THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Transforming the Foundation of Canada's Health Care System

Solutions to bolster primary care

Family Practice Reform Policy Proposal Package

July 2023

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How to cite this document:
College of Family Physicians of Canada. *Transforming the Foundation of Canada's Health Care System – Solutions to bolster primary care*. Mississauga, ON: College of Family Physicians of Canada; 2023.

Overview

Background

The College of Family Physicians of Canada (CFPC) calls for federal government leadership in health care through national standards and dedicated federal funding to provinces and territories to deliver results in areas of shared priority.

The Government of Canada recently announced an investment of $198.3 billion over 10 years, including $25 billion in new funding dedicated to the four shared priorities[1]:

- Expanding access to family health services, including in rural and remote areas.
- Supporting health workers and reducing backlogs.
- Improving access to quality mental health and substance use services.
- Modernizing the health care system with standardized health data and digital tools.

The CFPC proposes actionable recommendations for the government investment that align with these commitments as they pertain to primary care, the foundation of Canada's health care system. The recommendations are also strongly aligned with the principles laid out in the Health Workforce Crisis report recently released by the Standing Committee on Health.

The CFPC identifies examples of best practices and provincial/territorial programs that could be funded and upscaled to alleviate short-term challenges in primary care and prepare the system for much-needed modernization in alignment with its Patient's Medical Home (PMH) vision. Together, these recommendations will improve access to care and create a more efficient and sustainable system for all in Canada.

Summary statement of the issues and proposed solutions

Solution 1: Fund interprofessional collaborative teams

Primary care is most effective when it is delivered by well-established, well-resourced collaborative teams, with continuous support and leadership from family physicians. As experts in family medicine, family physicians can elevate the work of other health professionals in providing high-quality, team-based care to larger rosters of patients. It is imperative that federal funding is directed toward **establishing additional interprofessional teams** similar to the current program in Prince Edward Island, which follows the CFPC's PMH vision.

Solution 2: Reduce administrative burden for family physicians

Administrative burden consistently ranks as one of the most significant contributors to physician burnout. As more providers intend to reduce their clinical hours and/or exit practice, physician well-being is essential to health system sustainability. Investing in partnerships to simplify and reduce paperwork/forms, hire additional team members to share administrative tasks, and introduce medical scribes to family practice can be used to target a **reduction in physicians' administrative burden**. This will maximize family physicians' time for direct patient care, improve work-life balance, enhance patient-centredness, and prevent burnout.

Solution 3: Minimize the burden associated with adopting new technologies in practice

Canada lags behind other countries in its ability to use health information technology to coordinate care. Physicians in Canada have indicated interest in a variety of technologies not yet in use at their respective practices. Given that family physicians provide over half of all physician services in Canada, it is critical to enable them to integrate technologies into practice and to share digital patient data within and between practice settings. It is a necessary step toward implementing a pan-Canadian health data strategy and modernizing the health care system toward a One Patient, One Record electronic health record (EHR) approach. Approaches focusing on facilitating referrals, such as centralized referral systems, must be prioritized.

Solution 4: Support national licensure and improved locum availability

Locum coverage (one doctor temporarily filling in for another) is exceedingly hard for family physicians in Canada to find. Many physicians are unable to take a break from their practice without disruptions to care because they can't find someone to cover their absence. Improving the availability of locums can enhance family physicians' work-life balance, helping them avoid burnout and further staffing shortages. More locum support could also attract more doctors to work in rural areas. Locum coverage could be improved by federal support for national/regional licensure or temporary funding to reimburse physicians for obtaining additional jurisdictional licenses.

Solution 5: Invest in fair physician remuneration that incentivizes team-based practice and complexity of care

The fee-for-service (FFS) model remains the predominant model for the remuneration of family physicians in Canada. However, it does not align well with providing complex care or team-based primary care. Blended capitation models are a viable alternative to FFS that are more compatible with the values of comprehensive team-based care. Policy-makers should invest in initiatives that shift toward capitation-based payment programs that compensate family physicians for their full range of tasks and are compatible with high quality, team-based care. **Fair and competitive compensation of family physicians** will make sure that the specialty remains attractive to medical graduates and offers sustainable professional experiences.

Solutions and Recommendations for Government

Solution 1: Fund interprofessional collaborative teams

Patients continue to face challenges accessing primary care in Canada.[2] At the same time, family physicians are leaving practice due to burnout and overwhelming administrative burden.[3,4] Stabilizing the primary care environment through establishment of well-resourced interprofessional teams is imperative to improving access while also ensuring a work environment that supports provider well-being and improves the appeal of practising family medicine in Canada.

Working in collaborative teams, family physicians can contribute to elevating the work of other health professionals through their in-depth clinical expertise and knowledge of the health care system. In this arrangement, family medicine specialists are readily available to lead and/or support other members of the team. Care may be provided by either a family physician or another health care provider with appropriate knowledge and skills, resulting in faster patient access to care based on team member availability. Optimizing the scope of practice for each provider results in improved efficiency and accessibility of care. Patient information is shared effectively so that a documented patient encounter with one provider is available to other team members who are involved in the patient's care. Even when the most responsible provider is not a family doctor, they are able to maintain their own patient roster while having family physician expertise within reach to consult on more complex cases. This is essential as Canada's population continues to age and, consequently, requires increasingly complex care.

Data indicate that health professionals providing primary care independent of family physicians may not achieve outcomes of comparable quality.[5,6] For this reason, **collaboration** with and not **substitution** of family physicians is required to meet the evolving health needs of communities across Canada.

Recommendation

1.1 The federal government should allocate funding toward the creation, maintenance, and development of interprofessional practices to strengthen primary care across Canada.

Benefits of investment

Team-based care is preferred by family physicians[7] and patients,[8, 9] and results in better continuity of care, stronger focus on preventive care, improved health outcomes, and reduced reliance on emergency departments.[10,11] It is also cost effective as returns on investments (ROIs) in primary care are realized through efficiencies achieved in other areas of the health care system.[12]

Provincial funding is required to enable collaborative team-based care to meet current provider and patients' needs, including programs such as Family Health Teams in Ontario,[13] Family Medicine New Brunswick clinics in New Brunswick,[14] Groupe de médecine de famille in Quebec[15] or, most recently, Patient's Medical Homes in Prince Edward Island.[16] In most of these examples, physicians work in capitation or blended remuneration models with allied health professionals (social workers, nurse practitioners, pharmacists, and others) funded through government resources.

Though progress in collaborative care exists across Canada, it often depends on provincial/territorial resource availability. For example, the Ontario list of Family Health Teams was stagnant for several years prior to the recent announcement of new investment into collaborative clinics. In other cases, like the Prince Edward Island model, assessment demonstrates that initial government investment may be insufficient to reach the full program potential. Federal funding earmarked specifically toward creation, maintenance, and development of interprofessional practices would go a long way toward strengthening primary care across Canada.

Solution 2: Reduce administrative burden for family physicians

Over half of family physicians in Canada report high levels of burnout,[17] with administrative burden consistently ranking as one of the most significant contributors to physician burnout,[3,4] as family physicians spend more than a full day's work on administrative tasks.[3]

Reducing administrative burden for family physicians would free up more time to spend with patients, improve patient-centredness, enhance access to care, and prevent burnout. As more physicians intend to reduce their clinical hours and/or exit practice over the next few years,[*,18,19] physician health and well-being is essential to health system sustainability. A 2023 Canadian Federation of Independent Business report indicated that if governments across Canada decreased administrative burden by 10 per cent, it would have a significant effect on Canadians' access to care: it would free up time that could facilitate 5.5 million more patient visits per year.[20]

Dedicated funding must address the root causes of administrative burden. Simplifying paperwork/forms, eliminating unnecessary processes, and introducing medical scribes to family practice are among the solutions that this funding can go toward.

Recommendations

2.1 Dedicated funding must be targeted to projects that:

- 2.1.1 Identify and eliminate unnecessary forms.
- 2.1.2 Simplify forms or reduce unnecessary aspects of forms where elimination is not possible.
- 2.1.3 Fairly compensate physicians for filling out forms that cannot be eliminated or simplified.
- 2.1.4 Offer funding for the administrative staff needed to conduct this work.

2.2 Federal funding should be earmarked to pilot projects within the provinces/territories to employ medical scribes within family practices and measure their effectiveness and impact.

[*] Over half of family physicians are likely to reduce their clinical hours in the next two years and in Toronto, one in 25 family physicians intends to close their practice entirely in the same time frame, with that number reaching one in 10 family physicians in the next five years.

Benefits of investment

Funding solutions to reduce administrative burden can help make certain that existing family physicians have **more time for patients** and can **achieve a work-life balance**. This can also help improve the appeal of family practice in Canada for domestically and internationally trained medical graduates and physicians, and reduce burnout and the likelihood of family physicians leaving the practice. All of these benefits contribute to improved access to care.

Case in Point:

Simplification of forms in Nova Scotia

In 2019 Doctors Nova Scotia (DNS) established a partnership with Nova Scotia's Office of Regulatory Affairs and Service Effectiveness (ORASE) to review administrative requirements for physicians and determine where administrative burden could be reduced or eliminated.[21] ORASE conducted a survey of nearly 500 Nova Scotia physicians and found that the **average doctor spends over 10.5 hours per week on administrative work**, 38 per cent of which they deemed unnecessary. Of this work, nearly a quarter could be completed by another health care professional, which would make 327,000 hours available[22] for physicians to spend time with patients, have a better work-life balance, or allow them to increase their patient rosters.

ORASE has credited physician support of this project as crucial to its success so far. Physician knowledge and experience allows ORASE to determine the source of administrative burden, address it, and measure the outcome. Measuring is also emphasized as a key part of the process; quantifying and understanding the impact of administrative burden is essential to addressing it.

The federal government should work with the provinces and territories to incentivize partnerships similar to ORASE/DNS, where jurisdictional regulatory offices (or their equivalents) work with provincial/territorial colleges or medical associations to: measure the impact of administrative burden in their respective regions; identify and eliminate unnecessary forms; simplify forms or reduce unnecessary aspects of forms where elimination is not possible; and fairly compensate physicians for filling out forms that cannot be eliminated or simplified.

Case in Point:

Eliminating unnecessary processes in Hawaii

In Hawaii a team of health care providers launched a program called "Getting Rid of Stupid Stuff," (GROSS) where all employees were asked to examine their daily documentation experience and put forward anything within the electronic health record (EHR) system that they believed to be unnecessary or badly designed.[23] This led to prompt changes and quick fixes to reduce time spent in the EHR system. For example, collapsing three check boxes into one for specifying types of incontinence on a form when it pertained to babies. The GROSS program's implementation has now gone beyond the EHR system and staff are looking for other areas in the clinic where low-value work could be eliminated or reduced.

This program shows the potential for the federal government to earmark funds for quality improvement (QI) projects similar to GROSS, including funding family practices to hire administrative staff who can implement and continue optimizing the tools physicians must use in their daily work.

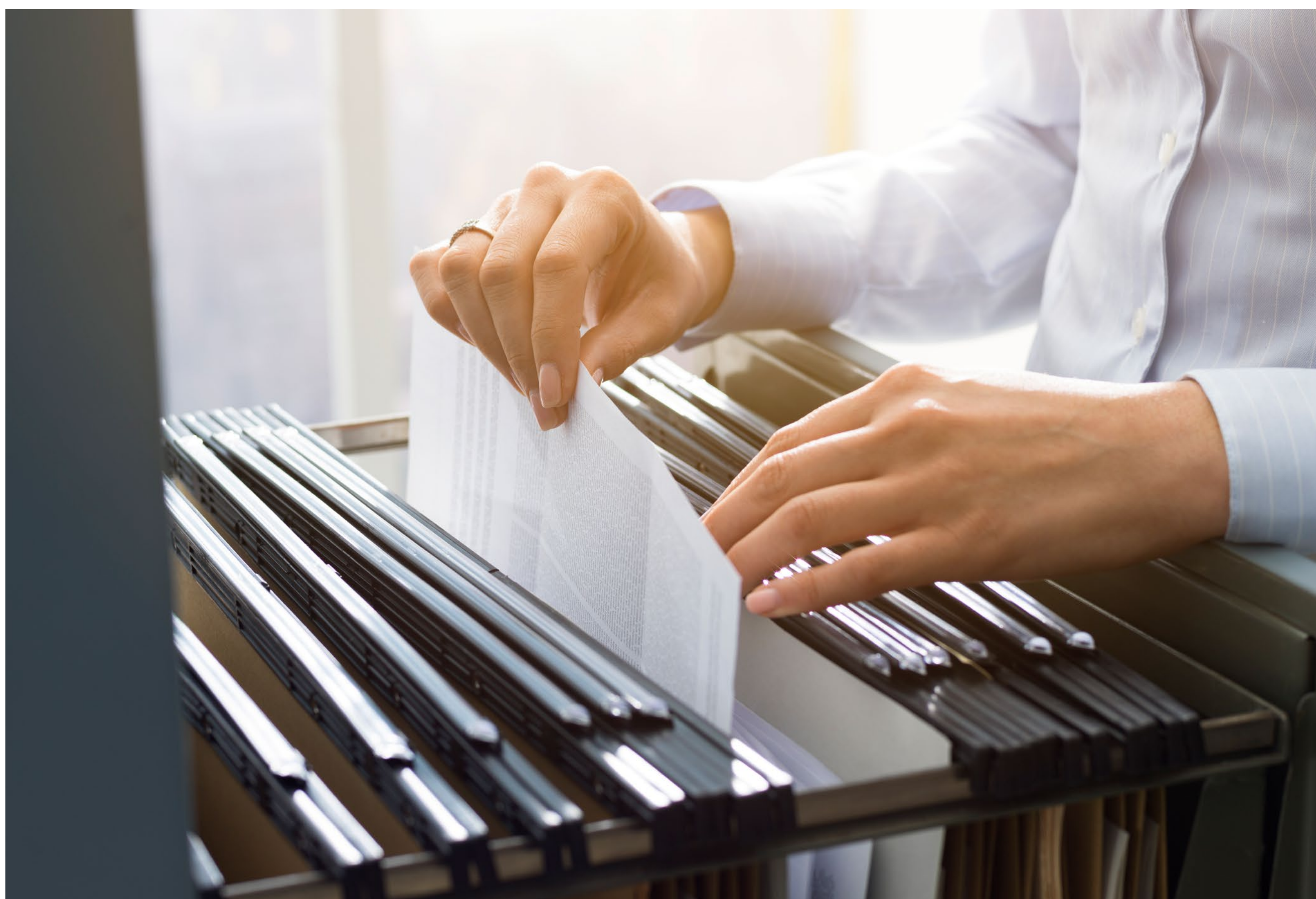
Case in Point:

Introducing medical scribes to family practice in the United States

Research from the United States has shown that for every hour family physicians spend in direct face-to-face patient care, they spent **two more hours on EHR documentation** and administrative work. Many spend one to two hours each night, outside of office hours, doing charting in the EHR.[24]

Medical scribes are "non-licensed team members trained to document patient encounters under the direct supervision of a physician."[25] Medical scribes can help to unburden physicians from taking notes and charting during and after visits. In a randomized controlled trial, a family medicine clinic was provided a scribe for one week, followed by one week without a scribe for the duration of a year. Scribes were found to enhance physician satisfaction across all indicators, including having enough face-to-face time with patients, reducing charting time, improving chart quality and accuracy, and increasing overall satisfaction with clinic. These improvements did not detract from patient satisfaction.[25]

Despite the upfront cost of training scribes, the financial impact of scribes is positive as a result of improved productivity and efficiency.[26] Another QI study in an American family practice found that implementing scribes significantly reduced the amount of time spent on charting and enhanced physician wellness/work-life balance with no negative impact on patient satisfaction. After introducing scribes, family physicians spent 5.1 fewer hours per week on documentation, with a growth in productivity from nine to 29 per cent. The researchers annualized the results of the pilot program: it was projected to increase revenue by $168,600 per year, which was over twice the $79,500 cost of two full-time equivalent (FTE) scribes per year (112 per cent ROI).[27] As part of funding team-based care, a portion of federal funding should be dedicated to provincial/territorial pilot projects that employ medical scribes within primary care teams. While research is scant on the use of medical scribes in Canada, research from the United States is promising: scribes can act as another part of a primary care team to enhance patient encounters and improve access to care across the board.



Solution 3: Minimize the burden associated with adopting new technologies in practice

Canada lags behind other countries in its ability to use health information technology to coordinate care.[28] This includes the ability of family physicians to electronically exchange information with other physicians and health care providers outside their practice. In a 2021 survey physicians indicated a strong interest in technologies they were not using at their respective practices,[29] including those that would enable them to fully integrate electronic medical records (EMRs), access all records through an EMR system, perform secure messaging, use artificial intelligence, make requests through e-referral, conduct home monitoring, and more.

Family physicians provide over half of all physician services in Canada.[30] Family practices must be enabled to adopt new technologies without introducing undue burdens to the practice staff. It is also necessary to enable sharing data within and between care settings as Canada moves toward a One Patient, One Record EHR approach.

While physicians are interested in digital technologies to help communicate electronically with other providers and to improve patient care, the Pan-Canadian Health Data Strategy Expert Advisory Group has highlighted that:

> "Clinicians are challenged to incorporate new requirements for data collection while receiving few or no benefits in reduced workload nor seeing better outcomes for their patients, contributing to burnout."[31]

Over half of family physicians are burnt out,[32,33,34] six in 10 already report spending a high or excessive amount of time on EMRs at home,[32] they are overburdened with administrative tasks,[35] and are in short supply.[36] Dedicated support through financial compensation and funded QI specialists is needed to minimize the burden associated with integrating technologies of interest efficiently into practice workflows.

The CFPC supports the federal government's commitment to expanding sharing and using common key health indicators,[37] and the Pan-Canadian Health Data Strategy[31,38,39] to create a world-class health data system for Canada. Ensuring family practices are supported in adopting new technologies allows them to be a part of this evolution.

Recommendations

3.1 Invest in provincial/territorial centralized data technology initiatives to implement new, or advance existing, centralized data systems that support a One Patient, One Record approach.

3.2 Fund family practice subsidies to invest in QI projects aimed at adopting or optimizing digital tools in family medicine.

3.2.1 Focus on enabling family physicians to share patient information and coordinate care with health care professionals outside their practice.

3.2.2 Include funding for QI specialists with expert knowledge of clinical workflows to ensure efficiency and usability of technologies that are already in use or desired by a practice.

3.2.3 Invest into programs that allow family practices convenient access to their practice data to enable family medicine-based research

3.3 Prioritize ongoing federal action to enable access to reliable high speed Internet in all communities across Canada,[40] especially in rural and remote areas.

Benefits of investment

Investing in primary care digital solutions will help Canada achieve a world-class health data system that is timely, usable, connected, patient-centred, and comprehensive. Digital technologies strategically integrated with the help of QI specialists can enable family physicians to more easily share patient information with providers outside their practice and to shift toward a One Patient, One Record approach to health data can have the potential to improve the efficiency of various daily clinical activities. Resulting outcomes include more efficient use of physicians' and other health providers' time and system resources, improved patient outcomes, and improved access to care.

Case in Point:

Family physicians in Alberta are able to access and share patient information outside their practice.

Connecting to the provincial EHR system

Connect Care is a clinical information system in Alberta that provides a central access point to patient information, common clinical standards, and best health care practices. First launched in 2019, provider and patient access to Connect Care continues to expand throughout Alberta with a final launch anticipated for 2024.

Though providers from rural and urban care sites across the province connect directly to the system, many family physicians and other primary care providers are unable to access Connect Care directly due to issues related to private business ownership of primary care practices.[41] To address this, Connect Care leadership implemented a portal for primary care providers to connect indirectly using the Connect Care Provider Portal. This portal complements the existing Alberta Netcare system (the province's EHR) and can be adapted to work with any EMR software, so a family physician can continue to use their EMR software of choice.

Automatic delivery of patient information into EMRs

Family physicians can opt to use a secure push service called eDelivery to automatically send patient information authored in Connect Care to their EMRs. This means that patient information such as lab results, diagnostic imaging, and notes from other providers are easily made available to family physicians without having to track down or duplicate work.

Centralized referral system

A new central access and intake program for managing referrals called Alberta Facilitated Access to Specialized Treatment (FAST) rolled out in 2022; new specialties are being added over time. FAST simplifies the referral process by providing a single fax number through which providers can submit a referral to either the next available provider with the shortest waitlist within their health care zone or to a specific provider within or outside their health care zone. On-call support is available to assist with referral questions and confirmation is sent back to the referring provider to share where the referral is.

Patient access and ability to add to an existing EHR

Patients can access their own health information through an interactive online tool called MyAHSConnect. This empowers patients to better manage their own care by allowing them to view and add to their existing health record, permit access to friends and family, pose questions to a health care team, track personal health trends, and more.

Case in Point:

QI specialists from the eHealth Centre for Excellence helped Ontario physicians implement eReferral, ePresciption, and online appointment booking

eReferral

When a policy update required physicians to adapt quickly to new expectations related to acknowledging referrals and communicating appointments to patients, the eHealth Centre of Excellence worked with partner organizations to implement eReferral in Ontario clinics.

North Eastern Ontario Medical Office (NEOMO) primary care clinic was one of those clinics. eReferrals improved their efficiency by reducing time to process orthopedic referrals and wait times, and by improving referral completion rate.

Compared to paper-based referrals:

- Average referral processing time was reduced from 3.4 to 0.6 days
- Average wait time to assessment at referred clinic decreased from 42 to 20 days
- Rate of referral completion increased from 82 per cent to 92 per cent

Investment by the Ontario government (and collaboration with Think Research) enabled expansion of eReferral to three Ontario health regions (West, East, North). More than 2,000 end users adopted eReferral by 2020.[42]

ePrescription

It's been estimated that close to a third of new prescriptions go unfilled,[43] which can lead to preventable hospitalizations. With expert support from the eHealth Centre of Excellence team, Dr. Patricia Froese from Kitchener, Ontario, was able to reduce that number to one tenth at her clinic by successfully integrating PrescribeIT® in her clinic workflow.

PrescribeIT is a Canada Health Infoway digital initiative that facilitates digitally secure and timely transmission of prescriptions to the patient's pharmacy of choice. When sent prescriptions are not dispensed, that information is communicated back to Dr. Froese through PrescribeIT, presenting an opportunity for Dr. Froese to follow up with patients to better understand the circumstances surrounding prescriptions not being filled.

Online appointment booking

Online booking offers patients flexibility and convenience. For providers, online booking may result in fewer phone calls, outgoing confirmation calls, no-shows, and late cancellations. The eHealth Centre for Excellence team helped clinics identify potential benefits of online appointment booking (including cost savings and reduced administrative burden) and effectively integrate this technology with their EMR systems.[44] For example, booking an appointment by phone can cost between one to five dollars each for the receptionist's time and can amount to 25 percent of the cost of running a clinic.[45] Online booking can decrease these costs by approximately 70 percent by reducing the need for a designated receptionist to field patient booking calls.[44]

In each of the examples above, not having the dedicated (and funded) expertise of the eHealth Centre of Excellence would make adopting the new technology more time-consuming and onerous, resulting in disruptions to providing care, more burnout for providers, and longer implementation periods. Dedicated funding for implementing new technologies helps alleviate these concerns.

Case in Point:

The Government of Manitoba funded a QI initiative to improve access to clinics across the province

Also known as same day or open access, advanced access is a comprehensive scheduling system that allots time every day for same-day appointments while balancing appointment supply and demand and streamlining other clinical processes.[46,47,48,49,50] The Government of Manitoba began sponsoring clinics to take advanced access training in the mid-2000s. Participation was voluntary, and clinics did not incur additional costs because the Manitoba Ministry of Health covered the cost of training.[51] Implementation of advanced access required administrative work and clinic staff were supported throughout the implementation process by QI professionals.[52] By 2007 more than 30 clinics had been trained in advanced access.[51]

The Burntwood Community Health Resource Centre (BCHRC) in Thompson, Manitoba, was one of those clinics. The BCHRC had been facing appointment wait times of up to two or three months and, in 2008, began implementing advanced access. Under the direction of the clinic's leadership and with support from the QI professionals, changes in scheduling, communication, resource use,[53] and coordination were implemented, and access-related complaints began to decline, walk-in clinic usage decreased, and the BCHRC, with its new-found capacity, was able to roster more than 1,500 additional patients.[53]

These improvements would not be possible without the dedicated QI capacity funded through the government initiative. More capacity for such projects would allow for more successful outcomes like those in the BCHRC.

Solution 4: Support national licensure and improved locum availability

Family doctors across Canada deserve the flexibility to take time away from their practice while patients deserve to know that health care services are still available to them. Locum coverage—where one doctor temporarily fills in for another—helps achieve these things but is exceedingly hard for family physicians in Canada to find. For example, the Alberta Medical Association noted that the 2021 **need for locums was 40 percent higher** than the five-year average. Staffing disparities leave many physicians unable to take a break from their practice without disrupting care. Burnout from working throughout the COVID-19 pandemic and an increasing number of physicians retiring exacerbate this problem.[54]

Improving the availability of locums can enhance family physicians' work-life balance, helping them avoid burnout and additional staffing shortages. Better locum coverage could also allow doctors to work for longer in rural communities, as reliable coverage would provide the relief and support physicians need to mitigate the risk of burnout and preserve workforce longevity. More locum support could also draw more doctors to working in rural areas—a key deterrent for many physicians to work in rural areas is the lack of coverage for time off.[55]

The federal government must work with the provinces and territories to urgently address the need for locum availability. One initiative that would increase the pool of locum availability is the widely-supported call for national physician licensure. The change is substantive, and while awaiting its enactment the government can support existing efforts to establish regional licensure (across a localized group of provinces/territories), support changes in physician agreements to allow part-time work, and provide funding for provinces and territories to reimburse or reduce physicians' licensing fees in each jurisdiction across Canada.

Recommendations

4.1 The federal government must work with the provinces and territories to address urgently the need for locum availability by:

4.1.1 Expediting and funding work to shift toward national licensure.

4.1.2 Subsidizing provinces/territories to reimburse physicians for licensing fees in each jurisdiction.

4.1.3 Encouraging provinces/territories to ensure their respective provincial and regional physician agreements allow for flexibility and physician work-life balance.

Benefits of investment

National licensure and improved locum availability would enhance the well-being of family physicians and the long-term sustainability of family medicine as a discipline. This is necessary to retain and recruit physicians to family medicine in Canada—a key factor in improving access to care.

Case in Point:

Regional licensure in Atlantic Canada

The CFPC supports national licensure[56] so that physicians who are licensed in one Canadian jurisdiction may practise across the country without paying fees and confronting the complex process required to obtain an additional license. However, it will take time for national licensure to come to fruition. In the meantime, the Atlantic provinces are demonstrating that there is a pathway to regional licensure that could significantly improve locum coverage, particularly for border communities.[57]

In 2021 the premiers of Nova Scotia, New Brunswick, Prince Edward Island, and Newfoundland and Labrador signed an agreement to collaborate to guarantee care access for the region and meet local health care needs while minimizing duplication. The premiers' council clarified that they are working to develop a system that will permit physicians to work across the provinces.

Nearly two-thirds of physicians agree that complexity in the process to obtain a license was a major barrier to practising in another jurisdiction.[58] This is one example where federal funding should target a solution that could be implemented at a faster pace than national licensure. This regional model could be followed in Western, Central, and Northern Canada to facilitate physicians' movement between border communities and improve rural communities' access to care.

Case in Point:

Changes to physician agreements in rural and Northern Canada

In Ontario the former Rural and Northern Physicians Group Agreement (RNPGA) was met with criticism for requiring doctors to commit to full-time work. Physicians argued that requiring doctors to work full time would dissuade them from working in the North, particularly if they want a good work-life balance.[59]

In March 2022 a new agreement was ratified that allowed part-time work for doctors under the RNPGA contract. The new agreement also facilitates handovers of practices by permitting a three-month contract overlap so that outgoing physicians can mentor the incoming doctor. These are welcome changes that will help encourage more physicians to take on clinical work in Northern

communities that have been facing severe staffing shortages within the health care system, which have led to emergency department closures on several occasions.

When negotiating with provinces on health care funding the federal government should encourage and fund provinces/territories so that their respective physician agreements allow for flexibility and work-life balance, such as allowing physicians to work part-time, in line with the changes made to the RNPGA contract in 2022.

Case in Point:

Reimbursement or reduction in physician licensing fees in Prince Edward Island and Northwest Territories

In Prince Edward Island the fee that physicians pay to obtain a license to practice is reimbursed through the provincial government.[60] For locum physicians who want to practise where they are needed, across several regions, provincial/territorial licensing fees add up.[†,61,62] Reimbursement can be a strong motivator for obtaining or renewing their licenses.[55]

The Prince Edward Island Locum Support Program covers application fees with the Medical Society of Prince Edward Island, the cost of return travel to Prince Edward Island, as well as accommodations and vehicle rental.[60]

In addition to licensing fees the provincial government also covers the cost of return travel to Prince Edward Island, accommodations, and vehicle rental. In places where locums are sorely needed so that patients have access to care and their regular family physician can take a break to avoid burning out, locum physicians should be incentivized to take their place. They should not deterred by costly fees, expensive living arrangements, and travel costs (particularly if they will be working in higher-cost areas than their home city).

In 2022 the Government of the Northwest Territories (GNWT) announced that the health system will reimburse licensing fees paid by locums upon completion of a contract with the NWT Health and Social Services. The GNWT also promised to expedite the licensing process for locum physicians so they are able to work earlier after being hired.[63] If reimbursing licensing fees is not feasible in all jurisdictions, the federal government should encourage and subsidize the ability of provinces/territories to significantly reduce the fees to attract locum physicians. Provinces and territories could guarantee that locum fees are similarly reimbursed or subsidized upon completion of a locum contract in a location or serving a population that have been identified as in-need.

[†] For example, licensing fees in Ontario cost $1,725 per year, and licensing fees in British Columbia cost $1,715 per year.

Solution 5: Invest in fair physician remuneration that incentivizes team-based practice and complexity of care

The fee-for-service (FFS) model—or compensating physicians per service rendered—remains the predominant model for the remuneration of family physicians in Canada. This model incentivizes volume of visits over quality of care, which does not align well with the values and incentives for team-based primary care.[64] Blended capitation models are a viable alternative to FFS that is more compatible with the values of comprehensive team-based care.[64]

Blended capitation models combine capitation (a flat fee paid annually for each patient enrolled in a practice) with FFS, allowing for more fair compensation of the full range of tasks family physicians provide and align better with the complexity of health care systems across Canada. Blended capitation models incentivize high-quality, comprehensive, team-based care, and better patient and provider satisfaction without detracting from physicians' professional or financial well-being.[65,66]

The new payment model and new Master Agreement in British Columbia[67] and the Blended Capitation Clinical Alternative Relationship Plan (ARP) in Alberta[68] are examples of capitation-based programs that support team-based care and equitable blended remuneration for family physicians. Federal support for initiatives such as these will help Canada move away from FFS and toward more equitable and sustainable payment for family physicians. It must also be noted that the **rate for family physician remuneration must increase** to further boost the appeal of family medicine as a sustainable and rewarding career for medical graduates.

Implementing new blended capitation models requires additional funding for physician remuneration, as well as funding and expertise (e.g., administrators and change management professionals to conduct financial modelling, orientation, approval, and implementation) to support implementing the new models. However, some of these additional costs are offset by lower system-wide health costs, achieved through higher staff retention and lower use of more expensive forms of treatment like emergency departments and inpatient hospital stays.[69]

Recommendations

5.1 Facilitate the transition from FFS to blended capitation by investing in capitation-based payment programs that compensate family physicians for their full range of tasks and are compatible with team-based care.

5.2 Increase the appeal and sustainability of comprehensive community-based family medicine by ensuring fair and competitive remuneration for physician as an appropriate incentive to enter and remain in practice.

Benefits of investment

Implementation of blended-capitation models Canada-wide can improve access to team-based care, overall quality of care, patient and provider satisfaction, and system-wide cost efficiency.[65,69]

Case in Point:

BC Master Agreement and new full-service family doctor payment model

On October 31, 2022, the British Columbia government announced a new comprehensive Physician Master Agreement for all physicians and a new payment model for family physicians, both co-developed by the province and Doctors of BC. The agreement stipulates an increase of $708 million over three years and represents an increase in funding of 13.5 per cent, or 15.2 per cent if inflation remains high.[70] The new payment model is designed to attract and retain family physicians and will introduce, among other things, new hourly premiums for after-hours services, new funding to support full-service family practice, additional funding for new or adjusted family physician fees, and funding to support full-time equivalents working under alternative payment models including blended capitation.[70]

The new family physician payment model was designed to improve access to comprehensive primary care, support the integration of primary care in the broader health care system, and attract and retain family physicians seeking to provide this type of care. Family physicians with a patient roster who agree to providing coordinated, community-based, full-service care aligned with the PMH are eligible to opt into this payment model.[70]

The agreement addresses many concerns by offering increased compensation for rising business costs, administrative and indirect clinical tasks, and to reflect time spent with patients, the number of patient encounters, as well as roster size and complexity. Additional payments are based on panel size and complexity with physicians paid $34 per average patient annually, subject to adjustment depending on patient complexity. The BC Ministry of Health estimates that a **family physician would make $385,000** annually under this model, provided they practice 1,680 hours, roster 1,250 patients of average complexity, and complete 5,000 visits in a year.[70] This represents a significant increase from the **current average of $250,000**,[71] increasing the appeal of community family practice as a career choice.

Under the new payment agreement, family physicians may also **bill for indirect care and administrative tasks** including documentation, reviewing labs, charting, asynchronous care, conferencing, consulting, panel management, chronic disease management, and EMR management requiring physician expertise.[71] Compensation for these tasks is a welcome change for physicians looking to adopt the new payment model, since under FFS payment agreements these types of tasks go typically uncompensated.

According to Doctors of BC, more than **2,000 physicians—or 45 per cent of currently practising physicians**—had signed on to the new payment model within the first five weeks of it coming into effect.[72,73] Given the uptake of the new payment model and the breadth of research supporting the idea of capitation-based funding to facilitate providing high-quality, comprehensive team-based care,[65,66,69] the federal government should consider providing dedicated funding for implementing similar programs in other provinces to encourage the shift away from the FFS model in Canada.

Case in Point:

Alberta's blended capitation ARP

Alberta's ARP is a collection of non-FFS payment models for physicians. Having been adopted by approximately 2,200 Alberta physicians, ARPs are designed to promote physician recruitment and retention, increased access to team-based care, patient satisfaction, and added value for investment.[74] The blended capitation model, a subvariant of ARP, was developed by Alberta Health in partnership with the Alberta Medical Association and Alberta Health Services and was first introduced in December 2016. The model has since been adopted at six practices in the province, showing promise as an alternative form of remuneration.[75]

The blended capitation model compensates family physicians based on roster size, patient complexity, and volume of services provided. Physicians' pay is comprised of 85 per cent capitation—determined by the number of rostered patients and their complexity—and 15 per cent of out-of-basket services on a FFS basis.[75] The model allows family physicians to roster as many patients as they wish, incentivizing work with a team of health care professionals to allow for larger patient rosters. The goal of the model is to provide accessible, patient-centred, team-based care at a predictable cost for the province. Like other variations of blended capitation, this model is designed to incentivize interprofessional care, greater continuity of care, and more time spent with complex patients.[75]

Before adopting the blended capitation model, interested clinics must undergo financial modelling led by Alberta Health to determine the extent to which the model is viable. Interested clinics must then apply for the blended capitation model through a Ministerial Order with Alberta Health. Once approved, clinics receive ongoing support from the blended capitation model implementation team, including training and administrative and clerical support.[76] All the clinics that have transitioned to the blended capitation model to date were estimated to earn between 7 and 29 per cent more under the blended capitation model compared to FFS (Alyssa Scott, Policy Analyst, Alberta Health; correspondence; January 20, 2023).

Capitation in practice: Taber Clinic and Crowfoot Village Family Practice

Although they did not adopt the blended capitation model, the Taber Clinic and Crowfoot Village Family Practice have had tremendous success with a closely related, capitation-based ARP. Taber and Crowfoot both adopted forms of pure capitation in the 1990s and have since experienced improvements in provider satisfaction, quality of care, as well as reductions in system-wide costs.[69]

A 2019 report by Health Quality Council of Alberta (HQCA) found that the capitation-based ARP used at the two clinics was a key factor in their success.[69] Family physicians reported that they could better meet their patients' needs because interactions were not fee-driven. They also highlighted the added incentive of working within a team of allied health and administrative professionals, improving quality of care, accessibility, and workflow. System-wide health care savings were observed as a result of these improvements in care and clinical efficiency. For instance, the report found that in

2016–2017 Taber and Crowfoot saved the Alberta health care system $4.3 million and $7.2 million respectively in preventive downstream costs. **Over the 10-year period preceding 2016–2017, Taber and Crowfoot saved the Alberta health care system $57.3 and $62.2 million respectively**.[69]

Although family physicians at Taber and Crowfoot practise under pure capitation, the HQCA report recommends that blended capitation models should be expanded across the province because they best enable the implementation and delivery of team-based care aligned with the principles of the PMH.[69] The report suggests that investing in this style of funding could help increase provider satisfaction, improve access to and quality of care, and reduce system-wide cost by preventing more costly forms of treatment.[69]

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About the CFPC

The voice of family medicine in Canada

The College of Family Physicians of Canada (CFPC) is the professional organization that represents more than 42,000 members across the country. The College establishes the standards for and accredits postgraduate family medicine training in Canada's 17 medical schools. It reviews and certifies continuing professional development programs and materials that enable family physicians to meet certification and licensing requirements.

The CFPC provides high-quality services, supports family medicine teaching and research, and advocates on behalf of the specialty of family medicine, family physicians, and the patients they serve.

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