general approach, though some services and specializations were an exemptions to the rule.

Thus the fee-for-

culture since before the inception of medicare. Beginning in 1992 Saskatchewan Health undertook some of the most extensive reforms since the 1962, the nature of physician payment was a subject once again broached by the government. One participant in the civil service explains:

> province of having non fee-for-service physicians but the alternative payment unit was actually established in 1994 and was in the medical

marketing to physician

too reform. When the alternative payments unit was set up and government was advocating a non fee-for-service method of payment, the federal Health Minister, Allan Rock expressed interest in alternative payment methods as an aspect of the federal initiatives on health care funding. But once the discussion moved from policy to funding a number of provinces, Quebec, Alberta and Ontario, became focused on to what extent they would be accountable to the federal government. The issue then became about federal-provincial relations as opposed to health care om[(BT1 0 0 1 -7(tent)] TETBT1 0 0i45(a125 -0.1213

While federal support and inter-jurisdictional learning played a role during some

reluctance on the part of some civil servants given the huge amount of change that had gone into the health system by that time. One more change, and a change as large as moving physicians off a fee-for-service system, may have been too much for the public, the government, and most importantly, physicians, to accept at that time. This lends evidence to why government decided to move forward with a voluntary plan. Around the same time, there had been massive restructuring efforts followed by hospital closures. While physicians were in favour of restructuring, once government announced hospital closures, physician opposition dramatically increased. Given this already strained relationship, the government believed it was wise to opt for a voluntary program.

Furthermore, the SMA has traditionally represented fee for service physicians and thus did not lend much support to the government on this issue.

> The relationship between the department and the SMA on that issue was it
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> in a way other than the fee-for-
> because they are largely geared to represent me at that time they saw themselves as representative of fee-for-
> trying to sign a memorandum of understanding for negotiations with non fee-for-service primary care physicians which will provide the groundwork anyways to do this.[18]

It must be noted, however, that while the SMA is not enamoured with the idea of alternate payments, some individual physicians may be open to the concept.[19]

> Physicians are distrusting of change as a group. It is inevitable that physicians are going to have to be moved off of fee-for-service and onto alternative payment mechanisms. The Americans have done this through the creation of managed care. So that you either work for an HMO and if
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> organization for

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the wellness model. It was thus not an interest dri

inception of medicare, physicians were paid on a private-payer fee-for-service basis; patients would pay their physician based on the services they received. As with anything that has been around this long and embedded in the culture, you have to be careful in

In terms of influence from external sources most has come from published reports extolling the virtues of alternative payments as compared to fee-for-service. Informing

-Stoddart report and the Hastings report.

> The national government, the federal government, had a commission on recommended community health centres put physicians on [alternative
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> was a physician and specialist in community health actually at the University of Toronto. And he did a commission for the federal government in the
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> that physicians be put on some kind of salary or per capita payment.[36]

The Barer-Stoddart report sought to address the problem of physician retention and improving medical services in rural/remote areas. They prescribed three areas for reform; the first is a medical services funding model linked to a population based system, second expand the role of non-physician health care workers and finally an education-related strategy linking rural/remote access to academic health centers.[37] Barer-Stoddart like Hastings saw the necessity of reforming physician funding from a provider basis to one focused on population. These external factors are putting pressure on physicians to address changes in the way government pays for these services.

Furthermore, a social values change was, and still is, taking place both within the medical community and in government providing internal factors to reforming physician pay schemes. Whereas once physicians were willing to work long hours and always be on call, this is no longer the case. One participant suggested that physicians want more balance in their life and do not want to work agonizingly long weeks. Alternative

[36] 06ap
[37] Morris Barer and Greg Stoddart, *Improving Access to Needed Medical Services in Rural and Remote Canadian Communities: Recruitment and Retention Revisisted*, Discussion paper prepared for Federal/Provincial/Territorial Advisory Committee on Health Human Resources, 1999, p. 39-40.

payments fit with this change as physicians would no longer feel obligated to push many patients through to guarantee a certain level of income.[38] Also,

> from the Department side, the issue was a challenge in rural Saskatchewan
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> containment issue. The factor was a change in behaviour so that doctors had more time for chronic disease management and had more time to
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> of the biggest reasons for change was patient behaviour so that doctors had more time for chronic disease management and had more time to spend with their patients.[39]