The Introduction of APPs in Alberta

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In 1995, the Government of Alberta signed a Letter of Understanding with the Alberta Medical Association. As part of the agreement, the Government and the Association gave formal recognition to a new method for reimbursing physicians in the province. In this case, we examine why Alberta chose in 1995 to introduce an Alternative Payment Plan (APP) for reimbursing physicians based on a plurality of potential funding models, governed by common guiding principles. The choice has facilitated a gradual movement towards shifting physicians from fee-for-service to other methods of reimbursement for services.

The case study is one of six developed in Alberta as part of a cross-provincial study on the determinants of health reform in Canada. These cases collectively cover four policy categories: setting out governance and accountability arrangements, establishing financing arrangements, making program delivery arrangements, and defining program content[1]. The introduction of Alternative Payment Plans (APPs) is an example of the second category, where the policy issue relates to changes in how health care is financed.

Pertinent documents and public records (e.g., media, Hansard) were reviewed to establish the background for the case study. These information sources were complemented by 21 semi-structured interviews with key informants. The data were analyzed using a coding framework developed from the public policy literature that focused on key institutional, idea, and interest group concepts, as well as important

external events that may have impacted on or shaped the policy making process. After providing an historical overview of events, we will then examine the case in greater detail within the context of the conceptual framework.

Historical Overview

Alberta's decision to introduce alternative methods of reimbursing physicians was the result of a variety of factors, including: several years of contract negotiations with the AMA which occurred in the shadow of a change in provincial political leadership and the subsequent introduction of significant reforms to the health system tied to a conservative fiscal agenda. As part of an overall health reform strategy, the Government of Alberta has been interested in reforming the way in which physicians are reimbursed. In 1998, Alberta established an Alternate Payment Plan based on a plurality of potential funding models, governed by common guiding principles.

Fiscal Crisis

As a result of a downturn in the price of oil and gas during the early 1980s, punctuated by growing deficit spending by the provincial government and mounting debt, Alberta experienced an economic downturn during the mid-late 1980s. Concern about expenditure issues began to surface in 1989 when The Premier's Commission on the Future of Health Care for Albertans[2] sounded the warning bell on the implications of increasing expenditures in health care:

> "The 1989/90 estimate for Alberta Health is $2.982 billion. Provincial revenue from personal income tax is estimated to be $2.326 billion and from corporate income tax, $0.650 billion, for a total of $2.976 billion. Thus, if all revenues from personal and corporate tax in Alberta went to health, we would incur a $6 million deficit. *Every dollar provided by Albertans through taxes, personal and corporate, would not be enough to cover our annual health budget.*"[3] [Commission emphasis]

By mid-1992, the Minister of Health was busy delivering the fiscal message that became a hallmark of the Government after the 1993 election:

"expenditures since 1981 to the present fiscal have increased by 178 per cent [15 per cent/annum] although population and prices during the same 12 year period increased by 17 per cent and 66 per cent respectively…To meet the historical expenditures of the social sector and balance the budget on the current revenue base, virtually all of the remaining government departments would have to be closed. "[4]

As the Government moved closer to a provincial election in 1993, substantial focus was placed on a mounting provincial debt of $ 32 billion that had accumulated during the 1980s, because of deficit budgeting, in part, directed towards economic diversification. Getty's term as Premier had been punctuated by the collapse of a number of major firms, such as the Principal Group, that had developed as a result of government largesse. The Government had also accumulated financial losses from the support of Novatel, a failed attempt to enter the cellular telephone manufacturing industry. In addition, the Getty Government faced a major plunge in oil revenues. Although the government responded by cutting expenditures and raising taxes, it remained unable to overcome the mounting financial problems. The net result was a loss of confidence in the strong state presence in the marketplace initiated by Lougheed.[5]

In addition to these internal problems, the provincial Progressive Conservatives faced a significant challenge from the federal Reform Party. With a platform of fiscal austerity and smaller government, and its political base in Alberta, the Reform Party was a threat to move into the provincial political arena, if the Progressive Conservatives did not fill the political vacuum. This set the stage for the emergence of a political agenda of radical expenditure reduction. Not surprisingly, provincial conservative political strategists perceived that failure to address this issue could have serious electoral consequences.

The emerging political agenda was further solidified with the resignation of Premier Don Getty as the leader of the Conservative party and his subsequent replacement by Ralph Klein in the fall of 1992. The win by Klein signalled a shift in power as the more moderate and affluent wing of the party was swept aside by the more radical right-wing constituency.

Following the shift in party leadership, Government embarked on an extensive public consultation process, dubbed provincial Round Tables. These Round Tables were well planned exercises, arguably designed to convince Albertans of the new political agenda prior to calling a provincial election.[6] The process itself was a masterpiece in public relations and a tribute to the tradition of limited democracy in Alberta. The first in the series of Roundtables on the provincial budget was held in the Spring of 1993. The object of the exercise was to convince Albertans that there was simply no alternative but to cut costs quickly, or put the security of future generations of Albertans in jeopardy. [7]

As part of its election strategy in 1993 the Government passed the Deficit Elimination Act in the Spring Session of the Legislature. The Act required Government to eliminate the deficit within the next electoral mandate. Armed with this legislation and public confirmation of its political agenda through the Roundtables, Government called a provincial election and won a majority of seats in the provincial legislature. What is noteworthy about the election is that the Conservative's percentage of the popular vote was only marginally higher than that of the provincial Liberals, the Official Opposition. Both parties had run a political campaign centred on fiscal austerity.

Following closely on the heels of the election, Government initiated the second series of Roundtables in August-September of 1993; this time on health care. Again, the Roundtables

were well crafted exercises in public relations. When Government released its report about the Roundtables on Health Care, the conclusions were consistent with the larger political agenda.[8]

Government-Physician Relations

Traditionally, the Government of Alberta and the Alberta Medical Association have been ideologically aligned on major issues affecting the practice of medicine. Alberta resisted entry into national Medicare during the early 1960s and also sought to protect the rights of physicians to extra-bill during the debate surrounding the introduction of the Canada Health Act. Although this has been the case, the AMA only received official recognition as the sole representative of physicians in the province in 2003. Prior to this, the role of the AMA as primary representative of the collective interests of physicians in Alberta was an informal convention that existed on a contract-by-contract basis.

Within this conventional role, the AMA has negotiated a multi-year, collective (Master) agreement encompassing the reimbursement of physicians and since the introduction of capped budgets has determined the distribution of the funding within the collective agreement across medical specialties. The 1986 master agreement contained provisions for bilateral consultation on matters relating to capped budgets.

A cap on the overall physician budget was achieved through negotiations leading to a seven-year agreement beginning in April 1992. The agreement, which included a 5.5 per cent increase at 85% of the previous year CPI (year one of the agreement), marked the first time that the government had placed any limits (a hard cap) on the overall physician budget. Under the agreement, individual physicians earning above a set dollar limit could have their income reduced during the next quarter. In essence, if doctors

billed more than a quarter of the total amount in any three month period, a joint management committee (AMA and AHW) could roll back fees in the following quarter to recover the over-expenditure. The joint management structure was also designed to allow physicians to have significant input into decisions affecting the health system.[910]

However, with the arrival of Ralph Klein as the new leader of the Progressive Conservatives and provincial Premier in the fall of that year, physicians would soon find themselves faced with a much more significant budget challenge. With increased government concerns about overall public expenditures during the early 1990s, particularly after the election of Ralph Klein, the AMA would be pressured to accept significant expenditure reductions.

In June 1993, the President of the AMA wrote to members warning of impending pay cuts:

> In the provincial budget released just before the election, the Alberta Government called for cutting $127 million this year in health expenditures from the 1992-93 forecast of $4.08 billion. If the current administration is re-elected, then a June 28th round table is scheduled where the health players will advise on how this could be achieved…Already there are indications that the medical profession will be targeted. For example, some hospital administrators have been pointing to the 5.5% increase in physician expenditures for 1992-93, the 1.79% added to the schedule April 1, 1993 and the monies for utilization and new items scheduled for 1993-94. They are postulating that physicians should absorb a greater portion in cuts than the 22% which AHCIP physician payments account for in the health budget…Of more immediate concern is the level of utilization for 1993-94. Preliminary statistics for the first three months (April, May and June) suggest that fees will have to be reduced mid-year in order for the profession to stay within the global budget.[11]

MacNichol mentioned a potential cut of 25% in media interviews. For the average physician, this meant a reduction from $195,009 to $146,250 ($48,750).[12]

After the election of the new Klein government in June of 1993, the political executive moved quickly to begin implementation of its fiscal austerity agenda. In the

case of physicians, the government called for a 5% roll-back of salaries for physicians and other health care workers with a November response deadline. In November, the AMA responded indicating a willingness to take a pay cut, but only within the context of negotiations for a greater say in health reforms. In the ensuing negotiations, the AMA agreed to a 6.8% rollback during 1994/95, including a recognition that an additional 10% reduction found in the Alberta Health business plan would be required. In total, $200 million was to be slashed from the physician services budget in the following two-year period. Included in the agreement was a plan to consolidate private lab services to save $56 million, de-insure $5 million in services annually and place a temporary limit on the number of new doctors who could establish practices in the province. What the AMA did not achieve was recognition as the sole representative of physicians in the province or physician representation on regional health boards.[13] In a follow-up vote in June of 1994, 56% of members ratified the deal.

In January of 1995, negotiations between the two parties began again. The objective of the negotiations was to find $100 million in savings from the physician services budget. During the negotiation, the AMA proposed the introduction of a managed care model, Fee-for-Comprehensive Care, as an alternative method of payment to fee-for-service. The proposed model was to be optional and would involve either individual physicians or groups of physicians who would "be prepaid a set amount to provide a defined set of primary care services to a defined population for a defined period of time."[14] While preliminary consensus was reached on the Fee-for-Comprehensive Care proposal, the idea was subsequently rejected by Alberta Health. In light of the continued government insistence on an additional $100 million in savings from the physician

budget, the AMA abandoned negotiations.[15] From the point-of-view of the AMA, physicians were being asked to accept a total reduction of 40 percent of their net income over a three year period.[16]

In the wake of the failed negotiations, the AMA launched a public relations campaign "Tell Us Where It Hurts", to solicit input from Albertans on their perceptions of the impacts that government budget cuts were having on patient care. Among the results reported: 89 per cent of respondents believed that it was "appropriate or very appropriate for physicians to speak up about health care cuts that affect the quality of care"; 74 per cent were "concerned about budget cuts in health care," and 60 per cent believed that "budget cuts in health care in Alberta had gone too far." [17,18] With a spring election in the offing, the government was forced to respond by returning to the bargaining table with a more conciliatory approach.

In mid-December of 1995, a tentative, three-year (letter of) agreement was reached between the two parties. The new agreement called for $168 million in cuts with a five per cent pay reduction ($45 million), $ 5 million in savings from de-insurance and $50 million from lab restructuring. The original cut of $100 million to come from the physician budget was dropped. Included in the agreement was a recommendation to establish a "Tripartite" policy committee comprising membership from Alberta Health, the AMA and RHAs to oversee the development of "managed care proposals," including a framework for structuring joint ventures and partnerships. These joint ventures were expected to achieve $50 million in savings annually. Several initiatives relating to drug funding, utilization and management were expected to save an additional $50 million per year. Any amounts in excess of these combined savings would be re-distributed equally

to the AMA, government, health regions and pharmacists. In addition, a "Fee-for Comprehensive Care (FFC) option [would] be established by April 1996 to provide physicians with a population based alternative payment option for primary care services."[19] The principles underlying the new reimbursement option included:

- Movement toward population funding of primary care services
- Patients should continue to have the right to choose their primary care physician. Albertans should be encouraged to establish a mature relationship with a single primary care physician.
- Primary care physicians should have the option to be reimbursed on a FFS basis or to enter other methods of payment as they are developed. [20]

By September of 1996, a committee structure involving politicians, and representatives from Alberta Health, the AMA and the health regions was in place. One of the first activities of the new working committee was to file a Request for Proposals for APPs. From this process, several applications were funded on a pilot basis.

While the Tripartite process was underway, the AMA and Alberta Health entered into a new round of negotiations. Signed in 1998, the resulting Master Agreement embedded APP as a recognized funding stream within the overall physician budget. Where the 1995 agreement provided one-time pilot funding for APPs; the 1998 agreement made APP funding a regular line item in the physician services budget.

The general principles of population-based funding and fee-for-service as a right have been maintained in subsequent agreements. From this initial formal basis of agreement, the province and the medical association have negotiated on an expanding range of related issues including a relative value guide and general primary care reform. Structure and process related to APPs have also been further elaborated (discussed further below).

Role of Institutions

Master Agreement

In general, since the late-1980s, Master Agreements have been negotiated as multi-year arrangements of increasing length. For example, the 1989 agreement was for three years; the 1992 agreement was negotiated for seven years with periodic negotiations around certain aspects; the 1998 agreement was for five years; and the 2003 agreement is for eight years with periodic negotiations on certain aspects. From the early 1990s, both parties became increasingly focused on joint management of the physician services budget and health care delivery issues. This relates to the governments interest in managing within fixed budgets and the AMAs interest in securing a more formalized role in decision making about the health care system. Both of these issues became increasingly acute during the early 1990s as a result of expenditure cutbacks.[21] As discussed below (Policy Choice) the 1998 Master Agreement became the vehicle through which APPs were institutionalized in Alberta.

A pattern that also emerged after 1995 was the creation of separate pots of discretionary money to fund "innovation." Starting with the Tripartite initiative, the Medical Services Budget Innovation Fund (MSBIF) in 1998 funded projects that enhanced the delivery of insured services or improved patient access. Following this was a master agreement re-opener in 2001, Medical Services Development Innovation Fund (MSDIF), to ease transition to alternative funding models. Finally, the Local Primary Care Initiative in 2004 allowed for the development of local primary care physician networks in partnership with RHAs (see Attachment 2). With the exception of the 1995 arrangement, all of these subsequent initiatives have been over and above existing fee-for-service or APP arrangements.

Tripartite

Prior to Tripartite, there were a number of alternative payment arrangements that had been negotiated over time. Often these arrangements were tied to efforts by hospitals to attract specialists and were buried in the details of hospital budgets.[22] More to the point, they were negotiated through the acute care services branch and were not connected to negotiations between the department and the AMA over physician services. Thus, neither the department nor the AMA representatives involved in negotiating the physician services budget were aware of the details of these arrangements during negotiations:

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In 1996, a Tripartite Senior Committee was struck to oversee the management of joint ventures including APPs.[23] Membership on this committee included the Minister of Health and two other Government MLAs, the President and Past-President of the AMA and the several board chairs from health regions.[24] To assist in this task, a Tripartite Working Committee was established in September 1996. This committee comprised representatives from Alberta Health, the AMA and health regions. While APP was one major focus, the committee was also concerned with re-establishing relationships between local physicians and RHAs.

The first task of the Working Committee was to issue a Request for Proposals (RFP) for APPs. Of the ninety Letters of Intent received, nineteen were asked to submit full proposals. From this, five full proposals were selected in 1997, although in a number of cases it took several years to finalize agreements (see Appendix 1)

With a committee of six with equal representation from Alberta Health and the medical association, achieving consensus was often very difficult:

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Interestingly, the term APP, which was associated with Tripartite, is no longer used. It has been replaced by the term Alternative Relationship Plans, giving it a distinctive Alberta identity. Although Tripartite proved to be a challenging process, the movement towards joint decision making allowed all parties to continue talking and struggling with issues.

Given the large number of applications received through the original RFP, the committee realized that it faced significant logistical issues. If a large number of pilots were funded, significant resources would be required to monitor the progress of all the projects. Thus, a decision was made to fund a small number of projects on a pilot basis. At a more fundamental level (revealed somewhat later) the AMA feared that to proceed otherwise, as suggested by some academics, risked destroying the health care system:

> Dr. Birch also favours a learn-as-you-go approach as opposed to pilot projects which… "might influence patterns of behavior of those being studied."
>
> The learn-as-you-go approach, however, is essentially a wholesale change to the system and can be very damaging. It assumes there is a great deal of knowledge about risks and outcomes, and expresses little concern for what could go wrong. Inherent in the approach is the assumption that any mistakes would be minor.
>
> Pilot projects are more easily evaluated because of their finite nature and because they are confined to a defined group. Pilot projects also allow for a number of options to co-exist and perhaps be evaluated comparatively. By their nature, they have more safeguards and allowances for evaluation and fine tuning.

Although, the structures and processes stemming from Tripartite proved dysfunctional, the 1995 Letter of Agreement raised APPs as a legitimate issue for discussion and placed it on the decision agenda for both government and the AMA.

Alberta Health

As discussed above, the Department was in a state of significant flux during most of the 1990s. The capacity of the health department was significantly reduced during the 1990s through expenditure reductions, external health system restructuring, rolling internal departmental restructuring and constantly shifting departmental leadership. As a line department, Alberta Health was still in its infancy when health reforms were announced in 1993. The department was created in 1988 through the amalgamation of the former Hospitals and Medical Care Department with the Community and Occupational Health Department. Between the date of its creation and the onset of health reforms in the early 1990s, the department was engaged internally, in sorting out the issues of amalgamating the department and getting the policies together on how it would work.

However, just as the department was starting to get on its feet, the launch of health reforms in 1993 had a major impact on its policy capacity. First, the culture of decision making in government changed. Where Alberta Health had led policy development under the previous regime, it was now relegated to the role of policy secretariat, in support of policy committees driven by government MLAs. This transformation came about as a result of a back-bench revolt in reaction to the policy activities of the previous Minister of Health in relationship to regionalization in health care and a general sense that bureaucrats needed to be reined in. In general, under the Klein government, there was a distrust of bureaucrats and other knowledge workers.[25]

Second, the devolution of responsibility for service delivery to health regions and the subsequent significant reduction or elimination of staffing in many program areas[1] left the Ministry with little capacity or expertise about the day-to-day workings of the health system. Between 1994 and 2004 a total of eight Deputy Ministers were rotated through the department. Several reorganizations of the department also ensued. Observers concluded that after such tumult, here was little policy capacity left inside the department anyway.

Further complicating the capacity issue was the tendency within the department to "stove pipe" issues. Of relevance to APP was the lack of coordination during the 1990s between those areas of the department developing policy around primary health care and those areas dealing specifically with APP and physician services.

Specific to negotiations between the department and the AMA, the high turnover in staff placed the department at a distinct disadvantage. Of the fifteen committees related to physician compensation, there always appeared to be new faces from Alberta Health appearing at the meetings. The Tripartite process suffered from a similar lack of continuity. Alberta Health managers were rotated in and out of Tripartite on a fairly frequent basis. Increasingly, the file became viewed as a bit of a hot potato.

As the Master Agreement evolved beyond talking about APPs in isolation of other issues, the department began to organize in an attempt to overcome the traditional stove-piping. In particular, since 2003, there has been a greater effort to minimize the historical stove-piping through the creation of an Alternative Relationship Branch, under which the various payment and related funding options are managed. The process has also moved from a one-off approach to more of a standardized approach.

[1] For a discussion of this see Church and Noseworthy, 1999, 192.

Regional Health Authorities:

The arrival of RHAs created the opportunities to explore new relationships and methods of paying physicians. Given that the government was not clear on where it wanted to go with primary (health) care reform, or other aspects of health reform for that matter, the regions as they have evolved have come to drive policy development. While steps towards APPs likely would have occurred without regions, they would have taken a very different form.

FPT Relations

In December 1989, the Federal/Provincial/Territorial (FPT) Deputy Ministers Conference launched a process to develop a national strategy to reform the health system. As part of this process, three reports were generated that would become crucial to shaping discussions about physician resources generally and physician reimbursement specifically. The Barer-Stoddart Report (1991)[26] sounded the alarm on FFS as inefficient, recommending that capitation or a mixed payment method be implemented to replace it. The Birch Report (1994)[27] suggested a system-level shift toward a population-based method of reimbursement (capitation), with explicit criteria for assessing performance and based on the shared objectives affected stakeholders. The Kilshaw Report (1994)[28] recommended establishing a capitation funding plan for primary care organizations, established through RHAs, physicians, other providers community organizations or universities. The report also suggested that there were an excess number of physicians practicing in Canada. The College of Family Physicians of Canada responded with a Green Paper[29] calling for the maintenance of a single-payer, patient-centred system, with a blended method of payment tested through pilot projects.

In January 1997, the Provincial/Territorial Ministers of Health released a shared-vision document.[30] One of the key areas of concern in the document was the federal funding commitment to health care and the sustainability of the system. In response to this concern and a National Forum on Health recommendation, the federal government announced a Health Transition Fund (HTF) in the fall of 1997. The federal government agreed to provide $150 Million of one-time funding to support testing and evaluating innovative ways of delivering health services in home care, pharmacare, primary health care and integrated delivery of services:

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Of the total, $120 million was allocated to fund provincial initiatives in one of the four theme areas. Alberta chose to spend the $11 million it received to fund pilot projects in primary health care reform:

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Within this context, Alberta funded 27 projects including: system restructuring; system utilization; multi-sector collaboration; illness/injury prevention, health promotion, and wellness; community health centre models; building capacity for healthy communities; multidisciplinary teams; and information technology. A number of these projects involved paying providers through alternative payment mechanisms. In some cases, the projects enhanced existing Tripartite APP arrangements by funding partnerships with health regions or other infrastructure issues. The HTF money acted as a catalyst for provincial and regional initiatives.

This initial foray into primary health care by the federal government was further reinforced through an $800 million federal initiative, the Primary Health Care Initiative, announced in September 2000. The fund was designed to support the provinces and territories in their efforts to develop and implement new initiatives in primary health care and address overarching national or cross-jurisdictional primary health care issues. Alberta received an additional $100 million.

Other Funding Initiatives

In 1999, Alberta Health announced a Health Innovation Fund with a total of $32 million committed to projects over the 2000-2004 period. The intention was to encourage regional health authorities and other health care providers to partner to develop innovation in health care delivery. A total of 48 projects were funded.

Policy Legacies Affecting APP

Prior to the introduction of a hard cap on the overall physician services budget, the contract between the government and the profession was virtually open-ended with the government being obligated to provide a billing number to any qualified physician in the province. Even after the introduction of a hard cap, the contract still remained virtually open-ended at the level of the individual physician. In other words, there were no specific requirements about the range and mix of services to be provided by individual physicians. Moving to fixed budgets for physician services had an important impact on framing subsequent policy possibilities. Under a fixed cap, increased use of APPs can result in redistribution of resources among physicians. One of the attractive aspects of the

Fee for Comprehensive Care model introduced in 1995 was the possibility of redistribution of resources among physicians (discussed further below).

Another policy legacy impacting on APP was the existing tax structure that gave physicians tax advantages as corporations under the FFS model that would no longer apply if they became salaried employees.

Policy Legacies Affecting PHC Reform

What is possible for general primary (health) care reform was impacted by the wording of the Master Agreement. For example, FFS rules require that physicians have direct contact with patients if they are to bill for services rendered; other providers, such as nurse practitioners, could not be the sole patient contact. Thus, developing primary care teams could only occur through physician practices with direct physician contact. In turn, the existing framework around legal liability maintained physician responsibility for all care rendered to patients, whether directly provided by them or not. One of the rationales for the reform of scopes of practice through the Health Professions Act (1999) was to remove non-financial barriers to the use of inter-professional teams:

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Indeed, policy changes have now made it possible for other primary care practitioners such as nurse practitioners to get their own liability insurance.

The Role of Interests

Politicians

The arrival of the new political regime under the leadership of Ralph Klein was punctuated by a shift in policy style. Where the previous government had moved cautiously to implement policy change in health care, due to negative reaction especially

from rural constituencies, the new government forged a consensus around the necessity of significant change to eliminate a growing deficit and debt. In this policy environment, the luxury of being able to arrive at a stalemate in medical negotiations ended. Alberta Health received clear instructions from Treasury Board to cut physician costs by 20 per cent in three years. Although politicians were committed to this larger objective, they were less certain about specific policy solutions.

When it came to shifting method of payment to capitation, the related requirement of patient rostering did not sit well with politicians:

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Thus at the time (1994/95), while the idea of capitation was on the negotiating table, there wasn't the political will on the government side to move forward.[31] Alberta Health had put capitation on the table, but the politicians didn't buy into the idea.(P46)Prior to this, while there had been some interest in physician payment mechanisms from within the bureaucracy, the political focus had been on acute care and long-term care reform.[32]This focus may have reflected the narrower mandate of the previous department of hospital services that drove health policy until the late 1980s.

Bureaucrats

As mentioned above, APP/PHC was brought to the attention of government during the early 1990s from within the bureaucracy. The necessity of expenditure cuts created an environment in which APP as a policy option became more acceptable to the AMA. In fact, Alberta Health and the AMA arrived at agreement in principle in 1995 on a new Master Agreement that would have introduced capitation as a payment option. However when it was sent to the political executive for approval, the idea was rejected

for reasons of political feasibility.[33] Subsequent to this, the ADM, who had been responsible for negotiations since 1989, was fired. What became clear in the aftermath was that the ADM and a newly-hired DM (Jane Fulton) had a fundamental disagreement on how to deal with physicians.[34] In the following year, the AMA noted that the Deputy Minister had stated publicly:

> Costs are skyrocketing because of infatuation with costly, still unproven, high technology programs and an overindulgence on expensive institutional care…That can change, she argued, by ending fee-for-service, imposing user fees, using nurse practitioners instead of doctors, evaluating new and old medical procedures and ways of delivering care including a push toward private care and two-tiered medicine, putting more checks on decision making by physicians…[35]

As mention above under "Institutions" Alberta Health also had a significant capacity issue. When it came to dealing with the AMA, which had greater continuity and preparation for negotiations, the Department was at a distinct disadvantage. As health reforms unfolded and staff turnover in the Department became noticeable, cynicism and apathy increasingly defined the organizational culture. In the case of APP, moving from a strictly FFS system to APP required building relationships of trust and doing a lot of foundational work. The removal of the ADM, who had held the position since 1989, and had brought APP to the negotiating table, left bureaucrats and the AMA with the impression that there was not a commitment to doing this kind of work. Politicians were only interested in quick and easy results.

Also a key concern for bureaucrats was recognition of the political sensitivities around physicians and primary care. Given that access to the health care system had been perceived by the public as being compromised by health reforms, tinkering with the first point of access to the system was a risky business.[36] Clearly, keeping physicians on-side

was a primary consideration for politicians, although the political homogeneity of the province ultimately gave government the upper hand.

Regional Health Authorities

In general, RHAs were interested in APPs because of the competition for scarce resources, such as rural physicians. Thus, they tended to watch each other closely for the impact of new physician initiatives. Since they were in competition with each other for doctors and nurses, coming to the table and speaking with one collective voice was a challenge. Where the province may seek some sort of consistency in service delivery through initiatives, the regions may use the initiatives to attract physicians from other regions.

Given that regionalization involved a process of rapid implementation, at the time that APPs were first put on the table in 1994, RHAs were entirely focused on local implementation and would remain so for several years. Although they were invited to the table through the Tripartite process, they acted more as observers than participants. In fact, RHAs were only brought in as full signing partners at the end of the Trilateral negotiation process in 2003.

RHAs have been strong champions of health reform and primary (health) care reform when appropriate conditions are present. Local culture, individual leadership (and the extent of physician interest have been important influences on regional decision makers. How APP funding can be used to address other issues, such as keeping a hospital open, has also played an important role. The periodic infusion of new, targeted money (HTF, HIF, PHCI) has given additional impetus to primary (health) care reform.

Alberta Medical Association

In contrast to the organizational turmoil experienced by Alberta Health bureaucrats, the AMA was a well-organized and relatively stable organization that was responsive to its membership. When it came to negotiations with government, the AMA always came well prepared, having consulted both the existing body of academic evidence and policy learning from other associations across the country. Thus, for all intents and purposes, the AMA drove negotiations around the Master Agreement, especially during the 1990s. Although it has developed a cooperative stance in negotiations with government since the early 1990s, the AMA has argued consistently for physician-led (centred) primary care reform through a variety of reimbursement options. The maintenance of FFS as a reimbursement option and physician choice have continued to be priorities.

A number of issues relative to these negotiations emerged in the early 1990s. Although through convention, the AMA played the role of bargaining agent for its members, the role was not legislated and was thus subject to being reaffirmed at the beginning of each negotiation. With the advent of health reforms, this role was potentially threatened both from within the ranks of the profession and from other political actors. For example, in the wake of the negotiated fee cap in 1992, the Calgary-based Multidisciplinary Association of Medicine challenged in Court of Queen's Bench the right of the AMA to negotiate an agreement with government that was binding on all Alberta physicians.[37]As previously discussed, by the early 1990s there were a number of APP arrangements in place of which the AMA had little or no knowledge.

In additional to the F/P/T policy discourse, other external forces also threatened to disrupt the traditional role of the profession:

> Others, notably some health economists and nurses, are pursuing their own agendas. For them, eliminating *Fee For Service* is only one step in changing the role and contribution of physicians. The Alberta Association of Registered Nurses continues to press for all physicians to be paid salary and has lobbied the regional health authorities to implement nurse-directed primary care models.[38]

A second issue was the role that the new RHAs might play. At the time that regionalization was being developed, some discussion occurred around the devolution of the physician budget to the new regions.[39] While in the end government did not choose this option, at the time, the possibility posed a serious threat to the continuing central role of the AMA. In general, the rapid change in government's policy approach to health reform had left the AMA and its membership increasingly marginalized. This became evident in the unilateral decision to reduce funding for medical schools.

The link between local physicians and RHA had not been clearly thought through when regionalization was implemented. The local link that had existed between physicians and local hospitals had been effectively broken by health reforms.[40] Regionalization forced physicians to think about accountability.

A third issue related to the growth of walk-in-clinics/Medicentres and the negative impact on physicians in family practice and emergency rooms. Less complex cases provided relief from more intensive cases and also were more clearly remunerated than more complex cases. In a more general sense, the profession was concerned that continuity and quality of care was not maintained through walk-in clinics. Both the profession and government were concerned that costs were being doubled through walk-in clinics- follow-up with regular family physician.

A fourth issue related to the perception that an increasing number of doctors were "churning" or pushing patients through to maximize income (linked to walk-in clinics).Alberta Health shared this concern. The AMA was also hearing increasingly from its members about lifestyle issues related to the demands of FFS practice.

For these various reasons, but in particular because of government's new policy style, the AMA felt the need to be proactive around health reforms and to have a recognized place at the decision-making table:

> The Alberta Government's goal of 17.6% reduction in health care expenditures by 1996-97 necessitates innovation if patients are to have access to continued quality care…These fiscal imperatives have been compounded by the immense restructuring occurring simultaneously. Just as the 17 regional health authorities (RHAs) must define their future, so must physicians.[41]

Given this recognition, the AMA Board of Directors instructed the AMA Negotiating Committee to present an APP option, Fee for Comprehensive Care (discussed further below).

The Role of Ideas

Method of Payment

As discussed above, APPs existed on an ad hoc basis prior to becoming an issue for formal discussion between Alberta Health and the AMA. Within this earlier context, the idea of primary care reform was associated with changing method of payment for physicians. However, during the early to mid 1990s, primary care reform was not really a government priority. Acute and long-term care reform were the focus of restructuring efforts. The fiscal imperative driving cuts to the physician services budget pushed APPs onto the decision agenda.

In the general policy discourse, fee-for-service as a method of payment for medical services was seen as encouraging undesirable behavior including: volume-driven care or "churning" rather than service provided based on need ; lack of focus on promotion and prevention or chronic disease management; and a lack of fairness in the distribution of financial resources across medical specialties (relative value). For these reasons, the long-term viability of FFS as a sole method of payment was in doubt.

As discussed above (Institutions), the focus on changing method of payment was reinforced in the academic community by a focus on the viability of other methods of physician reimbursement.[42] During the early 1990s, switching method of payment as a means of saving the system money became an idea in good currency. This fit well with the search for policy instruments in health care to address the larger fiscal agenda. This also fit with the prevailing academic orthodoxy:[43]

> Governments across Canada have endorsed Stephen Birch's 1994 report, *"Paying the Piper and Calling the Tune; Principles for Reforming Physician Payment Methods in Canada."* It calls for dramatic and immediate overhaul of physician payment systems.[44]

A second and more general theme that resonated more within the bureaucracy was the idea that the real issue was not method of payment per se, but the underlying issue of physician responsibility and accountability. The policy legacy of physician-state relations granted physicians an open-ended contract with no specified deliverables. Add to this the various APPs that were around prior to 1993 and accountability became even less clear. This was eventually flagged by the Provincial Auditor General (2001). Under these circumstances, government was unable to influence physician behavior to address issues

such as the shortage of rural doctors or the need to pursue more promotion and prevention as best practice.

Alberta Health had been working on developing a general accountability framework since the Getty era. As early as 1989, the Department of Health (as it was then called) developed an internal discussion paper "to provide a common basis of understanding to facilitate a discussion of 'accountability' and 'accountability mechanisms' among a variety of players within the Department of Health."[45] Some of this preliminary internal thinking was shared with other jurisdictions through the Minister's speech at the F/P/T Conference of Health Ministers in September 1989.[2] As an idea in good currency,

> the whole discussion around accountability I think was politically attractive too and aligned with the conservative philosophy that if you give people an amount of money they have to be responsible for what happens to it and be able to account for what happened to it.

In 1991, the way to achieve accountability included:

> "planning for health services based on identified needs, goals and outcomes; enhancing health information that will assist in monitoring and evaluating the health system; **increasing provider responsibility and accountability in managing resources** [our emphasis]; and facilitating consumer choice and responsibility in health resource utilization."[3]

By 1993, Alberta Health was contemplating defining accountability relationships among health providers, the Department and Government and drew heavily on the earlier concepts of accountability mechanisms and measurement:

> Work performed by health providers across various disciplines is currently compensated by either salaries or fees. However, there are no guidelines to ensure proper use of either method. The consequence is excessive payment for some

[2] Alberta Health, Discussion Notes, undated, 1.
[3] Alberta Health (1991b), 1.

> providers and insufficient payment for others. Ultimately, the taxpayer pays for this waste…Guidelines for proper compensation of providers will reduce costs and increase efficiency and flexibility.[46]

A third line of thinking within the bureaucracy stemmed from two sources: a well-developed provincial system of home care and the emerging national thinking about the importance of population health. Both of these perspectives emphasized the need to deliver services to defined populations through teams of health providers. By linking these ways of organizing practice to APPs, such as capitation, government could begin to define the deliverables while recognizing the variability in physician practice and compensate physicians in a fair and transparent way. Although in theory, this was seen as a desirable linkage to make, in practice, there was a good deal of skepticism about the link between method of payment and other aspects of primary care reform. Given this, the two focuses –primary health care (organizational) and primary care (APP) operated in isolation of each other during the 1990s. Finally, government was interested in seeing physicians work closely with RHAs to ensure integration and coordination of services; although this sentiment came in the aftermath of the introduction of health regions and the significant backlash from local physicians who felt left out of the reform process.

The counter-argument to APP put forward by some in the medical and academic communities was that, at the time, the academic research on FFS and capitation was flawed and that FFS was necessary to ensure that adequate levels of service continued to be provided. Subsequent research has demonstrated that earlier assumptions about FFS were flawed.

A final idea that emerged nationally during the 1990s and would have some bearing on the position of the AMA on APPs derived again from work done for the F/P/T

Conference of Deputy Ministers of Health. Among, other things, the Barer-Stoddart Report suggested that there was an oversupply of physicians and current approaches to determining medical human resource needs would not likely resolve persistent problems, such as the shortage of physicians in rural areas. In the early to mid-1990s, all provinces responded to this logic by reducing funding for medical schools. Again, as an idea in good currency, this meshed with the political imperative to reduce expenditures in health care.[47]

Because of the significant financial and power implications of the reforms for physicians, the AMA was pro-active in developing APP options. In preparation for the 1995 negotiations, the AMA produced a discussion paper on Fee for Comprehensive Care, an APP option for primary care.[48] The paper became the foundation for the development of APPs in Alberta. As described:

> The proposed *Fee for Comprehensive Care* (FCC) is a strictly optional, alternative mechanism – in addition to *FEE FOR SERVICE* [original emphasis] – for payment of Alberta physicians. It is remuneration for prepaid medical care based on dollars per patient rather than dollars per service. The generic equivalent would be capitation.[49]

In providing a rationale for the new payment mechanism, the AMA noted that:

> The status quo is no more. Major changes are happening in Alberta and restructuring means both opportunities and risks. There is risk in embracing and fashioning change. There is also risk in trying to avoid, delay or subvert change…Payment mechanisms other than fee for service are becoming more common in health systems around the world and across Canada. Whether it's the United States, Sweden, Ontario, New Zealand or Alberta, those who pay the health care bills and those who deliver the services are looking at ways to be more cost-effective.[50]

The magnitude of these changes had affected the perceptions of individual physicians:

> For some family physicians, this means an alternative to *Fee For Service.* They are not only requesting it, they are actively pursuing it and have approached the AMA for assistance in developing new delivery models.[51]

The proposal touched on many of the underlying issues confronting the association and its membership. The proposed option:

- Maintain[ed] a single fund for paying for physician services throughout Alberta. (The alternative could be dividing it among the 17 regional health authorities.)
- Add[ed] a second payment option. Primary care services would be paid by a fee for service or a fee for comprehensive care.
- Offer[ed] local flexibility, while remaining within provincial standards for defining services and establishing the appropriate compensation.
- Offer[ed] common opportunities through joint venture to physicians, the regional health authorities and government.[52]

Underlying principles included:

- Participation by physicians and patients [being] strictly voluntary.
- Physicians [had] certain rights for joining and leaving.
- There must be common standards to measure quality of care
- Special needs of research and teaching must be recognized.
- Adequate and fair compensation must be available to physicians
- Drive must be to greater efficiency through quality care and appropriate utilization.[53]

In terms of building partnerships, FCC offered new possibilities

- Primary care physicians on *FCC* may opt for a managed care plan by which both they and the regional health authorities would bring funding into joint ventures.
- There may be new incentives, and therefore new alignment, among physicians, e.g. primary care physicians and radiologists on *FCC* of in managed care plans.[54]

About the impact on physician practice, the document indicated that FCC would create new incentives to allow physicians to avoid over-servicing, employ or contract with other providers, and provide 24-hour comprehensive coverage.

For patient care, the proposal would require rostering for a predetermined minimum of time and a commitment to seek only services from the FCC physician. The patient would have the choice of switching providers after the period of minimal commitment. The physician would be responsible for coordinating overall care for the patient, although not necessarily providing all services directly.[55]

Overall, FCC would benefit the profession by [helping] "to secure the pivotal role of primary care physicians…physicians can be empowered as managers and planners and not just be viewed as providers."[56]

In a follow-up discussion paper after the signing of the Master Agreement in late 1995, a review of the literature on physician reimbursement, specifically the work by Birch, Kilshaw, BC Nurses Association, noted the "breathtaking leap of faith" to adopt a single model of payment – capitation, despite significant evidence to the contrary. Maintaining standards within local variation, competition, transition and transaction costs were cited as issues that had occurred in the New Zealand and British cases[57].

In summing up the lessons learned from international experience, the AMA expressed concern that long-held relationships of trust that had been developed between providers, funders, patients and communities might be damaged by shifting to a single model of funding and that quasi-market models worked better in theory than practice.

Within the Alberta context, a "made in Alberta solution" was seen as necessary. Such a solution would involve local flexibility with provincial standards on core services, quality of care, equitable access and fairness of funding was recommended. Striking a balance between the political and economic clout of either physicians or RHAs was also seen as essential. Finally, respecting existing arrangements and avoiding throwing out the baby with the bath water were essential.

Five major issues to be addressed through the Tripartite process were identified:

1. Overall Provincial Context

Establish an overall provincial context under which primary health care alliances can be established. To overcome physician fatigue with health reform, Alberta Health, AMA and the health regions collectively would need to reach agreement on common goals and working relationships, develop a clear workplan, develop clear principles for pilot projects, and generate joint discussion papers on alternative financing and delivery mechanisms.

2. Funding Flow From the Medical Services Budget[58]

Principles and mechanisms must be developed for flowing funds from the hard cap of the Alberta Health Insurance Plan budget to physicians. Physician remuneration mechanisms are key to encouraging closer ties between physicians and regions. Therefore, establishment of such options should be a priority. The six core criteria that the AMA felt should apply to any payment mechanism should include: voluntary movement off of FFS, maintenance of clinical independence, independent expert evaluation, clear terms and conditions, linkage to the global medical services budget, and development of the necessary tools to support alternative payment and delivery mechanisms.

As for the alternative payment options, four were identified: FFS, Fee-For-Comprehensive Care, Segregated Fee-For-Service and Contractual Arrangements.[59]

3. Formation of Physician Groups and Physician Acceptance of Payment Alternatives

   This deals with how local physicians form practice groups using alternative payment methods. To make this happen, Tripartite would need to effectively communicate remuneration options, encourage the use of pilot projects, and develop support tools to assist physicians to determine which payment option was best suited for their local circumstances.

4. Alliances

   Alliances of communities, physicians and other providers could be encouraged through the Tripartite Process, including pilot projects to assess the cost-benefit impact of alliances. To accomplish this, opportunities for new relationships between providers through APPs needed to be considered; APPs needed to be directly managed through Tripartite; appropriate inducements fpr those considering pilot projects needed to be developed; and, a process for public involvement needed to be developed.

5 Flow of Resources from RHA budgets

   If, and how, the RHAs flow funds and resources to local communities will partly drive the alliances that are possible. The AMA committed some time ago to

collaborate with RHAs in decision making about method of physician remuneration and other major policy activities. [60]

A publicly released document on primary care reform reiterated the principles related to APPs elaborated on in these earlier documents.[61]

Two other issues were seen by the AMA as crucial to ensuring buy-in from the overall AMA membership: the creation of a funding stream that was pool-neutral[62]; and health information systems that would support the new form of managed care.

As the Master Agreement negotiations approached Alberta Health issued there own policy document outlining its position. Its seven point plan included:

1 Fairness in what doctors are paid

- Alberta's doctors should receive fair and reasonable compensation.
- Doctors should be paid more fairly for the different kinds of work they do.

2 Flexibility in how doctors are paid

- The "one size fits all" approach should end.
- More doctors should have flexible options for working on contract, on salary or in other alternative payment arrangements.
- The fee-for-service option will remain.
- New alternatives will provide better incentives for doctors to work with other health care providers , provide more comprehensive care and be actively involved in preventive care.

3. The right number and mix of doctors in the right places to meet the Albertans' needs

- Deliberate action plans will help bring more doctors to rural and remote parts of the province and help keep them there.
- New alternatives for paying rural doctors should assist them in dealing with the workload and the pressures of being on call.
- Alberta Health, the AMA and regional health authorities should work closely on plans to make sure we have the right number and mix of doctors to meet Albertans' needs.

4. Closer ties between doctors and regional health authorities
    - New approaches for paying specialists and rural physicians will bring closer links with regional health authorities.
    - Regional health authorities should have more responsibility for funding some physician services.
5. Clear guidelines for decisions about tests, procedures and prescriptions
    - More clinical practice guidelines should be in place and part of medical practice.
6. A new approach to medical schools
    - A sustainable and predictable base of funding should be in place for academic medical centres.
    - Academic medical centres will continue to provide excellent undergraduate, post-graduate and continuing medical education for Alberta's doctors.
    - Albertans will benefit from new medical talent and expertise attracted to the province.

7. Fiscal responsibility and accountability
    - A cap on the total amount of spending on physician services will be maintained but t will provide sufficient revenues to support a growing and aging population.
    - A new agreement will balance fiscal responsibility with fairness for physicians.
    - Clear objectives and expected results should be specified and delivered.[63]

The Policy Choice

The 1998 Master Agreement included provisions for the following: an APP to be reimbursed through the Medical Services Budget (clause 5.4); an Innovation Fund created from resources flowing from the potential savings incurred through initiatives described in the 1995 Letter of Agreement (clause 5.7); a Finance Committee to determine, among other things, the payment rates and conditions of payment for APPs (clause 11.4); and the establishment of a Relative Value Commission to determine structures, methods and processes for developing a relative value guide to ensure equitable fees for physicians (Article 10).[64] In essence the Agreement institutionalized the APP:

> From 1995 to 1998, there wasn't really a mechanism within the Master Agreement to pay physicians differently. . It was all fee-for-service based agreement…It wasn't until the Master Agreement of 1998 that the groundwork was laid for APP to become a reality within the Agreement. So we could then have fee-for-service as well as alternative payment plans.

APP became one of several means by which physicians might be reimbursed through the Medical Services Budget, one "spigot" that might be turned on or off

depending on the circumstances. This also began the process of bringing the variety of existing APPs into greater alignment with the Physician Services Budget.

The 2003 Trilateral Master Agreement further elaborated the structures and processes that had developed from the 1998 agreement. A total of $100 million over three years was committed to develop Local Primary Care Initiatives involving partnerships between local groupings of physicians and RHAs. In addition, RHAs became formal signatories of the Master Agreement and the AMA role as sole representative of *all* physicians in the Province of Alberta was formally recognized for the first time. This stemmed from a long-held desire on the part of the AMA to formalize this role.[65]

Conclusions

The institutionalization of APPs in Alberta was driven by a number of related factors. The emergence of Ralph Klein as leader of the provincial Progressive Conservatives and Premier in 1992 led to a significant shift in the policy style. Where the previous regime had attempted to control costs through gradual consensus building and voluntary stakeholder response, the Klein government opted to move aggressively on an agenda of deficit and debt reduction.

The announcement of significant cuts in public expenditures for all sectors in 1993, created a policy environment in which APPs as a policy option became viable. In essence, the need to find significant economies within a reduced physician services budget, placed APPs on the policy agendas of both the government and the AMA. When combined with other initiatives, especially the emergence of RHAs, the AMA and its members were threatened by impending reforms to the health system. Specifically, the central roll of the AMA as the collective bargaining unit for organized medicine and the

threat to FFS as the primary method of payment for physicians represented a direct challenge to the core bargain between physicians and the state. In this environment, the AMA chose to move proactively to ensure a continuing central role for itself as the collective representative of physicians, and the central role of individual physicians as key decision makers in the health system.

Alberta Health, which had been thinking about ways to make physicians more responsible and accountable for the services provided, was open to the introduction of APPs. However, the impact of health reforms on the department left it with inadequate capacity to lead such a significant policy shift. Initially, lack of sufficient political buy-in for patient rostering as an aspect of APPs prevented Alberta Health from responding to the AMA proposal and resulted in a breakdown in overall contract negotiations.

In the tradition of "conflict and accommodation" characterizing relationships between the state and organized medicine in Canada,[66] the AMA publicly challenged the government, forcing it to adopt a more conciliatory approach to bargaining. One of the byproducts of this was the acceptance of APPs as an idea in good currency. Once it was placed on the table, it became a legitimate policy instrument for addressing a variety of issues for both government and the profession. In the subsequent negotiation in 1998, APPs were placed on the decision agenda.

The initial choice in 1995 to introduce APPs on a voluntary and pilot project basis reflected a desire on the part of the AMA to introduce change gradually and to build consensus within its membership without significantly disrupting the existing FFS method of payment or the broader health system. The move in 1998 to embed APPs within the medical services budget, reflected a growing level of trust between Alberta

Health and the AMA. It also reflected a growing acceptance within the membership for a range of reimbursement methods.

In choosing an APP based on a plurality of potential funding models, governed by common guiding principles, Alberta struck a balance between the continuing desire of organized medicine to maintain FFS as a method of remuneration and the political and bureaucratic desire to increase the responsibility and accountability of the profession for expenditures within the medical services budget and across the broader system. In addition, the AMA realized its organizational goal of being formally recognized as the sole representative of the collective interests of physicians in Alberta.

By bringing RHAs to the negotiating table, first through the Tripartite and more recently the Trilateral process, the province has formalized a process for joint management of the health care system. In formalizing these relationships government has been able to build consensus to move beyond changes to physician remuneration to discuss broader issues related to primary (health) care reform.

References available from authors upon request.