PAYMENT IS POWERFUL:
Overcoming Canada's Shortage of GPs by Increasing Family Practice Compensation

IDA RAYSON

February 2005

The Atlantic Institute for Market Studies (AIMS) is an independent, non-partisan, social and economic policy think tank based in Halifax. The Institute was founded by a group of Atlantic Canadians to broaden the debate about the realistic options available to build our economy.

AIMS was incorporated as a non-profit corporation under Part II of the *Canada Corporations Act* and was granted charitable registration by Revenue Canada as of October 3, 1994; it recently received US charitable recognition under 501(c)(3) effective the same date.

The Institute's chief objectives include:

a) initiating and conducting research identifying current and emerging economic and public policy issues facing Atlantic Canadians and Canadians more generally, including research into the economic and social characteristics and potentials of Atlantic Canada and its four constituent provinces;

b) investigating and analyzing the full range of options for public and private sector responses to the issues identified and acting as a catalyst for informed debate on those options, with a particular focus on strategies for overcoming Atlantic Canada's economic challenges in terms of regional disparities;

c) communicating the conclusions of its research to a regional and national audience in a clear, non-partisan way; and

d) sponsoring or organizing conferences, meetings, seminars, lectures. training programs, and publications, using all media of communication (including, without restriction, the electronic media) for the purpose of achieving these objectives.

Board of Directors
Chair: David McD. Mann; Vice-Chairs: John F. Irving, Peter C. Godsoe, John C. Walker
Chairman Emeritus: Purdy Crawford
Directors: George Bishop, George T.H. Cooper, Hon. John C. Crosbie, Brian Lee Crowley, Jim Dinning, J. Colin Dodds, Frederick E. Hyndman, Bernard Imbeault, Phillip R. Knoll, Colin Latham, Martin MacKinnon, G. Peter Marshall, John T. McLennan, Norman Miller, J.W.E. Mingo, Elizabeth Parr-Johnston, Derrick Rowe, Jacquelyn Thayer Scott, Paul D. Sobey, Dianne Kelderman
President: Brian Lee Crowley

Advisory Council
John Bragg, Angus A. Bruneau, Don Cayo, Purdy Crawford, Ivan E.H. Duvar, James Gogan, Denis Losier, Hon. Peter Lougheed, James W. Moir Jr., James S. Palmer, Gerald L. Pond, John Risley, Cedric E. Ritchie, Joseph Shannon, Allan C. Shaw

Board of Research Advisors
Chair: Professor Robin F. Neill, University of Prince Edward Island
Professor Charles S. Colgan, Edmund S. Muskie School of Public Service, University of Southern Maine; Professor Jim Feehan, Memorial University of Newfoundland; Professor Doug May, Memorial University of Newfoundland; Professor James D. McNiven, Dalhousie University; Professor Robert A. Mundell, Nobel Laureate in Economics, 1999; Professor David Murrell, University of New Brunswick

2000 Barrington Street, Suite 1006, Halifax, Nova Scotia B3J 3K1
Telephone: (902) 429-1143; fax: (902) 425-1393
E-mail: aims@aims.ca; web site: www.aims.ca

PAYMENT IS POWERFUL:

Overcoming Canada's Shortage of GPs by Increasing Family Practice Compensation

IDA RAYSON

Atlantic Institute for Market Studies
Halifax, Nova Scotia

February 2005

© 2005 Atlantic Institute for Market Studies

Published by Atlantic Institute for Market Studies
2000 Barrington Street, Suite 1006
Halifax, Nova Scotia B3J 3K1

Telephone: (902) 429-1143
Fax: (902) 425-1393
E-mail: aims@aims.ca
Web site: www.aims.ca

I would like to thank AIMS President Brian Lee Crowley and Vice President and Director of Operations Charles Cirtwill for providing me with the opportunity to complete this project and for their support and guidance through it. Many thanks also to David Zitner, Director of Medical Informatics, Faculty of Medicine, Dalhousie University, for his ideas and comments on the draft of this paper.

I would also like to express my gratitude to Edwin Coffey, Brian Ferguson of the Department of Economics, University of Guelph, and Neil Seeman of the Department of Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto, who offered their thoughts and criticisms.

This paper could not have been possible without the generous support of the Max Bell Foundation.

Edited and prepared for publication by Barry A. Norris; design by Gwen North.

The author of this report has worked independently and is solely responsible for the views presented here. The opinions are not necessarily those of the Atlantic Institute for Market Studies, its Directors, or Supporters.

CONTENTS

About the Author iv

Executive Summary v

Introduction 1

Billing for Uninsured Services 3

Primary Health Care Cooperatives 5

GPs with Specialist Interests 8

Conclusion 12

References 13

About the Author

Ida Rayson is the summer 2004 intern at the Atlantic Institute for Market Studies. She has a B.A. with honours in Business and Society from York University, specializing in Economics and Political Science, and an M.A. in Canadian Politics from the University of Windsor.

Ms. Rayson's Master's paper was entitled "Say Aah: An Examination of the Shortage of Physicians Compared to Dentists in Small Communities in Canada", which concluded that the system of remuneration for general practitioners (GPs) contributes to their lack of supply in Canada. Her internship project expands on her Master's project by exploring potential models for GPs to increase their incomes and/or practice revenues by systematically integrating uninsured services into their practices.

Ms. Rayson also has experience with content analysis and an interest in reproductive technology and Middle Eastern politics.

Executive Summary

Canada is facing difficulties recruiting medical graduates to practice family medicine, and the range of services offered by the current supply of general practitioners (GPs) is shrinking. Poor working conditions, a consequence of existing remuneration systems, are contributing to the dwindling supply of comprehensive primary care services, and the current system of remuneration creates inefficiencies in the delivery of primary health care.

There are, however, various ways to improve primary care practice and increase GPs' practice revenue without resorting to additional public funding. For example, GPs could bill patients more aggressively for services they now deliver at low cost or free of charge but that are uninsured by provincial governments. Under the fee-for-service approach, physicians simply charge the patient directly for the service provided. Under flat-rate billing,GPs charge the patient an annual rate in exchange for the delivery of uninsured services, including such popular ones as telephone, e-mail, and fax prescription renewals. And under hourly billing, physicians simply set an hourly rate for services, taking account of the kind of service provided, the physician's experience and expertise, and the cost of materials.

GPs could also make better use of associated primary care staff, such as nurse practitioners, and they could join multidisciplinary practice settings, such as primary care cooperatives. For patients, cooperatives offer "one-stop shopping" of an array of services across disciplines and specialties. For physicians, cooperatives offer improved benefits and increased revenue, as well as the possibility of a more challenging professional environment and relief from burdensome administrative duties.

Finally, GPs could develop skills in lucrative primary care subspecialties, both insured and uninsured, that pay higher hourly rates than the normal menu of primary care services. Such services include plastic surgery, travel immunization, and weight loss and diet counselling.

All these options have the potential to improve the efficiency of Canada's health care system. By making better use of their time and delegating more tasks to non-physicians, GPs could spend more time on primary health care and other services Canadians demand. By following proper business practices in billing patients for uninsured services, GPs could increase their compensation, which, in turn, would attract more doctors to family medicine. By joining a cooperative, physicians could lighten administrative and other burdens, interact more efficiently and effectively with their colleagues, and offer patients a multiplicity of services. For Canadians generally, the result would be much-needed better access to primary care, fewer emergency room visits, shorter waiting times, and better preventative care. The savings from these positive results could then be put to better use elsewhere in the health care system.

INTRODUCTION

Canada's health care system is suffering. Canadians face long waiting times for specialty care and many do not have access to a family doctor, which violates the *Canada Health Act*'s principle of universal access to health care services. In large part, this situation can be attributed to the way health care is organized and to growing discontent among general practitioners (GPs).[1]

GPs play a vital role in the health care system in both health promotion and treatment. Yet they are becoming harder for Canadians to find. Fewer and fewer medical school graduates opt to become GPs, and many current practising physicians refuse to accept new patients.

The shortage of GPs is particularly acute in rural areas, where about one-third of Canadians live but only 18.6 percent of family physicians practise (Canada 2002, 8). In large urban centres, too, the problem is serious: the Quebec College of Family Physicians estimates that, in 1999, 300,000 Montrealers had no family physician (Rachlis 2004, 200).

The reason for the growing disenchantment of GPs is simple: they are overworked and underpaid. Physicians work extreme hours, many of which are spent on administrative tasks for which they are not compensated and which are best left to less-skilled individuals. Many physicians also provide "uninsured" services that their province's health insurance does not cover, but for which they are reluctant to bill patients. As a result, doctors are often obliged to discontinue such services because the rewards are insufficient to sustain the supply, which then exacerbates the difficulties Canadians face in obtaining high-quality primary health care when they need it. In short, GPs' poor working conditions, inefficient use of their time, and inadequate remuneration are creating inefficiencies in the delivery of primary health care and contributing to Canada's diminishing supply of comprehensive primary care services.

GPs could take several steps to lessen the pressures they face and make family practice a more attractive option. For one, they could lighten their workload and use their time more efficiently by making better use of associated primary care staff, such as nurse practitioners (see Box 1). The focus of this paper, however, is on the compensation side of the equation: how GPs could increase their remuneration without the need to ask for additional public funds. In that light, the paper examines

1 Family physicians deal with the day-to-day health problems of family members. Because of the wide variety of health problems they examine, they are considered to be "non-specialists". In general, over the past decade, new medical graduates who practice as family physicians have completed their MD degree, followed by a two-year residency program, and have passed the certification requirements of the College of Family Physicians of Canada. Many physicians who have been in family practice for a longer period of time and who do not have College certification are referred to as "general practitioners". See web site: < http://atlas.gc.ca/site/english/learningresources/glossary >.

Box 1: ***Can Nurse Practitioners Help Canadians Access the Health Care System?***

Nurse practitioners (NPs) are registered nurses who are qualified to perform additional services such as health assessment, minor medical treatment, and preventative care. NPs also order diagnostic tests, perform screening tests, monitor stable chronic conditions, and may even prescribe certain drugs. NPs work in a variety of settings, including nursing homes, hospitals, community heath centres, general practice, ambulatory care clinics, and northern nursing stations.*

Nurse practitioners may be able to fill the primary care void in rural and remote regions and help physicians in urban settings practise medicine more efficiently. By taking on many simple procedures now performed by physicians, NPs could allow doctors to focus on more complex cases, increase the volume of patients that a practice can handle, and generate more revenue for the practice — that is, if the practice is allowed to bill patients to cover the cost of an NP and associated overhead. In Ontario, however, physicians are not allowed to bill for the services that NPs provide and must pay the salaries of NPs they employ out of the practice's gross income. In effect, NPs in Ontario take patients and billings away from physicians.

A number of barriers exist to implementing the nurse practitioner model broadly across Canada. First, rural and remote areas of the country face the same challenges in recruiting and retaining NPs as they do for GPs. Second, legislation concerning NPs is either lacking or inconsistent across the provinces — even the definition of "nurse practitioner" remains unclear — or in need of reform to allow NPs to be more effective. In Ontario, for example, NPs are authorized to prescribe a range of drugs but cannot independently renew prescriptions for certain stable chronic conditions. Third, legal issues surrounding the use of NPs remain unresolved — for example, unclear delineation of medical-legal responsibilities may make GPs hesitant to become involved in shared decisionmaking with NPs. (See Way et al. 2001.)

* See the web site of the Nurse Practitioner Association of Manitoba: <http://www.nursepractitioner.ca>.

three methods by which doctors could obtain compensation for the uninsured services they perform. First, they could bill patients more aggressively for uninsured services they now deliver free or at low cost. Second, they could join a primary care cooperative, which offers the potential for substantial increases in administrative efficiency and, for patients, "one-stop shopping" access to health care services. And third, GPs could develop skills in primary care subspecialties, whether insured or not, that are more lucrative than the normal menu of primary care services.

The widespread adoption of these methods by general practitioners could do much to ameliorate Canada's shortage of family physicians, increase efficiency in the health care system, and improve Canadians' access to high-quality primary health care.

Billing for Uninsured Services

According to one estimate, between 5 and 15 percent of a physician's gross income might not be billed or collected in any given year because, among other reasons, physicians are uncomfortable asking patients to pay for uninsured services, particularly patients they suspect lack the financial means to do so, or because staff members have been inadequately trained to handle the fee-collection process (Price 2003). Yet there is no reason physicians should not bill patients for uninsured services they have rendered. Lawyers and accountants bill for all services, and everyone accepts this as normal and fair — why should seeing a doctor be any different?

Of course, some specialists — for example, private clinics in Alberta that offer cataract removal surgery — and family physicians do charge patients for incidental fees and services that are neither insured nor expressly described in their provincial health system's benefits schedule but are considered to be routine procedure. For the most part, provincial governments have chosen not to notice this sort of revenue building (Naylor 1999). Critics may see such practices as contradictory to Canada's health care system, but how does it help the system for physicians to lose compensation because they fail to bill for their services or for patients to wait ever-longer times for apparently decreasing supplies of services?

It should also be noted that, although a provincial health plan may not cover a particular service — because it is not considered "medically necessary" or because there is not enough money to provide it — such services are still important to many patients, particularly certain groups such as women or the elderly. Many of these uninsured services make a vital contribution to patient outcomes, health promotion, and disease management.

Billing Procedures

The *Canada Health Act* permits physicians to charge for services that are not covered under their provincial health insurance systems, and all the provinces have similar general guidelines for billing for such services. Usually, these amount to a requirement that physicians inform patients beforehand of the cost of the service and the setting of ways in which physicians may bill patients. The Ontario Medical Association (OMA), for example, outlines three ways for physicians to collect fees for uninsured services: fee-for-service, flat-rate, and hourly billing.

Under the fee-for-service approach, physicians simply charge the patient directly for the uninsured service, taking into consideration the nature and complexity of the service provided, the time taken

to provide it, the physician's experience and expertise, and the cost of materials not included in the fee for the service (OMA 2003). This approach might be attractive to patients who believe that they will require an uninsured service only occasionally.

Under flat-rate billing, physicians charge their patients an annual rate in exchange for the delivery of uninsured health care services. In Calgary, for example, the Crowfoot Village Family Practice offers patients the option to pay an annual flat rate to cover such popular uninsured services as telephone, e-mail, and fax prescription renewals.[2] Flat-rate billing is a useful alternative for patients who think they will make extensive use of uninsured services. Patients will also be more inclined to pay for uninsured services on a flat-rate basis if the price of each individual service is comparatively higher than when the services are bundled together in an annual package.

Under hourly billing, physicians simply set an hourly rate for providing uninsured services, again taking account of the kind of service provided, the physician's experience and expertise, and the cost of materials.

2 See the practice's web site: <http://www.cvfp.com/patient_prescpolicy.html#>.

Primary Health Care Cooperatives

Cooperatives are, in essence, organizations that are owned by members who benefit from their services. Primary health care cooperatives differ from other types of cooperatives only in the sense that the members' concern is health care services. Health cooperatives are common in other countries and now are found in six Canadian provinces: British Columbia, Saskatchewan, Manitoba, Quebec, Prince Edward Island, and Nova Scotia.

Cooperatives improve patients' access to health care services because they offer an array of services across many disciplines and specialties — including counselling, nutrition, social work, and physiotherapy. Patients also have access to nurse triage services and nurse practitioners. In effect, cooperatives provide patients access to "one-stop" shopping. For physicians, the benefits and increased revenue associated with cooperatives may make family medicine more attractive. In a cooperative, the GP may find a more challenging professional environment and relief from burdensome administrative duties.

Physicians who practise in a health cooperative are usually paid a salary for providing both insured and uninsured services, with working conditions and the amount of compensation a matter for negotiation between the physician and the cooperative's board. Unlike a community health clinic, the cooperative's revenue comes both from billing the province for insured services and from billing either individuals directly or nongovernmental insurers for uninsured services. The cooperative's board decides how the revenue will be disbursed.

Importantly, the cooperative's members — that is, patients — pay a monthly fee that gives them access to uninsured services, either chosen from a menu or purchased in a bundle that may include the services of primary care nurses and possibly other health care professionals. Either way, members can opt for services that are specifically suited to their medical condition, thereby subsequently improving the quality of care they receive.

A membership fee has a number of advantages. One is that the guaranteed revenue stream from fees gives the cooperative the opportunity to negotiate with providers for lower fees per uninsured service. Another advantage is that the extra revenue allows the cooperative to hire more administrative staff and nurses, allowing better use of physicians' time, reducing waiting times for patients, and improving the efficiency of primary care the cooperative can provide.

Opposition to Cooperatives

Opponents charge that cooperatives are simply a form of for-profit health care and, as such, they threaten Canadians' equal access to health care. But a great deal of for-profit health care already exists in Canada. Canadians already pay private providers for home nursing care, physiotherapy, occupational therapy, and a host of other health services not insured by government. They also pay their doctors a profitable rate for many uninsured services.

In any case, a large blindfold is necessary to sustain the belief that all Canadians currently have access to the same level of health care. For example, in most public sector collective bargaining agreements, including those in the health care sector, employer and employee share the cost of extra health insurance that gives the employee access to the full range of for-profit health care services not currently insured by government. Other Canadians receive improved services because they are articulate, know how to manoeuvre within the system, or are better able to use social capital.

For that matter, governments do not always provide equal access to health care services or pay physicians equitably. The average doctor receives about $95 per patient per year, but some practices receive as little as $65, while others, treating patients privileged by government, receive much more than average. The North End Community Health Association in Halifax, Nova Scotia, funded by the province, donations, and fundraising projects, is an example of such a privileged practice. Only residents of the local community may visit the centre, and they are not charged for uninsured services, a level of health care that many residents of other Halifax neighbourhoods may not enjoy.

Cooperatives also face opposition from physicians, particularly in urban areas, who may feel they can earn more in a fee-for-service system and maintain more independence in a solo practice, and from cautious neighbourhood residents with limited knowledge of what cooperatives are and how they work. Some potential patients may be deterred from joining a cooperative because they find a monthly fee of, say, $10 to $20 an onerous financial burden, particularly for services, such as telephone prescription renewals, that they may not view as vital to their health (see Hallam and Henthorne 1999, 22; Langill 2004).

Other Models of Canadian Health Care Cooperatives

The largest interdisciplinary health care clinic in the country is the Group Health Centre in Sault Ste. Marie, Ontario, which has 56,000 patients, 64 physicians, 8 nurse practitioners, 96 nurses, and 52 other staff members (Rachlis 2004, 103). The centre offers the full range of primary care services covered under the provincial health insurance system, as well as many uninsured services either free of charge or at a reduced rate.

The centre is funded by the province on a “capitation” basis — meaning that it is allocated a specific amount of money per patient based on age and sex, with penalties if patients obtain medical care

outside the cooperative. For example, if a patient sees a doctor located more conveniently to their place of work for a minor problem, the doctor's fee is subtracted from the amount the government pays the centre.

In Nova Scotia, Dr. Cathy Felderhof will soon open that province's first primary care cooperative (see Jacobs 2004). The $65 per patient that Dr. Felderhof receives from the province for her current practice is substantially less than the Nova Scotia average and does not cover fees associated with practice management, access to a primary care nurse, or other support. Dr. Felderhof believes that, by turning her practice of about 4000 patients — large by Nova Scotia standards — into a cooperative, she will be able to continue to afford to give her patients the level of care they require.

The cooperative proposes to secure funding by negotiating with the province for payments under a capitation system to cover the cost of insured health care services. If a member has third-party insurance coverage, the cooperative would charge the insurance plan for the cost of provincially uninsured health care services. Services not covered by provincial or third-party insurance plans would be billed directly to the patient, either on a fee-for-service basis or as part of a bundle, for which the cooperative would charge an annual fee. Physicians joining the cooperative would negotiate their own terms of employment and remuneration with the cooperative's board. The cooperative proposes to retain profits, if any, as a nonallocated reserve to finance operations and cover any deficits, a strategy that the Nova Scotia Cooperative Council agreed would likely not upset the government insurer, while providing equity for growth and stability.

A Final Word on Cooperatives

Cooperatives offer a good way to improve Canadians' access to primary care. They also promise better working conditions for physicians by challenging them professionally and relieving them of the burden of administrative tasks. Moreover, cooperatives make it easier for physicians to be compensated for the uninsured services they provide. Members' fees should cover the extra costs associated with cooperatives, such as hiring more staff and offering a broader range or services, but the effect this might have on family doctors' take-home pay is uncertain. The spread of cooperatives — a new concept in Canada for the delivery of primary health care — should encourage more physicians to become GPs, but only time will tell.

GPs with Specialist Interests

The third way in which GPs could improve their remuneration is by developing skills in more lucrative primary care subspecialties, whether insured or not. The problem with this approach, of course, is that many of these lucrative services may also be less useful to patients seeking quality primary health care. Only a few years ago, most GPs provided comprehensive continuing care services, such as obstetrics, house calls, nursing home visits, and minor surgery. Such services once fell within the scope of family medicine, but have now become extended services for which GPs are not compensated; instead, a variety of other health care professionals undertake these activities (see Box 2).

Demand is nevertheless growing for what one might call “atypical” health care services, especially in northern and remote areas of Canada. Rural hospitals in northern Ontario, for example, are encouraged to make space for physicians to offer extended services such as physiotherapy, speech pathology, and specialty clinics (Ontario 1997). These spaces are offered at a reasonable cost, and administrative services and equipment are shared, which lowers overhead costs and increases revenues for physicians providing uninsured services.

In Canada, GPs may offer any service they are qualified to provide — be it plastic surgery, travel immunization, weight loss and diet counselling, sports medicine, or ophthalmology procedures. For GPs who specialize, extra practice income can come from providing services that are uninsured by provincial health plans, from seeing a larger volume of patients for more routine procedures, and from providing less commonly available services that pay a higher hourly rate. Physicians also need to be aware of sound business practices, such as delegating work to lesser-skilled staff where possible and instituting efficient billing methods, to be appropriately compensated for their work. For physicians employed by a hospital, specialization in uninsured services raises questions about how the hospital’s global budget takes account of the overhead costs of providing such services.

One service that GPs are finding increasingly lucrative is travel immunization and counselling, whether the service is provided in a separate clinic or by extending the hours of GPs’ existing practices. In Thunder Bay, Ontario, for example, a travel clinic run by a physician and a nurse is open once per week. The clinic charges for each visit and for most travel vaccines, apart from routine or medically necessary boosters as defined independently by the provincial government.[3]

---

3 See the web site of the Thunder Bay District Health Unit: < http://www.tbdhu.com/vaccine/travel_clinic.htm >.

Box 2: ***Obstetrical Care in British Columbia***

GPs in British Columbia used to provide obstetrical care routinely, but many no longer do so. A recent study reports, for example, that only 64 percent of GPs in urban areas of BC and 77 percent of those in rural areas provide obstetrical care (CIHI 2003, 55). A major reason many physicians have abandoned obstetrical care is the poor compensation they receive for such time-consuming services. One doctor in Richmond, BC, reported, for example, that an induced labour and delivery took him approximately 58 hours to complete, for which the province paid him $2.65 per hour after taxes.*

In an effort to alleviate the growing shortage of GPs who offer obstetrical care, the BC government recently introduced the General Practitioner Obstetrical Care Incentive, which pays GPs a small bonus for performing deliveries and other obstetrical services — just over $200, a bit more for an emergency caesarean section. The program has severe restrictions, however: physicians may claim only one delivery on any single day and no more than 25 in the whole year (British Columbia 2004). Midwives, in contrast, receive more than $2000 for a normal birth, including pre- and postnatal care.

* "Murmurs, mayors and midwives", *North Shore News*, January 12, 1998.

Another potentially lucrative uninsured service is diet counselling. With obesity rates in Canada climbing, diets and trends in dieting are becoming increasingly popular and the demand for diet counselling services is rising. One has only to think of the large number of best-selling diet books by physicians to see the potential income to be derived from providing such services. In the Canadian context, a success story is that of Dr. Stanley Bernstein, who, disconcerted by the methods physicians were using to treat obesity, opened a weight-loss clinic in a single office in 1974. By 2004, his practice had grown, primarily by word of mouth, to 45 clinics across Canada.[4] It is puzzling that, although weight loss and exercise are regarded as a necessary part of treatment for conditions such as diabetes and heart disease, provinces refuse to cover these services. It would be interesting to know if patients are paying more for such services than provinces would pay if the services were insured.

Complementary and Alternative Medicine

Still another area of uninsured services that offers GPs the potential to earn considerable revenue is complementary and alternative medicine (CAM). Alternative medicine is taking on an increased role within the health care system, in both the diagnosis and treatment of disease. Patients particularly appreciate the fact that their visits with alternative medicine practitioners are longer than those with other physicians, who, because of price controls set by the province, cannot afford to spend as much time with patients as they would like.

4 See web site: < http://www.drbdiet.com/as/DrBProfile>.

Atlantic Institute for AIMS Market Studies

The growing importance of alternative medicine in the lives of Canadians is evident in a survey by the Canadian Institute for Health Information (CIHI 2002), which found that nearly seven out of ten Canadians use natural health products such as vitamins, herbal remedies, iron calcium, and mineral supplements, food, homeopathic remedies, and other natural homeopathic remedies. Another survey reported that 65 percent of Torontonians had used complementary medicine (other than vitamins) in the past year, although only about 25 percent of those surveyed stated they had seen a CAM practitioner in the past year (CIHI 2001, 23–24).[5] The survey also found that the use of alternative therapies was highest in the western provinces and lowest in Atlantic Canada.

The relationship between CAM and conventional health care is also growing steadily, as is evident in the increasing number of physicians who now offer alternatives to conventional medicine in many countries. In the UK, for example, 16 percent of GPs offer alternative therapies (Easthope et al. 1998, 169). A 2001 study found a high percentage of medical doctors among those who provide life-style diet counselling, while 31 percent of chiropractors and 24 percent of acupuncturists were medical doctors (Achilles 2001, 1.14). In Germany, no less than 95 percent of GPs incorporate alternative therapies into their treatment (Easthope et al. 1998, 169).

Private insurance companies now often cover alternative therapies, an illustration of the industry's recognition of their value. And where they are covered by public insurance, the use of alternative therapies increases significantly. In Australia, for example, reimbursement claims for acupuncture therapy increased from 665,000 in 1985, when the service was first covered by that country's health system, to 960,000 in 1996 (ibid.). Under Australia's system, offering patients the choice of conventional and alternative treatments in group practices is considered good marketing; the practice does not lose out whichever treatment the patient chooses.

For Canada and its similar health care system. Australia's experience is a good indication of the success physicians in this country might have if they offered CAM services. In a 1992 survey of GPs in Alberta and Ontario, Verhoef and Sutherland (1995) found that only 16 percent used complementary and alternative therapies, with hypnosis and acupuncture being the most commonly used treatments. Interestingly, 54 percent of the physicians surveyed stated that, although they may not have provided CAM services themselves, they referred patients to CAM providers. The survey is now out of date, and the use of alternative medicine has grown in popularity in Canada since that time.

The lesson for GPs is to take advantage of the growing demand for alternative therapies. As more and more Canadians find such treatments covered by their work insurance, demand for them will increase. Moreover, since private insurers are more inclined to cover CAM services that are provided by a physician, an opportunity exists for GPs to fill that demand.

5 According to the CIHI, alternative health care professionals include dietitians/nutritionists, psychologists, occupational therapists, physiotherapists, alternative and complementary medicine providers, massage therapists, acupuncturists, chiropractors, audiologists/speech-language pathologists, chiropodists/podiatrists, dentists, kinesiologists, midwives, optometrists, pharmacist/pharmacy assistants, psychotherapist/counsellors, and social workers (CIHI 2003, fig. 18).

Specialization versus Primary Care

By specializing, GPs may be able to garner higher fees and rewards, both financially and professionally, than they can obtain from offering primary care services. The concern, however, is that the time GPs spend providing specialist services is time not spent doing price-controlled work insured by government. Canadians' access to primary health care services is already under severe pressure, and the last thing they need is for physicians to switch from family practice to providing uninsured services.

On the other hand, the issue of access to primary care in Canada is increasingly that of a growing shortage of GPs. If encouraging some specialization in uninsured services would make it easier for current physicians to remain GPs and attracts more medical students to become GPs, such a strategy could make the goal of improving access to primary health care easier to reach.

CONCLUSION

Canada's health care system faces a growing shortage of general practitioners, due in part to the poor working conditions of many GPs relative to those of physicians in other types of practices. Much of GPs' time is wasted performing administrative tasks best left to others, and GPs are overworked and underpaid, or not paid at all, for many of the uninsured services they provide. As a result, fewer and fewer medical students are attracted to family practice and many current GPs are curtailing their services.

One way to make family medicine more appealing is to increase the revenue GPs derive from their practices. This paper has examined three ways in which GPs could increase their compensation without injecting more public money into the system: they could bill patients more aggressively for services that are not insured by government; they could join a primary care cooperative, which promises increases in administrative efficiency and "one-stop shopping" for patients; or they could specialize in more lucrative and in-demand services, such as diet counselling and alternative medicine.

A theme that runs through these options is *efficiency*. Physicians need to use their time more efficiently and delegate more tasks to nonprofessionals, which would free up more time for them to spend on primary health care or on other services Canadians demand. Physicians also need to follow proper business practices in billing patients for uninsured services, which would increase compensation and attract more doctors to family medicine. By joining a cooperative, physicians could lighten administrative and other burdens, interact more efficiently and effectively with their colleagues, and offer patients a multiplicity of services. In all these cases, Canadians would gain much-needed better access to primary care. Moreover, the benefits of that outcome could spill over to the rest of the health care system in ways as diverse as fewer emergency room visits, shorter waiting times, and better preventative care. The savings from these positive results could then be put to better use elsewhere in the health care system.

REFERENCES

Achilles, Rona. 2001. "Defining Complementary and Alternative Health Care". In *Perspectives on Complementary and Alternative Health Care*. Ottawa: Health Canada.

British Columbia. 2004. *Frequently Asked Questions, Full Service Family Practice Incentive Program*; available from web site: <http://www.healthservices.gov.bc.ca/cdm/practitioners/fsfpifaqs.pdf>.

Canada. 2002. Commission on the Future of Health Care in Canada. "Health Human Resources in Canada's Healthcare System". Issue/Survey paper. Ottawa. July.

CIHI (Canadian Institute for Health Information). 2001. *Health Care in Canada*. Ottawa: CIHI.

———. 2002. *Health Care in Canada*. Ottawa: CIHI.

———. 2003. *Health Care in Canada*. Ottawa: CIHI.

Easthope, Gary, Justin J. Beilby, George F. Gill, and Bruce K. Tranter. 1998. "Acupuncture in Australian General Practice: Practitioner Characteristics". *Medical Journal of Australia* 169 (4): 197–200.

Jacobs, John. 2004. "Health cooperatives: New Glasgow initiatives could set precedent". *Halifax Herald*, July 13.

Hallam, L., and K. Henthorne. 1999. "Cooperatives and Their Primary Care Emergency Centres: Organization and Impact". *Health Technology Assessment* 3 (7): iii–85.

Langill, Corrine. 2004. "Social Determinants of Health". Listserve, August 7; see web site: <https://listserv.yorku.ca/cgi-bin/wa?A2=ind0404&L=sdoh&T=0&F=&S=&P=3306>.

Naylor, David. 1999. "Health Care in Canada: Incrementalism under Fiscal Duress". *Health Affairs*, May/June; available from web site: <http://ist-socrates.berkeley.edu/~cush/pp172/temp/HA5699_canada_naylor.htm>.

Ontario. 1997. Ministry of Health. *Access to Quality Health Care in Rural and Northern Ontario: The Rural and Northern Healthcare Framework*; available from web site: <http://cranhr.laurentian.ca/pdf/RURAL_HEALTH_FRAMEWORK_June_1997.pdf>.

Ontario Medical Association. 2003. *Physicians' Guide to Third Party and Other Uninsured Services*, 2003 ed. Toronto: OMA.

Price, Don. 2003. "Practice Management: Developing a Successful Uninsured Services Program". *Ontario Medical Review* 70 (7): 65–66.

Rachlis, Michael. 2004. *Prescription for Excellence: How Innovation Is Saving Canada's Health Care System*. Toronto: HarperCollins.

Verhoef, M.J., and L.R. Sutherland. 1995. "General Practitioners' Assessment of and Interest in Alternative Medicine in Canada". *Social Science in Medicine* 41(4): 511–15.

Way, Daniel, Linda Jones, Bruce Baskerville, and Nick Busing. 2001. “Primary Health Care Services Provided by Nurse Practitioners and Family Physicians in Shared Practice”. *Canadian Medical Association Journal* 165 (9): 1210–14.

Selected Publications from the AIMS Library

Urban Futures Series

Organization and Opportunities: Local Government Services in Greater Saint John, by Robert L. Bish

Financing City Services: A Prescription for the Future, by Harry Kitchen

"Smart Growth": Threatening the Quality of Life, by Wendell Cox

Do Cities Create Wealth? A Critique of New Urban Thinking and the Role of Public Policy for Cities, by Patrick Luciani

Books

Retreat from Growth: Atlantic Canada and the Negative-Sum Economy, by Fred McMahon

Road to Growth: How Lagging Economies Become Prosperous, by Fred McMahon

Looking the Gift Horse in the Mouth: The Impact of Federal Transfers on Atlantic Canada, by Fred McMahon (photocopies only)

Commentary Series

Locking Up the Pork Barrel: Reasoned Economic Development Takes a Back Seat to Politics at ACOA, by Brian Lee Crowley and Bruce Winchester

Following the Money Trail: Figuring Out Just How Large Subsidies to Business Are in Atlantic Canada, by David Murrell

First, Do No Harm: What Role for ACOA in Atlantic Canada? by Brian Lee Crowley

Jobs! Jobs! Jobs! The Numbers Game, ACOA Watch 1

Research Reports

Doing Business with the Devil: Land, Sovereignty, and Corporate Partnerships in Membertou Inc., by Jacquelyn Thayer Scott

Framing the Fish Farmers: The Impact of Activists on Media and Public Opinion about the Aquaculture Industry, by Jeff Chatterton

You Can Get There from Here: How Ottawa Can Put Atlantic Canada on the Road to Prosperity, by Brian Lee Crowley and Don McIver

Grading Our Future 2: Atlantic Canada's High Schools' Accountability and Performance in Context, by Rick Audas and Charles Cirtwill

The Atlantica Power Market: A Plan for Joint Action, by Gordon L. Weil

Fencing the Last Frontier: The Case for Property Rights in Canadian Aquaculture, by Robin Neill

Definitely Not the Romanow Report, by Brian Lee Crowley, Brian Ferguson, David Zitner, and Brett J. Skinner

Rags to Riches: How "The Regions" Can and Should Be Leading Canada's Productivity Push, by Brian Lee Crowley

Taxing Incentives: How Equalization Distorts Tax Policy in Recipient Provinces, by Kenneth J. Boessenkool

Fiscal Equalization Revisited, by Professor James M. Buchanan, Nobel Laureate

Testing & Accountability: The Keys to Educational Excellence in Atlantic Canada, by Charles Cirtwill, Rod Clifton, and John D'Orsay

Public Health, State Secret, by Dr. David Zitner and Brian Lee Crowley

Taking Off the Shackles: Equalization and the Development of Nonrenewable Resources in Atlantic Canada, by Kenneth J. Boessenkool

Beyond a Hard Place: The Effects of Employment Insurance Reform on Atlantic Canada's Economic Dependency, by Rick Audas and David Murrell

Conferences

"Smart Growth": How Urban Planners Are Threatening the Quality of Life in Our Cities, February 23, 2004, Halifax, Nova Scotia

Nation States and Economic Regions in the Global Network, May 13, 2004, Halifax, Nova Scotia

These publications are available at AIMS, 2000 Barrington St., Suite 1006, Halifax NS B3J 3K1
Telephone: (902) 429-1143 Facsimile: (902) 425-1393 E-mail: aims@aims.ca
They can also be found on our web site: www.aims.ca

2000 Barrington St., Suite 1006
Halifax NS B3J 3K1

Telephone: (902) 429-1143
Facsimile: (902) 425-1393
E-mail: aims@aims.ca
Web site: www.aims.ca