

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

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The issues of alternate physician payment and primary health care reform have been present in Newfoundland and Labrador in recent years. What typically occupies policy and decision-makers, however, are programs to enhance the recruitment and retention of physicians practicing in rural areas of the province. For decades, the province has struggled to provide decent levels of remuneration, adequate lifestyles and opportunities for career advancement for physicians. Since the late 1990s, government has embraced primary health care as a means to provide basic medical services to rural and underserved regions in the province. The intersection of primary health care reform and alternate physician payment occurred around 2000 largely because government has yet to establish a model that will provide suitable compensation for family physicians to be part of a primary care team. Our paper is divided into two parts. Part one recounts the long road to reform for physician payment, retention and recruitment and highlights some of the reform efforts to date. There has been movement on these issues and it would be premature to suggest that Newfoundland and Labrador is a “no go” case. The second part of the paper offers responses from our participants with respect to the public, decision and policy choice agendas. Physician payment has not captured the public’s imagination and remains well entrenched within the policy community dominated by the Newfoundland and Labrador Medical Association (NLMA). We argue that the chief barrier to primary health care reform in Newfoundland and Labrador is an acceptable payment model for physician buy-in and support. Other barriers include health human resource issues (scopes of practice, opportunities for clinical and educational training, payment for ER services), lack of support in rural areas and the inability of government to provide adequate financial resources for project implementation.

Alternate Physician Payment and Primary Health Care Reform Chronology

1934: Following the imposition of a Commission of Government and the suspension of democracy in the Dominion of Newfoundland, the country’s health service was reorganized. As a key part of the country’s public health service, physicians were appointed as part-time health officers and these doctors along with those who were unable to earn a sufficient income through the practice of medicine, were paid a salary by the government. This is the first time that doctors had the option of being paid a salary rather than earning an income through a fee-for-service payment model.

1963: In an effort to correct the longstanding shortage of physicians in the province (joined Canada in 1949), the government started a program to provide financial assistance to individuals seeking to obtain degrees in medicine and dentistry. In September, 15 students registered at Memorial University for the two year Diploma course in Public Welfare.

1968: Establishment of medical care for residents of Newfoundland and Labrador and the start up of the School of Medicine at Memorial University.

1969: The Newfoundland Medical Care Plan (MCP) is introduced.

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

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

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

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

- The provincial Department of Health, the Newfoundland Medical Association and the Faculty of Medicine at Memorial University jointly undertake a critical analysis of the physician fee schedule for non-hospital services as a way of refining the fee-for-service schedule. Suggested modifications included: (1) encouraging physicians, especially general practitioners, to interact with specialists prior to referring patients for hospitalization and (2) to accurately reflect the amount of time clinically required by each patient visiting a physician.²

¹ . Government of Newfoundland, Health Study Group. *Health Care Delivery: An Overview*. St. John's: May, 1973, 125.

² . Royal Commission on Hospital and Nursing Home Costs. *Executive Summary*. St. John's: Government of Newfoundland, February 15, 1984, 58-59.

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

The Royal Commission noted that the fee-for-service payment model was not flexible and responsive to patient needs and physician activities. As well, the Commission focused attention on the lack of incentives for physicians to use hospital resources more efficiently and effectively. The report noted that “physicians still carry virtually no accountability for the economic consequences of their decisions and practice patterns.”⁴ In closing, the Commission suggested that the subject of physician remuneration was beyond the scope of the Commission’s mandate.

1990: The first primary health care project is introduced in Newfoundland. The project incorporated the definition of primary health care endorsed by 134 countries at the World Health Organization sponsored international conference held at Alma Ata in the former USSR in 1978. Primary health care is defined as

“essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.”⁵

The project was conceived by a group of Newfoundland and Danish nurses who were interested in discussing the role they could exercise in the providing primary health care services to the community. A working group, composed of nurses from each jurisdiction’s professional body, decided to jointly fund the project. A project director was appointed and an international steering committee was established. Funding for the

³ . Ibid, 59.

⁴ . Royal Commission on Hospital and Nursing Home Costs. Report of the Royal Commission on Hospital and Nursing Home Costs to the Government of Newfoundland and Labrador. St. John’s: Government of Newfoundland, February 15, 1984, 517.

⁵ . Elizabeth Adey, “New Directions in Health: The Danish-Newfoundland Primary Health Care Project,” Canadian Health Care Management, volume 88, April, 1993, 88:21.

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

The purpose of the project was to contain health care costs while improving and maintaining the quality of health services through an emphasis on greater self-reliance, increased emphasis on health promotion and the use of nurses in the community to coordinate services.⁷ The Newfoundland Hospital and Nursing Home Association applauded the efforts of Newfoundland nurses to develop the primary health care project and recommended that future sites be established to provide health and community services to the population. The project was located on the southern Avalon peninsula (the Irish Loop) and involved 21 communities with a population of 8,800. The provincial government provided funds to upgrade two existing nursing stations as well constructing a third station for health delivery.

The project incorporated community involvement via the creation of a 14 member Community Advisory Board. Board members were drawn from various constituencies including youth, adult and seniors groups, municipalities, service organizations, school boards, and police. Meetings were held in public and were conducted on a monthly basis. The board's mandate was to assist nurses to identify and rank health problems and develop programs to meet needs. A quarterly newsletter was published and education sessions were held across the region to keep residents informed.

The pilot project did not continue. Following an evaluation by two Memorial University academics, as well as those carried out by the Newfoundland and Labrador Nurses Union and the Newfoundland and Labrador Medical Association, government decided not to renew funding for the continuation of the project. The evaluators from Memorial noted that while there were problems with the project, it was too early to evaluate the outcomes (improved health for people in the community with a concomitant reduction in health costs) because only three years had passed. The evaluations from the two health professional associations, however, were critical suggesting that the project had failed to meet its outcomes. The problem was that the outcomes could not be measured because an insufficient amount of time had elapsed.⁸

1992: The Newfoundland Hospital and Nursing Home Association published its report on ways to better deliver health services at a reduced cost. With respect to physician recruitment, the NHNHA recognized that the province continued to have difficulty

⁶ . Ibid, 88:22.

⁷ . Newfoundland Hospital and Nursing Home Association, Matching Realities and Dreams: Report of the Health System Funding and Delivery Committee. St. John's: September, 1992, 63.

⁸ . Abraham Ross, "Letter to the Editor", Evening Telegram, October 16, 1995. Ross was one of the two evaluators from Memorial University of Newfoundland.

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

1993: Newfoundland Hospital and Nursing Home Association report *Guidelines for Hospital Boards to Improve Recruitment and Retention of Physicians in Rural Newfoundland and Labrador* was the result of a workshop held in Gander in March, 1993. Participants were drawn from the NHNHA, the MUN Faculty of Medicine, the NLMA, and the provincial Department of Health. The aim of the workshop was to develop policies that would improve the recruitment and retention of physicians practicing in rural areas of the province. The workshop also addressed the issue of regionalization of health services in that newly created regional boards were now responsible for physician recruitment rather than individual health facilities and institutions. Some of the Association's recommendations include:

- Health boards should establish Recruitment Committees with five or six members representing the Board, Medical Staff, Administration and the communities served¹⁰;
- Recruitment Committee will undertake a systematic analysis of previous patterns of physician retention, working conditions, development of a community profile, a set of protocols for site visits by suitable candidates and follow-up activities to encourage the retention of physicians¹¹;
- Health boards are encouraged to directly recruit MUN Medical School graduates and to approach them early in their study. Representatives from the various Recruitment Committees should establish contact with potential physicians early and contact should be extended to those considering family practice in other Canadian medical schools¹²;
- Recruitment should focus on candidates with an interest in family practice, those who grew up in rural environments, those with fluency in English and those who are North American residents to minimize cultural maladjustment¹³;
- Potential candidates should be brought to the local community for a site visit, lasting between one and three days, to meet other medical staff, engage in private discussions with other doctors, tour health facilities, a tour of housing available in the community, sightseeing trips to points of interest, visits to schools if the candidate has children, opportunities to meet board members and the like;
- Working conditions for rural physicians must be addressed. Concerns include leaving scheduling to physicians themselves, adequate time off, ability to obtain locums, and allowing physicians to change their locations within a region every so often;

⁹ . *Matching Realities and Dreams*, 85-86.

¹⁰ . The Newfoundland Hospital and Nursing Home Association, Guidelines for Hospital Boards to Improve Recruitment and Retention of Physicians in Rural Newfoundland and Labrador. St. John's: IMB Associates Inc., August, 1993, 2.

¹¹ . *Ibid.*, 2-3.

¹² . *Ibid.*, 7.

¹³ . *Ibid.*, 8.

- Issues of physician payment: “There are some problems in working conditions which have arisen to which there appears to be no solution at the present time, not the least of which is salaried and fee-for-service physicians working in the same hospital/community with what appears to be considerable differences in income for the same amount of work. Where fee-for-service and salary arrangements co-exist, the salaried physician often considers only the salary and it is important that he/she be apprised of the value of fringe benefits and the overhead costs involved in a fee-for-service practice. The discrepancy in incomes of salaried versus fee-for-service physicians narrows considerably when all aspects are taken into account. Administrators should be capable of reconciling these differences in salary versus fee-for-service.”¹⁴
- Health boards need to consider lifestyle issues (especially housing), professional development and further opportunities for improving skills for physicians practicing in rural and remote areas.

Government announcements, Department of Health (pre-1998) and Department of Health and Community Services (1998-present):

1997

- Beginning in 1995, the province announced a recruitment and retention package for rural doctors with bonuses for salaried physicians who committed to a two year service contract in designated regions. Starting on April 1, 1997, the province will pay out \$700,000 in bonuses to 55 physicians. The Minister of Health in the provincial budget for fiscal 1997-98 announced that \$2.6 million would be allocated for salary increases for rural physicians.¹⁵ The details are as follows. Rural communities are divided into three groups based on their degree of isolation. Doctors who practice in the most isolated communities receive the largest salary increase. For group 1 physicians, there is a \$10,000 isolation bonus and a salary increase of \$31,200; for group 2 physicians, the figures are \$7,500 and \$23,400 and for group 3 doctors, \$5,000 and \$15,600. Isolation bonuses are payable upon two years completion of service. The salary and isolation bonuses had the effect of raising the annual incomes of rural physicians by 20 to 50 percent.¹⁶

1998

- Reform of the 50 percent billing policy for physicians: the Minister of Health made an exception to the 50 percent billing policy for physicians working in the capital region for doctors servicing the communities of Portugal Cove-St. Phillips and Torbay and surrounding areas. In the past, the 50 percent billing policy had considered these communities to be part of the capital region. Residents complained to government that physicians were leaving making access to medical

¹⁴ . *Ibid*, 15.

¹⁵ . Government of Newfoundland and Labrador, News Releases, Department of Health, March 2, 1997. Accessed at <http://www.releases.gov.nl.ca/releases/1997/health/0325n04.htm>

¹⁶ . Government of Newfoundland and Labrador, News Releases, Department of Health, May 6, 1997. Accessed at <http://www.releases.gov.nl.ca/releases/1997/health/0506n02.htm>

care difficult. The 50 percent billing policy was established to penalize physicians seeking to work in overserved areas such as St. John's and the surrounding region by paying them fifty cents on the dollar for medical services.¹⁷

- The Minister of Health and Community Services announced plans for the establishment of a provincial physician recruitment coordinating committee. The committee will act in an advisory capacity to the Minister on issues related to recruitment and retention. Membership includes the Deputy Minister of Health and Community Services (Chair), representation from the Newfoundland and Labrador Medical Association (NLMA), the Medical School Society, the Newfoundland and Labrador Health Care Association, the Newfoundland Medical Board, the Professional Association of Interns and Residents, the School of Medicine at Memorial University, active rural physicians and the provincial government. The Minister of Health and Community Services noted that “[t]his type of partnership provides the chance to enhance our recruitment initiative and focus even more on a proactive and continuous effort to help meet the needs of our citizens.”¹⁸
- The province negotiates a new agreement with the NLMA. The contract extends for four and one-half years (1998-mid-2002) and provides an increase in salaries for both salaried and fee-for-service physicians. The government agreed to remove the 50 percent billing rule for doctors practicing in the St. John's region.

The Clarenville Experiment

- In the fall of 1998, government announced that an alternate health care delivery model was being planned for the Clarenville and Bonavista areas. The project's goals were to improve the quality of life for rural doctors, improve the scope of services and create an environment where physicians can work with nurse practitioners and other health professionals to make service delivery more effective and efficient. The Minister of Health and Community Services noted:

“The general/family physicians, jointly with the Peninsulas Health Care Corporation, have presented me with an exciting proposal which we [government] will be exploring in cooperation with the representatives and the Newfoundland and Labrador Medical Association.”¹⁹

The announcement of an alternate health care delivery model became known as the Clarenville experiment. However, the project was never implemented and negotiations between government and the NLMA were rife with conflict. In phase

¹⁷ . Government of Newfoundland and Labrador, News Releases, Department of Health, February 10, 1998. Accessed at www.releases.gov.nl.ca/releases/1998/health/0210n02.htm

¹⁸ . Government of Newfoundland and Labrador, News Releases, Department of Health and Community Services, June 25, 1998. Accessed at www.releases.gov.nl.ca/releases/1998/health/0625n02.htm

¹⁹ . Government of Newfoundland and Labrador, News Releases, Department of Health and Community Services, October 21, 1998. Accessed at www.releases.gov.nl.ca/releases/1998/health/1021n02.htm

one, government established a committee to work with the physicians in the Clarenville area as well as the NLMA, the Peninsulas Health Care Corporation and the Eastern Newfoundland Health and Community Services Board. The region covered by the project, the communities of Clarenville, Bonavista, and Trinity Bay includes nearly 30,000 people.²⁰

Nearly one year later, the project was still in the planning phase. A key barrier from the physician perspective is government's position that the project will be cost neutral. A past president of the NLMA who was involved with the project argued that government had to be prepared to put additional resources into the project. From government's perspective, this type of project was not really new since nearly one-third of the province's physicians are on salary and there have been several block funding projects in place prior to the announcement of the Clarenville experiment. What was different about Clarenville from government's vantage point is that the project would be formally evaluated to determine whether the model would be adopted across the province.²¹

What made Clarenville unique was that it was spearheaded by physicians themselves rather than coming from government. The physicians proposed replacing fee-for-service payment with a salary paid on an hourly basis with no difference as to whether services are performed in the emergency ward, the operating room or the clinic. Under the original proposal, medical care would be managed by the regional health board and the physicians involved would establish a new, not-for-profit corporation to oversee the project's development. The corporation would contract with other providers in a number of communities to provide services under a block funding payment arrangement. Doctors participating in the project would be responsible for providing primary care to hospitals and clinics and would use nurse practitioners and other health professionals to assist. These professionals, however, would be paid by the regional health authority. The project called for the use of telemedicine and electronic patient charts for more effective service delivery.

An agreement was close to fruition between government and the NLMA in the summer of 1999. However, by July of 2001, the project was moribund. In the spring of 2001, one final attempt was made to bring the physicians on-side. The doctors had agreed to a tax ruling to maintain their self-employed status but government then changed some of the other conditions of the project. As Clarenville physician Dr. Blaine Pearce stated, "it got down to the department [Health and Community Services] was going to have a lot of control ... over the number of hours we were able to work [and] where we were going to work... . It became like we were going to be salaried, essentially, so we backed away from it."²²

²⁰ . Pat Rich, "Newfoundland set for major primary care reform," The Medical Post, volume 35 (26), July 20, 1999. Accessed at www.medicalpost.com/mpcontent/article.jsp?content=content/EXTRACT/RAWART/...

²¹ . Ibid.

²² . "Newfoundland Rural PCR Talks Stalled," The Rural News, volume 3 (16), July 1, 2001. www.srpc.ca/News/issue316.html

1999

- An agreement is reached with emergency room physicians to pay them a base rate of \$88 hour using a block funding model. In return, ER physicians surrender their right to bill on a fee-for-service basis. Government claimed the agreement was cost neutral.
- Both the provincial and federal Minister of Health announced three primary health care projects for the communities of Port aux Basques, Twillingate and Happy Valley-Goose Bay. The province received \$2.2 million from the federal government's Health Transition fund. Minister Aylward stated "this announcement is about people working in partnerships. Governments working together with communities to identify needs, and health providers working together as a team demonstrates a positive direction which will improve primary health care throughout our province and our country."²³

2000

- In the provincial budget, \$2.1 million was set aside for hiring new salaried physicians. Government was spending \$8.5 million per year in 1999-2000 for more than 50 salaried physicians. New funding, totaling \$1.9 million was allocated for the increasing numbers of fee-for-service physicians in the province.

2001

- The provincial budget contains funding for physician recruitment and primary health care. A total of \$1.5 million was allocated to continue the recruitment of salaried physicians to fill vacant positions around the province.²⁴ A total of \$2.4 million will be allocated for primary health care as per the September 2000 agreement by First Ministers on health renewal.
- In September, government announced the creation of a Primary Care Advisory Committee (PCAC) responsible for examining issues focusing on health care delivery by family doctors. Kathy LeGrow was appointed committee Chair. The mandate of the committee is to "focus on physician issues including the most effective way to compensate physicians and improving communications through electronic medical records. It will also explore ways to better integrate medical services with those provided by other health and community services professionals throughout the province."²⁵

²³ . Government of Newfoundland and Labrador, News Releases, Department of Health and Community Services, September 14, 1999. Accessed at www.gov.nf.ca/releases/1999/health/0914n02.htm

²⁴ . Government of Newfoundland and Labrador, News Releases, Department of Health and Community Services, March 22, 2001. Accessed at www.releases.gov.nl.ca/releases/2001/health/0322n37.htm

²⁵ . Government of Newfoundland and Labrador, News Releases, Department of Health and Community Services, September 7, 2001. Accessed at www.releases.gov.nl.ca/releases/2001/health/0907n01.htm

- The NLMA’s request for an additional \$15 million to address gaps in funding related to family physicians and on-call issues for doctors is rejected by government. The Minister of Health and Community Services noted that “Government cannot afford to add \$15 million to the MOU (memorandum of understanding). Furthermore, if we did have an extra \$15 million, we would have to seriously consider the many pressures in our health system vying for extra dollars at this time – like cardiac care, health board deficits, home support and other drug therapies.”²⁶
- In response to government’s rejection for additional funding, the NLMA initiates a job action whereby all physicians will be withdrawn from government committees. The NLMA pressured government to re-open the memorandum of understanding in order to raise fees for family physicians and to broaden compensation for on-call coverage.
- In partnership with the Newfoundland and Labrador Health Boards Association (NLHBA) and the Faculty of Medicine at Memorial University, government announces the creation of provincial physician recruitment office. Funding for the office is provided by the Department of Health and Community Services and the NLHBA. Space will be created within the Faculty of Medicine. A coordinator is to be appointed and will be responsible for directly contacting medical students and informing them of vacancies and opportunities to practice medicine in the province as well as educating students about the various incentive programs in place. The coordinator will also help health boards and fee-for-service clinics to identify potential candidates. Physician recruitment will also occur within Canada and internationally. The Minister noted that “when our physician graduates are making decisions on where they want to pursue their medical careers, we want to insure they know of the opportunities in this province. We want to increase the number of graduates who make this province their first choice of where to practice.”²⁷

2002

- Report of the Primary Care Advisory Committee is released in January. Key concerns expressed by citizens, physicians, health boards and health professionals include: (1) inability to find a family doctor; (2) lack of continuity in health care because of high turnover among physicians; (3) inappropriate use of ERs; (4) lack of 24/7 health services outside of ERs and (5) a disconnect between family doctors and regional health institutions.²⁸ The report contained 14 formal

²⁶ . Government of Newfoundland and Labrador, News Releases, Department of Health and Community Services, September 14, 2001. Accessed at www.releases.gov.nl.ca/releases/2001/0914n06.htm

²⁷ . Government of Newfoundland and Labrador, News Releases, Department of Health and Community Services, October 18, 2001. Accessed at www.releases.gov.nl.ca/releases/2001/health/1018n02.htm

²⁸ . Government of Newfoundland and Labrador, News Releases, Department of Health and Community Services, January 23, 2002. Accessed at www.releases.gov.nl.ca/releases/2002/health/0123n04.htm

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

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

2003

- NLMA Arbitration Ruling: following the physicians' strike in the fall of 2002, the NLMA and government agreed to binding arbitration in order to strike a new collective agreement for the next three years. Specifics included a parity award of \$23.9 million with respect to fee-for-service compensation to bring Newfoundland and Labrador physicians up to 95 percent of the pay levels of Maritime physicians; a general increase of \$10.5 million; and 18 percent increase for salaried physicians over three years; \$5 million for a universal on-call payment policy; \$1 million for the development and implementation of after-hours emergency coverage in St. John's and the implementation of a Service Coverage Committee to address province wide issues in service.³¹

2004

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

²⁹ . Ibid.

³⁰ . Government of Newfoundland and Labrador, News Releases, Department of Health and Community Services, December 12, 2002. Accessed at www.releases.gov.nl.ca/releases/2002/health/1212n03.htm

³¹ . Government of Newfoundland and Labrador, News Releases, Department of Health and Community Services, April 16, 2003. Accessed at www.releases.gov.nl.ca/releases/2003/health/0416n03.htm

new projects comes from the federal government's Primary Health Care Transition Fund. Seven project proposals have been accepted in the following areas: Grenfell, Bonne Bay, Connaigre Peninsula, Labrador East, Bonavista, Twillingate/New World Island and St. John's. Project funding will support costs associated with the organization, funding and delivery of health care services.³²

Summary of Primary Health Care Reform in Newfoundland and Labrador

The principles of reform are guided by the development of interdisciplinary teams of providers based on the health needs of regional populations. Participation in the teams is voluntary and the implementation of reform has been incremental. Primary health care reform will be integrated with the regional health authorities where an increased focus on wellness and community development can occur.

Reform efforts are being spearheaded by the Office of Primary Health Care (within the Department of Health and Community Services). The Office is responsible for supporting the development, implementation and evaluation of the province's Primary Health Care Framework. Other partners in reform include the Primary Health Care Advisory Council, the NLMA, the NLNU and ARNNL, pharmacists, the NLCHI, the Cancer Foundation and TETRA (Telehealth and Educational Technology and Resource Agency) to develop clinical based video conferencing. Various working groups have been established to discuss and shape the key components of primary health care reform. These components include composition of primary care teams; scopes of practice; emergency transportation; information management; health and wellness promotion; community capacity building; funding and payment models for physicians and governance models.³³

The major challenges to reform in Newfoundland and Labrador include the recent reduction in the number of health authorities and the change in the institutional structure of these; the new integrated boards combine both institutional and community health thus raising concerns about the commitment of resources to primary care reform; the inability to get doctors on side with reform because of the difficulty of devising a suitable payment and fee program, conflict over scope of practice with other health care providers and autonomy; community participation in reform is lacking with few avenues available to citizens to mobilize; most funding for reform has come from Ottawa, not the province and there is concern that once the funding ends in March, 2006 there will not be any further resources deployed; lack of a holistic information management system and evaluation of primary health care projects may be difficult since transitional funding is due to end in 2006.³⁴

³² . Government of Newfoundland and Labrador, News Releases, Department of Health and Community Services, March 30, 2004. Accessed at www.gov.nf.ca/releases/2004/health/0330n11.htm.

³³ . Ruth Wilson, S.E.D. Shortt and John Dorland (eds.), Implementing Primary Care Reform: Barriers and Facilitators. Montreal and Kingston: McGill-Queen's University Press, 2004, 168-169.

³⁴ . Ibid, 170.

Six Research Questions

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

1. How much reform has occurred for alternate methods of remuneration and primary health care reform in Newfoundland and Labrador over the last decade?
2. Under what conditions have alternate methods of remuneration for physicians and primary health care reform occurred over the last decade?
3. Under what conditions have alternate methods of remuneration for physicians and primary health care reform not occurred despite widespread calls for it?
4. Is there a feedback loop between alternate methods of remuneration for physicians and primary health care reform and the conditions that have contributed to it thus making “second round” changes in the domain easier to achieve?
5. Do current conditions make alternate methods of remuneration for physicians and primary health care reform more probable than other types of change?
6. What can be done to create the conditions that make alternate methods of remuneration for physicians and primary health care reform more probable? What can be done to change the conditions that hinder alternate methods of remuneration for physicians and primary health care reform in the province?

Question 1: How much reform has occurred over the last decade?

Most of our participants could not identify a specific date when alternative methods of remuneration first appeared on the government’s radar screen. Several noted that the issue appeared “long before the primary care issues were on the radar screen” (3) and one respondent referred back to the establishment of salaried physicians from the mid-1930s

³⁵ . Data employed to answer these questions have been generated from in-person interviews conducted by Stephen Tomblin. A total of 16 individuals were interviewed. These persons have been or are currently employed in government, in the health system or in advocacy groups. The interviews were recorded on cassette tape with the consent of each participant. An individual was hired to transcribe each interview. Jeff Braun-Jackson then edited each transcript to check for accuracy. All data were coded using the qualitative software package N6. The coding scheme and tables are included in Appendices 1 and 2.

cottage hospital system (12). In terms of time, participants seemed to recall the 1990s and the early part of the twenty-first century when the issue of alternate physician payments appeared. Much of this was connected to the province's interest in primary care reform which began with the federal government's funding program in the late 1990s. During this period, alternate physician payment models were developed for speciality physicians such as paediatricians because of the dwindling numbers. These specialists were treated by government as fee-for-service physicians but were paid a fixed income on a monthly or bi-monthly basis for providing a defined basket of medical services within hospitals. The contents of the basket would be negotiated between government and the NLMA. This model was adopted because the province "may not be able to keep the specialists ... if the compensation they get is on a strictly per service basis" (24). One participant argued that the issue attracting much more attention on the radar screen is not alternate payment models but rather scope of practice for physicians. For many residents in rural Newfoundland and Labrador, their doctor is a licensed practical nurse (LPN) and remuneration is less important an issue for government because of its fear of challenging the physicians: "Doctors don't like being monitored" (7). The appearance of the issue on the government's radar screen has become more sustained since the advent of primary health care reform but nothing of substance has been developed. Indeed, one of our participants remarked somewhat tongue in cheek that "there's been a lot of theoretical discussion, but I have yet to see a formally presented set of criteria on how this [payment models for primary care physicians] might work" (9).

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

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

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

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

The most frequently mentioned external driver was the federal government's provision of funds to establish primary health care projects in the provinces. Newfoundland and

Labrador's share of funding amounted to approximately \$9 million. Funds from the federal government have been used to establish the Office of Primary Care and the current pilot projects across the province. The federal money will run out at the end of March, 2006. There has not been any indication from the province that the Department of Health and Community Services will continue to earmark funds for the pilot projects to continue or provide resources to evaluate results. The lack of provincial funding is not lost on our participants. One participant wryly remarked, "You know, don't think for a second primary health care would be moving along in an agenda as it is now without that 9 million dollars" (7). Related to the provision of funding from Ottawa has been the adoption of primary health care reform in other jurisdictions. One participant noted "I think that [one] of the external driving factors is the movement across the country and internally would be some of the issues around access to primary care; access to 24/7 care and in terms of the ability to get primary care providers and have a primary care provider - those sorts of things - some of the access issues in the communities for us as a province" (21).

A key internal driver focuses on the efforts of other health care professionals to advance the establishment of primary health care teams that are interdisciplinary and flexible with respect to scopes of practice. For many in rural Newfoundland and Labrador, access to a doctor is nearly impossible and patients often receive basic medical services from a Licensed Practical Nurse (LPN) or Nurse Practitioner (NP). Nurses have been at the forefront of developing primary health care teams where every professional group's assets can be best utilized and deployed to treat patients in the best possible manner. A participant noted that "I think others are interested in having it [primary health care reform] moved; nurses for example, politically, are interested but they don't have the kind of power to move it forward" (12). However, patients, no matter how satisfied they are with the care provided by a non-physician health professional, still desire to see a doctor in their community. One participant remarked "you got a nurse or a nurse practitioner and people will say they're very, very happy with the service that they have seen but it's not a doctor; and every piece of research, every survey that has been done [show that] people in communities want their doctors" (12). Another participant suggested that enthusiasm for primary health care reform was more demonstrable among the non-physician health professionals and this posed problems for RHA administrators and CEOs because individuals could not be asked to perform tasks done by others as defined by scope. Our participant stated "I've often compared myself the private sector and said, I don't have the ability to be able to hire somebody to do a job that I want to be done. I am forced to take the fact that we have professional associations who carve out limits to these roles and, therefore, I have to hire a nurse in order to do that, or I have to hire a physiotherapist to do that. I can't hire somebody with the skill sets to do both" (27). Much of the debate with respect to scopes of practice comes from the privileged position occupied by physicians within the health system. Primary health care reform can not occur without support of physicians. With respect to the Clarenville project, it was physicians themselves who decided to put forward an alternate payment model so that patients would receive the best care. The pilot projects underway across Newfoundland and Labrador were established because there were groups of physicians in areas that were willing to endorse primary health care and work toward an alternate payment model other

than fee-for-service. One participant remarked “The department [Health and Community Services] is certainly looking at alternate ways to fund primary care services and the reason being or the challenge being is that the current system where we pay the physician, the money follows the physician versus... we think that the money should follow the patient” (13).

Reform in the field of alternate physician payment has focused more narrowly on the issues of recruitment and retention of doctors in rural and remote areas. Given the province’s vast geography, small population and limited fiscal capacity, physicians have been reluctant to work in isolated regions for limited pay. The province has the highest rate of salaried physicians in the country, many of whom practice in rural areas. However, lifestyle issues are important and efforts to reform payment models have been linked to issues such as workload, opportunities for further education, conferences and housing. Observed a participant, “the focus was on improving the recruitment and retention of physicians and we saw, in order to move that agenda forward, we had to move away from the one or two physicians, set it in small areas, being on call 1 and 1 or 1 and 2 - that we saw that in order to improve recruitment and retention, that we had to start sort of grouping physicians together” (13). Another remarked “there's another new element and that is a lot of the new physicians have come with a realization that they're not going to be working like their predecessors. There's a major population who are interested in raising families. They want to participate, but they're not going to be volume driven like their predecessors” (27). The desire to establish primary health care teams was, as one participant observed, “came from the grouping or clustering of physicians and, you know, other health professionals to support physicians and improve recruitment and retention” (13). The focus on physician recruitment and retention places government in a subordinate position vis-à-vis doctors because of labour mobility. If government fails to provide suitable compensation, incentives to practise in rural areas, opportunities to update skills and the like, then physicians will relocate to jurisdictions where they will be better compensated. Herein lies the power of the doctors. A participant noted that the success of primary health care reform rests with physicians: “the bottom line is without physician buy-in, it [primary health care reform] ain't going anywhere” (12). Another observed that “I think part of all this discussion has to recognize the power of the physicians. They are an incredibly powerful group in society and they're living in the dark ages [with respect to reform]” (16). The government does not want to alienate physicians and therefore it is this group that has framed the debate over whether or not primary health care reform will become a reality in Newfoundland and Labrador.

One other important driver of reform is the community. People in rural and remote areas have come together to pressure physicians and government to provide adequate medical services. Both groups have acknowledged community pressure with doctors acting in ways to secure compensation and lifestyle changes while government desires efficiency and affordability. As one participant noted, “community dissatisfaction and provider dissatisfaction were the two drivers there”(15). Another observed “I think the biggest driver that we have is communities who are crying out for the provision of primary care. I also think a huge driver is also the communities in which we know we actually have

primary care and we now just need to be able to set the funding model to what's happening" (20). However, some participants suggested that the public really does not understand the issues of alternate physician payment models and primary health care reform and thus have remained on the sidelines in the debate. When the public are not invited to participate, the agenda becomes dominated by the interests of physicians: "Well, I think they're [government] not getting pressure from the public around this because the public don't understand it, and that they're getting pressure from the physicians, so that's it"(12). For ordinary people, the issue is access to a physician.

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

Our participants observed that reforms have not occurred because of the power of the Newfoundland and Labrador Medical Association (NLMA); the inability of government to offer a suitable compensation package for physicians in place of the fee-for-service model; the difficulty of having physicians accept changes to their scopes of practice and the preoccupation of government with sustaining the basic health system.

The NLMA wields tremendous power with respect to physicians' interests. As a body, it acts as the negotiating agent with government on monetary and workload issues and represents physicians in their relations to the health boards. The failure of the Clarendville project was due, in part, to the NLMA arguing that government's fee model for the program was not sufficient to compensate the physicians for the work they would be performing. One participant suggested that "we're really not making much progress, and I believe that is because the physicians surely have not bought into it. So even though we're doing all the little pieces to get us ready to be there, we haven't made the jump into this is primary health care" (12). There are those decision-makers in government that fear change as well. These persons would prefer the status quo to reform: "... it's a reluctance to change, a wedded ness to MCP as the be-all and end-all and still some naysayers within government who are saying, you'd better be careful here" (20). Government has done a poor job communicating the goals of primary health care reform to the public. It has been only in the fall of 2005 that advertisements began to appear on local television stations and in newspapers touting the benefits of primary health care reform. Money for the advertisements comes not from the province but from Ottawa. The provincial government has not taken the lead on fostering a synergy among participants in a primary health care model. One participant lamented that "one of the things that government hasn't really done yet is the communication piece around the primary health care and the whole initiatives. We think they need to do more" (26). Calls for reform have grabbed the attention of government only when cast in terms of efficiencies and cost reductions without sacrificing patients' health.

Question 4: Is there a feedback loop?

From our evidence, it does not appear that a feedback loop is operating in this policy area. Reforms with respect to primary health care have existed independently of changes

to physician payment structures. The two issues intersected around 2000 as a result of government's embrace of primary health care as a method of providing more seamless care for small and highly dispersed rural populations. It is too early to tell whether or not the seven pilot projects will be successful with respect to outcomes.

Question 5: Do current conditions make alternate physician payment and primary health care reform more likely than other types of change?

An answer is difficult to produce because the key sources of funding for the pilot projects are due to run out at the end of March, 2006. However, Newfoundland and Labrador's fiscal position has become stronger as a result of the Atlantic Accord and the rise in oil prices following the war in Iraq and Hurricane Katrina. In the last fiscal year, government estimated oil to cost \$38 per barrel; in the first six months of 2005, the average price per barrel was \$57³⁶. While the province has raked in more money, there has not been any indication, formally or informally, about how much of these funds will be spent on health care and whether any funds will be used to further primary health care. Also of significance is the fact that the province and the NLMA are currently negotiating a new collective agreement. The NLMA wants pay increases for both salaried and fee-for-service physicians beyond the level that government imposed on civil servants after a lengthy strike in 2004. It remains to be seen whether physicians will resort to strike action should they fail to achieve their bargaining objectives. Our sense is that government will ultimately seek to satisfy physicians simply because of their hegemonic position within the health system. Failure to do so means that citizens are denied access to a doctor and government ultimately bares the blame.

Question 6: What can be done to make conditions for reform more favourable?

Fundamentally what needs to change to make reform more likely is for physicians to accept changes to their scopes of practice combined with some form of blended payment model that does not penalize fee-for-service doctors working in high volume areas. Government must take on the physicians and challenge the hegemonic position enjoyed by the NLMA. This will require leadership and political will and may result in some short term difficulty with respect to patient access. As well, government needs to provide incentives with respect to lifestyle to encourage more graduating doctors to enter into family practice in rural and other under serviced areas. Demographic changes to the physician population need to be addressed as well. Instead of allowing physicians to retire outright, perhaps government in negotiation with the NLMA can provide payment for these individuals to mentor younger doctors and work with them to ensure continuity in patient service. Making the conditions for reform more favourable requires leadership, a clear vision and additional resources, qualities which have been typically absent from government planning in health care in Newfoundland and Labrador.

³⁶ . Loyola Sullivan, Minister of Finance, Newfoundland and Labrador. Interview with Debbie Cooper, CBC News *Here&Now*, November 3, 2005.

Conclusion

We have attempted to demonstrate that much informal reform has occurred in the fields of alternate physician payment and primary health care in Newfoundland and Labrador. While legislation has not been enacted to provide for primary health care in the province, seven pilot projects are currently underway with an alternate payment model being developed as well. The main barriers to reform include the province's limited fiscal capacity, the lack of buy-in from physicians, struggles among health professionals with respect to scopes of practice and a lack of leadership and communication from government.

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