

# PHYSICIAN COMPENSATION MODELS: **A Backgrounder**

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## Foreword

This working paper provides a high level summary of key physician compensation models. The challenge in trying to produce such a summary is that assertions about a particular model's pros and cons are extremely context specific and dependent upon the environment in which the payment model operates and the specifics of its implementation. In order to discuss and compare Fee-for-Service (FFS) models or contract models, for example, consideration must be given to the specifics of the fees or terms of the contract.

Despite the challenge of discussing payment models devoid of context, a discussion of pros and cons (albeit based on broad generalizations) aids in understanding each model and supports consideration about how to offset potential advantages and disadvantages of each model.

This summary is intended to provide a basis for continued discussion and consideration. The stakeholders identified throughout this paper (government/health authorities, physicians and patients) will undoubtedly disagree with aspects of this paper, either theoretically or based on personal experience with a particular compensation model and a contextual backdrop which may make certain assertions untrue. We recognize that the generalizations made herein cannot reflect the differences of all practice environments and we want to hear from you as we continue to develop a layered understanding of the context-specific considerations of each compensation model and opportunities to offset the challenges of each.

We also recognize that there are significant issues that, while related to physician compensation, are beyond the scope of this working paper. Consideration of which model(s) may or may not support innovation, create potential for cost savings (and who reaps the benefit of any savings), impact infrastructure/physician overhead costs, and/or contribute to or reduce physician burnout are all important issues to consider at the individual physician level and at the system level. Those discussions are important, but beyond the scope of this paper. However, a foundational understanding of payment models will support those further analyses.

It is clear, based on our existing policy and provincial and inter-jurisdictional review, there is no single best payment model; physician participation in payment/funding reform should be, and almost always is, voluntary; integrated systems that have strong collaboration between GPs, specialists and other health care providers tend to be higher performing regardless of payment model; and effective integrated health care systems require robust IT systems and infrastructure.

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### Physician Compensation Models in BC

In BC, physicians are compensated through a variety of payment methods that include FFS payments, incentive payments, and alternative payment methods. Alternative payment methods in BC include service contracts, sessional contracts, salary agreements, and in some limited cases, population-based funding (PBF) and pay for performance (P4P) arrangements.

FFS continues to be the most prevalent form of payment, representing approximately 80% of total clinical payments to physicians in BC.<sup>(1)</sup> However, close to 66% of physicians in BC receive some form of alternative payments, with at least 16%<sup>1</sup> of physicians in BC being mainly paid<sup>2</sup> through alternative payment methods.<sup>(1)</sup> This highlights the fact that compensation models are not “pure” in that compensation is often comprised of a combination of models rather than purely reflective of a single model.

This paper, informed by a literature review of payment and funding reforms in various jurisdictions across Canada and internationally, provides a description of the main physician compensation models. It is important to note that, in researching and compiling this paper, a series of key high-level themes have emerged from the literature review of payment model reforms in various jurisdictions:

1. There is no single best payment or funding model. Most jurisdictions have either adopted or are moving toward adopting blended methods to balance each model’s strengths and weaknesses.
2. Physician participation in payment/funding reform is almost always voluntary.
3. Integrated systems that have strong collaboration between GPs, specialists and other health care providers tend to be higher performing regardless of payment model [e.g. Kaiser Permanente (USA) and Canterbury Model (New Zealand)].
4. Effective integrated health care systems require robust IT systems and infrastructure.

What follows is a brief summary of the main payment models. Each description is followed by an analysis of the various interests of government, health authorities, physicians, and patients in relation to each model. This discussion is, by necessity, simplified in order to make general statements about the different models. A specified ‘pro’ of a particular model may easily become a ‘con’ or vice versa with very minor changes in context, environment, policy, regulation, or legislation. It is important that the below statements not be interpreted as static and defining traits of each model, but rather the basis for further discussion and consideration, informed by continued understanding of context-specific experiences with the various models in different practice environments and reflecting different implementation.

#### Fee-for-Service (“FFS”)

In the FFS model, physicians are self-employed professionals who bill for services they provide. In most cases, physicians in BC bill the Medical Services Plan according to the Medical Services

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<sup>1</sup> Doctors of BC recognizes the limitations of this CIHI data, which may not accurately reflect the full range of compensation across all practice settings.

<sup>2</sup> “Mainly paid” refers to physicians who receive at least 50% of their income through alternative payment methods.

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Commission's Payment Schedule for services rendered. In some cases, physicians may bill public organizations, such as WorkSafeBC or the Insurance Corporation of British Columbia, or bill the patient directly for non-insured services.

FFS remains the predominant payment method for services provided by family physicians throughout BC. Alternative payment methods have a higher utilization by physicians delivering specialized services (e.g. surgical services, cancer care, palliative care, mental health care) in Health Authority administered programs.

Increases to FFS rates and mechanisms to change fees are negotiated centrally by Doctors of BC and Government.

### *Identifying Pros & Cons: Fee-for-Service*

<b>Stakeholder</b>	<b>Interest</b>	<b>Pros</b>	<b>Cons</b>
<b>Government/Health Authorities ("Gov't/HAs")</b>	<b>Cost certainty (budget predictability) and control over costs</b>	Gov't can negotiate lower fees to control costs.	Gov't/HAs have limited control over the quantity of physician services provided which limits ability to control costs or obtain cost certainty.  Fee schedules may not adjust in a timely manner to technological advancements that decrease time and cost of procedures, leading to increased costs.
	<b>Control over population health priorities</b>	Gov't can negotiate fee amounts for particular areas to reflect its health priorities.	Gov't/HAs have limited ability to direct physician services toward population health priorities.  Without compensation for team conferencing, FFS may not encourage inter-professional teams.
	<b>Administrative &amp; implementation complexity</b>	Existing billing and auditing structure in place.	
<b>Physicians</b>	<b>Fair income</b>	FFS rewards high volume practices.  Directly links payment to physician workload or effort.  FFS provides a baseline for comparison of other models of payment in BC.	FFS may not adequately reward complex care or low volume practices (eg. rural/remote regions).  Fee schedules may not appropriately adjust for patient complexity, relying on swings and roundabouts model.

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Stakeholder	Interest	Pros	Cons
	<b>Clinical autonomy</b>	Physicians are able to determine how to deliver patient care.	
	<b>Business autonomy</b>	Physicians are able to determine when, where, and how much they work.  Enables physicians to work in independent or group physician practices if they choose to.	Some physicians express concern that they are required to operate a business for which they are not adequately prepared.
	<b>Administrative complexity</b>	Billing system is generally well-understood by physicians.	
<b>Patients</b>	<b>Access to care</b>	FFS rewards high volume and may support access to care.  Quickly adaptable to increases in demand, need for access.	FFS may not be suitable for complex care or low volume settings (eg. rural/remote regions).  Without compensation for team conferencing, FFS may not encourage inter-professional teams.
	<b>Choice of providers</b>	Patients free to choose their primary care provider (choice of specialist restricted by referral system).	

### *“Fee-for-Episode” or “Bundled Payments”*

A variation of FFS is to pay physicians for an episode of care rather than for each individual service provided. Often referred to as “fee-for-episode” or “bundled payments”, this payment model pays physicians a fee for a basket of services related to a particular procedure or condition.

Currently, most bundled payment models are “retrospective”, meaning payers pay providers after they have delivered the care. From a transitional perspective, this makes it possible to combine bundled payment on a Fee-for-Service base, “trueing up” when the episode is over. However, it is possible that bundled payments could be paid prospectively, making upward or downward adjustments at the end for outliers, quality lapses, and other factors. Compared to FFS, a bundled fee may incentivize greater efficiency but may also encourage the underservicing of patients and/or the exclusion of the sickest patients.

Bundled payments are best suited for conditions or procedures which have clear clinical pathways but may be less suitable for complex cases that have a variety of possible clinical pathways (and costs) as well as procedures with low volumes, or few providers of care.(2)

BC’s experience with this type of physician payment model is limited. For example, the MSC Fee Schedule describes surgical procedural fees that ‘bundle’ periods of both pre- and post-surgical

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care and critical care fees that ‘bundle’ all critical care physician services provided over a 24-hour period.

Note that bundled payments may also be considered as a funding model where a group of providers (e.g. physicians and allied healthcare providers) is provided a fee to deliver services related to a procedure or condition. In this case, the group or organization is free to pay its providers with a variety of payment mechanisms.

### Incentive-Based Payments

Incentive payments reward physicians for delivering particular physician services.<sup>3</sup> In BC, incentive payments are mostly used to improve access to physicians in rural communities through the Rural Retention Program and other rural incentive programs, and to encourage the delivery of full service family physician services including improved preventive care, chronic disease management (CDM), complex case management, and longitudinal care. While incentive based payments are primarily used to enhance FFS practices, some incentives payments (e.g. Rural Retention Program, CDM fees) also apply to physicians paid under Alternative Payment Arrangements.

#### *Identifying Pros & Cons: Incentive Based Payments*

Stakeholder	Interest	Pros	Cons
<b>Government/Health Authorities (“Gov’t/HAs”)</b>	<b>Cost certainty (budget predictability) and control over costs</b>	Can negotiate defined budgets for GPSC and SSC incentive fees.	No fixed budget for Rural Retention Program.
	<b>Control over population health priorities</b>	Can use incentive fees to influence physician services in targeted areas.	
	<b>Administrative &amp; implementation complexity</b>	Incentive fees administered with existing FFS billing and auditing system.	
<b>Physicians</b>	<b>Fair income</b>	Opportunity for physicians to earn additional income (may be limited by global caps on incentives).	
	<b>Clinical autonomy</b>	While necessarily requiring broad uptake for incentives to meet their intended impact and effectiveness, to the extent that participation in incentives is voluntary, it does not detract from clinical autonomy.	Incentive payments may de-emphasize patient care not covered by incentive payments.  There is a risk that the incentive could generate judgement contrary to

<sup>3</sup> This is distinct from incentives for patient health outcomes. Such incentives are covered in this paper under “Pay for Performance – (P4P)”

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Stakeholder	Interest	Pros	Cons
			what pure clinical judgement would indicate in particular circumstances.
	<b>Business autonomy</b>	While necessarily requiring broad uptake for incentives to meet their intended impact and effectiveness, to the extent that participation in incentives is voluntary, it does not detract from business autonomy.	
	<b>Administrative complexity</b>	Physicians bill incentive fees with existing FFS billing system.	Some incentive payments may increase administrative burden.
<b>Patients</b>	<b>Access to care</b>	Improve patient access to particular incentivized physician delivered services.	Incentive payments may de-emphasize patient care not covered by incentives.
	<b>Choice of providers</b>	Patients free to choose their primary care provider (choice of specialist restricted by referral system).	

### Alternative Payment Models

In some settings in Canada, FFS does not support a reasonable income. In such settings a number of different compensation techniques have emerged, which have collectively been called “alternative payments”. These settings where FFS does not support a reasonable income include:

- Rural/isolated communities where FFS is insufficient to support a sustainable number of physicians in the community.
- Programs/facilities, often with low volumes (e.g. Community Health Centres), where physicians work in inter-professional teams focusing on particular population needs (e.g. mental health/addiction services).(4)
- Academic institutions where physicians provide teaching and research services in addition to complex patient care services.

Alternative payment models in BC include service and sessional contracts, salary, population based funding/capitation, and pay for performance. These models may also be used to supplement FFS payments. Each alternative payment model and their respective pros and cons are discussed below.

### Service & Sessional Contracts

Under the service and sessional contracts model of physician compensation, physicians are self-employed professionals who enter into a contract with a Health Authority or other publically funded agency to provide clinical and related teaching, research, and clinical administrative services. These contracts pay physicians for increments of time spent providing patient care and



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stipulate the deliverables for contracted physicians. Service contracts are utilized in both part-time and full-time practice settings while sessional contracts tend to be utilized only in part-time practice settings for the sessional services provided. In BC, sessional payments (used in combination with FFS payments) are extensively used to support physicians to provide complex care services, provide services as part of an integrated care team, and collaborate on system improvement initiatives.

Service and sessional contracts are negotiated locally by physicians and health authorities according to templates and payment ranges set out in the Physician Master Agreement for services specifically designed to meet local needs.

### *Identifying Pros & Cons: Service & Sessional Contracts*

<b>Stakeholder</b>	<b>Interest</b>	<b>Pros</b>	<b>Cons</b>
<b>Government/Health Authorities (“Gov’t/HAs”)</b>	<b>Cost certainty (budget predictability) and control over costs</b>	Gov’t/HAs can negotiate lower payment rates and/or limit the number of contract available to control costs.	
	<b>Control over population health priorities</b>	Gov’t/HAs can determine when and where to enter into contract agreements providing a greater ability to direct physician services to priority areas.	
	<b>Administrative &amp; implementation complexity</b>		Requires negotiations for new contracts and periodic re-negotiations for existing contracts.  Requires effective monitoring of contract terms and conditions.
<b>Physicians</b>	<b>Fair income</b>	Contracts provide stable and predictable income in low volume (i.e. rural/remote regions) and high complexity settings where FFS is not adequate.  Contracts may provide payment for non-patient care activities such as quality improvement, academic research, teaching, and community outreach.	Contracts may not adequately adjust for increases in patient demand or physician workload.
	<b>Clinical autonomy</b>	Contract terms and conditions do not generally limit a physician’s ability to independently determine how to deliver patient care.	Gov’t/HAs could potentially negotiate terms and conditions that limit physician’s ability to independently determine how patient care is delivered.

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Stakeholder	Interest	Pros	Cons
	<b>Business autonomy</b>		Contract terms and conditions may limit physician's ability to determine when, where, and how much to work.
	<b>Administrative complexity</b>		Requires negotiations for new contracts and periodic re-negotiations for existing contracts.
<b>Patients</b>	<b>Access to care</b>	Contracts may improve patient access to rural and high complexity health care services.  Contracts may improve patient access to inter-professional care.	Relative to FFS, contracts do not incentivize volume and may encourage physicians to see fewer patients.
	<b>Choice of providers</b>	Patients free to choose their primary care provider (choice of specialist restricted by referral system).	

### Salary

In BC, salaried physicians are employees of Health Authorities or other publically funded agencies and are paid a wage based on a unit of time equivalent to 1957.5 paid hours of employment per year (notionally). Salary agreements may outline a physician's responsibilities or such responsibilities may be communicated by the physician's supervisor. Similar to service and sessional contracts, salary arrangements are commonly used to pay physicians working in settings where FFS alone does not support a sustainable practice, such as complex care or academic settings. Salary contracts are based on templates and payment ranges set out in the Physician Master Agreement (PMA).

Outside of Canada, Kaiser Permanente ("KP") in the United States is a prominent delivery model employing salaried physicians.<sup>4</sup> In addition to salary payments, the KP model implements robust IT systems, performance and people management processes, and encourages collaboration between GPs and specialists.(5, 6) The KP model is generally considered to deliver cost-effective and high quality care (5), but it is questionable whether the positive effects attributed to the

<sup>4</sup> Typically, one year contracts renewable based on performance.

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system are transferable to environments that lack the robust IT systems, performance and people management processes, and/or a high degree of collaboration between health care providers.

### Identifying Pros & Cons: Salary

Stakeholder	Interest	Pros	Cons
<b>Government/Health Authorities (“Gov’t/HAs”)</b>	<b>Cost certainty (budget predictability) and control over costs</b>	Gov’t/HAs can negotiate lower payment rates and/or limit employment opportunities to control costs.	Salary agreements are typically more costly for Gov’t/HAs compared to service/sessional contracts.
	<b>Control over population health priorities</b>	Gov’t/HAs can determine when and where to hire physicians giving it a greater ability to direct physicians services to priority areas.	
	<b>Administrative &amp; implementation complexity</b>		Salary agreements require negotiations and effective monitoring of employment terms and conditions.  Salary agreements are typically more administratively burdensome for Gov’t/HAs compared to service/sessional contracts.
<b>Physicians</b>	<b>Fair income</b>	Salary agreements may provide stable and predictable income in low volume and high complexity settings.  Salary agreements may provide payment for non-patient care activities such as quality improvement, academic research, teaching, and community outreach.  Salary agreements may provide benefits such as health benefits and pensions.	Salary agreements may not satisfactorily adjust for increases in patient demand and/or physician workload.
	<b>Clinical autonomy</b>	With adequate legislative or contractual terms, clinical autonomy could be preserved.	Employment terms and conditions could potentially limit a physician’s ability to independently determine how patient care is delivered.

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Stakeholder	Interest	Pros	Cons
	<b>Business autonomy</b>		Employment terms and conditions may limit a physician's ability to choose when, where and how much to work.
	<b>Administrative complexity</b>		Requires negotiation of salary rates and employment terms and conditions.
<b>Patients</b>	<b>Access to care</b>	Salary agreements may improve patient access to rural and high complexity health care services.  Salary agreements may improve patient access to inter-professional care.	Relative to FFS, salary agreements do not incentivize volume and may encourage physicians to see fewer patients.
	<b>Choice of providers</b>	Patients free to choose their primary care provider (choice of specialist restricted by referral system).	

### Population-Based Funding (“PBF”)

Under PBF or “capitation” models, general practitioners receive a payment for a bundle of “core” services for each patient on their “roster” for a given period of time. In BC, this payment is risk adjusted by a patient’s age, sex, morbidity or other modifiers and may be reduced (negated) by the cost of “core” services if a rostered patient obtains such services from a GP not participating in the PBF practice. Currently, PBF is being utilized in a small number of primary care practices in BC.(7)

PBF models result in shared risk between insurers/payers and physicians. As such, careful attention needs to be paid to adjusting the patient payment rates for expected utilization. If a patient’s utilization of physician services is higher than that covered by the capitated payment or if the patient seeks services from other GPs equal to their capitated payment, then the capitated practice will suffer a loss. If, however, the patient’s utilization is less than that covered by the capitated payment, then the physician will experience a gain/profit. The inherent risk of underservicing patients is, in BC, offset somewhat by the potential effect of negation. Quality indicators are often also included in this payment model to discourage underservicing.

PBF contracts are negotiated locally between physician groups and the Ministry of Health. There are presently no provincially negotiated templates or payment rates for such contracts. It is also noted that PBF models require significant IT and administrative structures and systems to set, adjust, and payout PBF payments and those systems are not currently in place.

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### Identifying Pros & Cons: Population-Based Funding (“PBF”)

The pros and cons of PBF as it is applied in BC are described in the table below.

Stakeholder	Interest	Pros	Cons
Government/Health Authorities (“Gov’t/HAs”)	<b>Cost certainty (budget predictability) and control over costs</b>	Gov’t/HAs can negotiate fee amounts directly with physicians and determine the availability of PBF contracts to limit/control costs.	
	<b>Control over population health priorities</b>	Gov’t/HAs can determine when and where to make PBF contracts available to direct physician services to priority areas.	
	<b>Administrative &amp; implementation complexity</b>		Requires administrative structures and systems to set, adjust, and payout PBF payments.
Physicians	<b>Fair income</b>	Higher income for physicians with larger patient rosters.	Lower income for physicians with smaller patient rosters.
		Physicians that are able to implement quality and/or efficiency improvements to reduce patient resource use are rewarded.	PBF payments are negated if rostered patients seek care from other physicians.
		PBF rewards the provision of preventive care activities that reduce patient utilization.	Lack of transparency in how per capita rates are set to account for expected patient utilization and adjusted to reflect changes to patient health status.
			Lack of provincially negotiated general increases or PMA protections (PBF not currently covered by PMA).
	<b>Clinical autonomy</b>	PBF contracts generally do not impact physician’s ability to determine how patient care is delivered.	
	<b>Business autonomy</b>		Physicians’ ability to choose when and where to work is limited by the availability of PBF contracts which are determined by Gov’t/HAs.

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Stakeholder	Interest	Pros	Cons
	<b>Administrative complexity</b>		Physicians must implement patient rostering and PBF reporting systems.
<b>Patients</b>	<b>Access to care</b>	<p>PBF may enhance access for complex patients that may benefit from longer patient visits or inter-professional care.<sup>5</sup></p> <p>Compared to FFS, PBF may increase patient access to preventive care.</p> <p>Rostering of patients may encourage greater continuity of care.</p>	<p>Longer patient visits may lead to physicians seeing fewer patients.</p> <p>PBF may encourage physicians to underservice patients.</p>
	<b>Choice of providers</b>	Currently no financial penalties for rostered patients who visit other providers.	Rostering agreements between patients and physicians may discourage patients from visiting other providers.

### Pay for Performance (“P4P”)

Unlike the incentive payments discussed above that reward physicians for delivering particular physician services, P4P models use financial incentives to reward (or penalize) physicians for reaching (or not reaching) particular health care quality and/or efficiency indicators. While P4P models are rarely used in BC to pay for physician services, it is in limited use in BC.

Although P4P as a form of payment to individual physicians in BC is limited, other jurisdictions have implemented various forms of P4P as a physician payment model. One of the most extensively implemented and widely reviewed P4P program is the UK’s Quality and Outcomes Framework (QOF) for primary care.<sup>(8)</sup> In the United States, the Centers for Medicare and Medicaid Services (CMS) implements a number of P4P programs, some of which were combined into two programs: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APM).

<sup>5</sup> Unlike capitation in Ontario, PBF rates in BC adjust for illness burden (in addition to age and sex). The inclusion of illness burden may encourage physicians to roster patients with higher morbidity and expected resource use.

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### Identifying Pros & Cons: Pay for Performance (“P4P”)

Recognizing that there is limited experience with P4P in BC, the UK experience and the CMS (USA) P4P programs provide a basis for an analysis of trade-offs.

Stakeholder	Interest	Pros	Cons
Government/Health Authorities (“Gov’t/HAs”)	<b>Cost certainty (budget predictability) and control over costs</b>	Gov’t/HAs can adjust P4P indicators to make them more difficult to reach to control cost.  Gov’t/HAs can limit the number of P4P indicators available to control cost.  Gov’t/HAs can adjust payment reward for achieving indicators to control cost.	
	<b>Control over population health priorities</b>	Gov’t/HAs can develop P4P indicators to align with population health priorities.	
	<b>Administrative &amp; implementation complexity</b>		P4P systems require administrative structures and robust IT systems to develop, monitor, and report physician performance.
Physicians	<b>Fair income</b>	Impact on compensation is dependent on how the model is applied. Examples of where it has had a beneficial impact on income are:  In UK, GPs can participate in P4P to make additional income.  In CMS MIPS (USA), physicians with above average reported performance will be rewarded bonus payments.  In CMS APM (USA), qualifying physicians will receive bonus payments.	Impact on income is dependent on how the model is applied. An example of where it has had a detrimental impact on income is:  In CMS MIPS (USA), physicians with below average reported performance will pay penalties.
	<b>Clinical autonomy</b>		P4P indicators influence how physicians deliver patient care.

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	<b>Business autonomy</b>		P4P indicators may influence when, where, and how much physicians work.
	<b>Administrative complexity</b>		Physicians must document and report their performance to participate in P4P.  Requires additional investments in IT systems.
<b>Patients</b>	<b>Access to care</b>	UK studies indicate that P4P enhances access to incentivised aspects of physician care.  UK studies indicate that P4P helps equalize health care performance between poorer and wealthier regions.	P4P may encourage more process driven health care to achieve particular performance indicators, thus undermining the delivery of patient-centred care.
	<b>Choice of providers</b>	Patients free to choose their primary care provider (choice of specialist restricted by referral system).	

### Blended Payments

Recognition of the strengths and weaknesses of traditional payment models in their “pure” form has led to the introduction of blended payment methods to counterbalance the shortcomings of individual models, and the development of new and innovative ways to pay providers.

Most Organisation for Economic Co-operation and Development (OECD) countries have moved away from paying physicians solely through one payment model towards using blended models. For example, in Finland, physicians receive a base salary (60 per cent) along with capitation and FFS components.(9) The idea behind blends is that using more than one method of compensation can compensate for weaknesses in each method and can provide incentives toward achieving multiple goals.

Blended payments are less widely used for outpatient specialist care, where the predominant method remains FFS. However, some countries, such as Sweden and the United Kingdom, have incorporated blended forms of payment such as global budgets along with combinations of P4P and additional payments.(10)

For family physicians in Canada, blended payments are becoming an increasing norm. Although all provinces and territories have moved beyond a pure FFS model, not all jurisdictions have done



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so to the same degree. Indeed, physician payments in Western provinces are more likely to be FFS than that in Eastern provinces. For example, in Nova Scotia, almost half (45%) of total clinical payments to family physicians is non-FFS, while in BC, 17% of total clinical payments to family physicians is non-FFS.(11)

Blended physician remuneration models offered in Canada vary in structure, but all combine a FFS component with an alternative component. In general, there are (variants of) three main blended physician remuneration models offered in Canada:

1. FFS base plus capitation payments: Physicians bill on a FFS basis as they normally would and, in addition, receive a small fee per patient on their roster. This blend provides incentives to roster more patients and to provide more physician services.
2. Capitation base plus FFS payments: Physicians receive capitation payments for their rostered patients for the provision of a basket of core services. Physicians can bill on a FFS basis for services that fall outside of this basket. This provides the same incentives as capitation, but alleviates the risk of accepting complex patients with expected high utilization. The provision of additional services outside of core services (covered by capitation) would yield additional revenue for the physician.
3. Time-based payment base plus FFS payments. Physicians receive a payment for a specific time period and, in addition, bill the FFS system and receive a percentage of the FFS billings. This blend combines the incentives of a time-based payment (i.e. salary or sessional/service contract) while also incentivizing high service volume.

Each province also has its own policy mix and innovations. In BC, for example, sessional payments used in conjunction with FFS payments are extensively used to support physicians to:

- Provide complex care services.
- Provide services as part of an integrated care team.
- Collaborate on system improvement initiatives.

Often referred to as “value-based payments”, some jurisdictions combine quality/efficiency of care indicators with FFS or other alternative payment models. The purpose of this blended payment model is to tie physician income to particular performance indicators in order to improve the quality/efficiency of care and/or to deter the underservicing of patients.

Figuring out the appropriate blend for each context is not necessarily obvious. For example, it is not clear what the right balance is of FFS versus capitation. As well, should rural areas, where access to family physicians is an acute problem, offer a different blend than urban centres? Should family physicians have a different blend than specialists? Should the pay blend for community health centres or health care teams be different than that for physician-led independent practices?

### Conclusion

Doctors of BC recognizes the limitations of this review. Assertions of stakeholder interests and relative pros and cons are, by necessity, broad generalizations and in no way exhaustive. Despite these limitations, it is clear that each model has trade-offs, depending on the environment in which it is introduced, the way it is implemented, and the interests of the stakeholder assessing the model.

It is also clear that, despite a desire to identify an 'ideal' model, no one model is perfect. It is often a blend of models that best serves to offset the strengths of one model against the weaknesses of another and vice versa. Furthermore, the literature on payment models shows that the diversity of the environments in which payment models operate and the specifics of their implementation are fundamental to the effectiveness of a model when applied. The actual impact on physicians, patients, administrators, and the health care system cannot be assessed without regard to the specific details of the application. Those details of application vary from one country, one province, one community, and one practice to another.

This analysis confirms the wisdom of maintaining the key policy principle that currently defines our views on payment and funding models, namely that Doctors of BC supports a pluralistic system of publicly funded physician compensation where physician payment and funding mechanisms address BC's diverse health care needs and delivery types.(12)

Doctors of BC's position on physician compensation is further informed by the following principles:

- Physicians should be engaged and involved in the development of physician payment/funding models.(13)
- Changes in forms of payment/funding for physicians should be voluntary.(12)
- Physician payment/funding changes should be implemented in an iterative manner.
- Reform projects should first be piloted and externally evaluated for clinical and cost effectiveness.(12)
- Physician payment/funding models should be respectful of physicians' clinical and business autonomy.(14)
- Physician payment/funding models should enhance the patient's right to access timely and appropriate care.(13)
- The design of physician payment/funding models should reflect growing utilization of physician services and prioritize patient care over cost containment.(13)

Just as Doctors of BC policy provides that physician compensation changes should occur in an iterative manner, this paper provides a basis for further discussion that will evolve as strengths and weaknesses of various payment models, and blends of payment models, become known through trial and experience in various BC contexts.

When considering such new forms of payment, attention should be paid to the following:

- Testing such models in a safe environment that mitigates the risk to patients and providers.

## PHYSICIAN COMPENSATION MODELS

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- Ensuring that physician participation in any new model is voluntary.
- Supporting collaboration between GPs, specialists and other health care providers.
- Protecting physician interests, including fair economic reward, clinical autonomy, and business autonomy, while minimizing administrative burden.

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