

# **Paying Up for Paying Out: Tracking Trends in Patient Satisfaction at Mid-Main Community Health Centre**

by

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B.A., University of British Columbia, 2011

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# Approval

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## Ethics Statement



The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

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or

- b. advance approval of the animal care protocol from the University Animal Care Committee of Simon Fraser University

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## **Abstract**

The purpose of this report is twofold. The first purpose is to assess whether there has been an appreciable change in patient satisfaction at Vancouver's Mid-Main Community Health Centre in response to a transition in remuneration methods from salary to fee-for-service. This was accomplished through the administration of a patient satisfaction survey capturing both quantitative and qualitative data. Based on the 179 received responses it was determined that patient satisfaction did not differ significantly after the transition. However, the survey results, combined with expert interviews with individuals involved in primary care, and an examination of the literature on the topic, suggests that fee-for-service is not the optimal primary healthcare remuneration method. The second purpose of this report is to assess the trade-offs between four remuneration methods: enhanced fee-for-service, capitation, salary, and a blended model of capitation and enhanced fee-for-service. Ultimately, this report finds that the medium-term policy goal for Mid-Main, and clinics like it that want to engage in interdisciplinary models of care, is to attempt to transition to the blended model of capitation and enhanced fee-for-service.

**Keywords:** Primary healthcare; fee-for-service; capitation; salary; allied healthcare; remuneration

## **Dedication**

I am deeply indebted to Professor Doug McArthur, who decided to roll the dice on me, and in the process significantly changed the course of my life for the better. I would also like to give my sincerest gratitude to Professor John Richards, whose constant support, care, and dedication helped me through this project even when I had doubts about my own abilities. Thank you to the MPP class of 2016 – the Cutest Cohort – for being the amazing and wonderful group people that you are. Being able to laugh and learn with you all is a highlight of my time in the School of Public Policy. Finally, thank you to my mum for pushing me to strive for better things. My life would be very different without you.

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# **Executive Summary**

## **Policy Question**

The policy question is twofold. First, given the experience of Mid-Main Community Health Centre in switching from a salary-based physician remuneration system to a fee-for-service one, this report is concerned with whether there has been a decline in patient satisfaction at the clinic. Second, data collected through a patient satisfaction survey conducted at Mid-Main, a review of the literature on the subject, and expert interviews suggest that fee-for-service is not the optimal remuneration method. As a result, this report asks, “what remuneration system is likely to lead to the best overall outcomes for patients, doctors and major stakeholders and enhances the use of interdisciplinary care”?

## **Patient Satisfaction Survey**

A key portion of this report is based on a patient satisfaction survey conducted in January 2016. The survey collected both quantitative and qualitative data on patient satisfaction based on patients’ experiences in getting appointments, as well as their experience at the clinic. This was the first patient satisfaction survey to be conducted since the transition to fee-for-service. In comparison with surveys conducted in 2005 and 2008, it can be concluded that there has been very little change in patient satisfaction as a result of the transition in remuneration methods. However, based on patients’ written responses, qualitative data suggest that there is some concern about the concessions the clinic has had to make as a result of operating under fee-for-service.

## Expert Interviews

This report also collects data from three interview participants involved on the front lines of primary healthcare provision. Several key themes arose out of these interviews:

- **Flexibility of care.** This is the idea that care providers need to be able to design care plans appropriate in meeting the challenges patients might face. An example is home visits for people with reduced mobility. The interview participants felt that capitation and salary perform better than fee-for-service on this account.
- **Administrative burden.** Some remuneration methods are more burdensome in terms of bookkeeping than others. This negatively affects a physician's work-life balance, which is a growing concern for new doctors. Fee-for-service and capitation were both found to be fairly burdensome.
- **Facilitating allied care.** Remuneration methods vary in whether they increase or decrease barriers associated with the hiring and employment of allied care professionals, such as nurse practitioners and clinical pharmacists. Interview results suggest that capitation and salary do much better than fee-for-service.
- **Stakeholder Considerations.** Primary healthcare provision is a complicated policy environment and the interests of many stakeholders are involved. Three stakeholders considered here are the provincial government, medical suppliers, and Doctors of B.C. Through the interviews the position of the province remained somewhat "muddy". On the other hand the positions of the other two stakeholders are clear. Medical suppliers were suggested to be opposed to both capitation and salary as a result of the potential for reduced profits. This is because allied healthcare professions can present a new barrier of scrutiny between their products and clinic shelves. In addition, due to the Doctors of B.C.'s investment in fee-for-service as a means to maintain a high degree of professional autonomy, it is expected that they will oppose capitation and salary. However, it was also noted that due to the increase in young doctors in the organisation, they may be warming to the idea of capitation.
- **Tribulations of new doctors.** Interview participants noted that the experiences of new doctors when they enter practice is often at odds with the expectations they developed during their time in medical school. New doctors have serious concerns about work-life balance and the style of care they provide due to being forced into fee-for-service as a result of high post-graduation debt. Interview participants also suggested that the push towards fee-for-service negatively affects the overall skills development of these new doctors. As a result, fee-for-service was found to create a number of problems for doctors entering their careers.

- **The effect of remuneration systems on patient satisfaction.** Opinion was split on this account. Some interviewees followed the trend found in the literature that fee-for-service is not particularly good at maintaining patient satisfaction, and that capitation and salary perform better. Another participant felt that any of the methods could produce high patient satisfaction.
- **Efficiency.** Efficiency in primary healthcare can mean two things. From the clinic's point of view it could mean achieving a high rate of patient turn-around. From the patient's point of view it could mean getting the care they needed when they needed it. Interview participants felt that clinics needed to balance these two conceptions of efficiency. Fee-for-service was found not to be good at achieving this balance.
- **Remuneration realities at Mid-Main.** Interview participants revealed that, while attractive, capitation is not a reality for Mid-Main at the present time. Due to geography, patient numbers, and financial considerations, the clinic would be unable to maintain operation under this model.
- **Experimentation with remuneration is key.** Remuneration is not one-size fits all. Due to geography, patient population characteristics, and financial considerations one type of remuneration method might work better than another given the situation. It is important to encourage experimentation with remuneration in order to find a method which works well for patients and for clinics individually.

## Policy Options

This report suggests four potential policy options. The first is **enhanced fee-for-service**. This policy option would operate similarly to the current fee-for-service model employed at Mid-Main. However, it would also include extra billing codes to incentivise procedures involved in comprehensive care. The second is **capitation**. This option would operate exactly like a traditional capitation model. The third is **salary**. Like capitation this option would operate in the same way as a traditional salary model. The fourth is **blended capitation and enhanced fee-for-service**. This model uses capitation as its base and mixes in elements of enhanced fee-for-service.

## **Policy Assessment**

Policy assessment is carried out based on the following criteria:

- Patient satisfaction
- Incentives for care of complicated patients
- Incentives for use of allied care providers
- Stakeholder acceptability: government, medical suppliers, Doctors of B.C.
- New doctor outcomes

Criteria that deal with the experiences of patients and doctors are given the greatest weighting.

## **Recommendation**

The blended model of capitation and enhanced fee-for-service scores the highest based on the assessment criteria. As a result, this report recommends that in the medium term, clinics interested in pursuing a care model that includes allied healthcare professionals should pursue this model of remuneration.

## **Caveats**

There are important caveats to this report. First, while the blended capitation/enhanced fee-for-service model is recommended, one-size does not fit all. Clinics need to perform individual feasibility assessments in order to determine what remuneration methods can and cannot work for them. Second, allied care professionals cannot be utilised to their fullest extent while regulatory barriers prevent the billing of their own work. Regulatory reform of scope-of-practice needs to be seriously considered to increase the effectiveness of these healthcare workers. Third, analysis of remuneration methods is seriously hobbled by the lack of data regarding their impact on governmental

budgets. A robust analysis of budgetary impacts due to potential remuneration methods is sorely needed.



# Chapter 1.

## Introduction

Primary healthcare is often the first point of contact for people dealing with health issues. As such, it is important that the choices made in the delivery of primary healthcare balance the needs of patients and doctors, while being acceptable to important stakeholders like the provincial government and medical associations. While there are plenty of relevant variables, this report focuses on the effect of physician remuneration. A recent change in remuneration systems at Vancouver's Mid-Main Community Health Centre allows for a natural experiment allowing comparison of patient satisfaction under two models. This leads to the question: **has the switch from salary to fee-for-service negatively affected patient satisfaction at Mid-Main Community Health Centre?** The general policy problem is: **what remuneration system is likely to lead to the best overall outcomes for patients, doctors and major stakeholders and to enhance the use of interdisciplinary care?** And, in the medium term, what remuneration system should Mid-Main pursue?

In order to answer these questions this report proceeds as follows: a literature review (Chapter 2), method of analysis (chapter 3), analysis of a patient satisfaction survey conducted at Mid-Main in 2016 and comparisons with previous surveys (chapter 4), thematic interview analysis with individuals involved, or previously involved, in the delivery of primary care (chapter 5), the development of policy options (chapter 6), the development of criteria and analysis to measure trade-offs between policy options (chapter 7), analysis of policy options (chapter 8), and recommendations (chapter 9).

This report ultimately finds that patient satisfaction did not differ greatly after the transition to fee-for-service. Survey results combined with the literature review and

interview analysis however point to the fact that fee-for-service is not the optimal remuneration method. Therefore, the report recommends that for Mid-Main and clinics like it interested in pursuing interdisciplinary forms of care, **the medium-term goal should be a transition to a blended model remuneration system of capitation supplemented with enhanced fee-for-service.**

## **Chapter 2.**

### **Background**

This project is, in part, concerned with the impact of physician remuneration methods on patient satisfaction. A relevant question is, what is the likely impact on satisfaction of changing from one method to another? I undertook a patient satisfaction survey in early 2016 in Mid-Main Community Health Centre, a primary care health centre in East Vancouver with approximately 30 professional health care providers (see following chapter for description of the survey). The timing followed a natural experiment: between the previous satisfaction surveys in 2005 and 2008 and the most recent, Coastal Health required the health centre (in 2014) to transition its physician compensation from salary to fee-for-service. This allows for a before and after comparison.

This chapter provides background with regards to the three most commonly used primary-care payment methods, the importance of patient satisfaction with primary care as an indicator and some information regarding the Mid-Main Community Health Centre.

#### **2.1. Payment Methods**

There are three commonly used payment methods for primary health care in Canada: salary, fee-for-service, and capitation. Understanding the differences between the methods is important because, as Hurley (2010) points out, they “[create] financial incentives related to who provides services, what services are provided, the quality of the services provided, where the services are provided, and to whom services are provided” (p.303).

About a quarter of Canadian physicians receive most of their income as a salary (Blomqvist & Busby, 2012b). A salaried physician is contracted a set wage for a defined number of hours worked. Unlike the payment methods to follow, the annual income of a

physician is fixed per their contract. Under this scheme a physician's income is independent of the number of patients he or she sees or the number of services he or she performs.

Fee-for-service is the most common remuneration method in Canada with 40 percent of all physicians receiving most of their income in this way (Blomqvist & Busby, 2012b). Physicians who practise under fee-for-service are remunerated by the number of services performed. More precisely, a physician is paid through submitting codes assigned to various medical procedures to the Medical Services Plan of B.C. The codes are assigned in the MSC Payment Schedule Index, which is approved by the Medical Services Commission (MSC). The fee for each service is negotiated between the Medical Services Commission and the Doctors of B.C.

Capitation is much rarer in the Canadian context. Blomqvist and Busby (2012b) point out only about one percent of Canadian doctors receive most of their income from this method. Ontario is the province which has taken to capitation with the most zeal (Blomqvist and Busby, 2012b). Capitation can be viewed as having elements of both salary and fee-for-service. The income of a physician under capitation is based on the size of the roster (Blomqvist & Busby, 2012a). Their incomes are based on the total number of patients they have registered under them. Each patient is worth a fixed amount and the physician receives the sum of those values, adjusted for their expected state of health. This expectation is based on average patient usage of the medical system based on patients with similar characteristics in a set period of time in the past. Thus, the system attempts to infer future usage based on past usage (Interview A). Like fee-for-service, income received is conditional. Instead of being conditional on the number of services provided, it is conditional on the number of patients rostered.

The second most common remuneration method is blended models, which mix the three primary types to some degree. Blended models account for 33 percent of all remuneration models.

## **2.2. Advantages and Disadvantages of Alternate Payment Systems**

The relationship between physicians and their patients has an economic perspective. As Pierre Léger (2011) states, “economists generally define an efficient consumption of care as the type and quality of care that a fully informed uninsured individual would choose” (p.4). Unfortunately for homo economicus there are a number of barriers, which prevent efficient production and consumption of care. Significant information asymmetries exist (Léger 2011, 2000; Hurley 2010; Ellis & McGuire, 1990). Patients often have no ability to diagnose their illnesses or conceptualise appropriate treatments for them. As a result, a physician’s advice tends to carry very large weight in a patient’s decision-making process. In this situation, a physician could withhold information, or advance treatment options that benefit him or her more than an equally effective but cheaper option. Information asymmetry can go both ways. Patients often know things about their own medical states, histories, or current situations affecting their health, which they may not communicate to their physicians or insurance companies. The result is potentially increased costs borne by the medical system through unnecessary diagnostic testing, and ineffective treatment procedures.

In addition to information asymmetry, another major market inefficiency in the provision of medical care is moral hazard. Broadly, moral hazard arises when the costs of an activity are not fully borne, or not borne at all, by an individual. For example, a patient could request an expensive diagnostic test, which a physician knows will be ineffective. Because the cost of testing is borne by neither the patient nor the physician, the physician has no real incentive to decline the request. The physician may agree, in order to provide peace of mind to his or her patient.

Both of these market inefficiencies can lead to a principal-agent dilemma in which patients can be highly influenced by their physician’s recommendations (and perhaps how committed he or she is to the Hippocratic Oath) as to the treatment options presented. In addition to this, the principal-agent dilemma exists in a broader sense where the principal is the taxpayer funding the system and the agent is the doctor whom we expect to keep

medical costs to the system reasonable. However, because Canadians as patients, in most cases, do not make direct payments for medical and hospital care services they consume, there may be little concern about the actual cost of those services. Obviously these two issues do not produce efficient outcomes.

Governments are not without potential policy solutions to deal with the problems discussed in the preceding paragraphs. Choice of payment method applied to a health care system is one means of dealing with market distortions. However, each method has its own advantages and disadvantages. The following table gives a brief summary.

**Table 2.1 Summary of Advantages and Disadvantages**

	<b>Salary</b>	<b>Fee-for-Service</b>	<b>Capitation</b>
<b>Advantage</b>	<ul style="list-style-type: none"> <li>• Eliminates incentives for unnecessary tests and procedures.</li> <li>• No incentive to cream-skim.</li> <li>• More time spent on non-clinical activities.</li> <li>• Administratively simple.</li> </ul>	<ul style="list-style-type: none"> <li>• Promotes efficiency in seeing patients.</li> </ul>	<ul style="list-style-type: none"> <li>• No disincentive to providing longer appointments in short run.</li> <li>• Incentive for physicians to control overhead leads to flexibility of care (home visits, phone calls, etc.), and increased focus on preventative care.</li> <li>• Promotes use of allied healthcare professionals.</li> <li>• Incentive to provide quality care to avoid outflow.</li> </ul>
<b>Disadvantage</b>	<ul style="list-style-type: none"> <li>• No incentive to provide efficient care.</li> <li>• No incentive to control costs to the medical system.</li> <li>• No incentive to provide quality care.</li> </ul>	<ul style="list-style-type: none"> <li>• Administratively burdensome.</li> <li>• Quantity of care at the expense of quality of care.</li> <li>• No incentive to control costs to the medical system.</li> </ul>	<ul style="list-style-type: none"> <li>• Potential for cream-skimming</li> <li>• Supplier induced demand: Potential for overloading rosters and outsourcing care to specialists.</li> </ul>

	<ul style="list-style-type: none"> <li>• professional association lobbies for more doctors to serve unmet patient demand</li> </ul>	<ul style="list-style-type: none"> <li>• Supplier induced demand: short appointments to see as many patients as possible.</li> </ul>	
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### 2.2.1. Salary – Advantages and Disadvantages

Based on the previous description of how the salary scheme works, one of the most obvious advantages is that a physician does not have an incentive to induce demand (Blomqvist & Busby, 2012b), helping to ensure that the health care system is not bogged down by unnecessary tests or procedures. This in turn potentially reduces costs to the system. Also, since income is fixed, there is little incentive for selectivity based on patient characteristics (Blomqvist & Busby, 2012b).

Additionally, salaries can encourage physicians to increase the amount of time they spend on non-clinical activities like administration and teaching. In Quebec, among doctors whose income is based mostly on salary with a reduced fee-for-service component, Dumont et al. (2008) found that physicians increased their non-clinical activities by 7.9% after being switched from a purely fee-for-service system. While Dumont et al. (2008) found that physicians reduced their billable clinical services by 6.15%, time per service actually increased 3.81%, which suggested to the authors a substitution of quality at the expense of quantity. Since contracts are fixed and negotiated between the funding body and the receiving physician, overall costs to the health care system in terms expenditure on remuneration are easy to predict (Blomqvist & Busby, 2012b). Finally, since the method pays out based on a time period as opposed to other more complex criteria, the salary method is administratively simple to implement (Blomqvist & Busby, 2012b)

While not a specific focus in this report, it is important to acknowledge the role that salary has in encouraging recruitment and retention of physicians in rural and northern Canadian communities (Wranik & Durier-Copp, 2010). Rural and northern communities face a dual problem. First, the prospect of living in these types of communities is viewed as unattractive by many physicians. Second, the dispersed and relatively small population

base makes earning a sufficient income difficult under both fee-for-service and capitation. Salary contracts can be designed such that physicians are incentivised to move to these communities through ensuring generous benefits (student loan forgiveness for instance) and competitive earning potential (Wranik & Durier-Copp, 2010). While medical service provision in Canada's more remote communities remains difficult, salary is an important model in helping overcome some physicians' unwillingness to provide care in these areas.

The fact that payment by salary provides no financial incentive to increase levels of service provision is not necessarily positive. Léger (2011) astutely points out that "although a physician who is paid by salary has no incentive to induce demand, he also has no incentive to control costs" (p.5). As an example, a physician has no incentive to run a cheaper diagnostic test for a patient who has expressed that he would derive greater peace of mind from having a more expensive test done even if the physician knows the marginal gain in certainty would be negligible. In this scenario, because the costs of the testing are borne neither by the physician nor the patient but by the medical system, we encounter a principal-agent dilemma. The principal, namely the tax-paying cohort, expect the physician to control his or her costs, but she has no incentive to do so. In addition Léger (2011) goes on to suggest that, "because the salary is independent of patient outcomes, the salaried physician is provided little incentive to consider the quality of care" (p.5). Potentially Léger is being too pessimistic here. Perhaps it makes sense in stringent adherence to economic principles that a physician would not be incentivised to consider the quality of care or patient outcome if they are salaried, however physicians do not live in an ethical vacuum. Hurley (2010) and Gosden et al. (1999) both point out the importance of the Hippocratic Oath in applying a positive patient-centred ethic to the practice of physicians. Medical education and regulatory societies exist to curb the practice of physicians making purely self-interested decisions.

### **2.2.2. Fee-For-Service – Advantages and Disadvantages**

Because physicians are incentivised by the volume of services provided, fee-for-service encourages short clinic visits and rapid care (Blomqvist & Busby, 2012b; Léger, 2011; Dumont et al., 2008), which is generally advantageous in moving high volumes of



patients through clinic doors. In a review of existing literature Devlin and Sarma (2008) found that studies examining the effect of a switch from some other payment method to fee-for-service resulted in a 12% - 22% increase in patient visits.

Another advantage to fee-for-service is that traditionally physicians have viewed it very positively. As Warnik and Durier-Copp (2011) point out, fee-for-service is the superior remuneration method at providing: significant professional autonomy, opportunity to engage in entrepreneurship, expansion of practice, and self-employment with self-defined boundaries. As will be shown in Chapter 5, professional autonomy has been an important consideration for physicians in British Columbia. This has contributed to the Doctors of B.C.'s recalcitrance with regard to remuneration reform that strays from fee-for-service. However, as will also be show in Chapter 5, the shifting demographics of physicians from older males to younger females is pushing the desire to reform remuneration to the fore. Moreover, this is not a trend limited to B.C. A number of authors note that other provincial and international governments are making concerted efforts to shift away from fee-for-service (Hurley, 2010; Blomqvist & Busby, 2012a&b; Dahrouge, et al., 2012; Wranik & Durier-Copp, 2010).

While on the face of things it is advantageous to encourage a high volume of patients flowing through physicians' offices, there is the obvious worry that quantity is being substituted at the expense of quality. This problem is highlighted by the idea of supplier-induced demand –the idea that physicians can utilise their power over the health care market (in the form of information asymmetry as already mentioned) in order to shift demand to meet their own economic imperative. Hurley (2010) further points out:

[supplier-induced demand] biases providers towards inefficient over-provision of reimbursable services and under-provision of services not listed in the fee schedule. This latter feature makes it poorly suited for contexts for which good care requires a customised set of activities and services not easily listed in a fee schedule, such as the management of complex chronic disease (p.310).

This is reinforced by recalling the earlier discussion regarding salaries in which studies suggested that there were observable improvements to time spent on non-clinical

actives, such as teaching and administrative functions, and that this was a positive aspect of that method over fee-for-service.

Supplier-induced demand also means that there is little to no incentive for physicians to reduce costs to the health services system (Blomqvist & Busby, 2012b; Léger, 2011; Devlin & Sarma, 2008; Wranik & Durier-Copp, 2010 and 2011). As a result “many funders are trying to reduce their reliance on fee-for-service funding because of the financial incentives it creates” (Hurley, 2010, p.310). While this is a criticism that can apply to capitation and salary, I contest below that it is more significant to fee-for-service. Under capitation there is an incentive for physicians to increase their roster with the expectation that they will be referring their patients out to specialists, hospitals, or to labs to undergo testing. Thus, they provide care to their patients but bear limited costs themselves. In terms of a salary system, the lack of incentive to minimise time spent with patients can result in a demand for service that goes unmet. Put another way, physicians can spend so long with patients they cannot satisfy the total demand for their time by everyone waiting to be seen.

I assert that the problem of supplier-induced demand is more severe under fee-for-service however, and thus why I situate it as a problem in this section rather than the others. Under fee-for-service physicians have direct control of their MSP billings based on the types of services they choose to provide. As a result they have a closer connection between inducing demand and procuring benefit from that behaviour than do physicians under salary or capitation. Under salary, unmet demand may enable salaried physicians to increase the pool of physicians. Under capitation physicians aim to roster as many patients as possible while referring their care to specialists or hospitals so that they reap the benefits of the large roster while maintaining a low overhead.

But it is not just funders who want to reduce the reliance on fee-for-service as a payment method. According to the 2004 National Physician Survey, while 53.3% of physicians received 90% or more of their income from fee-for-service, only 25.1% of them preferred this state of affairs (National Physician Survey, 2004).

### **2.2.3. Capitation – Advantages and Disadvantages**

Like fee-for-service, physicians under capitation are concerned with volume. In this case it is the volume of patients enrolled on their rosters. The obvious benefit here is that physicians are encouraged to enroll as many people as they can, which is helpful in areas that experience high demand for regular family physicians (Blomqvist & Busby, 2012b; Léger, 2011). Since the physician earns income based on the number of patients registered, but not the amount of services provided to them, the economic incentive for a physician under capitation is: 1) to register as many patients as possible and 2) to keep them as healthy as possible so they do not visit the practice regularly. This keeps the physician's costs low while maximising his or her total income. As a result, physicians are more likely to engage in preventative health practices like lifestyle consultations and presenting information to help patients better manage chronic illness (Blomqvist & Busby, 2012b). By the same token, physicians are more likely to engage in non-clinical activities and activities that are non-observable like phone consultations (Léger, 2011).

An important advantage in terms of potential increase in cost control and patient satisfaction is that capitation can increase a practice's willingness to engage ancillary professionals in patient care (Blomqvist & Busby, 2012b). These professionals include nurse practitioners and clinical pharmacists among others. Engaging in a team-based provision of care strategy allows costs to be kept down, as ancillary professionals tend to cost less than physicians. More importantly they can help a practice run more efficiently in a way that benefits patients. For example, if a practice has a large number of diabetic patients, a clinical pharmacist can be engaged to educate patients about their medication as well as monitor them as opposed to requiring patients schedule individual visits to a physician (Blomqvist & Busby, 2012b). A major advantage from the patient's point of view is that this type of care improves the level of continuity of care they can expect (Warnik & Durier-Copp, 2011). Continuity of care can be defined as "the seamless delivery of all types of health services to a patient, without duplication, overlap, or interruption of service" (Warnik & Durier-Copp, 2011, p.244). In addition, continuity of care tends to promote the development of relationships between patients and their care providers. This is important because 20%-80% of patients do not adhere to their treatment plans in some way,

however ongoing relationships with care providers tends to increase adherence (Warnik & Durier-Copp, 2010).

Furthermore, patients under a capitation system are free to switch their enrollment between physicians. Hence, physicians are incentivised to maintain robust rosters because they face competition from other physicians who may offer better service and draw away patients (Blomqvist & Busby, 2012b). Clearly, patients benefit from this state of affairs.

Of course, there are potential drawbacks to capitation. The notion of cream-skimming is one of the most important to consider. Cream-skimming is the practise whereby physicians choose to enroll only relatively low-risk, healthy individuals (Hurley, 2010), in order to maximise the size of the physician's roster. This could result in a situation where the elderly, or people with chronic or serious disease might find it difficult to find a regular physician. This problem is not without solutions. First, physicians can be regulated, within reason, to accept patients who wish to enroll with them (Blomqvist & Busby, 2012b). Second, through a risk-adjusted schedule of payments to physicians, the government can reduce the incentive to avoid elderly or chronic care patients, (Blomqvist & Busby, 2012b). Risk-adjustment takes into account the particulars of patients, typically based on their use of the medical system in a set period of time in the past, age and gender. These particulars then place that patient into a capitated payment category negotiated between the government and the physicians.

Related to cream-skimming is the potential for skimping. Skimping refers to physicians who might attempt to keep their own costs down by under-providing care (Blomqvist & Busby, 2012b; Hurley, 2010). In addition physicians might skimp by rostering a large number of patients only to refer them out to specialists regularly. Physicians get the benefit of the large roster but keep their own costs low through the referrals. However, because skimping could have a negative effect on patient satisfaction, the potential for efficient competition could correct this problem.

There are problems with regards to the notion that capitation would increase competition between physicians. Efficiency born of competition naturally assumes that patients have the necessary information provided to them and the ability to distinguish who the best physician for them is. Gosden et al. (1999) assert that this is a “tenuous assumption” to hold. Competition is also hampered by a reluctance to switch physicians (Pike, 2010). For example, even if patients did have access to the appropriate information and could use that information appropriately to make decisions, having a history with a physician has its own value in terms of their firsthand knowledge of their patients’ health as well as the level of comfort and trust that develops over time. In other words the time it would take to rebuild the familiarity one has with their current physician might cause some people to avoid switching to someone better but who does not know them well

#### **2.2.4. Final Remarks – Advantages and Disadvantages**

It is important to at least briefly consider an issue that is common to each of the aforementioned methods of remuneration. Hurley (2010) reminds us that concerns regarding administrative feasibility and efficiency need to be considered when trying to implement a new system or reform and old system into something different. Hurley (2010) points out that the requirement of developing a funding schedule for fee-for-service, or understanding how to calculate risk adjustment and maintain accurate rosters under capitation might not be feasible for all funding organisations, and even where feasible, cost to funders might exceed benefits reaped.

### **2.3. Indicators of Patient Satisfaction**

Patient satisfaction is an important element of data for decision makers in health policy, be they at the governmental level or executive staff of a health centre. As Sánchez-Piedra et al. (2014) points out:

information on satisfaction, based on the perceptions and needs of users, allows policy-makers to identify areas for improvement. Consumers can

evaluate several dimensions of health services such as waiting times or communication with staffs, which can help providers strengthen their services (p. 148)

Both Sánchez-Piedra et al (2014) and Alhashem et al. (2011) note that patients who are positively satisfied with their care are more likely to follow their doctors' advice and treatment plans as well as to keep their appointments. In addition to this, Alhashem et al. (2011, p. 250, citing Shah et al., 1996 and Al-Hay et al., 1997) notes that patients dissatisfied with their primary care providers "do not utilise primary care services optimally and over-utilise the emergency rooms in general hospitals" (p.250).

This project is concerned with the impacts physician remuneration methods have on patient satisfaction. The bulk of academic literature regarding the impact of different remuneration methods deals with expected effects due to the change in physicians' financial incentive and how that will change their behavior. Little has been done with regards to how different payment schemes affect patient satisfaction.

Both Sánchez-Piedra et al., (2014), and Alhashem et al., (2011) found that patients' perception of their health status had a significant effect on their satisfaction with the primary care they receive. Put another way, both authors found that people who felt well were satisfied with the care they received. However, both authors again found that if a patient felt that she was in poor health, she was more likely to be dissatisfied with the care provided by their physician. The relationship between physician and patient is also an important predictor of patient satisfaction. This relationship is captured through a number of variables such as: having a family doctor, measurements of weight, cholesterol and blood pressure, being able to identify the clinical team, continuity of care with a care team, and finally managing chronic illnesses (Sánchez-Piedra et al., 2014). Sánchez-Piedra et al., (2014) also found that referrals to specialist had a negative effect on patient satisfaction. The authors posited this is because of the fractured nature of care patients experience and the requirement that they navigate the transition between the two physicians largely on their own, noting that "patient expectations of a seamless transition are often not met" (Sánchez-Piedra et al., 2014. p.152)

## **2.4. Mid-Main Community Health Centre**

Mid-Main Community Health Centre is located in the Mount Pleasant region of Vancouver, British Columbia. Established on June 22, 1988, as a non-profit charitable health care institution, Mid-Main provides dental and medical services to its surrounding community. It utilises an integrative approach to health provision. Distinct from a regular physician's practice, Mid-Main employs team-based health care. In terms of clinical staff, in 2014 Mid-Main employed a clinical pharmacist, a nurse practitioner, a periodontist, five medical office assistants, and six hygienists, in addition to six physicians and six dentists. Furthermore, the centre's planning and ongoing programme operations are heavily influenced by its surrounding community. Mid-Main's focus is on disease prevention, health promotion, health education, and community development. It engages in the management of chronic disease for 665 patients, smoking cessation for 100 patients, group medical visits for patients who have the same or similar conditions, home visits for 62 patients, and walking groups.

Until late 2014, Mid-Main received grant funding from the province, which accounted for approximately half of its revenues, the other half coming from its fee-for-service dental operation. On November 1, 2014 Mid-Main transitioned its medical operation to fee-for-service in response to the province ending grant provision. This loss of grant funding, which happened to several other clinics in the area with block grants, as well as Mid-Main, required significant financial adjustments. With the exception of Mid-Main, the other clinics shut their doors. The transition for Mid-Main was also difficult, resulting in the need to let some staff go. The main problem from the clinic's point of view was that there was a certain style of care in operation that involved allowing patients lengthy visits and employing team-based care. The change in remuneration meant that the care style developed would need to be re-evaluated. Since fee-for-service could become the antithesis of the team care model employed, the clinic staff have legitimate concerns as to whether patient satisfaction will be negatively affected.

## 2.5. Moving Forwards with Healthcare in the Province of British Columbia

Fee-for-service remains the dominant remuneration method in the province. However, consideration of the changing character of doctors may necessitate changes to the old regime outside of whatever other problems the method might have (Winston, nd.). Recent studies have found that especially among female, and new doctors, fee-for-service has become less attractive. As one study based off of a survey of recently graduated doctors indicated, “81% of respondents reported that payment models were important to their choice of future practice”, (Brcic et al., 2012, p. 280), and that “71% preferred non-[fee-for-service] (alternative payment) remuneration, including salaried, capitation, or blended models” (Brcic et al., 2012, p. 278). Furthermore, only three percent of respondents identified fee-for-service as their only preferred remuneration method (Brcic et al., 2012). Participants in the survey also identified that fee-for-service was not conducive to implementing the values that they had been taught in medical school (Brcic et al., 2012). As one respondent put it:

I am a new graduate in family medicine and, as such, I have been taught in the new culture of improved patient-centred communication. This means I will take longer per patient than a graduate from past years—with a large body of evidence supporting the fact that these patient-doctor interactions have potential to have larger positive impact—and I thus require an innovative way of receiving remuneration for my work. Family medicine in modern times requires alternative models of funding (Brcic et al., 2012, p. 279).

The inability to respond to patient needs in the way they had been taught in medical school is not the only negative aspect facing physicians in the fee-for-service models. Through dialogue with physicians and group and single interview settings *Heal Thy Self: An Inquiry into Physician Satisfaction and the Structure of Family Practice in BC*, found that the level of paper work involved in billing through fee-for-service placed high levels of administrative burden of physicians (Winston, nd.). In addition to this, financial stress was high. The combination of high overhead and large student debt incentivises “practitioners



to cycle high numbers of patients through short office visits that focus on single health issues rather than overall patient health” (Winston, nd. p.3-4). Furthermore:

the result of these pressures is for young doctors to gravitate towards walk-in clinics and locum work, although they expressed a sense of loss in not developing the long-term relationships with patients that were the primary reason they entered family practice in the first place. (Winston, nd. p.4).

Fee-for-service is not very well suited to dealing with meeting the expectation of the work and life balance for newer physicians. The *Heal Thy Self* report found that young physicians would prefer working in integrated healthcare teams, supported by nurse practitioners and other allied healthcare professionals, in order to increase the quality and continuity of care for their patients, especially those with complex or chronic illnesses (Winston, nd.). In addition, physicians participating in *Heal Thy Self* suggested that remuneration be moved towards a blended salary and capitation model. In this model physicians would be offered a base salary which could be increased through seeing a larger number of patients than ordinarily expected. Physicians looking to pay down debt are incentivised to work harder while those wishing to balance their work and their life can pull back somewhat and enjoy the base salary (Winston, nd.). While not mentioned in *Heal Thy Self*, it is important to understand that due to budget constraints this base rate will likely need to be lower than what physicians are typically accustomed to enjoying. However, physicians did feel it necessary to suggest that a cap on daily or weekly patient visits be included so as to avoid the problems of overscheduling seen in fee-for-service (Winston, nd.).

## **2.6. The Physician-Patient Relationship beyond Economics**

This report focuses on the impact of various remuneration systems on the provision of primary healthcare. A key consideration is how the physician-patient relationship is affected. However, there are important non-economic aspects of this relationship which should be given some consideration. Chipidza et al., (2015) describe the relationship as having four constituent parts: mutual knowledge, trust, loyalty, and

regard (n.p.). Mutual knowledge involves not only the physician's knowledge of, and familiarity with the patient, but also the patient's knowledge and familiarity with the physician (Chipidza et al., 2015, n.p.). Trust refers to both the trust expressed by the patient in the physician's competence and caring, and also their willingness to be fulsome in discussing their health issues (Chipidza et al., 2015, n.p.). Loyalty involves forgiving a physician for accidental inconveniences or mistakes, and the commitment from a physician that they will not abandon their patient (Chipidza et al., 2015, n.p.). Finally, regard "implies that the patients feel as though the doctor likes the as individuals and is 'on their side'" (Chipidza et al., 2015, n.p.).

The preceding paragraph briefly outlines the foundational elements of the physician-patient relationship, however it is important to understand the forms in which the relationship can be expressed. Chipidza et al., (2015) note that there are three major forms. The first is active-passive, in which a physician treats the patient as if they were an inanimate object. This model is used in situations where the patient might be unconscious or otherwise incapacitated. The second is guidance-cooperation, in which a physician, having superior medical knowledge, assesses and makes recommendations for a patient who is expected to comply. The third is mutual participation. Unlike the guidance-cooperation model, the knowledge of the patient is given significant weight by acknowledging that they are the expert in their own life. As such, the relationship is defined by an equal partnership. The patient and the physician both express their individual expertise. The physician's objective is to understand the patient's health goals and to develop care plans to help achieve them. Chipidza et al., (2015) suggest that "over the last several decades there has been increasing support for the mutual participation model wherever it is feasible" (n.p.).

It also should be noted that the physician-patient relationship is not one based simply on empathy. In fact, Weiner and Auster (2007) suggest that employing empathy is actually detrimental to the relationship. This is because empathy involves setting oneself in the shoes of another to understand their position. However, this is a reductive process wherein the physician assumes immediate and correct knowledge of the patient's state. This allows the physician to justify not taking the time to ask questions (Weiner & Auster, 2007). This has a negative impact on not only the physician-patient relationship, but also

patient outcomes. Instead, Weiner and Auster (2007) promote replacing empathy with caring which they define as “a sustained emotional investment in an individual’s wellbeing, characterised by a desire to take actions that will benefit that person” (Weiner & Auster, 2007, p. 216). Caring as a clinical concept involves “asking the ‘right’ questions and then listening precisely in a manner that is unselfconscious, non-judgemental, and open fully to the other’s perspective” (Weiner & Auster, 2007, p. 126).

What can be gleaned from the preceding discussion is that care models based on fee-for-service are not designed in a way that promotes a functional physician-patient relationship. Due to the rushed nature of interactions under this model it is difficult to develop mutual knowledge, trust, loyalty, or regard, nor does it allow physicians to engage in the act of caring. This is troubling because “[a] physician’s knowledge of [a] patient’s ailments and emotional state is associated positively with whether or not those physical ailments resolve” (Chipidza et al., 2015, n.p.). Furthermore, it is noted that patients have poor outcomes in situations where the physician-patient relationship has broken down (Chipidza et al., 2015, n.p.). While these are non-economic considerations of the physician-patient relationship, remuneration certainly has an important impact on how a physician might choose to conduct herself in terms of developing relationships with patients.

## **2.7. The Slow Uptake of Integrated Care**

The push towards improving the level of integrated care in the primary healthcare system in Canada has been a goal for a number of decades (Clements & Helmer, 2006, p. 16). However, clinics employing an integrated care model remain quite rare. One barrier to uptake centres on concerns regarding liability, and malpractice. Due to the varying education levels required to enter into certain allied healthcare professions (Elwood, 2013, p.1986), some physicians “worry they will be held responsible for the acts and omissions of their team members” (Thornhill et al. 2008 p.15). While Thornhill et al., (2008) point out that liability and malpractice will likely not be a significant problem, citing arguments made by the Canadian Medical Protective Association and the Conference

Board of Canada, this is still an issue given considerable attention by physicians' associations.

It is worth questioning how genuine the concern over liability and malpractice really is. A major impediment to the uptake of the integrated care model, as suggested by the literature on the subject and by expert interviews conducted for this report, are the professional medical associations themselves. Thornhill et al., (2008) make the case succinctly when they say there is a very real fear of "relinquishing their professional 'turf'" (p. 15). This often results in battles over scope-of-practice. Scope-of-practice defines what procedures a healthcare professional is able to perform, however it can also extend to "how a health professional can be addressed and what information must be on identification badges" (Elwood, 2013, p.1986). Even the minor latter issues are hotly contested in the American experience (Elwood, 2013). There is an economic incentive to protecting one's scope-of-practice. Governmental budgets are finite, and therefore "if one person benefits monetarily [...] then it only can be at the expense of someone else" (Elwood, 2013, p.1986). In other words, if other professions encroach on the scope-of-practice of physicians, physicians are likely to lose money through an increase in other providers performing treatments (in fee-for-service for example), or reductions in compensation due to a reallocation of limited funds to support the inclusion of allied healthcare professionals. Therefore, it is in the interest of physicians for their professional associations to strenuously prevent the increased use of integrated healthcare professionals.

## **Chapter 3.**

### **Methodology**

To support the policy analysis and ultimate recommendation, supporting evidence is derived from two sources beyond the literature review. The first is a patient satisfaction survey conducted in association with the Mid-Main Community Health Centre. The second is a series of expert interviews with people in the field related to the medical system.

#### **3.1. Patient Satisfaction Survey**

The patient satisfaction survey was launched on January 11th, 2016 and ran until February 1st, 2016. 200 surveys were distributed and 179 were returned for a response rate of 84%. This study and the survey instrument are designated minimal risk by Simon Fraser University's ethics office. The survey is presented in Appendix A. The survey was distributed to patients by front desk staff of the medical clinic. Patients were asked before seeing their care provider if they would like to participate. If patients agreed, they filled the survey out at the end of their appointment but before they left the clinic. Participation in the survey was completely voluntary. While Mid-Main includes both a medical practice and a dental practice, the survey distribution was limited to the medical practice. The questions were designed to allow as much comparison between the present survey and surveys performed at Mid-Main in 2005 and 2008. The response scale of the question asking how patients perceived their satisfaction with the length of time of their appointment was changed to increase the accuracy of responses, which limits the comparability between the 2016 survey and the two previous ones.

## **3.2. Expert Interviews**

Three semi-structured interviews were conducted between January 2016 and February 2016. The interview participants included Ms. Irene Clarence, executive director of Mid-Main Community Health Centre, and Dr. Margaret McGregor, a former physician at Mid-Main Community Health Centre and Researcher at the Department of Health Care and Epidemiology at the University of British Columbia. The final interview was conducted with a registered nurse and former senior executive in the health ministry (referred to as interview A). Each interview was recorded and transcribed to a digital document. The interviews lasted between thirty minutes to an hour in length. The purpose of the interviews was to flesh out the background of Mid-Main, as well as to gain an understanding of the challenges presented by the remuneration systems discussed in this paper, how they affect patient satisfaction, and to help develop criteria for analysis of policy options. This was done through analysis of the interviews for key themes. An example of the semi-structured interview schedule used is presented in Appendix B.

## **3.3. Limitations**

There were a number of limitations involved in carrying out the research for this report. First, considerable time constraints prevented reaching research saturation. Research saturation is achieved when data collected start to become repetitive and little new is learned, with regards to the scope of the project, by conducting more research. While the patient satisfaction survey likely did reach research saturation, information that could be collected through expert interviews did not. If time was not a consideration, it would have been valuable to conduct interviews with members within the provincial Ministry of Health. An element sorely missing from this report is an understanding of the government's perspective on remuneration methods and reform. This likely would have provided information dealing with: acceptability, feasibility, and the budgetary impact of the proposed alternatives to fee-for-service detailed below. Relatedly, while tangentially accessed through the expert interviews conducted, it would have been enlightening to have received the perspectives of The Doctors of B.C. directly from a representative.

Again this would have improved this report's understanding of how they view the acceptability of the various potential reforms presented. Finally, an out-of-province perspective would have also been welcome had time been sufficient. Specifically, speaking to a member of the Ontario Ministry of Health to explore their experience with remuneration experimentation would have been invaluable.

Time was not the only limitation experienced. The survey design involved making some concessions to the administrative staff at Mid-Main. The clinic was concerned that a lengthy survey would negatively impact the client population's willingness to complete it. Therefore, the length of the survey was restricted to one page. This led to exclusion of some questions that could have revealed interesting results. In the absence of constraints the survey would have included the following questions. First, and most importantly, would be a question directed at understanding a patient's self-perception of their own health. As noted in the literature review, self-perceptions of health have an impact on a patient's satisfaction with received care. It is important to isolate whether a client population views themselves as relatively healthy or unhealthy. Second, identifying the relative value patients place on different care providers would have also been useful. Such a question could have probed patients regarding who they most trust to discuss certain issues including (but not limited to): drugs, chronic illness management, mental health issues, and the health concerns of other family members. Finally, a question that identified how patients valued the integrated care model provided by Mid-Main over more traditional clinics would have been valuable in determining how perceptions of the care model itself affects patient satisfaction.

## **Chapter 4.**

### **Patient Satisfaction at Mid-Main Community Health Centre in 2016**

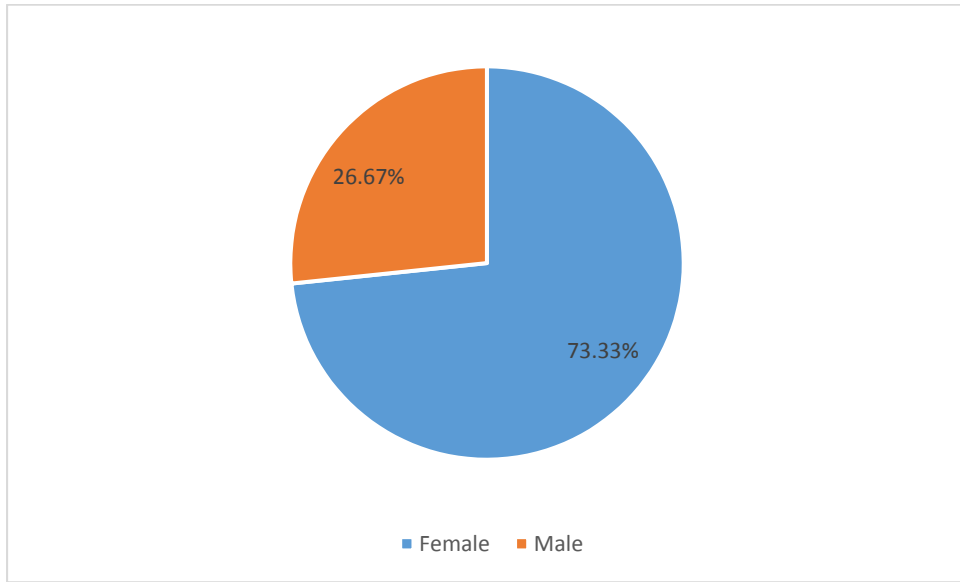
The requirement that Mid-Main Community Health Centre change its remuneration model as a result of shifting government priorities presents the unique opportunity to examine a natural experiment. This section will first present the results of the 2016 patient satisfaction survey. This is the first patient satisfaction survey conducted for the clinic since its change to fee-for-service. Following this will be an examination of the trend in patient satisfaction. Since, the clinic had conducted patient satisfaction surveys in both 2005 and 2008, under the block grant and salary model, we will be able to see the effects, if any, from change in remuneration model.

#### **4.1. 2016 Patient Satisfaction Survey Results**

##### **4.1.1. Response Profile**

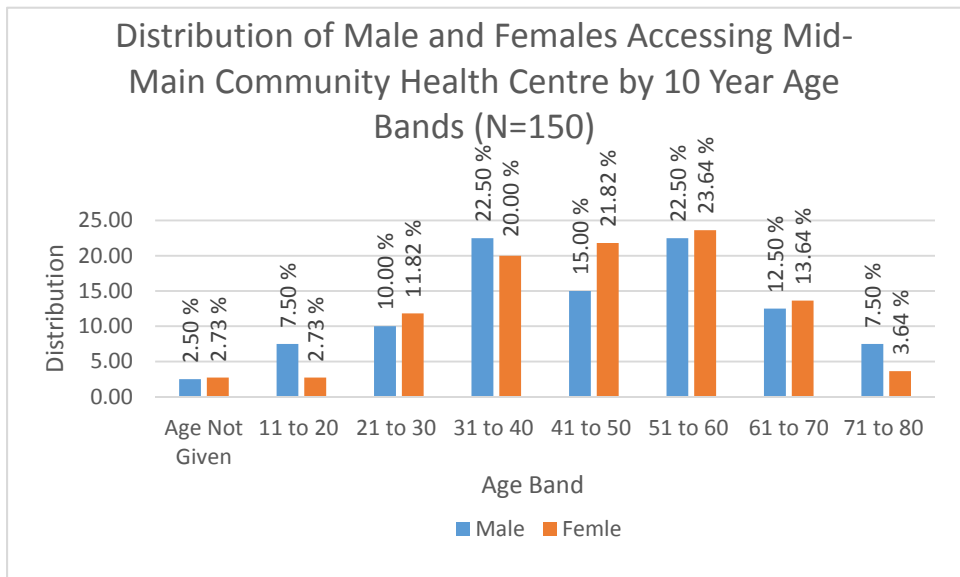
Conclusions drawn from the 2016 survey are drawn from 179 returned forms. I begin with descriptive statistics of the respondent population. As Figure 4.1 shows, nearly three in four respondents were women





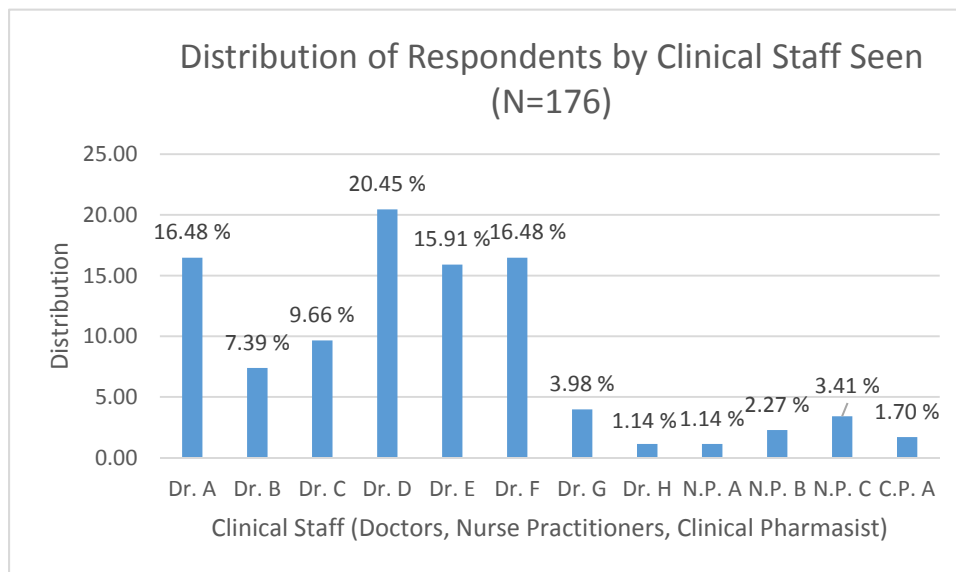
**Figure 4.1 Distribution of Respondents by Gender (N=150)**

The oldest respondent was 78 while the youngest was 15. The mean age was 46.8 and the median age was 47.



**Figure 4.2 Distribution of Male and Females Accessing Mid-Main Community Health Centre by 10 Year Age Bands (N=150)**

Figure 4.2 shows, the distribution of males and females accessing care at Mid-Main in age bands of 10 years. The pattern of access is interesting. With the exception of the youngest age band and those 41 to 50 years of age, the gender distributions of patients by age are similar. However, females access care in far greater numbers than males as described in figure 4.1.

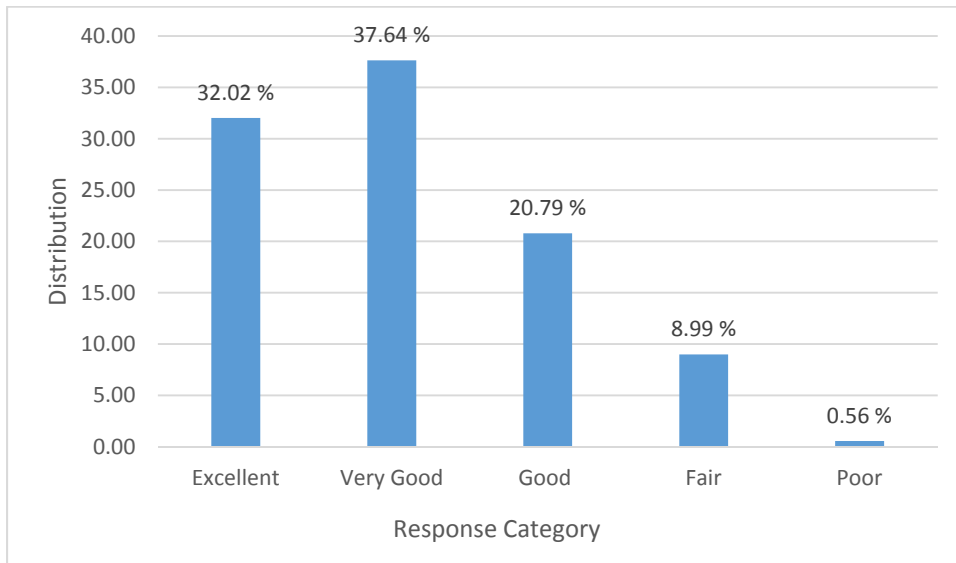


**Figure 4.3 Distribution of Respondents by Clinical Staff Seen (N=176)**

As Figure 4.3 shows, the number of responses per doctor are similar. For this question, respondents were able to select more than one option. For example, if a patient saw both a physician and the nurse practicing, they could indicate this on the survey. While allied care professionals were utilised far less than doctors, nearly ten percent of visits were to either the nurse practitioners or the clinical pharmacist.

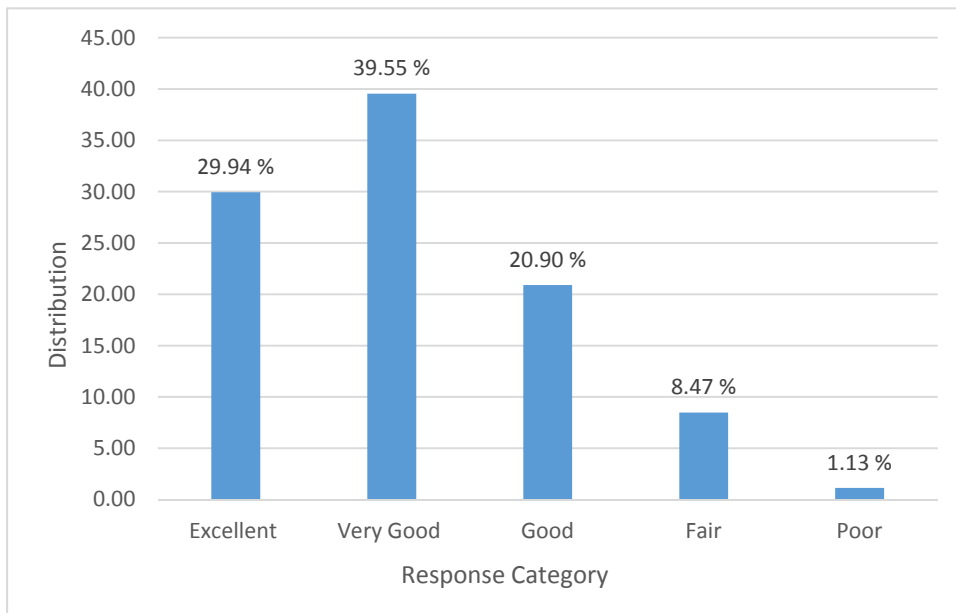
#### **4.1.2. Analysing Results – Quantitative**

In general the survey responses suggest that patient satisfaction remains quite high at the clinic despite the transition in remuneration models.



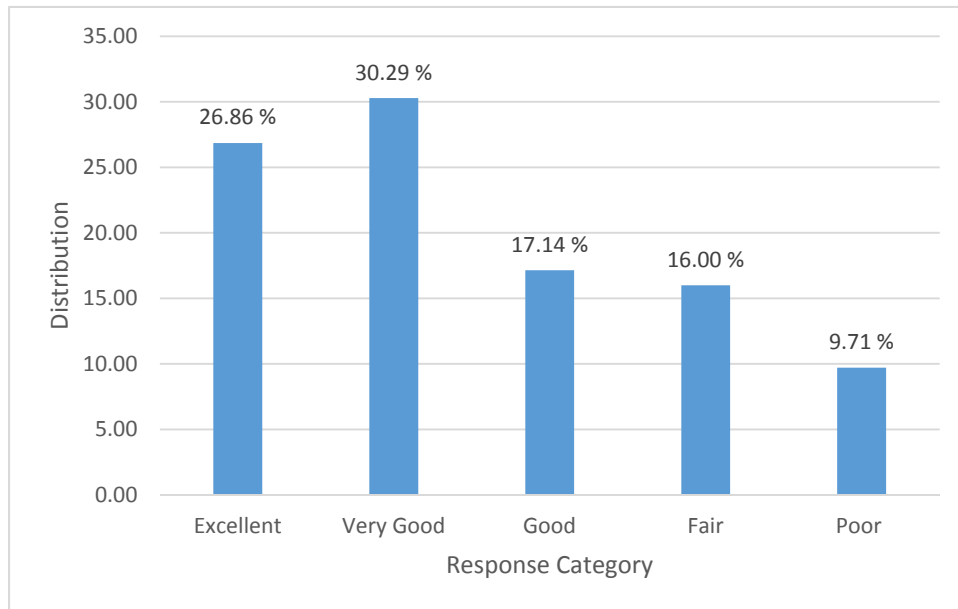
**Figure 4.4 Distribution of Respondents' Satisfaction with Getting Through to the Office by Phone (N=178)**

Figure 4.4 shows that, 70 percent of patients at Mid-Main described their ability to get through to the office by phone as excellent or very good.



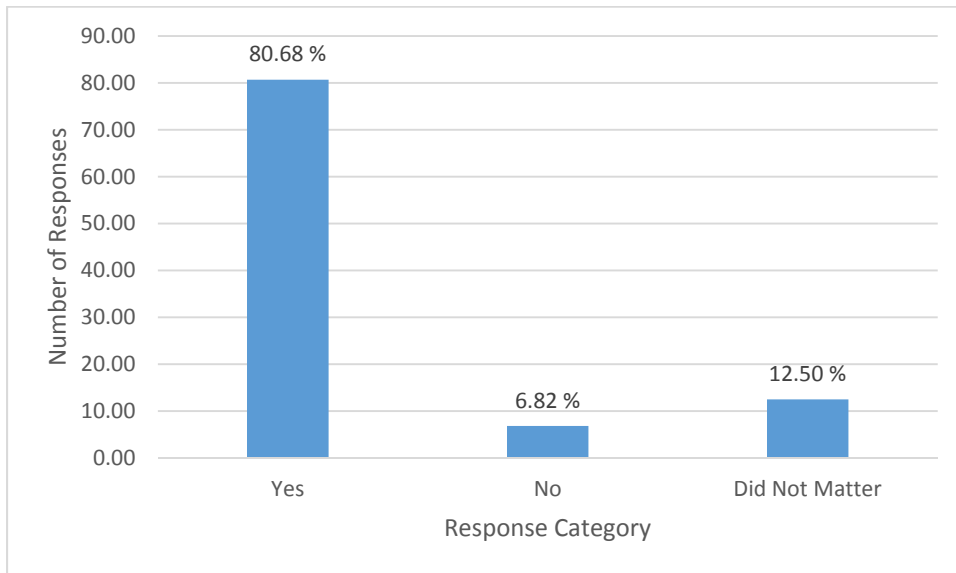
**Figure 4.5 Distribution of Respondents' Satisfaction with the Length of Time between Call and Appointment (N= 177)**

Figure 4.5 shows, a similar distribution of satisfaction experienced by patients with the length of the wait between their call and their appointment date.



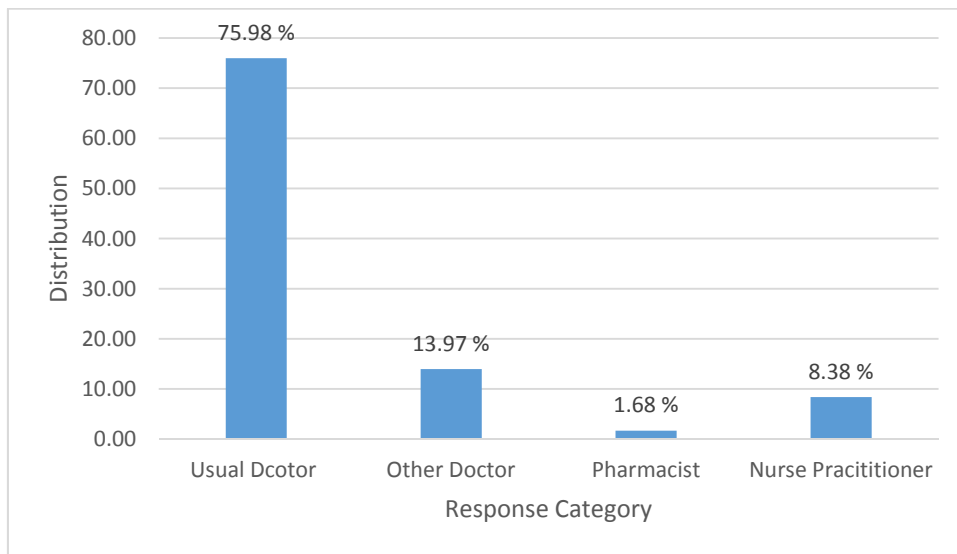
**Figure 4.6** Distribution of Respondents' Satisfaction with the Length of Time Waited at the Office before Appointment (N=175)

Patient satisfaction responses with the amount of time they spent in the waiting room were a bit more dispersed. As figure 4.6 shows that, while the majority of patients were still fairly satisfied, slightly over one quarter (26%) reported fair or poor. This is nearly the same share of respondents who felt that their wait time was excellent (27%).



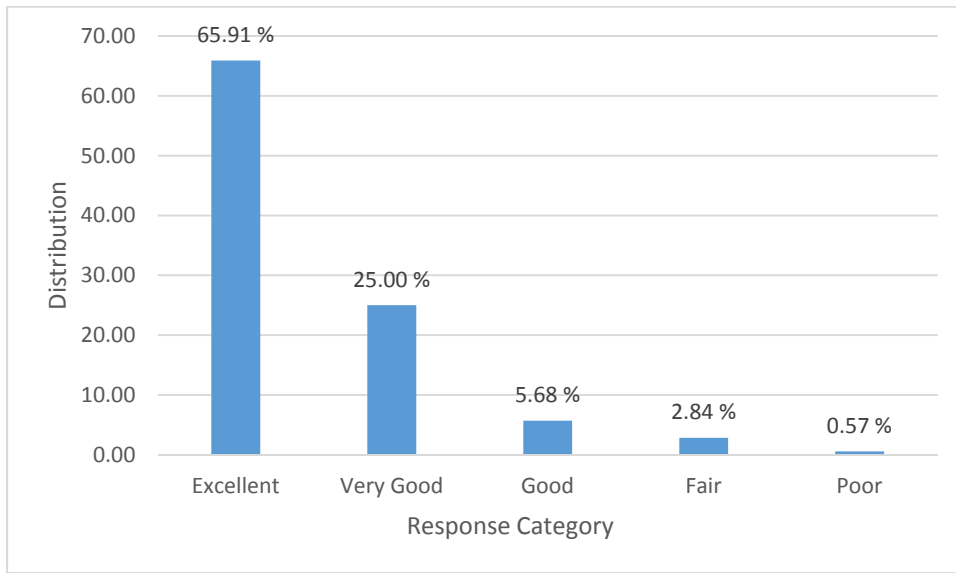
**Figure 4.7 Distribution of Respondents Accessing the Medical Staff They Wanted to See (N=176)**

As represented in figure 4.7, respondents overwhelmingly were able to see the medical staff they wanted to see that day. This includes being able to see doctors and members of the allied health professional team. While only 7 percent were unable to see whom they wanted, this still requires consideration. Being able to see a regular doctor is an important indicator of patient satisfaction as well as the ability to insure continuity of care. This is especially important for patients with complex health conditions whose satisfaction with care will likely be lower as a result of ill health.



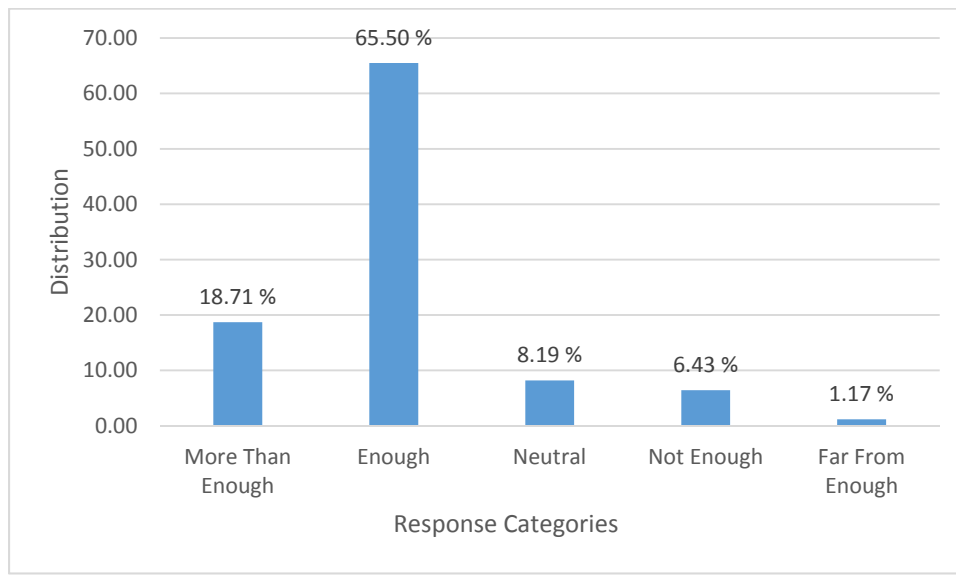
**Figure 4.8 Distribution of Respondents by Type of Medical Staff Seen During Appointment (Multiple Responses Allowed) (N=179)**

Figure 4.8, represents the type of medical staff seen by patients during the survey collection period. Answers are non-exclusive, meaning that a patient may have seen multiple medical staff members during his or her appointment. For example, a patient might see a doctor and the clinical pharmacist. Only four out of the total 179 (2%) returned surveys indicated that this took place. No patient saw more than two of the available medical staff. 90 percent of patients saw at least one doctor, and the vast majority (76%) of total visits were with the patient's usual doctor. This is a very positive sign in terms of the ability of Mid-Main to facilitate on-going relationships between physicians and patients, and in doing so effectively manage continuity of care for complex patients. One in ten (10%) of patients saw at least one of the allied care professionals.



**Figure 4.9 Distribution of Respondents' Satisfaction with Personal Manner of Medical Staff Seen (N=176)**

Figure 4.9 indicates that, patients find the medical staff's interaction with patients, in terms of courtesy, respect, sensitivity, and friendliness, of the medical staff overwhelmingly positive. Despite the problems some patients might have with the various steps involved in getting to an appointment event, the vast majority (92%) have high-end positive experiences during their appointments.



**Figure 4.10 Distribution of Respondents' Satisfaction with Time Spent with Medical Staff (N=171)**

As a result of the transition from salary to fee-for-service, staff and managers at Mid-Main were concerned that patient satisfaction with the time spent with the medical staff during their appointments would be negatively affected. Figure 4.10 shows that, at least in the short time since the transition took place, patient satisfaction with the length of their appointments remains high (84%). That said, a small but significant number of respondents were either neutral (8%) with respect to the amount of time received or unhappy (8%).

### 4.1.3. Analysing Results – Qualitative

In addition to the quantitative questions, the survey contained a field for written responses that patients could choose to fill out. Of the 179 surveys returned, 74 (41%) included patient comments. Of the 74 comments, 43 (58%) were positive; 15 (20%) were negative; 11 (15%) were mixed, and 5 (7%) were unrelated to patient satisfaction.

Of those comments that were unrelated to patient satisfaction, two had suggestions regarding the survey design; one was thankful that the survey was being undertaken; one was concerned with patient confidentiality as she could hear patients and



clinicians while she waited in an examination room to be seen, and finally one wanted to be able to contact the medical staff through e-mail, text or phone to get quick advice or ask questions about recurrent health issues.

Simple statements of gratitude, or enthusiasm for the clinic, and commendations for the quality and professionalism of the medical staff were the most common positive comments. “Awesome as ever”, “I love you guys”, “great service”, “great doctors”, “highly recommended” are examples of simple statements. Another patient wrote that he considers himself very lucky that he and his family are able to receive care at Mid-Main and that “accessibility and quality of care are great”. One patient sums up the general tenor of the positive statements writing that “Mid-Main is a precious community service”. Positive comments about the medical staff were mainly directed to the doctors, but the nurse practitioners and the clinical pharmacist received a few positive mentions as well. This is unsurprising given that the doctors were by far the most commonly seen type of staff. Based on the qualitative section, patients commented very highly on the medical staffs’ ability to communicate, compassion, thoughtfulness, genuine concern, ability to make patients comfortable, and intelligence. As one patient said, “I really like my medical team”.

There were other positive themes, which came up less frequently but deserve some recognition. Patients were happy to recommend Mid-Main to other people. Some reported that they were new patients who were very satisfied with their care. A few of the new patients felt lucky that they were able to get a regular doctor at the clinic, one saying that she was “very happy [she] found Mid-Main, especially as a new resident to Vancouver”. In addition to happy new patients, a number of long-time patients reported high satisfaction with the clinic. As one patient wrote, “I have been a patient at Mid-Main for over 20 years and have been very satisfied”. Long-time patients especially appreciated the strong bonds they had developed with their regular doctors, with one expressing sadness at the prospect of his doctor eventually retiring. Another positive theme to emerge was an appreciation for the clinic’s accessibility and quality. A number of people reported that wait times were not much of an issue, saying things like it only took “x minutes” to get to their appointment. Finally, one of the more interesting positive themes was the notion that Mid-Main was not like other clinics. As one respondent put it, “Mid-

Main feels like it's driven by concern for patients' well-being. Really. Not some marketer's idea of how to project this idea, but authentic care". Another patient wrote, "This place is great! I have come on several occasions and you are always treated with respect and listened to, and get good medical attention. Thank you! This is not the case a lot of places!! [sic]". Some of Mid-Main's patients clearly think that the clinic has a superior care philosophy, and operationalises that philosophy better than most other clinics they have experienced or heard about.

While positive comments were more common than the negative, one in five were negative in nature. The most common negative comment had to do with wait times. "I've experienced hour-long waits in previous sessions. This is not acceptable as a working professional! Several other people were waiting and frustrated by delays", wrote one patient. Another, explained that she had to wait almost an hour before her appointment, while another stated that she had waited 40 minutes past her appointment time and that she was leaving because she had to go back to work.

One respondent commenting negatively on wait times directly attributed the problem to the new fee-for-service system saying, "waiting room length [of time] much longer with new system implemented in 2015 [sic]. Disappointing". Linking negative changes with the change in remuneration system is an important theme, though the remuneration system was not frequently mentioned in the context of wait times. One patient who has been going to Mid-Main since 2001 also noticed that she no longer had a consistent doctor with whom she could build a relationship and who could advocate for her based on her medical history. Here we can see how the change has negatively affected care for some complex patients. Other long-time patients reported finding it more difficult to see doctors and that the doctors that they did end up seeing were less helpful to them. One very interesting comment noted that her visit with the nurse practitioner was fine, "but she had to call in another doctor to order tests". (This issue will be dealt with in the next section.) The notion of feeling rushed during their appointments was another theme that cropped up. One respondent felt that the rushed nature of her appointment led to misinterpretation and difficulty in communication. Another said, "I feel there is always a rush and sometimes I do not get the information and guidance I require", and ultimately felt that "the time spent is always inadequate". The rushed nature of

appointments was directly attributed to the switch to fee-for-service. She felt that her “session was extremely rushed”, and was surprised and dismayed when she found out that she could only bring up one or two issues during her appointment stating that, “if that is the case, [she] should be told”.

Among the mixed responses the most common negative aspect was, again, issues dealing with waiting room wait times. The most common positive aspect that accompanied any negative comments was an appreciation of the quality of the medical and front desk staff. Another common theme was that appointments often felt rushed, but that the doctors did their best “working within the system” as one respondent put it. Finally, the most interesting mixed comment came from a patient who noted that the doctors clearly had limited time to meet with patients, and that her doctor did not ask about other health concerns nor had the time to follow up on previous visits. However, she asserts that she is not very negatively impacted by this because of her good health. This is important because it recognises that the quick short session model of care that results from fee-for-service may not adversely affect those in good health, but can adversely affect those in poorer more complex health situations who often require longer visits.

## **4.2. Comparing Patient Satisfaction Survey Results**

This section compares results from the 2005, 2008 and 2016 patient satisfaction surveys. The results from 2005 are based on a sample of 51 patients at Mid-Main. It lacked demographic data including gender. The 2008 survey collected 100 responses, 25 male and 75 female. This mirrors the gender breakdown of the 2016 survey. The 2016 survey contains two questions not present in the 2005 survey and one question not present in the 2008 survey. Neither the 2005 nor the 2008 survey asked what type of medical staff was seen during an appointment. Because of coding decisions made in 2005, responses that fall into the categories of “excellent”, “very good”, and “good” are aggregated into the broad category of “positively satisfied”. Results from 2008 and 2016 are aggregated in the same way to allow comparison with 2005. However, the disaggregated data that exist for 2008 and 2016 are also reported to allow for a more

nuanced comparison. Finally, in 2005 and 2008 the response scale for the question, “how would you rate the amount of time you spent with the team member you saw today?”, was presented as “excellent”, “very good”, “good”, “fair”, and “poor”. The 2016 survey changed the response scale to “more than enough”, “enough”, “neutral”, “not enough”, and “far from enough”, to better help respondent understand what they were answering. As a result a meaningful discussion of trends from comparison with the previous surveys cannot be accomplished. I show it here only for the fulsomeness of the analysis. To create approximately comparable distributions the “more than enough” and “enough” categories in the 2016 survey are aggregated into the “positively satisfied” category of the previous surveys; “fine” and “neutral” are assumed to be similar enough for direct comparison, and “not enough” and “far from enough” are aggregated into the “poor” category of the previous surveys.

**Table 4.1 Question Panel Comparison 1**

Questions	Positively Satisfied (Excellent, Very Good, and Good)			Fair			Poor		
	2005	2008	2016	2005	2008	2016	2005	2008	2016
How would you rate your satisfaction with getting through to the office by phone?	92%	95%	90%	6%	4%	9%	0%	1%	0%
		Excellent: 39%	Excellent: 32%						
		Very Good: 39%	Very Good: 38%						
		Good: 17%	Good: 20%						
How would you rate your satisfaction with the length of time between your call and your appointment?	94%	95%	90%	8%	4%	8%	0%	1%	1%
		Excellent: 37%	Excellent: 30%						
		Very Good: 49%	Very Good: 40%						
		Good: 9%	Good: 21%						

<b>How would you rate your satisfaction with the length of time you waited at the office before seeing the clinician or team member?</b>	N/A	87%	74%	N/A	11%	16%	N/A	2%	10%
		Excellent: 31%	Excellent: 27%						
		Very Good: 35%	Very Good: 30%						
		Good: 21%	Good: 17%						
<b>How would you rate your satisfaction with the personal manner of the person you saw today (courtesy, respect, sensitivity, friendliness)?</b>	100%	100%	97%	0%	0%	3%	0%	0%	1%
		Excellent: 68%	Excellent: 66%						
		Very Good: 27%	Very Good: 25%						
		Good: 5%	Good: 6						

As we can see from table 4.1, patient satisfaction remains very high at Mid-Main. There has however been a decrease of 3 – 13 percentage points in all “positively satisfied” categories between 2008 and 2016. The greatest decline in positive satisfaction has to do with wait time at the office, with 74% of 2016 respondents falling into the positive response category as opposed to 87% in 2008. Satisfaction with the personal manner of the medical staff also remains very high. The distribution of “excellent”, “very good”, and “good” responses between 2008 and 2016 remains very similar. However, there has been a decline in positive satisfaction experienced by patients.

**Table 4.2 Question Panel Comparison 2**

Question	Yes			No			Did not Matter		
	2005	2008	2016	2005	2008	2016	2005	2008	2016
Did you see the clinician, or team member, that you wanted to see today?	71%	68%	81%	12%	8%	7%	14%	23%	13%

Table 4.2, shows that the ability of respondents to see the desired medical staff during their appointment has significantly improved. In other words, patients may be less satisfied with their waiting room experience, but they are ultimately more likely to see whom they want to see when they do get into their appointment.

**Table 4.3 Question Panel Comparison 3**

Question	Positively Satisfied (Excellent, Very Good, and Good (2005, 2008) / More Than Enough, and Enough (2016))			Fair (2005, 2008) / Neutral (2016)			Poor (2005, 2008) / Not Enough, and Far From Enough (2016)		
	2005	2008	2016	2005	2008	2016	2005	2008	2016
How would you rate the amount of time you spent with the team member you saw today?	96%	Excellent: 61% Very Good: 29% Good: 9%	84% More Than Enough: 19% Enough: 66%	4%	1%	8.19%	0%	0%	8% Not Enough: 6% Far From Enough: 1%

As explained in the introduction to this section, a direct examination of the trend over the three surveys is impossible because of the change in response scale. I believe the scale used in 2005 and 2008 caused an underrepresentation of dissatisfaction with the length of appointments. The 2016 response scale more accurately addresses

patients' concerns with how long they have to address their concerns, as evidenced by the disparity in percentage points between "excellent" and "enough". The fact that there is an increase in people who feel that they do not have enough time with medical staff is of some concern and could be attributable to the switch to fee-for-service. That said, results under both response scales are very positive. In all three surveys, most people have felt that they are being well served through the amount of time they have to spend with the medical staff during their appointments, though the decline in 2016 must be monitored.

### **4.3. Survey Results: A Broader Discussion**

Overall the survey results give an interesting picture of the reality at Mid-Main since the transition from salary to fee-for-service. Under fee-for-service we would expect to see less satisfaction with the amount of time available to patients during their appointments. However, the short-term reality at the clinic does not necessarily reflect this. There has been a significant decline in the most positive response categories with regards to satisfaction with appointment length. However, as previously suggested, some of this might be attributed to using a response scale that elicits a more accurate picture of patient feelings on this matter. Not all of the decline can be attributed to this however. As table 4.3 shows, there has been an increase in patient share in the two lowest categories. This result, coupled with the themes found through the qualitative analysis of survey comments, shows that the switch to fee-for-service has had some negative impact on patient satisfaction in this area.

That people are more dissatisfied with the length of time they must wait at the office is another interesting result. The expectation would be that a switch from salary to fee-for-service would improve the rapidity with which people are cycled through the office by shortening the length people have to spend with the medical staff. While there has been a decrease in appointment length, dissatisfaction with the length of waits has also increased. In fact, it is on this measure that Mid-Main has seen the greatest decline in patient satisfaction. From the survey data it is unclear what is causing this trend. One

obvious line of inquiry would be to examine whether the clinic is seeing a significantly larger volume of patients pass through its doors than in the past as a ratio of its capacity to handle them.

Finally, the themes of the quantitative section of the survey mirror the indicators of patient satisfaction discussed to in the background. Patients found significant satisfaction having long-term, communicative, trusting relationships with their medical staff. Even when patients were unhappy with some aspects at Mid-Main, they often spoke highly of the medical and front desk staff, and used that to temper their criticism. Patients who lost that relationship due to the switch to fee-for-service or other reasons indicated that this was a significant reason for their increased dissatisfaction. In addition, one patient directly spoke to the idea that her good health contributed to her satisfaction with Mid-Main. Ongoing satisfaction at Mid-Main will be dependent on the continued patient perceived quality of the staff.

Since the transition to the fee-for-service model is still in its early days, it is advised that the clinic redo the survey in its current form in the very near future to keep track of trends as they develop. The lack of decline in most areas of patient satisfaction might be a result of the afterglow of Mid-Main's past exceptional service under the salary model. In order to determine whether this is true patient satisfaction will need to be tracked fairly closely as the clinic and its clients settle into the new remuneration system.



## **Chapter 5.**

### **Thematic Interview Analysis: Key Themes**

#### **5.1. Flexibility of Care**

One of the major themes of the interviews is the differential expected effect of remuneration methods on the flexibility of care. By flexibility of care I mean the degree of freedom of care providers in design of patient care. Alternatives include longer visits, phone consultations, and discussions with allied healthcare professionals on how to manage chronic illness. Interviewees by and large felt that fee-for-service restricted flexibility of care. Ms. Clarence, executive director of Mid-Main Community Health Centre, pointed out that physicians are only able to bill for one, at most two, issues a patient raises (interview, Irene Clarence), which means patients may need to make follow-up appointments. This adversely affects patients with complex and/or chronic medical conditions the most.

Having experienced both a salary method under the Health ministry's alternate payments branch and now the fee-for-service model, both Ms. Clarence and Dr. Margaret McGregor, a former physician at Mid-Main, felt that salary allowed for more flexibility. Ms. Clarence stated that, "under alternate payments we would set up the care based on what made sense for us, what made sense for the patient [...] we were much freer to [...] be creative", (interview, Irene Clarence). This is reinforced by Dr. McGregor who suggested that salary under alternate payments branch allowed more agency to the physicians than does fee-for-service where "there is much more of a sense of being a cog in a wheel and having very little input or control over anything".

Neither Ms. Clarence nor Dr. McGregor had direct experience with capitation, but as a result of investigations into the small number of BC primary health care clinics using

capitation the interviewees have some familiarity with it. Both felt that capitation facilitates flexibility of care. Dr. McGregor noted that capitation,

recognises complexity, so people who are more complex, have more chronic diseases, greater frailty, come with greater remuneration. Then you can decide how you want to manage their care, whether it be by phone call, whether it be by going to visit them, whether it be by asking them to come in. You can take responsibility for their care in a global sense, and then you decide how you want to actually provide those services (interview, Margaret McGregor).

This sentiment was also expressed by Ms. Clarence who said of capitation that,

you would be free to design the care in whatever way makes sense to you for that person [...] Sometimes you would just call them at home and talk to them, and sometimes you would have them come, and sometimes you might have them come and have a really long visit and talk and have them talk to everyone on the team, and sometimes you might just have them drop in for a minute (interview, Irene Clarence).

Both Ms. Clarence and Dr. McGregor are very supportive of the idea that capitation leads to greater flexibility in patient care, and thus to better patient outcomes.

However, fee-for-service has some benefits. In learning how to practise under the new fee-for-service model, the physicians at Mid-Main realised that there were helpful service fee codes. For example, in order to bill certain types of fee codes, it is necessary to complete certain tasks (such as setting up a care plan or scheduling follow up visits) and the fee codes “were actually directing doctors into doing good things for their patients and then rewarding them for doing it” (interview, Irene Clarence).

That said, two individuals on the front lines of primary healthcare provision seem to agree that fee-for-service does not facilitate the flexibility of care needed by complex and chronically ill patients as well as either salary, under the Health ministry’s alternative payments branch or capitation.

## **5.2. Administrative Burden**

Administrative burden came up as a significant concern through the interviews. Once again, fee-for-service does poorly. Physicians need to spend significant time billing their services. The utilisation of fee codes is administratively complex. The experience at Mid-Main during the transition was daunting for the physicians. As Ms. Clarence recounted, “we sat through two or three days of sessions where we were just going through numbers after numbers, and [the doctors] were just looking very, very overwhelmed” (interview, Irene Clarence). In addition, the positive effort to make fee-for-service more responsive to complex and chronic needs increases the administrative complexity as, “unfortunately, the more activities built in for funding, the more time it takes to do the billing” (interview, Margaret McGregor). Fee-for-service is not alone in administrative complexity. From Dr. McGregor’s experience in investigating capitation it became her understanding that a lot of work goes into the billing side of that method, but that successful models often hire an administrator dedicated to doing that work for the clinic (interview, Margaret McGregor).

## **5.3. Facilitating Allied Care**

Fee-for-service rewards certain activities and not others. Some of the activities neglected by fee-for-service are those involved in team building and allied care. As Dr. McGregor points out, “one big drawback is that it doesn’t support protected time for team reflection, and conversations about how to improve patient care. It doesn’t build teams; it builds increased activity” (interview, Margaret McGregor). When asked directly if she thought fee-for-service facilitated allied care, Dr. McGregor responded that “fee-for-service does terribly” (interview, Margaret McGregor).

The expectation of the interviewees is that capitation and salary do much better on this score. As Ms. Clarence puts it, capitation “would seem to be the [most] accommodating model for team-based care” (interview, Irene Clarence). It gives the most freedom to the health clinic because it provides a pot of money with no constraint on use

of allied health professionals (interview, Margaret McGregor). As a result, the practice has a high degree of control over its staffing and its care planning. The experience with salary at Mid-Main is interesting with regards to use of allied healthcare. There was no mechanism to pay for allied health professionals. The clinic had core funding, which was to be used solely for the remuneration of physicians. The clinic's administrative funding was fairly limited and Mid-Main could not dip into the dedicated core physician funding to cover costs of allied care providers. In order for team-based care to work at Mid-Main, the clinic required separate grants from the government to fund allied health professionals (interview, Irene Clarence). For example, the clinic was given separate grants to pay for a nurse practitioner and a clinical pharmacist (interview, Irene Clarence). Dr. McGregor stated that salary, "did fine as long as we had the health authority at our back doing our hiring and our paying for allied health professionals" (interview, Margaret McGregor).

The experience with salary introduces an interesting concept in that the regulatory environment restricts what allied health professionals can do as much if not more than the remuneration method itself. This is the position taken by the interview participant "A". As was stated in our interview he felt that,

Money isn't the issue here. The problem is the rules. The rules that the medical profession has imposed [...] actually block the use of auxiliary workers [...] You can use [auxiliary workers] in any of the remuneration models as long as the rules that the medical profession has used to block their usage are changed (interview, A).

It is this participant's belief that each of the remuneration systems could work in facilitating the use of allied health professionals, (interview, A). However, the medical profession (read Doctors of BC) imposes regulations "to block changes that are common place everywhere else" (interview, A). Discouraging the use of allied health professionals is a means used by physicians in maintaining their bargaining power with government to maximise income (interview, A). While I cannot comment on the tactical motive in regulatory obstruction, it seems that fee-for-service regulations effectively restricting team-based care. For example, in B.C., "because the allied health professionals do not have billing numbers, all billings have to be made, at least formally, by physicians" (interview,

Margaret McGregor). What this meant is that the physicians at Mid-Main have to go and “lay eyes on a patient [they] weren’t really assessing or treating for the purposes of billing” (interview, Margaret McGregor). This is an issue that was first addressed in the qualitative section of the survey results analysis. One participant recounted that the nurse practitioner that she was seeing required a physician to order the required tests for the patient. There is some leeway under fee-for-service to utilise allied care. As Ms. Clarence points out, “we started to realise there was a little play within the fee-for-service model for bringing in a registered nurse to work beside a doctor, or a pharmacist, or anybody who has a scope of practice that is separate and unique” (interview, Irene Clarence). However, “you really need to have a good business background to understand how to utilise the time of any other practitioner besides doctors wisely” (interview, Irene Clarence).

This leaves us in a complicated position. On the surface, it would seem that fee-for-service does not facilitate allied care. On the other hand, capitation, and the model of salary used at Mid-Main in the past do facilitate team-based health approaches. However, it seems that there is a level of regulatory obfuscation that makes the used of allied health professionals difficult beyond the technicalities of the remuneration system in play. As a result, very often it is, “only the physician [who] is paid, and [...] only them there to care for you, even if [the care supplied is] not within the best scope of practice” (interview, Irene Clarence).

## **5.4. Stakeholder Considerations**

The forgoing discussion about regulations provides a good transition into stakeholder interests. The major physician stakeholder is Doctors of B.C., formerly the British Columbia Medical Association. Doctors of B.C. is the organisation that represents physicians’ interests in negotiations with the province. As mentioned above, interview participant “A” believes that Doctors of B.C. intentionally protects the regulations restricting the practice of allied health professionals in order to maintain a bargaining advantage with government (interview, A). Dr. McGregor believes that “our professional association [read the Doctors of B.C.] is very much invested in fee-for service and, generally speaking, it

believes that model is the best model for physicians” (interview, Margaret McGregor). Doctors of B.C. recognises fee-for-service as allowing physicians the greatest amount of control over their work environment’ “[doctors] are reluctant to give that up to become employees” (interview, Margaret McGregor).

The provincial government is another key stakeholder. Based on the interviews the provincial government’s position is somewhat “muddy”. On one hand, there would be political opposition to remuneration reform due to strong lobbying forces against change, (interview, Irene Clarence). On the other hand, it is not clear that the government would oppose or favour change in principle, as there has not been an adequate economic analysis of the impacts of the various remuneration systems (interview, Margaret McGregor).

The final major stakeholder discussed through the interview process is businesses attached to healthcare, which supply medicines, supplies, and diagnostics, among other things. For example, companies have an interest in patients choosing one drug over another (interview, Irene Clarence). As a result, doctors are under constant pressure from pharmaceutical representatives to stock new drug samples (interview, Irene Clarence). The use of allied healthcare practitioners can create obstacles to this kind of behaviour. For example, at Mid-Main, all new drugs stocked go through the scrutiny of the clinical pharmacist before reaching the shelves (interview, Irene Clarence). The clinical pharmacist is in a better position to make decisions about the efficacy of new drugs than the doctors, who often do not have the time to do a proper investigation (interview, Irene Clarence). Change from fee-for-service could result in significant losses in revenue to pharmaceutical companies. To this point, Irene Clarence said,

There is a group of medical businesses that benefit from high-pressure fee-for-service care. If we switched over to team-based care, – thoughtful, creative care with a lot of lifestyle education, and a lot of alternative ways of approaching your health – that would mean a huge decrease in income for some businesses and they would not be happy (interview, Irene Clarence).

While doctors themselves seem like an obvious stakeholder, the issue of new doctor outcomes came up as a theme of discussion and it is given its own section below.

## **5.5. Tribulations for New Doctors**

New doctors, especially those who are young and female, have different expectations than their older peers about how to care for their patients, and their work and life balance. “Young doctors are more and more aware of things like social determinants of health; they’re more familiar with communication and continuity in their training” (interview, Margaret McGregor). However, when they leave medical school, there is a “dissonance between what they’ve been taught and their experience of having to churn through patients” (interview, Margaret McGregor). New graduates are often forced into fee-for-service practices, often walk-ins, because of the high post-graduation debt burden they carry out of medical school (interview, Irene Clarence). The impact of this is that “it would be really hard to be focused on what’s best for [their] patients, and what’s best for [their] own lives. [They] would just be worrying constantly about the bottom line.” There is a long-term effect as well. In Ms. Clarence’s opinion, “fee-for-service encourages all the wrong attributes in our new doctors” (interview, Irene Clarence). The years spent in quick, volume-based patient care do not help develop skills in new physicians. In Ms. Clarence’s experience with new doctors who have gone through this system, “they don’t really feel like they’ve got two or three years of solid experience behind them” (interview, Irene Clarence), because they, generally, do not have opportunities to do follow-up with patients, to deliberate on patient care strategies, or get feedback from more senior physicians (interview, Irene Clarence). As Dr. McGregor puts it, the attraction of walk-in work for new doctors has created “a very unfortunate time for primary care because it’s a time when we need continuity, when we need a strong team to be able to care for high-needs people to keep them out of emergency.”

What is the solution then? Research suggests that newly graduated physicians want to see a blended model of salary and capitation (Winston, nd). This idea was partly reflected in the interview with Ms. Clarence. She noted that,

if you want the combination of being able to do what is right for your patients, have a little bit of personal life yourself, and some balance in your own life, and be able to be creative about how you use your time in caring for your patients, population health<sup>1</sup> provides some of those elements (interview, Irene Clarence).

It is hard to suggest that the fee-for-service model serves newly graduated doctors in the present, or in the future, in terms of the development of their skills. In addition the model creates a dissonance between the expectation of what practicing medicine will be like, and what it actually is outside of medical school.

## **5.6. The Effect of Remuneration Systems on Patient Satisfaction**

Under fee-for-service remuneration, “relatively less value is given to people who are complex, frail, and high needs” (interview, Margaret McGregor). The more interesting theme to come out of the interview process was that perhaps the remuneration method does not matter too much to patient satisfaction. Interview participant “A” suggest that,

the money [paid to care givers] is invisible to patients. They don’t pay it; they don’t know how much it costs to go see a medical practitioner or to follow through on any of the things that the medical practitioner directs them to do. So I think [good] patient satisfaction can be achieved under any of the systems; it has to do with different factors that may or may not be influenced by the payment model (interview, A).

This returns to the idea that the regulatory hindrances are the big issue rather than the remuneration systems themselves. If it were possible to achieve team-based healthcare under any of the remuneration system given an opening up of the regulatory

<sup>1</sup> In the interview with Ms. Clarence the terms capitation and population health were used interchangeably.



environment, then it would seem that even under fee-for-service patients would be able to access robust and creative care plans.

Another factor that came up in the background and qualitative analysis is that people in good health are not deeply affected by the remuneration system of their care providers. For example, with regards to the transition to fee-for-service which took place at Mid-Main,

if you are an average healthy patient, and you don't have high needs, you'd notice very little different, and maybe even notice better service because you've got the walk-in clinic now, and [Mid-Main] has got the incentive to see you (interview Margaret McGregor).

While it is too early to tell with certainty, based on the results of the quantitative section of the patient satisfaction survey, the expected decline in patient satisfaction with the amount of time spent during an appointment did not materialise.

## **5.7. What Does Efficiency Mean**

Efficiency can mean two very different things to the healthcare recipient and the healthcare service provider. For the patient what matters is how much time it takes from finding out they have a problem to having a correct solution (interview, Irene Clarence). For the manager of a primary health clinic, efficiency could mean getting patients through the door, to their appointment and then back out again without consideration as to whether patients were helped (interview, Irene Clarence). As a provider of healthcare it is essential that the patient's sense of efficiency is not disconnected from the business sense of efficiency (interview, Irene Clarence). In Ms. Clarence's opinion, fee-for-service engenders this disconnect because, in general, it places a prime focus on the inflow and outflow of money "and whether the patients get amazing care, average care, or terrible care is really a side issue" (interview, Irene Clarence).

## 5.8. Remuneration Realities for Mid-Main

At some point considerations regarding fiscal feasibility need to be considered. Since Mid-Main was forced to transition away from salary (based on alternate payments branch grants) to fee-for-service, the viability of the salary option was not discussed to a great extent.

The viability of capitation arose during the interview process. It has been determined that capitation is not a viable alternative for Mid-Main at present. Capitation relies on a loyal roster of patients. If patients rostered with a clinic seek care elsewhere, referred to as outflow, the Health ministry claws back part of the money paid to the original clinic. This is especially problematic if patients' prioritize convenience over continuity. Based on Health ministry estimates for Mid-Main patient flows and consequent income for the clinic, capitation is not "in terms of numbers of patients, and number of staff, and overhead costs [...] financially possible" (interview, Irene Clarence). Capitation may be possible in Vancouver. There are a number of successful capitation models running in Vancouver. The key to their success is that they take a very proactive approach to patient education with regards to being part of a capitation based practice (interview, Margaret McGregor). For example, patients are informed that they must seek care from that clinic or else they will be de-rostered, but in return the resources of the clinic will be available around the clock (interview, Margaret McGregor).

The ability to "outflow" is not completely negative. It lets the patient become "the big player" (interview, Irene Clarence). The result is that, under capitation, "you would really need to engage with your patients; you'd need to listen to them, you'd need to understand why they outflow, if they are, and what you could do about it" (interview, Irene Clarence).

## **5.9. Experimentation with Remuneration is Key**

It would be unrealistic to assume one-size fits all for physician remuneration. Certain models work better in certain situations. A rural town might be very well suited to capitation because of the captive client population, though we have seen in the previous section that this is not necessarily a requirement of success (interview, A). Capitation would not do well in a situation like the Downtown Eastside, where you have a very transient, and hard-to-reach population (interview, A). At the same time, fee-for-service would not be a good fit either since the patients are complex users of healthcare and would require longer visits than fee-for-service is designed to provide (interview, A). In this case, salary makes sense: doctors make a prescribed income and can decide how best to care for the patients (interview, A).

An examination of the dominant provincial model is worthwhile. The application of one model as the majority remuneration system can create systemic problems, which should be investigated. As stated by interview participant “A”, experimentation with different models is essential (interview, A).

## **Chapter 6.**

### **Policy Opinions**

The policy options presented in this section deal with remuneration options appropriate in the medium-term for Mid-Main Community Health Centre and other clinics like it that are interested in pursuing interdisciplinary models of care.

#### **6.1. Option 1: Enhanced Fee-for-Service**

This model would continue the trend toward creating billing opportunities for a diverse set of procedures offered by allied care providers, as well as physicians. The proposed model is inspired by Ontario's Family Health Groups remuneration system. The model includes incentives for care by physicians not found in traditional fee-for-service. The incentives include premiums for comprehensive care during and outside of regular hours for patients enrolled with a clinic (Kantarevic et al., 2010). Comprehensive care includes preventative care (pap smears, immunisations, flu shots, among other things), primary mental health care, HIV care, diabetic assessment, and more (Kantarvic et al., 2010). In addition, a small capitation fee, adjusted on sex and age, is included for committing to the care of enrolled patients (Kantarvic et al., 2010). Finally, performance-based initiatives are included for preventive care, special payments (for activities like obstetrics, home visits, or palliative care), and chronic disease management fees (Kantarvic et al., 2010).

#### **6.2. Option 2: Capitation**

This model requires clinics to take all patients who wish to join the practice in order to avoid cream-skimming. In addition, clinics will be required to adhere to an upper cap on the number of patients they can roster in order to avoid being unable to meet demand

for quality care. It will be important for clinics to properly educate their rostered patients on the impacts of outflow under this policy option.

### **6.3. Option 3: Salary**

This option is based on the now-canceled alternative payments branch agreement between the province and Mid-Main. This option would include increased oversight so the province can assess whether an adequate number of patients are being seen.

### **6.4. Option 4: Blended Capitation/Enhanced Fee-for-Service**

This model mixes elements of the capitation model with elements of the enhanced fee-for-service model. This model would fund clinics primarily based on their roster of patients. Clinics would be required to take all patients who wish to join the practice in order to avoid cream-skimming. In addition to this, clinics would be required to adhere to an upper cap on the number of patients they can roster. In addition enhanced fee-for-service features would include the 20% premium for after-hours care, and the performance based incentives seen in policy option 1.

## **Chapter 7.**

### **Criteria and Measures**

#### **7.1. Criteria and Measures Table**

The criteria and measures presented in this section are intended to provide a systematic and consistent assessment of the trade-offs among policy options. Table 7.1 outlines the criteria as well as how they will be measured. The outcome measures will be assessed on a high, medium, and low scale. The high outcome will be awarded a score of “3”, a medium outcome “2”, and a low outcome “1”. A sum of scores for each individual policy option will inform the recommendation of this report. Some criteria are weighted greater than others. The reasoning behind this will be discussed in the appropriate subsections below.

**Table 7.1 Criteria and Measures**

<b>Criteria</b>	<b>Definition</b>	<b>Measure</b>	<b>High/Medium/Low</b>
<b>Patient Satisfaction</b> <i>Weight x3</i>	Will the remuneration method lead to an increase in patient satisfaction?	Increase satisfaction	High
		No change in satisfaction	Medium
		Decrease in satisfaction	Low
<b>Incentives for Care of Complicated Patients</b> <i>Weight x3</i>	Does the model incentivise care for complicated patients?	Yes	High
		Partially	Medium
		No	Low
<b>Use of Allied Care providers</b> <i>Weight x3</i>	What is the likelihood that allied care is utilised under the remuneration method?	Very likely	High
		Relatively likely	Medium
		Not likely	Low
<b>Stakeholder Acceptability (Government)</b> <i>Weight x2</i>	Acceptability by the provincial government	High Acceptability	High
		Medium Acceptability	Medium
		Low Acceptability	Low
<b>Stakeholder Acceptability (Medical Suppliers)</b> <i>Weight x0.5</i>	Acceptability by medical suppliers	High Acceptability	High
		Medium Acceptability	Medium
		Low Acceptability	Low
<b>Stakeholder Acceptability (Doctors of B.C.)</b> <i>Weight x2</i>	Acceptability by the Doctors of B.C.	High Acceptability	High
		Medium Acceptability	Medium
		Low Acceptability	Low
<b>New Doctor Outcomes</b>		Highly Reflected	High
		Moderately Reflected	Medium

	Does the remuneration system reflect the priorities of new doctors?	Poorly Reflected	Low
	Does the remuneration system allow for positive skills development?	High Skills Development	High
		Moderate Skills Development	Medium
		Low Skills Development	Low

## 7.2. Patient Satisfaction (Weight x3)

This criterion is concerned with how the policy options will affect patient satisfaction. The assessment will be based on whether the policy enhances or reduces certain key indicators of patient satisfaction, as well as the 2016 patient satisfaction survey at Mid-Main Community Health Centre. Key indicators of patient satisfaction include the likelihood that patients will have enough time to discuss their issues in full with their care provider, continuity of care, flexibility of care, time in the waiting room, and the number of issues that can be dealt with in one meeting. Important factors like ability to deal with complex patients and the use of allied care providers, are not included here to avoid double counting. They are included as their own criterion. This criterion is given a weight of times 3 because healthcare is eminently focused on the patient. This should be reflected in the scoring of policy options.

As will be discussed at the beginning of chapter 8, the analysis of options will proceed with some simplifying assumptions to make the process more straight forward. As a result the key indicators discussed above are rendered moot in determining the trade-offs between the options with regards to this criterion for this report. Despite this, I mention the key indicators here because they are important considerations to keep in mind when considering issues of remuneration since the assumptions made here will not hold up in application due to real world constraints.



### **7.3. Incentives for Care of Complicated Patients (Weight x3)**

This criterion is concerned with how the policy options will affect the treatment of patients with complicated health profiles. The assessment will be based on whether the policy enhances or reduces the likelihood that care for complicated patients is incentivised, and to what degree. Key indicators include the following: does the policy option provide direct financial incentives to care providers, are care providers incentivised to provide lengthy care, and are flexible care plans, such as phone calls and home visits, remunerated. Again this criterion has been given a weight of times 3 because of the importance of the patient's experience in the healthcare system.

### **7.4. Use of Allied Care Providers (Weight x3)**

This criterion is concerned with how the policy options will affect the likelihood of an allied care model being utilised. This assessment will be based on whether the policy options encourage or discourage the use of allied care providers. Key indicators include whether the policy options provide funding to support allied care, and whether they allow allied care professionals means of billing their own work. This criterion has been given a weight of times 3 because of its focus on patient care.

### **7.5. Stakeholder Acceptability: Government (Weight x2)**

This criterion is concerned with how likely that the provincial government will find the policy option acceptable. Key indicators include whether the policy option will have a significant impact on the provincial budget, and whether significant change will be required in the administration of payments to clinics. This will be informed by interview data. This criterion has been given a weight of times 2 because it does not deal directly with the experience of patients. That said, it is important that it is given some extra consideration because governmental budgetary constraints are of great importance.

## **7.6. Stakeholder Acceptability: Medical Suppliers (Weight x0.5)**

This criterion is concerned with how likely that medical suppliers will find the policy options acceptable. The key indicator is whether the policy options will have a perceived significant negative impact on medical supplier revenues. This will be informed by interview results. This criterion has been given a weight of times 0.5 because this report does not consider the impacts on the medical supplier industry as of vital importance. The criterion is only important in so far as a perceived negative impact on revenues might lead to lobby pressure from the industry on government to prevent reform.

## **7.7. Stakeholder Acceptability: Doctors of B.C. (Weight x2)**

This criterion is concerned with how likely that Doctors of B.C. will find the policy options acceptable. The key indicator is whether the policy options align with the organisation's priorities regarding remuneration. This will be assessed based on interview results. While this report is centred on the interests of patients and primary care providers, it is also important to maintain the support of the province's physicians. As such, this criterion has been given a weight of times 2. The criterion is important in so far as policies misaligned with the organisation's priorities might lead to lobby pressure on government to prevent reform.

## **7.8. New Doctor Outcomes (Weight x0.5/x0.5)**

Assessment of this criterion will be based on how well the policy options provide the features of practising medicine desired by new doctors. Key indicators include providing new doctors with a desirable work-life balance, and reducing their administrative burden. In addition, this criterion is concerned with how well the policy options allow for new doctors to develop skills. As such, as second set of key indicators is whether a policy

allows for: new doctors to practise in the way they were taught in medical school, detailed assessments of patients, stable mentoring from senior physicians, and follow-up with patients? This criterion has been given a weight of times 0.5 for the first set of key indicators and times 0.5 for the second set, for a number of reasons. First of all, a policy option that adequately deals with this criterion is likely to be forward thinking. The issues brought up by new doctors are likely to become more prominent as they replace older physicians. Components of the new doctors' agenda are likely to be part of the next round of negotiations between the Doctors of B.C. and the government (interview, Margaret McGregor). In addition to this, the quality of new doctors, in terms of their skills and their professional satisfaction, has an important impact on the care of patients. However, since this criterion has two sets of important indicators it would be inappropriate to give them a unit weight. The reduced weighting prevents this category from becoming overly influential in the analysis of options.

## **Chapter 8.**

### **Policy Analysis**

In order to proceed with the analysis of policy options some simplifying assumptions need to be made. First, this report assumes that the enhanced fee-for-service model will operate like a traditional fee-for-service model. Physicians will bill their services, with the only major difference being the number of billable treatments offered. Capitation would run on the same basis as the fifteen other capitation based clinics in the city. Salary would also be more or less the same, however the government would engage in more surveillance to ensure that clinics are treating about the same number as patients as would be treated under fee-for-service.

Another major assumption deals with the generosity of remuneration. An issue with a remuneration system like capitation is that if the capitation agreement is not sufficiently generous then physicians must roster large numbers of patients in order to maintain the standard of pay they expect, or accept the reality of lower pay and roster a small number of patients. Rostering a large number of patients potentially results in a situation which undercuts the major benefits of the system. Therefore, for the purpose of analysis this report assumes that each of the policy options will be generous enough as not to compromise the expectations for doctors on this account. It should be noted that this assumption would likely not hold up in reality. The health budget is relatively fixed. It would be difficult to maintain the current level of remuneration for physicians if they were to see fewer patients under capitation or salary. In fact, the sense on the part of the province that physicians were not seeing enough patients under salary was one of the reasons why it ultimately cancelled the alternate payments branch agreement with Mid-Main and the other clinics.

**Table 8.1 Analysis Matrix**

Policy Options/Criteria	Policy Option 1: Enhanced Fee-for-Service	Policy Option 2: Capitation	Policy Option 3: Salary	Policy Option 4: Blended Capitation and Enhanced Fee-for-Service
Patient Satisfaction <i>Weight x3</i>	9	9	9	9
Incentives for Care of Complicated Patients <i>Weight x3</i>	6	9	3	9
Use of Allied Care providers <i>Weight x3</i>	3	9	3	9
Stakeholder Acceptability (Government) <i>Weight x2</i>	6	2	2	2
Stakeholder Acceptability (Medical Suppliers) <i>Weight x0.5</i>	1.5	0.5	0.5	0.5
Stakeholder Acceptability (Doctors of B.C.) <i>Weight x2</i>	6	4	2	6
New Doctor Outcomes Work/life balance <i>Weight x0.5</i>	0.5	1	1	1
Learning new skills <i>Weight x0.5</i>	1	1.5	1	1.5
<b>Sum</b>	<b>33</b>	<b>36</b>	<b>21.5</b>	<b>38</b>

## **8.1. Analysis of Criterion Outcomes: Patient Satisfaction**

Given the assumption that remuneration under each payment model will be sufficient, it is expected that good care will be provided and patient satisfaction will be high under all models. A dedicated staff of physicians as well as appropriate external monitoring, coupled with sufficient remuneration would ensure that there are no adverse incentives to providing quality care. Each method is able to provide lengthy appointments, continuity and flexibility of care, acceptable waiting room times, and the ability to address multiple concerns during one appointment.

This conclusion is reinforced through the results of the patient satisfaction survey. As has been shown, patient satisfaction did not change significantly between salary and fee-for-service. Given the assumptions this report has made, it is reasonable to think that levels of patient satisfaction will hold fairly constant between any of the given models.

## **8.2. Analysis of Criterion Outcomes: Incentives for Care of Complicated Patients**

### **8.2.1. Policy Option 1: Enhanced Fee-for-Service**

Enhanced fee-for-service does moderately well at incentivising care for complicated patients. Direct financial incentives are provided through premiums for comprehensive care and performance-based incentives. Enhanced fee-for-service would enable some increase in the length of appointments; however there is still an incentive to move patients quickly through. The extension of possible billable activities, such as phone calls and home visits, certainly improves care plan options available to physicians resulting in greater flexibility of care.

### **8.2.2. Policy Option 2: Capitation**

Capitation does well under the criterion of incentives for care of complicated patients. The success of a capitation clinic is dependent on the loyalty of its patients. To prevent outflow clinic staff have incentives to provide excellent care, which would include care to complicated patients. This includes activities like phone calls, home visits, and chronic disease management. In the presence of regulations which prevent cream-skimming, and with a suitable risk-adjusted capitated payment, there is no financial incentives to refuse care to complex patients. Such a refusal would certainly lead to outflow.

### **8.2.3. Policy Option 3: Salary**

Salary does poorly under the criterion. It does not provide any fiscal incentive to treat patients with complex problems. That said salary can do well given the presence of dedicated clinical staff. As previously mentioned, one of the major concerns of the salary method is that physicians might spend their time inefficiently, and therefore might not leave enough time to see many complicated patients. There are no direct financial incentives for performing activities related to comprehensive care since salary is based on a fixed hourly rate. Care providers are not incentivised to provide lengthy appointments, but neither do they face a disincentive.

### **8.2.4. Policy Option 4: Blended Capitation/Enhanced Fee-for-Service**

Based on key indicators, the blended model does very well under the criterion of incentivising for care of complicated patients. The policy option includes an enhanced fee-for-service element, which directly remunerates physicians for conducting the comprehensive care that complicated patients require. This model also incorporates an incentive to roster complicated patients, provided the capitated formula is appropriately risk-adjusted.

## **8.3. Analysis of Criterion Outcomes: Use of Allied Care Providers**

### **8.3.1. Policy Option 1: Enhanced Fee-for-Service**

Enhanced fee-for-service, as prescribed in policy option 1, does poorly in terms of utilising allied care professionals. The policy option does not provide funding to support the employment of allied care professionals. In addition, the extra remuneration incentives apply to physicians alone. There are no provisions made to allow for allied care professionals to bill activities that are not already found in traditional fee-for-service.

### **8.3.2. Policy Option 2: Capitation**

Capitation does very well in terms of use of allied care professionals. Capitation provides clinics funding for patient care, without regulations constraining the use of allied care professionals. Because capitation clinics can allocate their roster pool of funding freely, the clinic can decide how much it allots to the use of allied care professionals based on the priorities of management and care staff. Arrangements for how that would proceed would be developed internally at each clinic.

### **8.3.3. Policy Option 3: Salary**

A salary system performs poorly in terms of use of allied care providers. While Mid-Main was able to staff a number of allied care professionals while under salary, that was only possible as a result of extra grant funding. Use of allied care professionals required the negotiation of supplemental grants. This is an extremely burdensome process, and would inhibit many salary based clinics from attempting to pursue an allied care model.



#### **8.3.4. Policy Option 4: Blended Capitation/Enhanced Fee-for-Service**

Based on the key indicators, the blended model does very well under this criterion. Since the major component of the model is based on capitation, clinics have the roster pool of funding to draw on in order to fund their use of allied care providers. Whether allied care providers would be able to bill their own work is more complicated. Because the enhanced fee-for-service element extends only to physician activities, allied care providers would not be able to take advantage of this.

### **8.4. Analysis of Criterion Outcomes: Stakeholder Acceptability: Government**

#### **8.4.1. Policy Option 1: Enhanced Fee-for-Service**

Enhanced fee-for-service does moderately well in terms of acceptability to government. Because a robust economic analysis of the various remuneration models does not exist, it is difficult to estimate the impact of alternate funding models on the provincial budget. This policy option receives a poor outcome as a matter of precaution, due to the fact that no costing has been undertaken. There would likely be little in the way of changes to the administration of payments to clinics. Any changes to fee codes and any additional fee codes would need to be negotiated with the Doctors of B.C. and integrated into the fee schedule, but beyond that, payment would be administered in the same way as under traditional fee-for-service.

#### **8.4.2. Policy Options 2 and 4: Capitation and Blended Capitation/Enhanced Fee-for-service**

Capitation does poorly under this criterion. Out of “fear of the unknown”, the provincial government is likely to be sceptical. Because capitation is not widely used as

means of remunerating doctors, implementing it will require many iterations to the capitation formula to reach appropriate remuneration for services required.

The blended model also does poorly under this criterion. This model would suffer the same problems mentioned above. In addition there would be the added complexity of creating and negotiating new fee codes.

### **8.4.3. Policy Option 3: Salary**

This report assumes a poor outcome on this key indicator. A transition to salary would likely involve significant complex monitoring by government of payments to clinics. Government are in general sceptical regarding use of salary as means to remunerate primary care physicians, because it provides weak incentives to care providers to see patients. If not sufficiently committed to the Hippocratic Oath, care providers might spend their time inefficiently, seeing fewer patients than desirable. This concern was in part why the province canceled its alternative payments branch contracts with Mid-Main and other clinics.

## **8.5. Analysis of Criterion Outcome: Stakeholder Acceptability: Medical-Suppliers**

Enhanced fee-for-service does well with regards to medical supplier acceptability because it does not limit pharmaceutical firms' ability to promote pharmaceutical firms' ability to deal directly to physicians. The three other options provide the potential to engage clinical pharmacists. They promote a more critical examination of pharmaceutical firms' promotional activities. Hence, from the perspective of medical suppliers options 2 – 4 are undesirable.

## **8.6. Analysis of Criterion Outcomes: Stakeholder Acceptability: Doctors of B.C.**

### **8.6.1. Policy Option 1: Enhanced Fee-for-Service**

Enhanced fee-for-service will be highly acceptable to the Doctors of B.C. Since it is a variant of the fee-for-service based model, the policy option aligns well with the organisation's investment in this form of remuneration. It maintains the autonomy of doctors. At the same time, enhanced fee-for-service partially deals with the concerns of new doctors in terms of remuneration for skills they developed in medical school, and as a means to deal with financial stress.

### **8.6.2. Policy Option 2: Capitation**

Capitation is moderately acceptable to the Doctors of B.C. Because the organisation is invested in the fee-for-service model and the freedom it affords the physicians under it, capitation will likely receive pushback from many physician members. However, younger doctors in the organisation are more open to this option. Doctors of BC will likely discuss the issue of capitation at its next round of negotiations with the government.

### **8.6.3. Policy Option 3: Salary**

Doctors of B.C. is heavily invested in the fee-for-service model because of the freedom it affords to physicians as independent professionals. Their organisation will likely oppose any suggestion that salary be a significant model of physician remuneration. However, salary does address some of the priorities for new doctors.

#### **8.6.4. Policy Option 4: Blended Capitation/Enhanced Fee-for-Service**

Based on the key indicator, the blended model does well under the criterion of acceptability from the Doctors of B.C. The inclusion of the enhanced fee-for-service element aligns with the organisation's investment in fee-for-service as a means to protect physician autonomy. The capitation element, which does not directly align with the organisation's priorities, does address some of the major concerns raised by new doctors.

### **8.7. Analysis of Criterion Outcomes: New Doctor Outcomes**

#### **8.7.1. Policy Option 1: Enhanced Fee-for-Service**

In terms of the priorities of new doctors, enhanced fee-for-service does poorly. While the model allows physicians to engage in a style of care similar to what was taught to them in medical school, a fee-for-service model means that finding a satisfactory balance between work and other priorities is likely to be difficult. Additionally, the administrative burden increases as fee codes are added and become more complex.

In terms of the second dimension, enabling new physicians to develop skills, enhanced fee-for-service does moderately well. The emphasis on comprehensive care, and performance-based incentives allows physicians to practise patient-centred communication, and provide the in-depth analysis taught in medical school. Furthermore, by incentivising comprehensive care, physicians are rewarded for providing detailed assessments of their patients. Whether enhanced fee-for-service leads to greater mentorship is difficult to say. It depends on whether new doctors continue spending much of their time working as locums. If they do, then mentoring will not be possible. I assume the trend towards staying in the locum pool will continue under enhanced fee-for-service; therefore the policy option does poorly on this indicator. Whether the model allows for

follow-up with patients is also dependent on the locum trend. Based on the previous assumptions, enhanced fee-for-service does poorly on this indicator as well.

### **8.7.2. Policy Option 2 and 4: Capitation and Blended Capitation/Enhanced Fee-for-Service**

In terms of the priorities of new doctors, these options do moderately well. If the assumption at the start of this chapter holds, then capitation does not force care providers to churn through patients at a high rate for long hours, and is therefore more conducive to a healthy work-life balance. As per the discussion raised in the interview analysis, it is likely that capitation will be administratively burdensome. However, since clinics have more direct control over their finances, they can choose to use some of their funding pool to hire an administrator dedicated to dealing with that work to reduce the level of burden on care providers.

In terms of whether the remuneration system allows physicians to develop skills, these options do very well. Physicians have more occasion to focus on patient-centred communication. Furthermore, as already mentioned, individual appointment lengths will probably increase, allowing new doctors to make in-depth assessments of their patients. New doctors would join capitation clinics rather than remain in the locum pool, facilitating an environment where not only would new doctors receive mentorship from more senior physicians, but would also allow them opportunities to follow up with their patients. Again, this only holds true based on the assumption that the capitation agreement is generous.

### **8.7.3. Policy Option 3: Salary**

Salary does well in terms of work-life balance. Because salary is based on a fixed amount per hour, physicians can be reasonably certain about their income in any given period. The administrative burden would be quite low under salary. Physicians would need to input their hours. The rest would be taken care of by the administrative and managerial teams. In terms of the second dimension, salary also does moderately well.

Like capitation, salary does not force physicians to push through patients at a high rate, therefore they can focus on patient centred-communication. Furthermore, as already mentioned, individual appointment lengths will increase allowing new doctors to make in-depth assessments of their patients.

## **Chapter 9.**

### **Recommendation**

Policy option 4, the blended model of remuneration, scores the highest in terms of assessment criteria and is therefore the recommended policy goal for clinics in the medium-term looking to practise a model of care that includes interdisciplinary care teams. This is not to say that it is a perfect option. There are some trade-offs that need to be considered. This policy option performs very well in terms of patient satisfaction, incentives for care of complicated patients, use of allied care, acceptability with the Doctors of B.C., and the professional development of new doctors. However, this policy only performs moderately well in terms of the priorities of new doctors. Furthermore, this policy option performs poorly in terms of its acceptability with government and medical suppliers. This is not the whole story when it comes to trade-offs. When examined against the other policy options we see that it is equally as good at achieving patient satisfaction as the other three models. However it out performs all the other models, other than capitation, in terms of its ability to incentivise the care of complicated patients. On the issue of use of allied care it is superior to enhanced fee-for-service and salary, but equal to capitation in performing very well. It also outperforms all options, with exception to capitation, in terms of the professional development of new doctors. The only criteria where it is beaten by any of the other policy options are acceptability with government and medical suppliers. However, because the stakeholder criteria are not as important as criteria focused directly on the patient or on new doctors this is a relatively minor negative trade-off for the blended model to concede.

## **Chapter 10.**

### **Caveats and Conclusion**

Despite the recommendation made in the previous section it is important to mention three important caveats to this report. The first is that no size fits all. The recommendation above is a general one that clinics, including Mid-Main, should push towards in the medium-term if they are interested in interdisciplinary care models. However, analysis of feasibility at the level of individual clinics is important to conduct. Geographic, or demographic considerations might make a model with capitation at its base untenable if outflow cannot be appropriately countered. Some clinics might not have the administrative capacity to deal with the complexity of dealing with both the billing structure of enhanced fee-for-service and capitation. For these reasons, and others, the blended model might not be suitable.

Since we cannot assume that one size fits all in terms of remuneration for clinics, it is important to remember that experimentation is key. The province and the Doctors of B.C. need to work with clinics to innovate new models of remuneration which may be superior to the recommended model in certain, or even all, situations.

Second, the recommended blended model does nothing to ease the regulatory restrictions placed on the billing capacity of allied care providers. Before the full potential of allied care providers can be realised, a regulatory overhaul must take place to allow them to bill the wide range of activities they perform for themselves. This will not only acknowledge the important place they have within the healthcare system, but also free up physicians from having to bill on behalf of their allied healthcare colleagues.

Third, it is essential that a robust analysis of the cost impacts of various remuneration models, not limited to the ones present in this report, takes place. Discussions regarding remuneration reform are hobbled by not having adequate data in order to determine the effects they might have on the provincial budget.



To conclude, much can be gained through the use of a blended model based on capitation and enhanced fee-for-service. The two models synergise well together dealing with each other's deficiencies while enhancing each other's strengths.



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## Appendix A.

### Patient Satisfaction Survey for Mid-Main Community Health Centre – 2016

	
<b>Patient Satisfaction Survey</b>	
	SCHOOL OF PUBLIC POLICY
<p><i>Mid-Main Community Health Centre is interested to know what patients think about their visits to the clinic. We are doing this survey in conjunction with Dan Ramroop, a student at Simon Fraser University. We are inviting you to take a moment and complete the survey. Your answers are confidential and anonymous. Data will be used to improve service at the clinic, and in a Master's thesis report. Whether you participate or not will not affect the service you receive. Thank you for your interest.</i></p> <p><i>If you have any inquiries about the survey, please contact Irene Clarence, executive director (at <a href="mailto:midmain.info@gmail.com">midmain.info@gmail.com</a>), or Dan Ramroop (at [...]). You may also contact Professor John Richards (Board Member at Mid-Main Community Health Centre) at [...]. If you have any concerns, you may contact the SFU Office of Research Ethics at [...].</i></p>	
<b>Today's Date:</b>	<b>Your Age:</b>
<b>Female</b> __	<b>Sex: Male</b> __
1. How would you rate your satisfaction with getting through to the office by phone? Excellent __    Very Good __    Good __    Fair __    Poor __	
2. How would you rate your satisfaction with the length of time between your call and your appointment? Excellent __    Very Good __    Good __    Fair __    Poor __	
3. How would you rate your satisfaction with the length of time you waited at the office before seeing the clinician or team member? Excellent __    Very Good __    Good __    Fair __    Poor __	
4. Did you see the clinician, or team member, that you wanted to see today? Yes__    No__    Did not matter who I saw today __	
5. Please indicate who you saw: Usual Doctor __    Other Doctor __    Clinical Pharmacist __    Nurse Practitioner __	
6. Please indicate the name of who you saw today: _____	
7. How would you rate your satisfaction with the personal manner of the person you saw today (courtesy, respect, sensitivity, friendliness)?	

Excellent __	Very Good __	Good __	Fair __	Poor __				
8. How would you rate the amount of time you spent with the team member you saw today?								
More than Enough __					Enough __	Neutral __	Not Enough __	Far From Enough __
9. Comments								

## **Appendix B.**

### **Semi-Structured Interview Panel**

#### **Sample Interview Schedule:**

#### **Questions for Mid-Main staff**

1. Tell me a bit about the history of Mid-Main from your perspective. Why do you choose to work at Mid-Main?
2. In 2014 Coastal Health canceled your block grant and required that you rely on fee-for-service to finance medical services. What have been problems due to the switch from salary to fee-for-service? What have been advantages?

#### **Questions for senior managers or physicians**

What are your general opinions on the three basic payment methods for the provincial government to finance primary health care: salaries for doctors and other medical staff based on a block grant, fee-for-service, capitation (compensate care providers based on the number of patients)?

- a. Benefits, drawbacks if applied in BC
- b. Applicability to medical practices of different sizes
3. Is a hybrid system viable?
4. (If speaking to medical staff) What system does your facility use?
  - a. Do you feel like it impacts your job satisfaction? If so in what ways?
  - b. Do you feel like it impacts patient care? If so in what ways?
5. In your opinion what is the most cost-effective method? Why?
6. In your opinion what payment method leads to the greatest satisfaction for staff and patients?