



EVIDENCE SYNTHESIS

APPROACHES TO REMUNERATION OF PHYSICIANS
FOR VIRTUAL CARE

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EVIDENCE BRIEF

Approaches to Remuneration of Physicians for Virtual Care

Introduction:

Virtual health care continues to be an evolving practice that has extended far beyond Canadian jurisdictions. Given the current shift to more virtual mechanisms of health care service delivery, remuneration of service providers is both a practice and policy concern. A recent report indicates restrictions on billing codes for virtual appointments is

a key barrier that prevents physicians from using virtual methods of service delivery (1). Moreover, the Canadian Medical Association notes that physician payment for virtual care services is a major barrier to the uptake and expansion of digital tools (2). There is a timely opportunity to look critically at the payment models used in Canada and Internationally, to consider what policies might best support the uptake of virtual care delivery.

While most provinces and territories offer a fee-for-service or salaried model, some international jurisdictions have opted to compensate their physicians by using the capitation model. In Canada, only the province of Ontario has adopted components of the capitation model to compensate physicians; full capitation models have not been adopted in the rest of the country to date. This brief provides an overview of evidence for four models of remuneration; capitation, fee for service, salary, and pay-for-performance models.

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Ontario Medical Association, 2020

- **Capitation Model:**

The capitation model is where physicians are paid set amounts for each enrolled person assigned to that physician or group of physicians, whether or not that person seeks care. For example, a physician is paid \$50 for each of the 250 patients under their care per month, even though the physician may end up seeing only a small percentage of them in an average month. While many patients do not require the physician's services that frequently, the physician still receives an average of about \$100 per each patient visit in an average month (3). The amount of remuneration is therefore based on the average expected healthcare utilization of that patient, where more compensation is provided for patients with extensive medical histories and needs.

Other factors that are considered include age, race, sex, type of employment, and geographical location (3). The capitation model provides financial certainty to both providers (physician's and the health care system in general) and payers (insurance companies or governments) in care delivery. Providers assume the risk of taking on more patients than they expect to become ill and need care but will be increasingly compensated by the number of individuals they are responsible for (3). The UK follows this model of remuneration and uses a standardized mortality ratio to give insurers an idea of what to expect from an individual in terms of health care usage, and is based on age and sex (4).

- **Fee-For-Service Model:**

The fee-for-service (FFS) model is currently offered in all Canadian jurisdictions. According to one report, Ontario inaugurated a "Primary Care Reform" characterized by the sequential introduction of new payment models that were designed to replace traditional FFS models for general practitioners. Since the introduction of a blended model in 1998, the number of physicians paid by traditional FFS models has dropped from 100 percent to just under 30 percent by 2013 (5). Even with the blended model, physicians are still required to receive a portion of their salary through FFS, resulting in 97% of physicians in Canada still receiving a portion, or all, of their salary through FFS (6).

There is evidence to suggest that fee-for-service models overuse medical resources compared to capitation payment models (7). Overall, physicians in the capitation group enrolled fewer new patients than did physicians in the enhanced FFS group, the same being true of new medical school graduates. These studies suggest that physicians using the capitation model were less likely to take on additional workload that could make them overworked and unable to deliver timely healthcare to all of their patients (7). However, it is noted that given the current lack of physicians and large waiting lists for patients to access general practitioners, more recruitment and retention of physicians would be required to ensure care can still be delivered at the current rate if alternative models were employed.

- **Salary Model:**

In the salary model, physicians often have work-hour stipulations built into contracts to maintain productivity and health care goals. There is conflicting evidence regarding the success of the salaried model in comparison to a FFS approach. Some studies suggest salaried physicians had smaller patient lists and provided shorter consultations; however, they also prescribed less, spent less time on administration (8), and were more likely to provide pro bono care (9). Other studies found no differences in preventative care practices, patient lists, or self-help promotion between salaried and FFS physicians (8). Specific characteristics such as the practice type, personality, and environment of the physician could also have had an effect on this evidence, potentially rendering the salary model more effective in specific practice settings.

- **Pay-for-performance Model (P4P):**

The P4P model aims to improve the quality of health care delivery by remunerating physicians based on clinical measures and quality goals. There is mixed evidence around the effectiveness of this model, as it brings with it much complexity to remuneration. Specifically, two studies evaluating the model found that physicians seemed to focus care around meeting particular clinical targets and were less efficient with care sectors that were not incentivized, or were less efficient in particular areas once targets were reached. From a policy perspective

there are implementation challenges to this model as payment end points are not clear and physician motivation is a key driver of such a model (8).

Changes in Payment Models as a Result of the COVID-19 Pandemic:

The COVID-19 pandemic has shone light on the fragmented system currently in place for physicians' remuneration and exacerbated issues as to how physicians are currently compensated. It has been noted that physicians who depend on fee-for-service payments have seen their incomes drop considerably during the pandemic, while those paid under other models (salaried, blended) have been relatively unscathed financially (10). This can be attributed to several factors, including the fact that in many cases, the FFS model does not compensate physicians for simple, but vital, interventions like checking in with patients over the phone. In many jurisdictions, billing codes for virtual health services have been put in place to alleviate some of the additional work physicians are being asked to do, however, when FFS interventions such as 'text messages' are worth such a small amount of money, it is not financially beneficial for the physician to file for this money due to the administration fees and lost time (11). A survey of 4900 physicians was completed by the Ontario Medical Association, where more than half have had to lay off staff due to the pandemic, and 49% have said they would have to close their practices if they did not receive financial support soon (12). In response to physicians struggling financially, Nova Scotia has implemented a stabilization program to ensure physicians are receiving most of their expected income, and to ensure that the province retains their physicians beyond the pandemic. To qualify for this program, physicians must agree to be redeployed, if necessary, to meet the demand of potential COVID-19 patients (13,14). Other jurisdictions across Canada have not yet put similar programs in place as of January 2021. Internationally, the UK is committed to developing their virtual health care programming, setting out the goal of making sure every patient will be able to choose between in-person consultations and virtual consultations by the year 2024. Furthermore, physicians in the UK have generally embraced the introduction of virtual care solutions; evaluations of their payment model strategy that examine its capacity to handle a greater influx of patients using virtual tools should be conducted to support further innovation in health care systems (15).

Conclusion:

Virtual health care programming is being rapidly incorporated into the new normal of health care service delivery in Canada. While the disruption posed by virtual health tools may increase costs for governments while the system adjusts, the long-term impacts of virtual health care are likely an increase in accessible, quality care for Canadians. While FFS remains the most popular model across Canadian jurisdictions, the capitation model, salary model, P4P model, and blended model offer provincial and territorial governments different options to consider in designing a better solution for their future health care system needs. For governments and physicians, a system that offers flexibility, quality care for patients, and reduces the financial burden for all parties involved, is a priority to building a sustainable future for virtual health care services in Canada.

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