Alternative payment models

A path forward

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Ironically, at the very time definitive data are confirming primary care's essential contributions to health care … practicing primary care physicians are demoralized, retiring early, and advising others not to go into the field.

Allan H. Goroll et al[1]

Most Canadian FPs would suggest that little has changed in the 15 years since the above statement appeared in a journal article calling for reforms to primary care remuneration.[1] Canada has a higher than ever ratio of FPs to the population, yet Canadians continue to struggle to access comprehensive primary care.[2-4] New-to-practice FPs are choosing hospital-based work and focused practice rather than comprehensive family medicine (FM), which we define as longitudinal primary care for a defined population of patients across the life cycle that addresses a spectrum of clinical presentations.[5] Many of these new FPs never venture into comprehensive FM and those who do often leave, citing the long-standing problems associated with fee-for-service (FFS) remuneration.[6] Most recently, the coronavirus disease 2019 pandemic has exposed additional problems with the FFS payment model.[7]

Increasing evidence suggests that the availability of remuneration models influences newly graduated FPs' decisions about future practice.[8] Payment model reform alone will not be enough to reinvigorate comprehensive FM, which requires other pillars such as engaged leadership, incentives for innovation, and continuous quality improvement.[9] However, it is one part of the solution that can enable team-based care and help address deterrents such as mounting administrative tasks and paperwork.[10] Governments and provincial and territorial medical associations would be wise to adapt payment systems accordingly.

Here we discuss the threat posed to longitudinal primary care by continued reliance on FFS payment models, and the payment reforms needed to maintain and expand the practice of comprehensive FM.

The remuneration issue in context

For more than 50 years, Canadian FPs have been primarily remunerated through FFS, wherein they are paid a predetermined amount for each service rendered for a patient. Fee-for-service remuneration has fallen out of favour as a preferred form of payment, particularly for those early in their careers.[8] Reasons include concerns about the quality of care provided to patients under this model, the negative impact of "one problem per visit" and time limitations commonly associated with FFS, and difficulties in serving marginalized or less advantaged patients.[8,11] While there are examples of interdisciplinary team–based primary care models that are funded through FFS, they tend to be the exception rather than the rule.[12]

The coronavirus disease 2019 pandemic has highlighted further problems with the FFS payment model, such as income instability and the need for rapid practice change that often outpaces fee schedule cycles.[7,13] As a result, the College of Family Physicians of Canada has renewed its call for the introduction of more alternative funding models.[14]

Taken together, these issues have led to heightened physician interest in alternatives to FFS such as salaried, capitation, and blended compensation models, collectively termed *alternative payment plans (APPs)*. Alternative payment plans have been implemented in a patchwork fashion in several Canadian provinces.[10] Capitated payment models pay physicians a fixed amount per patient per year for delivery of a primary care "basket" of services, with payment adjusted for factors such as age and patient complexity. Successful risk-adjusted capitated models have been piloted in British Columbia (BC)[15] and have been in widespread use internationally for decades.[16] Blended payment models often combine elements of both capitation and FFS.

Payment reform is an essential element of successful transition to a Patient's Medical Home model of care.[17-19] The shift to APPs allows increased ability to fund and support collaborative, team-based care because funding can flow independently from direct physician-patient interaction. Teams can be funded directly in a clinic managed by a health authority or community-governed not-for-profit organization. Alternatively, they can be funded in physician-owned practices through increased flexibility in delegation of patient care to nurses, pharmacists, and allied health care providers. Alternative payment plans also allow increased flexibility for FPs to spend more time with patients, when needed, to address increasingly complex health and social needs.

Across Canada, the limited introduction of APPs and innovations in team-based care have already helped recruit and retain FPs in longitudinal care.[8] Physicians remunerated through salary and capitation models report higher levels of satisfaction compared with those working in FFS settings.[20,21] Patient care delivered through an APP-funded Patient's Medical Home is also associated with a higher likelihood of preventive screening for diabetes and malignancy.[11]

Previous research suggests that payment models are important in guiding decision making about future practice among early career FPs, with most strongly preferring APPs.[6] Despite the emergence of APPs in some jurisdictions across Canada, FFS remains the predominant payment model. Ontario has several different payment models, including salary and capitation, resulting in the lowest rates of FFS-funded FPs. Unfortunately, the availability of these payment models has been curtailed by the province in recent years.[22] At the other end of the spectrum, BC has only limited alternatives to FFS and has the lowest levels of primary care reforms to date.[23-25]

Recent movement toward payment reform in several provinces has fueled conversations about optimal payment schemes. For example, BC recently developed new contracts for FPs,[26] Ontario is examining cross-organizational funding options for the recently implemented Ontario health teams,[27] and Nova Scotia is developing a blended capitation funding model.[28]

Understanding potential solutions

Initial results from our pan-Canadian study of early career FPs in BC, Ontario, and Nova Scotia[29] are helping us better understand this issue. Our research, to be fully reported in a future publication, points to a preference for alternatives to FFS and suggests that a lack of alternatives shifts practice preferences away from longitudinal comprehensive primary care.[30]

Our team conducted in-depth semistructured interviews with 63 FPs across the 3 provinces, all in their first 10 years of practice. Participants were recruited to explore a range of personal characteristics and practice settings. Of our participants, 41% exclusively practised comprehensive FM, while the remainder spent either part or all of their time in a focused area of practice. Fifty-one percent of the practice settings in which they worked were urban or suburban.

Our data suggest that the availability of remuneration models is an important factor shaping the practice choices of early career physicians. In areas of the country where FFS was the only payment option, some FPs were deterred from practising comprehensive FM. In these settings, many opted for serial locums or focused areas of practice, despite a desire to provide longitudinal primary care. A BC-based physician told us, "We want to set up practices; we want to care for a set population; we want to follow them. This is why we went to school; this is what we went into residency for. [Yet] a lot of us don't do that work because the system in BC is not set up to do that." Participants shared serious concerns about burnout, viewing a career in a hospital-based or focused area of practice as a way of protecting themselves from the unsustainable demands of FFS-based comprehensive FM.

For the early career FPs interviewed, it was not simply a dislike of the FFS model that was driving their decision making. Rather, FFS impeded their ability to provide high-quality medical care in alignment with their values. A physician from Ontario shared, "I will never work in a fee-for-service clinic because I just know that the approach I have towards medicine and what I want to focus on doesn't co-align with the values you need to be financially successful in those models." Participants compensated through FFS noted that it compelled them to see high volumes of patients without sufficient time with each patient to address their increasingly complex needs.

Finally, many participants believed FFS afforded limited options to establish interprofessional primary care teams. Despite many completing their residency training in interprofessional team settings under APP models, they expressed concerns that these models of care were not later available to them as they entered practice.

The path forward

While we continue to graduate large numbers of FPs, we will not solve the problem of dwindling comprehensive FM practices without introducing more alternatives to FFS. Even when FM residents are trained in interprofessional teams and under APPs, upon graduation they have few options to enter similar models of practice. In Ontario, where there have been the greatest payment reforms to date, graduates interested in comprehensive FM are left either to purchase a practice from a retiring physician at substantial cost or to start up an FFS clinic. Instead, they are choosing other forms of practice that are well supported by interprofessional teams, do not require business ownership, and are more predictably remunerated.

There have been recent positive changes to remuneration models that will alter the landscape. The 2019 Nova Scotia Master Agreement includes a commitment to develop a blended capitation funding model, adding to existing FFS and APP options.[28] In BC, a process was outlined in the 2019 Physician Master Agreement for consultation with physicians around the development of APPs.[31]

Provincial governments and provincial and territorial medical associations across Canada need to carefully adapt how they fund primary care. There are existing Canadian models for viable and attractive APPs that do not substantially increase per-patient primary care costs compared with FFS. British Columbia has an ongoing pilot project for such a capitation model that adjusts for patient age and medical complexity, with per-patient payment indexed to FFS billing costs for patients with a similar health profile.[15] In addition, across the country there are physician contract and other salaried options that can allow for predictability in yearly income for FPs, with fewer administrative burdens.

As these important conversations continue, APPs need to be developed, expanded, offered widely, and carefully studied for patient-, physician-, and system-level outcomes. By doing so, we can ensure the provision of

high-quality, accessible, team-based care while supporting FPs in practising comprehensive FM. Without APPs that acknowledge and value the foundational role that FPs play within our system, we risk eroding comprehensive practice even further.

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Competing interests

None declared

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