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CANADIAN HEALTH SERVICES RESEARCH FOUNDATION
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mythbusters

USING EVIDENCE TO DEBUNK COMMON MISCONCEPTIONS IN CANADIAN HEALTHCARE

MYTH BUSTED JANUARY 2010

MYTH: MOST PHYSICIANS PREFER FEE-FOR-SERVICE PAYMENT

Since the introduction of Medicare in 1966, physicians in Canada have operated as independent, self-employed entrepreneurs, billing their provincial ministries of health and other payers for each insured service they provide. This payment method – commonly called *fee-for-service* – reimburses doctors for each of their clinical activities, based on a set of billing codes established by the payer.

Fee-for-service is believed to be the payment model most trusted by physicians, possibly because it reflects their desire for professional autonomy.[i] However, some doctors may also prefer this form of payment because it enables them to use fee-for-service billing to generate more revenue. This tactic arguably drives the "one problem per visit" policies adopted by a number of family doctors.[ii]

Recent decades have seen the introduction of alternative payment plans such as salary, capitation (under which doctors receive a yearly fee for each patient on their roster) and blended models (which combine multiple payment schemes). More recently, some payers have introduced new payment plans as part of a primary healthcare reform agenda that promotes interdisciplinary team-based care, with the goal of improving accessibility and comprehensiveness of care.[iii] It is generally understood, however, that any shift in the way doctors are reimbursed requires their voluntary buy-in; accordingly, some payment plans offer financial incentives to further entice physicians to make the switch.

NEW PHYSICIANS, NEW PREFERENCES

In contrast to conventional wisdom that physicians prefer only fee-for-service, research shows that a growing number of Canadian physicians are interested in alternative payment models. According to the

National Physician Survey (the largest survey of Canadian doctors), the percentage preferring fee-for-service as their sole source of income declined from 50% in 1995[iv] to 28% in 2004[v] and to 23% in 2007.[vi] The preference for non-fee-for-service is even more pronounced among female physicians, only 18% of whom preferred fee-for-service compared to 26% of their male colleagues. Age also appears to be a factor: support for fee-for-service ranged from a high of 41% among physicians aged 65 or older to a low of 17% among physicians under 35.[vi] As older, predominantly male, cohorts of physicians retire, support for fee-for-service as the sole source of income is expected to fall even more rapidly.

The growing popularity of alternative payment plans is also reflected in medical billing trends. From 2001 to 2002, clinical payments under alternative plans rose 40% and accounted for 16% of total physician clinical service costs.[vii] The percentage of physicians receiving

at least some of their income from non-fee-for-service arrangements also rose: between 2000 and 2006, the figure increased from 28.1% to 39.1% of all Canadian physicians.[viii]

As well, work satisfaction data indicate that physician support for fee-for-service arrangements may be weak. For example, a 2006 Canadian Institute for Health Information report found a correlation between higher income share from fee-for-service arrangements and lower physician satisfaction with professional lives.[ix] Meanwhile, Green et al. (2009) found higher levels of satisfaction among physicians working in capitation and salaried environments, compared to their fee-for-service counterparts.[x] However, this is not to say that physicians have enthusiastically embraced non-fee-for-service payment models, even if they recognize that change is needed. A 2004 survey of Ontario family doctors reported that 60% agreed that the financing of primary care requires change, but less than half of respondents felt well-informed enough about new capitated models (part of the province's proposed Family Health Networks) to make a decision to join, and many opposed specific elements of primary health-care reform, such as financing incentives for prevention or extending operating hours.[xi]

COMPENSATION FOR COMPREHENSIVE CARE

Satisfaction with alternative models may be due in part to the accompanying financial premiums designed to encourage physicians to change their practice model. Indeed, Green et al. (2009) found that physicians who switched from fee-for-service to an alternative payment model saw their incomes increase as much as 30% (depending on the model chosen); whereas physicians who stayed in traditional fee-for-service environments, with minimal changes in the type or volume of services provided, saw minimal increases or decreases in their income over the same period.[x] The higher level of pay under alternative payment models is often a result of incentives to doctors to deliver certain types of services.

Fee-for-service practice is sometimes criticized for discouraging physicians from offering comprehensive or whole-person care in favour of high patient volume,[ii] while some alternative plans reward physicians whose patients do not seek out other sources of primary care, such as the ER or another family doctor.[xii] Access to care has been identified as a problem for practices operating within the fee-for-service payment model; Chan (2002) has documented reductions in the provision of obstetrics, nursing home visits, hospital inpatient care, and house calls by family doctors.[xiii] Alternative payment plans, by contrast, often include a variety of incentives to encourage physicians to provide after-hours care, obstetrics and hospital visits.[iii] However, given that the alternative plans have been introduced only in the past five to 10 years and in some, but not all, provinces, there is limited research available to assess their impact. Existing evidence indicates only modest differences in patient outcomes and service delivery.[iii, xii, xiv]

Governments see alternative models as offering greater flexibility in achieving health human resources and health policy goals. Alternative models have long been recognized as desirable for physicians practicing in rural and remote communities too, where demand for medical services is often low and unpredictable, while the personal and professional costs of a rural practice can be quite high.[xv] Another much-touted function of alternative payment models is that they encourage new practice models, primarily team-based medicine and preventive care.[iii] Alternative models also purportedly accommodate valued non-clinical activities like teaching and research, or the administrative overhead associated with adopting electronic medical records.[xvi]

EXISTING EVIDENCE INDICATES ONLY MODEST DIFFERENCES IN PATIENT OUTCOMES AND SERVICE DELIVERY.

CONCLUSION

The modern physician is moving toward an alternate form of payment plan. However, it would be premature to sound the death knell of fee-for-service; when respondents to the 2007 National Physician Survey were asked to define their ideal blended payment plan, 82% included a fee-for-service component.[vi] Some

payers require fee-for-service "shadow billing" in order to monitor changes in cost and service provision between the fee-for-service model and newer, alternative models of payment.

A decade-old green paper from the College of Family Physicians of Canada argues that flexibility in payment models is imperative: "A one-size-fits-all approach is a straightjacket for both the patient and the physician."[xvii] Blended systems offer a range of payment and policy options, each of which will have varying attractiveness to physicians, politicians and patients. The challenge is to determine which models deliver the greatest overall benefits – to patients, taxpayers and healthcare providers.

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