The Doctor Is Not Available to See You Now: Alternate Physician Payment Models and Primary Health Care Reform in Newfoundland and Labrador

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1973: First class graduates from the School of Medicine, Memorial University.

1973: The provincial government outlines plans for reform of the health care system in a document titled *Health Care Delivery: An Overview*. The report makes the following recommendations with respect to physician payment, recruitment and health human resources:

> The distribution of physicians across the province be correlated solely with the need for medical services with sufficient acknowledgment of population size and distance from primary care centres.
> Physicians should not be stationed or asked to practice in a community without the services of at least one other doctor. Community health clinics should have a minimum complement of two physicians with a required population of between 4,000 and 6,000. In rare circumstances, a small hospital serving a population of 3,000 or fewer would also be staffed by two physicians.
> Some responsibilities performed by physicians should be transferred to nurses and nurse practitioners to allow for both groups to make the best use of their training. This change is contingent upon adequate financial compensation for the expanded role performed by nurses and resolution of the legal situation with respect to medical licensing and practice legislation.
> An intensive study be carried out of remuneration models for physicians including consideration of providing incentives and fringe benefits where a part of a
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> The report recommends that physician services be evaluated with respect to work, that opportunities exist for doctors to have access to further training and that solo practices be reduced to provide relief for physicians who suffer from fatigue.
> Further study be carried out on the methods of evaluation of medical services in non-institutional settings in order to construct an accreditation system for community health clinics and other community services.[1]

1984: The Peckford government releases the *Report of the Royal Commission on Hospital and Nursing Home Costs*. The Royal Commission, chaired by David Orsborn, makes several recommendations with respect to physician payment models, recruitment and retention and health human resource issues. These recommendations include:

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> Hospital boards implement a system of timely and comprehensive peer review mechanisms for clinical use and that the maintenance and continuation of physician privileges be based on keeping practices that are clinically and economically prudent.
> A selective capitation method of remuneration be applied for family physicians treating patients older than 65 years. This policy would be initiated as a pilot project for a minimum three year period provided that at least fifty fee-for-service physicians agree to participate.
> Fee schedules for physicians be dictated by health human resources concerns and that payments be used to influence the supply and practice locations of different types of physicians. It was recommended that both the Department of Health and the Medical Care Commission accept the greater role of fee schedule allocations to ensure that physician supply is consistent with provincial needs.[3]
> The Faculty of Medicine at Memorial University offer a course on physician accountability for the economic use of resources.

The Royal Commission noted that the fee-for-service payment model was not flexible and responsive to patient needs and physician activities. As well, the Commission focused attention on the lack of incentives for physicians to use hospital resources more

Newfoundland part of the project came from the provincial government who agreed to support the practice component for a three year period. The World Health Organization provided funds to ease collaboration between the nursing groups to develop the project. An additional funding proposal was submitted to the National Health Research Development Program of the federal government. This agency agreed to provide funds for the research component of the project. A team of researchers, including a psychologist, a nurse and an economist, was established to evaluate the project.[6]

The purpose of the project was to contain health care costs while improving and maintaining the quality of health services through an emphasis on greater self-reliance, increased emphasis on health promotion and the use of nurses in the community to coordinate services.[7] The Newfoundland Hospital and Nursing Home Association applauded the efforts of Newfoundland nurses to develop the primary health care project and recommended that future sites be established to provide health and community services to the population. The project was located on the southern Avalon peninsula (the Irish Loop) and involved 21 commun

because of competition from other Canadian jurisdictions but also due to an inequality in financial resources among hospital boards (prior to regionalization). The NHNHA recommended that physician recruitment be centralized and based on guidelines and policies developed in consultation with hospital boards.[9] There was no mention of

which have arisen to which there appears to be no solution at the present time, not the least of which is salaried and fee-for-service physicians working in the same hospital/community with what appears to be considerable differences in income for the same amount of work. Where fee-for-

care difficult. The 50 percent billing policy was established to penalize phy
surrounding region by paying them fifty cents on the dollar for medical services.[17]

The Minister of Health and Community Services announced plans for the establishment of a provincial physician recruitment coordinating committee. The committee will act in an advisory capacity to the Minister on issues related to recruitment and retention. Membership includes the Deputy Minister of Health and Community Services (Chair), representation from the Newfoundland and Labrador Medical Association (NLMA), the Medical School Society, the Newfoundland and Labrador Health Care Association, the Newfoundland Medical Board, the Professional Association of Interns and Residents, the School of Medicine at Memorial University, active rural physicians and the provincial government.
type of partnership provides the chance to enhance our recruitment initiative and focus even more on a proactive and continuous effort to help meet the needs of [18]

The province negotiates a new agreement with the NLMA. The contract extends for four and one-half years (1998(w a)-3(gr)3(e)4(e)4(m)-[(-e)63acr

recommendations to government with the objective of removing barriers to family doctors participating in primary health care. The most salient goals identified by the recommendations are as follows: (1) the establishment of provincial standards of reasonable access for all residents to primary health care services required regardless of location; (2) primary health care services must be integrated and provided by teams of health professionals at the community or regional level; (3) physicians will negotiate formal agreements with regional health boards to provide a specific basket of medical services to patients and within hospitals. The basket of services will be determined by the health needs of the region, and (4) payment arrangements for physicians need to be developed to support primary care, enhance physician retention and allow for a continuous upgrade in skill levels.[29]

Creation of a Primary Health Care Advisory Council was announced in December. The Council is composed of representatives from various groups including health professionals, nurses, physicians, pharmacists, the Faculties of Medicine and Nursing, regional health boards and the Department of Health and Community Services. Members are responsible for advising government on the development and implementation of the provincial Primary Health Care Framework. The Council is chaired by Kathy LeGrow. As well, government established an Office of Primary Health Care within the Department of Health and Community Services to assist with the creation of the Primary Health Care Framework.[30]

2003

NLMA Arbitration Ruling: fo
the NLMA and government agreed to binding arbitration in order to strike a new collective agreement for the next three years. Specifics included a parity award of $23.9 million with respect to fee-for-service compensation to bring Newfoundland and Labrador physicians up to 95 percent of the pay levels of Maritime physicians; a general increase of $10.5 million; and 18 percent increase for salaried physicians over three years; $5 million for a universal on-call payment policy; $1 million for the development and implementation of after-

Coverage Committee to address province wide issues in service.[31]

2004

Government announces in the provincial budget an investment of $4.3 million to develop new primary health care projects across the province. Funding for these

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[29] . Ibid.
[30] . Government of Newfoundland and Labrador, News Releases, Department of Health and Community Services, December 12, 2002. Accessed at www.releases.gov.nl.ca/releases/2002/health/1212n03.htm
[31] . Government of Newfoundland and Labrador, News Releases, Department of Health and Community Services, April 16, 2003. Accessed at www.releases.gov.nl.ca/releases/2003/health/0416n03.htm

Six Research Questions

In this section of the paper, we attempt to address six key analytical questions to determine why the government of Newfoundland and Labrador has not yet adopted alternative methods of remuneration for physicians for primary health care reform.[35] This document is informed by a research framework that is designed to help us better understand the factors that shape health care restructuring and reforms. The specific research questions to be addressed are as follows:

1. How much reform has occurred for alternate methods of remuneration and primary health care reform in Newfoundland and Labrador over the last decade?

2. Under what conditions have alternate methods of remuneration for physicians and primary health care reform occurred over the last decade?

3. Under what conditions have alternate methods of remuneration for physicians and primary health care reform not occurred despite widespread calls for it?

4. Is there a feedback loop between alternate methods of remuneration for physicians and primary health care reform and the conditions that have

   achieve?

5. Do current conditions make alternate methods of remuneration for physicians and primary health care reform more probable than other types of change?

6. What can be done to create the conditions that make alternate methods of remuneration for physicians and primary health care reform more probable? What can be

cottage hospital system (12). In terms of time, participants seemed to recall the 1990s and the early part of the twenty-first century when the issue of alternate physician payments appeared. Much of this wa

1990s. During this period, alternate physician payment models were developed for speciality physicians such as paediatricians because of the dwindling numbers. These specialists were treated by government as fee-for-service physicians but were paid a fixed income on a monthly or bi-monthly basis for providing a defined basket of medical services within hospitals. The contents of the basket would be negotiated between

. One participant argued that the issue attracting much more attention on the radar screen is not alternate payment models but rather scope of practice for physicians. For many residents in rural Newfoundland and Labrador, their doctor is a licensed practical nurse (LPN) and remuneration is less important an issue for government

(7). has become more sustained since the advent of primary health care reform but nothing of substance has been developed. Indeed, one of our participants remarked somewhat tongue in cheek that

of criteria on how this [

Based on the summaries provided in part one of the paper, it was nurses who established the first primary health care project in 1990. We know, too, that since the advent of Medicare in Newfoundland and Labrador in 1968, governments have struggled to find suitable models for physician remuneration that would allow for recruitment and retention of doctors practicing in rural and isolated areas. Reforms have been incremental, driven by external forces (federal funding for primary health care) and very much physician centred.

Question 2: Under what conditions have alternate methods of remuneration for physicians and primary health care reform occurred over the last decade?

There are a number of key drivers for the reform of physician remuneration models and primary health care. These drivers can be categorized as external (outside the province) and internal (within the province). Our participants suggested the following as the most critical drivers of reform:

1. federal money for primary health care reform;
2. efforts of other health professionals (especially nurses) to establish interdisciplinary teams for medical services;
3. improving recruitment and retention of physicians in rural areas, and
4. community pressures on government to provide a basket of primary care medical services.

funds to establish primary health care projects in the provinces. Newfoundland and

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federal government have been used to establish the Office of Primary Care and the current pilot projects across the province. The federal money will run out at the end of Marc

than fee-for- The department [Health and Community Services] is certainly looking at alternate ways to fund primary care services and the reason being or the challenge being is that the current system where we pay the physician, the money follows the physician versus... we think that the money should follow the patient

Reform in the field of alternate physician payment has focused more narrowly on the issues of recruitment and retention of doctors in rural and remote areas. Given the

been reluctant to work in isolated regions for limited pay. The province has the highest rate of salaried physicians in the country, many of whom practice in rural areas. However, lifestyle issues are important and efforts to reform payment models have been

to physician payment structures. The two issues intersected around 2000 as a result of

Conclusion

We have attempted to demonstrate that much informal reform has occurred in the fields of alternate physician payment and primary health care in Newfoundland and Labrador. While legislation has not been enacted to provide for primary health care in the province, seven pilot projects are currently underway with an alternate payment model being

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