Alternative Payment Plans in Saskatchewan
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Physician payment is often a contentious issue between governments and the physician groups. Governments have argued that fee-for-service payment, which is the dominant method of physician payment in Canada, offers incentives for physicians to see many patients to the perceived detriment of high-quality care. Fee-for-service payment is volume-driven, meaning that time-intensive practices such as pediatrics or geriatrics where the physician needs to spend a significant amount of time with each patient are not as well rewarded.[1] Most of the literature shows that salary or capitated payment provides incentives for physicians to spend more time with patients, devoting more time to health promotion and disease prevention. Physicians, on the other hand, most often make the argument that salary and capitated payment reduce clinical autonomy as they make physicians *employees* of the government. Physicians are worried that this would hamper their ability to provide the best possible care for their patients due to bureaucratic restraint and interference. The diversion of views is perhaps why alternate payments have not taken a firm hold in many parts of the country. While the debate over alternative payments is certainly more complex than that it would seem by this analysis, these are the key issues.

One province where alternate payments have not taken a firm hold is Saskatchewan. Despite considerable literature documenting the successes of alternate payments in other parts of the world, support for alternative payments on the part of government, and a willingness by individual physicians to take a look at alternate forms

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of payment, there has not been significant movement away from the fee-for-service payment system in the province. Beginning in 1992 as part of a large-scale health system restructuring, the Government of Saskatchewan set up a branch of Saskatchewan Health dedicated to alternative payments (the Alternative Payments Unit) and began a number of pilot projects in various communities across the province. The physicians were paid using a capitated payment plan and were part of primary health care teams consisting of a diverse group of health care practitioners. This approach included service delivery and performance expectations that focused on team rather than individual results for individual patients and the population being addressed by the team. The projects were viewed as unsuccessful and did not create a large following for alternate payments. That was until the 2002 Action Plan sought a greater role for primary health care teams as part of the "wellness" initiative.

It must be noted that payments to physicians other than using a fee-for-service plan is not a new phenomenon in the province. With the introduction of medicare in 1962, a number of clinics sprung up around the province called *community clinics*. These rural clinics, which are still functioning today, have as few as a single physician paid for the most part through a non-fee-for-service method. However, given that these clinics have been operational since 1962 and have not been largely influential in the struggle over physician payment to date, it shows that the physicians who choose to work in these types of setting are first in the minority, and second, have the desire to practice in that type of setting. It may very well be that physicians more inclined to alternate payments gravitate toward the community clinic model in their practice.

Even though the option, either through the projects set up in 1994 or through community clinics, has been around for quite some time, there is still not see a large-scale move to non-fee-for-service payment a decade later. As of the 2003 fiscal year, fee-for-service paid physicians totaled 69% of total spending of the Medical Services Branch of Saskatchewan Health[2] whereas non-fee-for-service paid physicians accounted for 1.5%.[3] This project has attempted to answer the question of why the government decided to examine a voluntary alternate payment scheme through pilot projects set up throughout the early 1990s though not until 2002 with the *Saskatchewan Action Plan for Primary Health Care* were alternate payment plans viewed as a possible solution to delivery problems and supplemental to that, why has the voluntary program has not seen much growth in its decade of being. The Primary Care Network teams set up under the *Action Plan* are the predominant voluntary alternative payment program. These teams seek to integrate a physician into a comprehensive health care team; in 2006 only 23 per cent of the population is covered by a primary care team, though the goal is for 100 per cent coverage.[4] To help understand these questions, nine key informant interviews were carried out with various members of the health community. Members of the civil service, previous elected officials, representatives of various stakeholder groups such as: SAHO, independent researchers, and representatives from the Saskatchewan Union of Nurses as well as academics were interviewed. It should be noted that representatives from the physician stakeholder organizations, the Saskatchewan Medical Association and the

[2] The Medical Services Branch of Saskatchewan Health manages the Medical Services Plan. The plan provides Saskatchewan residents with physician, chiropractic, optometrist, and limited dental services. Management of the plan includes the administration of physician remuneration and exploring and implementing alternate payment plans.
[3] Saskatchewan Health: Medical Services Branch Annual Statistical Report, 2003/2004, p. 7-8
[4] Greg Marchildon and Kevin O'Fee, *Health Care in Saskatchewan: An Analytical Profile*, Regina, SIPP, 2007, p. 96.

College of Physicians and Surgeons were not made available for interview on this subject.

Definitions/Context

In discussing alternate forms of physician payment there are three main types of payment plans used by governments. While the average person is familiar with salaried payment, fee-for-service and capitated payments are not as well know. A salaried payment, for a physician as for most people, is a flat rate paid to the payee regardless of the amount of work they perform within the statutory limitations. As it pertains to physicians, this means that they would be paid the same amount of money regardless of how many patients they see in a day. The argument for this form of payment is that it removes the element of time as a concern during patient consultations therefore the physician is able to spend any amount of time with a patient without it affecting his pay. A fee-for-service payment is slightly more complex than a salary payment in that physicians are paid based on each individual service they perform. Saskatchewan Health consults with the Saskatchewan Medical Association and determines the amount a physician is to be paid for each individual service that is performed. When the physician performs services, they submit a bill to the government for the services that they have performed and government remits payment on this basis. The argument for this form of payment is that it provides physicians with an incentive to see as many patients as possible. Capitated payments are the most complex to understand of these three main types. Capitated payments are based on the number and characteristics of the population that a specific doctor or clinic services. Demographics such as age, sex, mortality and morbidity rates all come together to create a rate of pay for the physician in that specific

area. The National Health System in the United Kingdom has established an incentive based capitated system which includes a number of patient health related factors in determining some physician's salaries.

Salary, fee-for-service and capitation are the three main ways of paying physicians. There are other, less often used, methods and any number of permutations of blended payments. The pilot projects in Saskatchewan used largely the capitated form of payment, with one project specifically using the principle of *negation*. Negation is the process of taking away payment whenever a patient decides to venture outside of the capitation area for treatment. Patients are placed on a *roster* for a particular physician or clinic and anytime a rostered patient seeks care outside of that clinic, payment is reduced to the original clinic for the amount of that patient's outside visit. Such a system would work more easily in a rural area where there is not limited choice when it comes to the patient seeking out another physician, unlike urban areas where there are more clinics from which the patient can choose.

The Saskatchewan Story

The debate over physician payment in Saskatchewan dates back to the inception of medicare in 1962. At this time, physicians were worried that with the "socialization of medical care" there would be a reduction in clinical autonomy. Prior to medicare, physicians were paid by individual patients based on services provided: a fee-for-service system. Under medicare, the government agreed to keep a fee-for-service system, but each service would have a standard billable amount which would be paid by the government instead of the individual patient. This was the general approach, though some services and specializations were an exemptions to the rule.

Thus the fee-for-service system has been a part of Saskatchewan's medical culture since before the inception of medicare. Beginning in 1992 Saskatchewan Health undertook some of the most extensive reforms since the 1962, the nature of physician payment was a subject once again broached by the government. One participant in the civil service explains:

> there's a strong history I think in most provinces and certainly in this province of having non fee-for-service physicians but the alternative payment unit was actually established in 1994 and was in the medical services plan. And it was largely…a response to growing interest among physician and I think health providers in general to looking at different ways of delivering services. So there was interest then in looking at could we do contracts, could we do sessionals, what else could we do?[5]

The reforms to the health system begun in 1992 thus expressed renewed interest in alternative physician's payment models.

Two participants offered that ideas surrounding the movement to alternative payments started to become more prominent during the previous Conservative government:

> first of all I think some of the genesis of the thinking started coming out as…the utilization work that was done in the '80s. And…when you look at some of the cost drivers in the system and the role that physicians play as the gate keeper, I think people really began to think about some of the incentives in the fee-for-service system or the unintended incentives or disincentives in the fee-for-service system.[6]

These utilization studies were performed using community clinics "which have seen stable performance in the health care system. Community clinics used 17 physician days less despite the socioeconomic demographics being less well-off. They also used fewer drugs. So community clinics pioneered the alternative payment plans, but there hasn't been much acceptance from physicians to expand it. We have been very sensitive to the

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marketing to physician groups".[7] Although the projects are largely conceived as coming about after the decision to reform the system beginning in 1992,

> in the late '80s, early '90s because we were actually already proceeding with setting up our first pilot in the 80s…well 90 I guess which was Turtleford. And looking at funding… we were already doing some of the design work in terms of funding formulas. And then the government changed so there was a new administration and that I think was very receptive to a lot of change in the health system. But as well…the province was facing some fairly critical financial constraints. Health spending was growing at a rate that the economy could not support. And so I think that…and there were also some advisors in the system who came in with the new administration and had spend time working with the feds and looking at some of the northern models. And some folks who really I think bought into primary health care, but from a very philosophical as opposed to technical perspective. And there…a lot of client participation and…there was sort of a receptivity but more than that, it was not a data driven analytical – not that the data wouldn't have gotten you to the same place, but it tended to be sort of the philosophical orientation which I think at the end of the day caused its own set of problems, but that's neither here nor there…I just think there was a lot happening around the system in the '80s that were prompting people, in many different areas of the country, to really look at some of the new models and then you know the opportunity, there was…now under the…with the change in administration the physicians piece was very much left out of the health reform process.[8]

Before undertaking the large-scale reforms in the early 1990s, the Saskatchewan Government published a document entitled *A Saskatchewan Vision for Health: A Framework for Change* in 1992. Contained in this document was the vision behind the changes to be made to the health system. Included was a vision to better use health resources, which included physicians: "the medical professional is receptive to innovation and to reviewing its role in the health system, including working as team members with other health professionals. Major consultation has begun and a new dialogue is emerging. *Alternative methods of payment for physicians and the lack of*

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physicians in rural areas will be explored".[9] Two years after the document was published, the *Alternative Payment Unit* was set up within the Department of Health

> which worked with small rural communities for the purpose of bringing stability to the rural communities' health services. A fee-for-service system works well when the doctor is busy (and when there is sufficient population to do so. A small centre does not necessarily have the number of people to make fee-for-service viable for the physicians. Apps allowed the department/regional health authority to identify what they were willing to pay for their service on a contract this was fairly positive in terms of stabilizing physicians services for the community. People then began to talk about primary health care: wouldn't it be good if we could have a team that would share their expertise in the care of the patient? In Saskatchewan this arrangement was considered unworkable unless the physician was off the fee-for-service system the idea was that they would be paid a sum to look after a groups of patients.[10]

It must be noted at this point that a discussion of alternate payment in Saskatchewan invariably includes a discussion of primary health care. "The issue of APPs [alternative payment plans] came forward as a means to have physicians work more with other providers without losing income and the desire to have physicians be within the overall responsibility structure of the RHAs".[11] Alternative payments were a mechanism to get physicians working with other health practitioners in a more team-like manner. The framework for this was the Primary Health Care teams which place a physician with a diverse group of health care professionals; including nurses, nutritionists, physiotherapists, social workers and psychologists. The attempt is to provide comprehensive health care, prevention and maintenance.[12]

Federal-Provincial relations also played a role in why the alternative payment issue came up when it did as the federal Health Department also had the same propensity

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[9] Saskatchewan Health, *A Saskatchewan Vision for Health: A Framework for Change*, 1992, p. 21; emphasis added
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[12] Saskatchewan Health, *The Action Plan for Saskatchewan Health Care*, 2002, p.11.

too reform. When the alternative payments unit was set up and government was advocating a non fee-for-service method of payment, the federal Health Minister, Allan Rock expressed interest in alternative payment methods as an aspect of the federal initiatives on health care funding. But once the discussion moved from policy to funding a number of provinces, Quebec, Alberta and Ontario, became focused on to what extent they would be accountable to the federal government. The issue then became about federal-provincial relations as opposed to health care reform.[13] So negotiations were taking place at the federal level that were conducive to these kinds of policies, but after talks fell apart, they never resumed to the extent that concrete policies were able to be made. This, however, is only one contributing factor to the largely unsuccessful reform of physician payment.

In terms of inter-jursidictional learning, alternative payments is one case in which there is a plethora of literature and examples in other areas of the world where such programs are working quite successfully. Even within the country, in Ontario, Health Service Organizations (HSOs) have been using Alternative Payments in a successful manner. The United States, with its Health Maintenance Organizations (HMOs) also use non fee-for-service methods of payment.[14] In an attempt to advocate alternative payment mechanisms, government brought in physicians from other jurisdictions including those working under Ontario's HSO to speak to Saskatchewan's physicians about their experiences with alternative methods of payment. [15] But the physician culture of Saskatchewan is deeply ingrained against non-fee-for-service methods of payment such that little movement occurred despite the evidence supporting alternative payment plans.

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While federal support and inter-jurisdictional learning played a role during some stages of alternative payment policy development, the interplay between government and health stakeholders cannot be discounted as an important factor influencing policy. An interesting aspect of the issue of alternative payments is that because of its intrinsic link to primary health care and team-style practice, many of the health organizations in the province have a vested interest in the reform of physician's remuneration systems. It is not just the health department and physicians who weighed in on this issue, although they can be considered the key players in this.

This concept was largely brought forward through the civil service. The alternative payment unit created in 1994 was responsible for the setting up of various pilot projects across the province consisting of primary care teams where physicians were paid on a non-fee-for-service basis. Members of this particular unit were enthusiastic about this model of care. However, other members of the civil service were not as enthusiastic.

> But when you go within the department, outside of that group, and you talk to middle managers, the director level and below, there's a lot of skepticism about it…and I'm not sure that's something that they would be willing to admit or the department would be willing to admit but I've certainly encountered it. When you speak to the deputy ministers they're very much in favour of it. And when you speak to the politicians, most of the ministers that we've had in that last few years have been in favour of this. But within the department itself I think there's a good deal of skepticism.[16]

There were also those within the government that argued a change in remuneration mechanisms would be just "too much change all at once and… not enough work had been done with the physicians in terms of physician buy-in." .[17] So there was

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reluctance on the part of some civil servants given the huge amount of change that had gone into the health system by that time. One more change, and a change as large as moving physicians off a fee-for-service system, may have been too much for the public, the government, and most importantly, physicians, to accept at that time. This lends evidence to why government decided to move forward with a voluntary plan. Around the same time, there had been massive restructuring efforts followed by hospital closures. While physicians were in favour of restructuring, once government announced hospital closures, physician opposition dramatically increased. Given this already strained relationship, the government believed it was wise to opt for a voluntary program.

Furthermore, the SMA has traditionally represented fee for service physicians and thus did not lend much support to the government on this issue.

> The relationship between the department and the SMA on that issue was it always…a view that if I have a physician out there that's interested in being paid in a way other than the fee-for-service…what does that matter to you, right. But because they are largely geared to represent me at that time they saw themselves as representative of fee-for-service physicians you know they didn't like that, right…right now we're just trying to sign a memorandum of understanding for negotiations with non fee-for-service primary care physicians which will provide the groundwork anyways to do this.[18]

It must be noted, however, that while the SMA is not enamoured with the idea of alternate payments, some individual physicians may be open to the concept.[19]

> Physicians are distrusting of change as a group. It is inevitable that physicians are going to have to be moved off of fee-for-service and onto alternative payment mechanisms. The Americans have done this through the creation of managed care. So that you either work for an HMO and if you don't practice economic medicine you're out on your ass or you have a private practice but you are a PPO, you're a preferred provider organization for an insurance company or for an HMO and if you don't practice economic medicine you're out on your ass. And the insurance

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> companies and the HMOs have the power to force physicians off of fee-for-service.[20]

However, the SMA did made strides in addressing the issue:

> from the outset there was an alternate payment group with the Saskatchewan Medical Association…and one of the things that we tried to do was come up with a model contract with the association and to come up with a…sort of their agreement to the funding…a funding formula approach…and my understanding is…umpteen years later we still don't have a model contract, or their agreement on the funding formula…I guess while I was [working in] alternate payments one of the groups that I started working with very early on was the Department of Family Medicine…at the U of S. And I worked very closely with the department of health and we looked at…moving the whole group into an alternate payment arrangement.[21]

Given the recent restructuring and the taint that reform had come to have, there was concern in some cases that moving physicians to an alternative payment scheme was a cost-cutting measure.

> There was a public…nervousness about…this was just kind of a cost-cutting initiative…the SMA...had concerns about that this would restrict their job market…I think they were also concerned about that…the health district were very new, they were kind of a new creature and they really wanted to protect their independence of their decision making…I think many of them had worked in the managed care systems in the States where they felt that managers were sort of prescribing…what they could or could not do because it was an insurance approach…they were concerned about a bureaucrat, and I don't mean just a government bureaucrat but a bureaucrat in the health authority…putting those kinds of constraints on their clinical judgment and freedom to practice…And they did express concern about the quality of you know how could a nurse with an advanced practice do the things that they did.[22]

Another issue is that of team practice:

> Turf protection was big – doctors didn't want nurses taking over some of their scope of practice…we (government) marketed alternative payments as a lifestyle change. No you do not have to work 16 hour days and put many patients through. Also came from the idea that we could use nurses

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> more effectively…this way is seen as more flexible – doctors do not have to focus on throughput – and this would benefit their lifestyle.[23]

Even though government marketed it as a lifestyle change, physicians were still concerned about scope of practice issues within the team setting.

> Physicians are still, particularly older physicians are still reluctant to practice with a nurse practitioner, partially because they see it as a financial threat and partially because they see it as a positional threat. Younger graduates certainly are more willing to do it than the older ones are. And so to a certain extent this is a problem that will go away with retirement. Part of the reason is that we actually have a surplus of family practitioners and GPs in urban areas and…there's very little room for this kind of model because there's already too many doctors. So if we created…one of the advantages of these primary care projects is that physicians are not going to have to see every patient.[24]

There was one particular group of physicians, however, that was more accepting of the concept of working in a team setting and working on alternative payments mechanisms. International Medical Graduates (IMGs), largely from South Africa in Saskatchewan, have had experience working with members of a team, such as nurse practitioners, and are thus not as reluctant to do so. Our participant from SAHO stated: "we recruited largely from South Africa so you know those physicians in many cases had already worked with nurse practitioners who were working in that kind of a team environment where you know they had more sharing of the patient workload." [25]

While physicians were not particularly enthusiastic about the program, nurses were receptive to the idea of alternate physician payment through primary health care teams. At this point, though, it is difficult to determine whether nurse groups would have weighed in solely on alternative payments or if their support was lent to the idea of primary health care teams. The government

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> worked…with both SUN and the SRNA I guess even early on because once we had the first graduates coming out of the SIAST program we… sort of had to negotiate their entry into the system. Because…and unfortunately you know physicians wanted them to be not part of the union and SUN really wanted them to be part of the union and at the end of the day they were in the union which caused some degree of concern on the part of the SMA…because our legislation did not allow them to work in an advanced practice, they worked in an advanced practice under a transfer of medical function and so we worked very closely with the College of Physicians and Surgeons and the [College of Pharmacists]…in the mid 90s when we actually set up the primary health services branch… The professional associations had actually established a primary health care sort of network of all the sort of professional bodies….And so we really worked through them because it was very helpful to have a mix from the outset. And so we really worked through them because it was very helpful to have a level of support from the system and at the time there was very strong support from the College of Physicians and Surgeons, the pharmaceutical association and the SRNA to move forward [with the primary health services approach].[26]

However, one academic participant noted that nurses became lukewarm to the idea of multi-disciplinary teams due to the fact that nurses on those teams would perform a different function from those in other workplaces. Nurses on interdisciplinary teams would be able to use a more full scope of practice and they would thus be treated differently than nurses in other settings.

> So these multi-disciplinary teams gain support from nurses groups until they start to realize that it might mean that some nurses are going to get treated differently from other nurses, particularly nurses with special qualifications such as nurse practitioner qualifications or clinical nurse specialist qualifications. And at that point their support tends to become a bit lukewarm. And so it's not that they're actually opposed to the way hat these multi-disciplinary teams might end up functioning. And so indirectly they become lukewarm to physicians' alternative payment plans.[27]

While physicians and nurses weighed in on the issue, it had come up in response to the wellness initiatives contained in the reform package and was thus an offshoot of

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the wellness model. It was thus not an interest driven model, but a government driven model.

> The wellness model called for community health centres…The model was that we were going to have multi-disciplinary teams including physicians. And when you have a multi-disciplinary team it doesn't make sense to pay physicians on fee-for-service because you don't necessarily want a physician to see the patient every time, if the patient doesn't see…if a physicians doesn't see the patient in a fee-for-service model the physicians can't bill.[28]

One participant with the civil service concurs:

> it came out of the health reforms of the early 1990s where the desired outcome was that local boards would do the decision making. This made things closer to home for communities (in theory the local board would take ownership). Saskatchewan at the time worked on a new governance model of delivery of services which consisted of a regional governance structure. This was flagged as the first thing for emphasis during the reform process. Once there was leadership at the Health District level, then the thinking was they would look at manpower. In the mid-90s they looked more seriously at how to draw physicians closer to the management structure for health delivery.[29]

Despite the support of various groups, participants overwhelmingly admitted that moving to a mandatory alternate payment scheme for physicians would cause disturbance in the medical community. "You can only really do big systemic change if you make it an involuntary process and I think in this province, given our size and given our need in terms of recruitment, to make it a mandatory process at that time, we would have been, it would have been extremely difficult." [30] The fear was that the SMA would believe that government was trying to control physicians' practice.[31] However, it would not be prudent to speculate that this actually was the case given more recent moves by the SMA

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and government to create a memorandum of understanding that allows the SMA to represent non-fee-for-service physicians.

According to one participant who dealt with physicians in this process, one idea in the back of physicians' minds during this process was that with an alternate fee structure, physicians would become employees of government rather than keeping their traditional entrepreneurial status (despite being paid by public money).

> Doctors are and have been independent businessmen and they are proud of that. Newer physicians are more attracted to the eight to five Monday to Friday lifestyle. But the older doctors like being businessmen where they make money on a fee-for-service and they are not put at risk. They do not want this taken away. If you make a contract with a physician, it has an expiry date. Physicians do not want government controlling their lives. Physicians want to know what is in it for them they want more money if it is going to be this way…So its' a tough sell. Nobody wants to take less money. So there is a lot of reservation on the part of doctors. Another part of it is that before 1990, doctors took more ownership and pride in maintaining the service of their hospitals. They would make sure that the hospital was running smoothly, they would stay on after hours or make sure that people were on call and able to be there etc. This was their social contract. In 1990, people started thinking that doctors had too much power, so boards took over a lot of the management responsibility and doctors began to withdraw. They felt they lost that social contract they felt marginalized.[32]

The issue harkens back to the beginnings of medicare as well: "this was the number one issue I think that caused the physicians strike in '62. Doctors did not like medicare but the things they liked about medicare the absolute least was the notion that physicians might become employees of the government and that the government might be able to tell doctors how to practice and might put doctors on salary."[33]

What must also be understood when analyzing issue of alternative payments is that this form of payment has been institutionalized for many years. Even prior to the

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inception of medicare, physicians were paid on a private-payer fee-for-service basis; patients would pay their physician based on the services they received. As with anything that has been around this long and embedded in the culture, you have to be careful in modifying it or you risk catastrophe. "You're talking about changing a system that…has been in place now for over forty years and so you talk about changing a system that's really ingrained in how they believe that they're going to operate, and I don't think change is every easy and certainly it's not going to be easy when we were doing these contracts, it's not an easy concept, it takes a lot of work."[34]

Furthermore, the intentions of government were not to control physicians practice with alternative methods of payment, but to facilitate cooperation within health care teams. It is not meant to drive short, quick patient visits, but to facilitate better cooperation and care. The team structure is meant to provide a thorough health care response that is not just therapeutic but also preventive. Requiring a team approach centered on the patient and if a single member of that team is paid on a fee-for-service basis that person is inclined to have a greater number of patients while the remainder of the team is attempting to focus on removing time constraints from patient care. Changing to non fee-for-service pay arrangements also changes the scope of practice to allow each member of the team to practice with a more full extent.

> How we go about enhancing sort of the public understanding that if physicians were actually spending their time investigating…(and) focusing on people with you know more complex conditions, that a lot of the…fairly straightforward things that people seek medical care for could really be managed by someone other than a physician. And people, professionals bring quite different skills…to a team and so our view is that you'd actually end up with a higher quality of care.[35]

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In terms of influence from external sources most has come from published reports extolling the virtues of alternative payments as compared to fee-for-service. Informing the government's decision were reports such as the Barer-Stoddart report and the Hastings report.

> The national government, the federal government, had a commission on community health centres in the '70s. It was a mission of inquiry. And it recommended community health centres put physicians on [alternative payment arrangements]…this was John Hastings, Hastings report. He was a physician and specialist in community health actually at the University of Toronto. And he did a commission for the federal government in the 70's on community health centres and part of that recommendation was that physicians be put on some kind of salary or per capita payment.[36]

The Barer-Stoddart report sought to address the problem of physician retention and improving medical services in rural/remote areas. They prescribed three areas for reform; the first is a medical services funding model linked to a population based system, second expand the role of non-physician health care workers and finally an education-related strategy linking rural/remote access to academic health centers.[37] Barer-Stoddart like Hastings saw the necessity of reforming physician funding from a provider basis to one focused on population. These external factors are putting pressure on physicians to address changes in the way government pays for these services.

Furthermore, a social values change was, and still is, taking place both within the medical community and in government providing internal factors to reforming physician pay schemes. Whereas once physicians were willing to work long hours and always be on call, this is no longer the case. One participant suggested that physicians want more balance in their life and do not want to work agonizingly long weeks. Alternative

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[37] Morris Barer and Greg Stoddart, *Improving Access to Needed Medical Services in Rural and Remote Canadian Communities: Recruitment and Retention Revisisted*, Discussion paper prepared for Federal/Provincial/Territorial Advisory Committee on Health Human Resources, 1999, p. 39-40.

payments fit with this change as physicians would no longer feel obligated to push many patients through to guarantee a certain level of income.[38] Also,

> from the Department side, the issue was a challenge in rural Saskatchewan in terms of workload and lifestyle…the Department never saw it as a cost containment issue. The factor was a change in behaviour so that doctors had more time for chronic disease management and had more time to spend with their patients…this often focused on the physician's side. One of the biggest reasons for change was patient behaviour so that doctors had more time for chronic disease management and had more time to spend with their patients.[39]

In the end, governments' main objectives as reported by a civil service participant were:

> to have a more integrated approach, to actually try and have health providers working to the full scope of their practice and to really ensure that we were…sort of using the health resources as effectively as possible…one of the real messages was this was a better model of care, it wasn't sort of a…lower alternative in terms of quality…we could have a higher quality of care and we could use our health providers more effectively. And the way that we compensated physicians on the fee-for-service system was a barrier to having them participate because we had a system that was set up based on fees for actually providing client service and sometimes it wasn't a direct service that they needed to be engaged in.[40]

Such goals fit nicely with the values change that is taking place among physicians. The civil service was the primary driver of alternative payment plans through primary health care teams. The support of individual physicians and stakeholder groups helped get the voluntary program off the ground.

However, while government was seeking to achieve a better way of providing health care, it must also be noted that they are struggling against years of tradition. Some physicians, largely of a younger generation, have different priorities than those of the older generation and hope to work on non-fee-for-service payment. As some participants

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suggested, it may prove that a generational shift will provide a more appropriate landscape for an alternative payment program. And yet it seems as though there had been no vigorous opposition to the scheme, as yet though this conclusion is made without input from the official physician professional associations.

Government participants suggested that the reason for a voluntary scheme was that an involuntary scheme would produce backlash in the medical community. The last time there was large-scale backlash in the medical community, physicians went on strike. The memory of the doctor's strike in 1962 seems to be quite fresh in the minds of many. Although physicians eventually ceded and called a halt to the strike, relations between the SMA and government have since been cordial, but cautionary. Government troad lightly on the issue of alternative payment plans due in no small part to the memory of 1962. This was not necessarily an unfounded action as a generational shift is most likely to produce movement towards a more encompassing alternate payment scheme.