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Better Canadian Health Care Access and Outcomes Requires Moving Toward a Combined Salaried Public and Selected Private Physician Remuneration Model

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ABSTRACT

Introduction: Canada's healthcare system produces below-average health outcomes and higher healthcare costs compared to economically similar European Union / OECD countries. Innovative healthcare policies are required. **M/M**: A scoping review methodology was used to compare and evaluate comparable OECD countries for fiscal and clinical indicators considering human resource planning, remuneration models, quality and outcome accountability criteria, and focused public-private service collaboration. **Evidence**: Canada has significant healthcare challenges requiring human resource planning, revision of funding models, provider accountability, outcome quality, patient satisfaction, and innovation. The OECD comparison identified areas to evaluate, including salaried funding models, public and private healthcare options commonly used in other countries, the need for increased hospital beds and physicians, and quality-associated processes to improve patient satisfaction. **Conclusion**: Comparative evidence indicates that a salaried public and private system remuneration models result in better healthcare outcomes. A collaborative provincial (fiscal) and medical provider (service) based process, using regulation, finance, and delivery processes for the revision of provider remuneration practices is required using a fiscally balanced and patient-focused remuneration program (benefit for patient, provider, and system) and clinical collaborative public and private services for ambulatory and hospital-based care with measured and evidenced-based criteria for clinical accountability and improved outcome quality.

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INTRODUCTION

The Canada Health Act, passed by Parliament in 1984, was designed to provide all Canadian residents equal access to high-quality health care unimpeded by the need for personal expenditures, with the costs of "covered" physician and hospital services solely dependent on government resources. [1] Available evidence has demonstrated that Canadians experience a level of healthcare quality that is well below that of other comparable high-income countries in Europe with similar annualized per-capita expenditures for healthcare that also ensure access for their entire population. [2] Canadians often cannot find a primary care provider, suffer inadequate access and delays to many diagnostic services, and experience long waits for specialty and hospital-based medical and procedural care. [3-6] Unlike the other OECD countries, including those with demonstrated better healthcare outcomes, Canada has uniquely prohibited the use of private funds for 'covered services', a circumstance that both denies citizens alternatives to the government system and requires budgetary shortfalls to be managed by rationing of resources in a way that often diminishes the quality of care. (Table 1 [6-17])

This article explores the issues of quality, accountability, and system-based cost plaguing Canadian healthcare access and quality outcomes. The goal is to identify physician remuneration models, where innovation and change, can improve the healthcare system with enhanced fiscal-based accountability, patient-focused quality, and cost-effective outcomes, including the opportunity for both public and private services through collaborative and evidence-based funding mechanisms. Such a public-private collaborative approach will be integral to the structural changes necessary for a sustainable healthcare system for all Canadians.

METHODS

A scoping review methodology was used for this health policy analysis [18, 19] with a focus on the following research questions:

- What is the 'collective status quo' for the 13 provincially mandated Canadian health care systems, as no single province demonstrates high-level health care metrics?
- How does Canada collectively compare, and what comparative evidence can be used to improve Canada's healthcare system using models of care from other comparable countries, focusing on OECD and the European Union countries, with demonstrated high care quality and similar or lower costs?
- What healthcare human resource processes or remuneration models have been used that can provide better access, quality, outcome, and satisfaction for both patient and provider?
- Can an evidence-based health policy process be developed that integrates and synergizes public and private healthcare services to provide accessible, high-quality, safe, and cost-effective healthcare delivered with high levels of satisfaction for patients and providers?
- What is the status and opportunity of private healthcare in Canada?
- Can the healthcare resources of the provincial/federal governments be managed more responsibly and efficiently, with reimbursement models for physicians changed from the predominate fee for service (FFS) system to a system for physician payment more in line with high-performing comparable OECD democracies?
- Can a new remuneration framework can be proposed to support fiscal and clinical responsibility for provincial healthcare management and providers?

RESULTS

Evidence from the Scoping Research Questions to Consider

What is the 'Status Quo' for the collective provincially mandated Canadian Health Care System?

Canada's provincial single-payor and public healthcare monopolies have historically achieved cost control by rationing healthcare access, often creating a culture of waiting for care. While the provincial healthcare system has demonstrated many urban and regional medical-surgical care strengths through the delivery by dedicated healthcare providers, there are many

clinical care variations in the 14 Canadian healthcare systems (13 provincial and territorial; single indigenous federal), including patient access, clinical service prioritization, variable provincial access and opportunity for private care options, and the lack of health service and provider accountability for clinical outcome, quality-safety of care, and cost.

A CMA-Deloitte Report indicated that the present Canadian healthcare system has significant challenges that require provincial, federal, and territorial collaboration in the context of a multi-pronged action plan that includes funding, health innovation, and reforms. Policymakers must contend with these more immediate and long-term challenges. Health expenses are the largest budget item for provinces and territories with the ongoing advances in health care technology, the changing demographic features of the Canadian population, and the magnitude of the health care expenses as their proportion of the available health-related budgets will likely continue to increase. These challenges must be addressed for sustainable healthcare cost containment while providing appropriate, safe, high-quality care. [20, 21]

There is a continuing lack of significant systemic change with ongoing healthcare deficiencies following the release of the 2002 Parliamentary and Senate reports (recommendations or principles) and a 2008 'A 10-Year Plan to Strengthen Health Care' report. [22-26]

The Expert Advisory Group for the Pan Canadian Health Data Strategy Report wrote that 'There is no "smoking gun" – the implementation challenges are the result of a complex set of interactions between multiple levels of government, health professionals and organizations, and the public and private sector with the common goal of access to data while preserving privacy and confidentiality. Accordingly, there are no simple solutions or easy fixes as indicated by 'the current Canadian health data ecosystem impedes the best possible health outcomes, results in a poor patient and provider experience, and incurs higher cost'. [27]

How does Canada's healthcare 'status quo' compare to that of other comparable countries? What comparative evidence can inform improvements in Canada's healthcare system using care models from other developed countries, including those in the OECD and the European Union, that perform with higher quality and lower costs?

We identified four systematic issues that collectively and adversely impact the quality of Canadian healthcare (Table 1 [6-17]):

1. Lack of healthcare reform,
2. Inability of the healthcare systems to handle the patient access needs,
3. Lack of human resource planning and management, and
4. Limited interest or activity in the provincial educational pipelines for increased provincial human resource opportunities.

The appropriate healthcare comparisons for Canada are: The OECD (37 democracies with market-based economies) that collaborate to create economic policies that foster prosperity, equality, opportunity, and well-being for all, including healthcare [2]; Group of Twenty (G20) (more financially focused) with a goal to promote cooperation towards sustainable economic growth [28, 29]; The European Union (EU) (22 countries) has identified three broad healthcare priorities: better health throughout life, strengthening health systems and universal coverage, and action to prevent and combat health threats [30].

The OECD publication, 'Health: at a Glance 2023', has comparative data to show the clinical key performance indicators (KPI), using the collective provincially-based healthcare outcomes for Canada, are very average for health outcome indicators. Additional 2022 data shows the average per capita healthcare spending in OECD countries (when adjusted for differences in purchasing power) is estimated at USD 5,000 (USD - United States 12,555; Switzerland and Germany 8,000; Norway and Austria, Australia, Canada, and New Zealand 6-7,000). While Canada's per capita spending is in the top 30% of OECD countries, clinical KPI outcomes are commonly below the OECD indicator mean. Table 2 identifies 25 high-level OECD KPIs, with Canada being below the mean for 16 of 25 KPIs and only 9 of 25 KPIs above the mean. [2]

The Commonwealth Fund's OECD-based report ("Mirror Mirror") using the collective provincial healthcare outcomes for Canada, has shown that when compared to 10 other OECD countries, Canada was ranked low in four of the five OECD quality comparisons (access to care 10/11, administrative efficiency 7/11, equity 10/11, healthcare outcomes 10/11) with the only

high-quality rank for the patient care processes available once hospital access had occurred (4/11). The overall healthcare high-performance scores have Norway, Netherlands, Australia, United Kingdom, and Germany at the top; performance to spending metrics identify Australia, Netherlands, and Norway; performance to affordability identifies United Kingdom, Netherlands, and Norway; and performance to equity identifies Australia, Germany, and Switzerland. The top nine healthcare systems are government-publicly funded but with additional patient choice options for selected private-based healthcare typically covered out of pocket or, more often, by private insurance. In this comparative quality ranking analysis, only the USA (11 / 11) was lower than Canada (10 / 11). The United States is an outlier because of its higher cost, poor performance, and absence of a universal healthcare system [31]. Given the performance of the nine countries ahead of Canada, with similar per capita health-related expenditures and private healthcare options, Canadians should avoid considering the US as the comparative example for private healthcare delivery. (Table 3 [2, 31, 32]) The Canadian health outcomes indicators are similar to the health indicators for the three EU countries in terms of demographics, healthcare per capita spending, and primary care providers. The three EU countries have KPIs that outperform Canada with hospital beds per 1,000 people, MDs per 1,000 people, patient satisfaction with their MD visit (time spent and care provided), preventive 30-day mortality, and avoidable deaths per 100,000. (Table 3[2, 31, 32])

Another important OECD difference between Canada and the three EU countries is the physician remuneration process, as the Canadian system largely relies on fee-for-service (FFS) reimbursement. [33-37] All three high-performing EU countries used for comparison have salary-based providers with variable public-private healthcare funding models. While all OECD countries (except the US) have healthcare systems that provide universal care, they all allow and, in many cases, depend on a private component to care for their citizens. Consequently, the designs of these national healthcare systems vary considerably from Canada as they are funded through many different combinations of public and private sources (compulsory health insurance, either government-administered or through private coverage). [2, 32]

These salaried-public-private remuneration differences may be a factor for their higher KPI rankings and EU patient satisfaction. [2] A FFS-Overhead evaluation has looked at an adjusted net hourly, daily, and annual income after considering clinical section / disciplines MD compensation, overhead costs, training and career length, and work hours. Overhead business expenses (rent, staff wages, supplies, insurance, building maintenance, professional dues, equipment) were a significant component (40-70%). This FFS-Overhead evaluation provides a version of a 'relative value fee' using the core professional factors, not the biased historical fee allocations. Understanding the educational training time, clinical complexity (on-call requirements), continuing medical educational needs, and business expenses are essential for creating an equitable, appropriate, and realistic Alternate Payment Plan (APP) remuneration. [38-40]

The importance of government transfers or subsidies as a source of fiscal support for the healthcare system can vary significantly amongst countries and within healthcare systems depending on local agreements and conditions. The Canadian federal-provincial healthcare model relies heavily on federal transfer payments for provincial fiscal support. [2]

Other evidenced-based reviews of Canada's collective healthcare system have identified significant healthcare deficiencies. [41-44]

What are the healthcare human resource processes or physician remuneration models that have been used?

For Canada, the predominant model of physician reimbursement is FFS, with some directed use of the Alternate Payment Plan (APP) model, which includes combinations of salary, sessional payments, capitation, and contracts. (Table 4 [2, 45-52]) While the estimated Canadian reimbursement for FFS and APP models is at a 70/30 level, 64% of physicians receive at least some payment via an APP method. In Canada, the FFS method is high in British Columbia, Alberta, and Quebec, while the APP method is high in Nova Scotia, Saskatchewan, New Brunswick, and the Yukon Territories. APP processes are used for many provincial academic clinical, research, and educational services. These differences may reflect the preferences of the clinical provider, healthcare administration, or both. [52]

The FFS method, in no way improves the public clinical care value, given its limited accountability, lack of quality measurement, and lack of outcome assessment. (Table 4 [2, 45-52]; Supp Table 1 [53, 54]; Supp Table 2 [55])

The alternate payment plan (APP) provides a flexible and typically contractual process, untethered from the volume of service, that can be used to remunerate providers fairly and equitably, improve the quality of care provided, and enhance patient outcomes via the service oversight, patient access, and human resource support for service requirements and

outcome measurement. Collaborative multidisciplinary care models can be part of a public-private APP service arrangement. (Tables 4 [2, 45-52); Supp Table 1 [53, 54])

Quality, safety, and accountability measurements are required by both the healthcare system and the provider, as trust and fairness are necessary for these groups. [56-59] Clinical accountability is an essential component of optimizing patient outcomes and satisfaction, including cost-effective practices.

What evidence can be used to support innovative but provider-system equitable physician remuneration models (for Canada)?

It is essential to understand that the governments of the OECD and EU countries guarantee healthcare for all but allow and, in many cases, rely on privately funded clinical access as a part of their healthcare system. Such an approach allows not only patient choice but keeps the government 'honest' by providing or allowing care alternatives as an essential part of the competitive choice inherent in Western democracies. In addition, a re-organization for patient access may allow for 'urgency offloading' from the public system to the public-private collaborative system in times of clinical need, with unexpected burdens of disease, immigration, or other healthcare issues.

The use of 'High-Value Health Systems' in G20+ countries has identified that many countries are attempting to transform their health systems to deliver both 'value for money and value for many', but these 'cost-effective and cost-efficient' innovations have not had large-scale population-level evaluation [60]. The bolded components below would be required for a proposed fiscally responsible remuneration model with clinical accountability and evidenced-based public-private access. The High-value Health System Model (HVHS) comprises ten interdependent components: (I) digital data systems, (II) analytics, (III) cost measurement systems, (IV) outcomes measurement systems, (V) benchmarking, (VI) integrated care pathways with bundled services, (VII) value-based payment models, (VIII) value-based procurement, (IX) integrated provider networks, and (X) strategic change and innovation ecosystems. [60]

Countries with economies similar to Canada have initiated some of the above components, but there is a great deal of variation when comparing the healthcare systems of these nations [60]:

- major process acquisition for the digital data and strategic change.
- only moderate progress for analytics, cost measurement, and outcome measurement.
- slow progress for value-based payment models and value-based procurement.

The HVHS components are difficult to implement and have a common human resources requirement (integrated care pathways, integrated provider networks, benchmarking (or relative value comparison)). The required strategies for creating a new and fiscally responsible remuneration system are the transition / change management strategy, medical leadership, administrative financing, global benchmarking with cross-learning, and innovative, supportive attitudes. [60]

There are many opinions regarding the necessity for a collaborative public and private service in Canada. The summary from the 2005 Quebec legal decision has been used to support this proposal for a focused (effective; ethical) and evidenced-based service model using 'non-paralleled' public and private healthcare opportunities to support the scheduled care/preventive care areas with access and efficiency. [61]

The Status of Private Healthcare in Canada

There is no simple model for private healthcare (regulation, finance, delivery) in Canada, as the scope and nature of privately funded services vary across provinces, providers, and the legislative framework. Notably, the private components of the Canadian healthcare systems include dentistry, pharmaceuticals, and ancillary services, not physician and hospital-based care, at least for covered services.

The CHA's primary focus was to provide 'no cost' access to physician and hospital services, but many other unanticipated patient healthcare needs continue to consume resources. Consequently, access to care is reduced; without some private component, patient access to care will remain limited. [1, 62]

The viability of private healthcare depends not only on each province's legislative framework but also on the public level of demand for healthcare services (Can the public sector effectively meet the demand?) and the nature of the healthcare workforce (What is the number and scope of practice for each public healthcare discipline?). [63]

The federal government's fiscal deterrent is to reduce the amount of federal healthcare transfer payments to the provinces that allow private healthcare services (provider extra-billing, patient user charges, private diagnostic services). [62]

Given the restrictive billing criteria, there are few 'opted out' physicians in the nine provinces that permit this category (NFLD, NS, NB, QC, ON, MB, SK, AB, BC), all except NB and AB, reimburse patients the cost of private services. Only five provinces have small numbers of physicians working outside the public system (QC 642 of 22,981; ON 14 of 34,798; SK 8 of 2798; AB 2 of 10,816; BC 2 of 12,376). [63]

The ability to meet the healthcare shortfalls for comprehensive and effective care by many OECD countries is covered by additional private insurance. Presently, Canada's provinces are not able to maintain healthcare sustainability (fiscally; operationally) due to 'healthcare inflation' factors (population growth, aging, inefficiency, labor costs, pharmaceutical, and technology pricing), as this 'inflation rate' for healthcare delivery exceeds the economic growth rate for all OECD countries (annual 'healthcare inflation' increase for Canada 1.3%; USA 2.1%). There appears to be no relationship between the rate of cost/price inflation and private healthcare financing in a healthcare system. The ability to control healthcare cost inflation and, therefore, healthcare sustainability requires new administrative decisions and methods. [64]

The integration of privately funded healthcare into the public system has been via private-public partnerships (P3). [65, 66] To date, these P3 agreements have been directed toward private purchases for subsequent public use, such as diagnostic imaging equipment. A 2023 CADTH report indicated at least 85 private diagnostic clinics are operating in seven provinces: Quebec (36% of the private clinics), Alberta (21%), British Columbia (18%), Ontario (16%), Saskatchewan (6%), New Brunswick (1%), and Nova Scotia (1%). [65, 66] The introduction of P3-like 'clinical service' agreements with evidenced-based private scheduled or urgent clinical services could be used for increased access due to unforeseen clinical events. The private pathway for provinces in Canada will be complex. Still, it is clear from the comparison with other high-functioning and economically comparable OECD countries that a remuneration model using publicly salaried clinical providers and contractual private service options, with outcome accountability, is beneficial.

Currently, Canadian provincial healthcare systems cannot meet the public demand for timely clinical access and comprehensive care as the physician and hospital services are limited by insufficient hospital beds, emergency room triage, operating room time, and human resource supply. While the present recruitment models are primarily directed toward international nursing sources, Canadian medical graduates, and some directed strategies to certify international medical graduates, the use of provincial university 'educational pipelines' to increase training positions in medical, nursing, and allied healthcare professions has had little provincial discussion or consideration based on media review. (Table 1 [6-17]); [5])

An Angus-Reid survey identified only 39% of Canadians were against privately funded clinical access, while the remaining 33% and 28% were either hesitant or supportive, respectively. [9] The CMA has indicated that one of its guiding healthcare principles is advocacy to create a mix of public and private resources to provide clinical services. [5]

The legality of provincial healthcare systems has been challenged in Quebec (2005) and British Columbia (2023) due to limited access and issues related to delayed care for publicly covered services that could be secured via private healthcare services. [61, 67] These challenges of the patient (QC) and physician (BC) were not supported by the Provincial Supreme and Appeal courts [61, 67]. However, in the Quebec case, the Supreme Court found against the province but could not provide a verdict in the case against the CHA as the justices were three in favour, three against, and one abstention. While the judges were evenly split in the Quebec case against the CHA, an opinion from Chief Justice McLachlin regarding private care is important to this discussion. [61] "Here, the evidence on the experience of other Western democracies with public health care systems that permit access to private health care refutes the government's theory that a prohibition on private health insurance is connected to maintaining quality public health care. It does not appear that private participation leads to the eventual demise of public health care." The Judge stated, " We are of the view that the prohibition on medical insurance in s. 15 of the Health Insurance Act, R.S.Q., c. A-29, and s. 11 of the Hospital Insurance Act, R.S.Q., c. A-28, violates s. 7 of the Charter because it impinges on the right to life, liberty, and security of the person in an arbitrary fashion that fails to conform to the principles of fundamental justice". [61]

A Public-Private Healthcare Framework for Creating Fiscal and Clinical Responsibility: bottom to top and top to bottom.

Healthcare systems will usually have three constituent parts: regulation, financing, and service delivery, and they can include a public or private component (contracted ROI limited profit or not-for-profit). [Figures 1 and 2] Every province wants high-

quality, sustainable healthcare (regulation) at a reasonable cost (financial) for the provincial population (service delivery), using appropriately trained service providers (public or private) with the system principles of efficiency, equity, access, and accountability with quality outcomes (service delivery).

Figure 1 integrates the regulatory responsibility, delivery equity of patient access, delivery efficiency, and the financial human resource sustainability. The provincial regulatory, negotiation, and management of a public-private service will require improved collaboration between providers, urban and rural locations, neighboring provinces, or in defined remote geographic or regional groupings. [68, 69]; (Supp Table 2 [55]) Financial 'black box' planning and oversight must use evidence, equity, transparency, logic, and creativity to find the philosophical and fiscal balance for the healthcare outcome requirements via the use of tax-based public funds and the private business ROI requirements. Regulation and service delivery requirements for imaging capital P3 agreements have worked; therefore, P3-type agreements for private investment in the clinical ambulatory and treatment space for the scheduled public-private collaborative services could be a 'win-win' solution for both the public and private interests. The *delivery* opportunity *(Equity of Access; Delivery Efficiency)* could be accomplished with appropriate and sustainable processes for human resource planning, remuneration optimization, and service allocation via public and designated private services and facilities. (Figures 1 and 2; Table 4[45-52]; Table 5 [5])

A fiscal SYSTEM BENEFIT may be achieved through contracted APP and private providers, using an FTE 70-100% service role, to provide designated scheduled public and /or private preventive or treatment services using the added access with measured patient-directed accountability and quality outcomes.

A service SYSTEM BENEFIT will use the increased access capacity via the scheduled public-private system 70-80% component and the unscheduled urgent 'access reserved' component (20-30%). There is a need for some limited provider redundancy to allow for timely patient access flexibility, outcome quality, and clinical efficiency.

A fiscal PROVIDER BENEFIT may be achieved by directed funding for designated APP providers (outside their 70-80% scheduled care) along with selected private providers for the 20-30% urgent service capacity.

Canada has an increased comparative quality ranking related to hospital-based care (rated 4 out of 11 countries for the care process and is above the OECD mean for in-hospital care). Once in the hospital, the process allows for the identification of patients who need and get immediate medical or surgical care. (Table 2 [2]; Table 3 [2, 31, 32]) However, Canada has a decreased quality rating for access to care (rated 9 out of 11 countries for the access process, and it is below the OECD mean for efficiency regarding elective or non-urgent care).

The 'equity for access' goal for any scheduled (routine-preventive) public-private services (70-80%) would be within 1-6 weeks, while for the unscheduled emergent service (20-30%), the required clinical service is prioritized. The efficiency of service delivery is dependent on the patient's timely access to the healthcare providers, for the appropriate patient-directed triage / treatment process.

The ability to prioritize unscheduled but urgent clinical services (20-30%), should be in a cost-effective fashion with improved quality and relevant outcomes, but the process has not been well defined or studied. The clinical characteristics for these urgent and unscheduled services may be focused on high volume services, provided in an ambulatory environment, with service times of less than one hour, but the urgency for care has no immediate, time-sensitive impact or effects on the patient's quality of life. Screening protocols for disease (using serum or blood; mammography, ultrasound; examination (dermatology)) and /or specific operative treatment services (urology, colonoscopy, reproductive choice, hernia repair, ophthalmology) are likely to meet these proposed service characteristics. Emergent care would be triaged separately.

Figure 2 summarizes the details (system factors, elements of universal health coverage, provider service status, accountable health outcomes, and required collaborative education) for the collaborative healthcare services that could be considered across the 14 collective Canadian healthcare systems (green). The process highlights the jeopardy and professional 'buy-in' necessary for an innovative-equitable human resource remuneration and performance process with an increased accountability requirement for the patient and healthcare system (yellow).

The healthcare issue for Canada, regarding the use of private sector healthcare, is not about the specific service performance or the comparison to the public healthcare sector but how, through a focused and combined role, it can support (but not likely to detract from) the outcome goal of having a complete healthcare system with cost-effective, patient-centered, and quality outcomes. A provincial system, using equitable and transparent provider contractual arrangements, could agree to

designate care pathways (KPI) to measure and monitor patient health outcomes and efficiently distribute good quality, cost-effective, and accessible healthcare services, but with low requirements of private 'out-of-pocket' expenditure. [68-72]

DISCUSSION

The provinces in Canada are responsible for the oversight and management of their healthcare systems as designated in the CHA and clarified following unsuccessful legal challenges for private healthcare services in the provinces of Quebec and British Columbia. Provincial healthcare administration (initiated, negotiated, and directed) would have the best opportunity for the implementation of new remuneration models that are publicly financed, fiscally appropriate, provider-equitable, cost-effective, patient-accountable, and offering quality clinical outcome opportunities along with the elimination of FFS remuneration.

The Canadian political administrative failures relating to social and healthcare policy have resulted in the 'mirage of universality'. Human insight and patient-focused approaches must be central to healthcare design and delivery. The health and social system leadership can no longer overlook the profound disparities, even when there are no direct financial barriers to access. [73]

There is a need to balance the benefits and risks related to the provincial healthcare systems by fiscal responsibility for patient and medical-surgical provider satisfaction through ethical service prioritization, appropriate, timely access, and high-quality clinical care system as measured by key performance indicator (KPI) outcomes. (Figures 1 and 2)

Human Resources

Professional generational attitudes are changing and impacting healthcare, related to the previous 24/7 roles for the 'Boomers' and the present work-life balance expectations and roles for the 'Zoomers'.

New human resource relationships for contract and union-based healthcare workers will be needed, as team-based care requires that all healthcare workers be respected and supported.

Creative and cooperative educational strategies will be required to provide more research capacity (basic, translational, and clinical investigators) and healthcare providers, including medical, nursing, and support staff. These essential initiatives will require clinical and discovery development infrastructure, including that necessary for basic and translational research. Joint educational ventures will require appropriate human resource planning with provincial healthcare, universities, and other educational organizations. Continued assessment for foreign-trained healthcare providers should be available but without the use of predatory international hiring tactics.

In addition, there are human resource factors that are affecting access to clinical service. Healthcare organizations are having issues meeting increasing patient demand for care due to the inability to attract and retain physician talent. Provider turnover is likely to continue, and physicians are aware that they have other job opportunities as 72% of respondents report that they are contacted frequently about alternative opportunities [94]. In Europe, there is frequent movement of doctors and nurses as Romania, Spain, and France are the countries which are most likely to send nurses abroad, while Germany, Romania and Italy are most likely to export doctors. Ireland and Switzerland are the European countries most dependent on both foreign-trained doctors and nurses. In Switzerland, the share of foreign-trained doctors increased from 25 % to 40 % during 2000 to 2010. Norway is highly reliant on foreign doctors and Austria depends on importing nurses.[95]

Approximately 50% of medical providers in the USA are employees for a hospital or medical group. Health-related services by health providers (surgeons; physicians), with access to either surgical or endoscopic or vascular procedures, receive on average, a higher annual remuneration. These services are generally provided in a hospital or ambulatory surgical centers, while there is limited or no overhead costs for the provider, there is a hospital-based cost billed to the patient or their insurance. Salaries in the USA are highest for surgeons in 6 of 10 disciplines (pediatric, plastic, orthopedic, otolaryngology, urology, ophthalmology, oncology) along with medical based services with procedures (cardiology, gastroenterology, dermatology and radiology). This groups average range is listed as $411,000 -576,000 USD. The other medical specialities, family medicine and general internal medicine have average ranges of $225,000 – 236,000 USD. [96]

Aligned to the remuneration and 'life balance' focus, it will be necessary for a CHA amendment or repeal to allow integrated public and private healthcare options for Canadians as an expectation for allowing and providing choice and for added protection for citizens when provincial-federal healthcare resources are 'stretched'.

Salaried MDs with focused accountability and quality outcomes

Any new clinical provider roles or remuneration options will most likely be impacted by system factors, human factors, and situational factors [74-76]:

- System: Overall capacity, equity of access, fiscal responsibility, and clinical efficiency
- Human: Loss of their independent contractor status to a contractual alternate payment plan with clinical oversight and accountability; historical hierarchy barriers such as 'town and gown'; the professional characteristics of the clinical providers; acceptance of a new remuneration process; clearly defined clinical roles and expectations (primary care; specialist [medical; surgical; sub-specialist]; academic; generalist); more collaborative service locations for urban; rural; remote sites
- Situational: Trust in the professional medical leadership (public, private, academic) and the government-managed healthcare administration to discuss, create, negotiate, implement, and manage the evidenced-based proposed change while, in the process, respecting the complex needs of the patient and provider.

Until the most recent funding agreements, federal money delivered through the Canada Health Transfer (CHT) was placed in the province's general pot, with a no-strings-attached system. In 2023, Ottawa announced a $46.2 billion increase in support for provinces and territories over 10 years. This new CHT has included $25 billion managed in these bilateral funding agreements. Therefore, access to this CHT support required each provincial jurisdiction to adopt new accountability measures and requirements. These bilateral agreements are structured to require greater accountability, requiring that the provinces and territories must report back on, how funds were actually spent in the previous fiscal year. While these agreements are immensely complex, this is the required fiscal and quality process necessity to strengthen funding outcomes with oversight. [97]

The bilateral agreements have included four shared health priorities, with established province and territory health care targets [97]:

- - expanding access to family health services, including in rural and remote areas;
- - supporting health workers and reducing backlogs;
- - improving access to quality mental health and substance use services;
- - modernizing the health-care system with standardized health data and digital tools.

Two OECD comparisons (Table 3 [2, 31, 32] provide a better understanding of the processes that may be transferable to Canadian provincial systems from economically comparable countries with high-functioning and fiscally appropriate healthcare systems. Three high-functioning countries, the Netherlands, Norway, and Sweden, have some obvious high-level factors, such as smaller populations and geography. Remuneration is predominately via publicly salaried providers, but with opportunity and access to private clinical care, the counties have larger numbers of MD providers and more hospital beds per 1000 population, better preventive care, better avoidance of mortality numbers, and more patient satisfaction re healthcare services and outcomes. [2] These quality factors for each country are obtained with comparable %GDP and healthcare spending per capita to Canada.

The FFS physician payment model is no longer an appropriate remuneration model for government-supported public care if outcome quality and accountability with patient satisfaction are the accepted quality indicators. [38-40] Salaried or contract-based remuneration models would allow for more ethical service prioritization, improved preventive care, better patient-provider time use, removal of gender-based provider disparities, better cost-effective care with improved patient outcome quality, enhanced workforce planning, and improved care satisfaction for both patient and provider. [38-40] Decreasing the historical variance for the clinical-based discipline remuneration by using clearly defined provider service FTE roles and evidenced-based outcome expectations will allow for directed clinical oversight /measurement while providing more appropriate quality and timely care. [77-91]

The public salaried-private option remuneration models used in most EU countries should be an important consideration for Canadian provincial healthcare administrators and providers. Table 4 [2, 45-52], Table 5 [5], and Supplemental Tables 1-2 [53-55] summarize the remuneration comparisons, models, definitions, and contract issues required to initiate an innovative and collaborative healthcare remuneration package.

Collaborative Complexity

While there is an obvious need and benefit for collaborative public-private care, the complexity will require more discussion for integration, as the possible two main scenarios are privately contracted services for high demand or poorly accessed public care and the creation of collaborative focused parallel clinical 'free-enterprise' services.

Geography

It could be important to re-consider the healthcare organizational size and the population under care as all three EU comparison counties have populations ranging from 5.4 – 17.5 million compared to Canada's provincial range of 1-14 million. In contrast, the population demographic comparisons between the three countries and Canada are very similar. While the geography in Canada is a significant barrier to care, the geographic population factors could be managed with:

Thirteen provincially initiated processes but with greater inter-provincial collaboration both for access to Medical Centers of Excellence and along the provincial borders where geographic access may allow the 'closer to home' concept to be appropriately utilized

The consideration for four clinical care regions with populations ranges of 5-14 million that could be better administratively managed (Region 1: British Columbia, Alberta, Saskatchewan, Manitoba, Yukon, North-west Territories, and Nunavut; Region 2: Ontario; Region 3: Quebec; and Region 4: New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland and Labrador).

The consideration for six North-South Corridors that may be more geographically manageable: 1. British Columbia and Yukon; 2. Alberta, Saskatchewan, and North-west Territories; 3. Manitoba and Nunavut; 4. Ontario; 5. Quebec; 6. Nova Scotia, New Brunswick, Prince Edward Island, and Newfoundland / Labrador

Canada has many rural and remote areas and communities, with 20% of Canadians living in an area designated or defined as rural. In the three focused OECD-EU countries, rural clinical issues are present in Sweden, Finland, and Norway. [92, 93]

New remuneration models, after discussion and implementation, could start with two main groups of healthcare providers: the first group, the urban and rural hospital-based MDs with hospital-affiliated physicians and surgeons, and the second group, the community-based primary care physicians. (Table 5 [5]) These two service groups would likely comprise more than 50% of Canadian physician numbers. Blended remuneration packages could be discussed using co-created service provider-dependent criteria (healthcare administrative and medical leadership) in FTE models for scheduled and on-call work of 80/20 -70/30 with public and /or private splits, respectively, for scheduled salary/contract/APP (with benefits) and on-call hourly / contract components. The present authors, supplemented by limited CMA media statements, describe additional public and private work-related requirements that include appropriate relative-value comparisons, evidence-justified incomes (tighter bell curves) with defined remuneration criteria, progressive remuneration grids, cost-effective-appropriate care, defined work hours, including "on-call" duty, and clearly defined provider accountability processes to allow for patient and provider satisfaction. (Table 5 [5])

There are many healthcare issues in Canada, but a 'big C' change is required, as the OECD comparative healthcare evidence repeats itself, year after year, with Canadians experiencing poor access to care, average quality of care and outcomes, and high costs of healthcare services. There is a need to break these required changes into achievable projects, but this will require the provinces to consider, negotiate, mandate, collaborate, and initiate the process. A Province, or geographically co-located provinces, could start with the remuneration change, eliminating FFS progressively over five years while moving to MD contract or employee-based FTE remuneration models using a fiscally equitable and balanced physician and surgeon remuneration program that provides clinical accountability, patient outcome quality, and evidenced-based clinical public and private collaboration from routine and preventive care to quaternary services.

The CMA statements for public and private care support are very limited as the voiced CMA principles for access, equity, and accountability are not implemented in the present public healthcare system [5]. Some of the failures in the public system are directly related to a lack of human resources (equity and access to provider and hospital care) and limited or restricted use of the healthcare outpatient and inpatient physical plants (access, equity, accountability).

Using a principles-based approach to guide policy discussions, decision-making / acceptance, and professional buy-in, related to the creation of an effective and functional public–private clinical health care, requires that the following policy principles be utilized [5]:

- Quality care (safe; equitable; timely; patient partnered; efficient; effective; appropriate)
- Accountable and transparent decisions
- Comprehensive services
- Integrated services
- Clinical autonomy
- Sustainable and affordable via human resources and funding
- Professional responsibility

Certain factors such as clinical autonomy and professional responsibility, while a cornerstone of professional discipline, have created large areas of human resource, clinical, and fiscal variance. Clinical care access, outcome clinical oversight, and fiscal management is required to find 'the balance' for quality, accountability, transparency, comprehensive, and integrated team-based system for a sustainable and affordable public and private clinical care services. The CMA has suggested some broad challenges which are summarized below: [5]:

A. Ensuring timely access / human resource sourcing and sustainability, defined service time commitment, contract-salaried remuneration

B. Implementing evidenced -informed care / research supported and protocol driven to reduce clinical outcome variance via the use of appropriate clinical evaluation intervals for review, decision, oversight, electronic audit, remuneration model with acceptable EMR documentations

C. Expanding equitable access to other public and 'private' health care services / ethical prioritization of the clinical services offered for effective, preventive, and acute services with evidence-supported funding decisions [Oregon Model]

D. Improving accountability and transparency / fiscal control of the provider and service activities via the prioritized process

It must be recognized, that balancing the public–private service mix alone, cannot address all the issues in Canada's dysfunctional health care system. Other system actions are required, which could include improving system governance, decision and implementation transparency and accountability, consideration of innovation and technologies for promotion of health and to meet the increased demands for care, and creation of a culture of quality improvement and effective health human resources planning to ensure that Canada has the sustainable levels of health human resources now and for the future.

The public-private health care change must be initiated at the provincial level with fiscal, human resource management, clinical outcome accountability, and the regional creation of larger population blocks for fiscal benefits as the first steps in creating the public-private solution. Finally, three clinical care opinions publications support the need for this big-C system-based change: 'Patient care has taken a back seat' [98], 'A system on the brink' [99], and 'Managing the Public-Private Interface to Support Quality Care (CMA) [100].

CONCLUSION

Provincial healthcare oversight and planning in Canada requires public and private healthcare service models of care with salaried physicians and accountable cost-effective quality care to achieve outcomes similar to those of the Netherlands, Norway, and Sweden. Canadians need to consider well-functioning public and private health care models and discard the thought that private healthcare can only function as the more costly and dysfunctional US healthcare system. Provincial health administrative and medical leadership must consider alternative choices for MD remuneration with non-FFS contract-salaried-based or alternate payment plan models to provide for better and evidenced-based quality patient outcomes with provider fiscal and outcome accountability and patient satisfaction. Larger regional patient populations (10-12 million) would allow fiscal benefits and minimize political oversite interference.

Provincially mandated processes with evidenced-based healthcare remuneration and public-private service collaborative correction is needed for a fiscally cost-effective and patient outcome balanced remuneration program (benefit for patient, provider, and system) with clinical accountability and outcome quality using an internationally tested, evidenced-based public and private clinical healthcare collaboration for Canadian's routine and preventive care through primary to quaternary medical, surgical, and other procedural services.

REFERENCES

1. Canada Health Act R. S. C., 1985, c.C-6; Last amended December 12, 2017; Current to December 15, 2023; http://laws-lois.justice.gc.ca; Accessed March 16, 2024.

2. OECD (2023), Health at a Glance2023: OECD Indicators, OECD Publishing, Paris. https://doi.org/10.1787/7a7afb.35-en.

3. Kirkpatrick K, Laupacis, A. A focus on access to health care in Canada. CMAJ 2023; 195: E123-4. doi:10.1503/cmaj.230040

4. National survey highlights worsening primary care access. CMAJ 2023; 195: E592-3; doi: 10.1503/cmaj.1096049

5. CMA Understanding public and private health chttps://www.cma.ca/our-focus/public-and-private-health-care/understanding-public-and-private-health-care /Accessed June 20, 2024

6. Globe and Mail; Why CMA is taking on public and private healthcare in Canada. Globe Content Studio August 29, 2023; https://theglobeandmail.com/bussiness/adv/article-why-cma-is-taking-on-public-and-private-health-care-in-canada/; Accessed 9/6/23.

7. Picard A. The Premiers need to get serious about health care reform, not just funding. July 10, 2023. https://www.theglobeandmail.com/opinion/article-the-premiers-need-to-get-serious-about-health-care-reform-not-just/ Accessed March 16, 2024

8. Picard A. Survey says: Improve access to health care-now. August 21, 2023. https://www.theglobeandmail.com/opinion/article-survey-says-improve-access-to-health-care-now/ Accessed March 16, 2024

9. After a 'decade of decline 'in health care, Canadians not convinced that money is enough to solve the crisis. Angus Reid Institute August 17, 2023. 2022 Copyright Angus Reid Institute. All Rights reserved.

10. Persaud N, Sabir A, Woods H, Sayani A, Agarwal A, Chowdhury M, et al. Preventive care recommendations to promote health equity. CMAJ 2023; 195: E1250-73. doi: 10.1503/cmaj.230237

11. Ma O, Verhoeff K, Purich K, Skinner SF, Dhaliwal R, Strickland M. Characterizing Canadian rural general surgeons: trends over time and 10-year replacement needs. Can J Surg2023; 66: E439; doi: 10.1503/cjs.015122

12. Varner C. Without more acute care beds, hospitals are on their own to grapple with emergency department crises. CMAJ 2023; 195: E1157-8. Doi:10.1503/cmaj.231156

13. Varner C. Emergency Departments are in crisis now and for the foreseeable future. CMAJ 2023; 195: E851-2. Doi: 10.1503/cmaj.230719

14. Pace D, Quigley S, Johnston L. Challenges and opportunities in providing high-quality surgical care in Canada. Can J Surg 2023;6: E602-4. Doi: 10.1503/cjs.009723

15. CMA Too much paperwork is hurting physicians, and health care. December 28, 2023. https://hospitalnews.com/too-much-paperwork-is-hurting-physicians-and-health-care/ Accessed March 16, 2024

16. Islam R, Kralj B, Sweetman A. Physician workforce planning in Canada: the importance of accounting for population aging and changing hours of work. CMAJ 2023; 195: E335-40. doi: 10.1503/cmaj.221239

17. Rosenbaum L. What Do Trainees Want? The Rise of House Staff Unions. NEJM 2024. doi: 10.1056/NEJMms2308224

18. Tulandi T, Suarthana E. Narrative Reviews, Systematic Reviews, and Scoping Reviews. J Obstet Gynecol Can 2021; 43(12): 1355-1356; https://doi.org/10.1016/j.jogc.2021.08.002

19. Mak S, Thomas A. Steps for Conducting a Scoping Review. Journal of Graduate Medical Education 2022; DOI: http://dx.doi.org/10.4300/JGME-D-22-00621.1

20. CMA – DeLoitte Report / Why the future of health care is salaried. CMAJ 2019;191: E1390-1. https://doi.org/10.1503/cmaj.1095819 /

21. Oregon Prioritized List of Health Services Methodology. Developed by the Health Services Commission (HSC) Updated 10 /25 /13. Accessed March 16, 2024

22. Kilby MJL, LeBreton M. The Health of Canadians-The Federal Role. Volume 1-6; Final Report 1999- 2002; Available at: https://sencanada.ca/content/sen/committee/372/soci/rep/repoct02vol6-e.htm; [accessed 03. 16.24]

23. Commission on the Future of Health Care in Canada; Available at: The Romanow Commission - Canada.ca; Final Report 2001-2002; November 2002; [accessed 03.16.24]

24. Strength ARCHIVED - A 10-year Plan to Strengthen Health Care - Canada.ca; [accessed 12.08.21]

25. OECD, Eurostat and World Health Organization (2017), A System of Health Accounts 2011: Revised edition, OECD Publishing, Paris; Available at: http://dx.doi.org/10.1787/9789264270985-en; [accessed 03.16.24]

26. OECD (2021), Health at a Glance 2021: OECD Indicators, OECD Publishing, Paris, https://doi.org/10.1787/ae3016b9-en. Accessed March 16, 2024

27. Pan-Canadian Health Data Strategy Expert Advisory Group Report 1. Charting a Path toward Ambition. PHAC June 17, 2021; Available at: https://www.canada.ca/en/publichealth/programs/pan-canadian-health-data-strategy.html; [accessed 03.16.24]

28. Canada and the G20 / https://www.international.gc.ca/world-monde/international_relations-relations_internationales/g20/index.aspx. Accessed March 15, 2024

29. Akashi H, Ishizuka A, Lee S, Irie M, Oketani H, Akashi R. The role of the G20 economies in global health. Global Health& Medicine 2019; 1: 11-15. Doi: 10.35772/ghm.2019.01008

30. European Commission. State of Health in the EU Synthesis Report 2023. Luxembourg: Publications Office of the European Union, 2023. ISBN 978-92-68-09705-2. doi:10.2875/458883

31. Eric C. Schneider et al., Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries (Commonwealth Fund, Aug. 2021). Available at: https://doi.org/10.26099/01DV-H208; [accessed 03.16.24]

32. OECD/European Union (2022). Health at a Glance: Europe 2022: State of Health in the EU Cycle. OECD Publishing. Paris.

33. Newton C. Family Medicine has become more complex. Can Fam Physician 2023; 69: 295. Doi: 10.46747/cfp.6904295

34. CBC British Columbia Fee-for-service model is deterring aspiring family doctors from setting up practice: report. November 12, 2021. https://www.cbc.ca/news/canada/brotish-columbia/fee-for-service-model-family-doctors-1.6247049. Accessed April 2, 2024.

35. CMA Physician Workforce Survey, 2017. National Results by FP/GP or Other Specialist, Gender, Age, and Province/Territory. CMA Physician Workforce Survey 2017, Canadian Medical Association. Accessed April 2, 2024.

36. College of Family Physicians of Canada: Equitable and Fair Remuneration for Family Physicians. Mississauga, ON. College of Family Physicians of Canada; 2023. Accessed April 2, 2024

37. Doctors of BC. Negotiating the Physician Master Agreement-Realities of physician compensation: How overhead fitsin. https://www.doctorsofbc.ca/negotions-process-behind-physician-master-agreement#tab-1-1. Accessed April 2, 2024.

38. Context Matters: The Facts about Physician Compensation in Alberta. Alberta Medical Association. albertadoctors.org; Accessed April 2, 2024

39. Physician Compensation Strategy. Alberta Medical Association Overhead Study. Final Report January 29, 2021. AMA Board Approved February 4, 2022. albertadoctors.org; Accessed April 2, 2024.

40. Income Equity Update August 10, 2023; https://www.albertadoctors.org/leaders-partners/income-equity/iei-update/income-equity--initiative-update-aug-10-2023. Accessed April 2, 2024.

41. Ridic G, Gleason S, Ridic O. Comparisons of Health Care Systems in the United States, Germany, and Canada. Mat Soc Med 2012; 24: 112-120. doi: 10.5455/msm.201224.112-120

42. Wilson, RD. Opportunities to improve healthcare processes and services outcomes in Canada. Canadian Health Policy, JUL 2022. ISSN 2562-9492, https://doi.org/10.54194/LHSA7302, canadianhealthpolicy.com

43. Wilson RD. Fourteen health care systems versus COVID-19: are these the best systems for future health care decisions and needs? Can J Physician Leadership 2020;7(1):27-30; https://doi.org/10.37964/cr24725

44. Wilson, RD (2024). A Canadian Healthcare Policy Framework for Clinical Care at the End and the Beginning of Life: Prioritization, Human Resource Management, and Remuneration Models. Canadian Health Policy, JUN 2024. https://doi.org/10.54194/DDMO2827. canadianhealthpolicy.com.

45. Couey C. What you need to know about the different types of medical practice payment models. March 29, 2023; https://www.softwareadvice.com/resources/healthcare-payment-models/; Accessed 03/16/24.

46. Physician payment models in Canada. October 25, 2023; https://www.dr-bill.ca/blog/billing-tips/physician-payment-models; Accessed 03/16/24.

47. What is Fee for Service in Healthcare?; https://prognosis.com/what-is-fee-for-service-in-healthcare/; Accessed 03/16/24

48. 17 Fee for Service pros and cons. Gaille L April 20, 2019; https://vittana.org/17-fee-for-service-pros-and-cons. Accessed 03/16/24

49. Berg M, Nuzum D, Parmar S. The seven characteristics of successful alternate payment models. January 2019. McKinsey & Company, Detroit Michigan. Accessed March 16, 2024

50. Mitra G, Grudniewicz A, Lavergne MR, Fernandez R, Scott I. Alternate payment models. Canadian Family Physician 2021; 67: 805-807. doi: 10.46747/cfp.6711805

51. www.dr-bil.ca/blog/billing-tips/physician-payment-modelsl

52. CIHI An overview of physician payments and cost per service. Total payments; https://www.cihi.ca/en/health-workforce-in-canada-in-focus-including-nurses-and-physicians/an-overview-of-physician. Accessed March 16, 2024.

53. Supplementary Table 1: BDC Employee or independent contractors-what is the difference? www.bdc.ca; Accessed 03/16/24.

54. Supplementary Table 1: Independent / Dependent Contractors, Employees: What's the Difference? West D. June 7, 2020; https://www.west-legal.ca/employment-law/independent-dependent-contractors-employee-difference/; Accessed 03/16/24.

55. Supplementary Table 2: CRA Guide

56. CIHI National health expenditure trends, 2022-Snapshot; https://www.cihi.ca/en/national-expenditure-trends-2022-snapshot. Accessed March 16, 2024.

57. CIHI National health expenditure trends, 2023-Snapshot; https://www.cihi.ca/en/national=expenditure-trends-2023-snapshot. Accessed March 16, 2024.

58. CIHI Workforce changes to address evolving health system needs. https://www.cihi.ca/en/health-workforce-in-canada-in-focus-including-nurses-and-physicians/workforce-changes-to-address. Accessed March 16, 2024.

59. Canadian Medical Association Report. Improving Accountability in Health Care for Canadians. 2023-07. Accessed March 16, 2024.

60. Garcia J, Reddy CL, Atun R. Transitioning to High-Value Health Systems in G20+ Countries. Health Systems Innovation Lab, Harvard University, 2023, Boston, USA. Doi: 10.54111/0001/HSIL/thvhs.

61. 2005 Chaoulli c. Québec (p.g.)).

62. Health Canada. Government of Canada Announces Deductions and Next Steps to Curb Private Health Care Paid Out-of-Pocket. https://www.canada.ca/en/health-canada/news/2023/03/government-of-canada-announces-deductions-and-next-steps-to-curb-private -health-care-paid-out-of-pocket.html. Accessed March 16, 2024

63. Fierlbeck K. Commentary NO. 651 The Scope and Nature of Private Healthcare in Canada. ISBN 978-1-77881-015-2 ISSN 0824-8001 (print); ISSN 1703-0765 (online) CD Howe Institute.

64. Lee SK, Rowe BH, Mahl SK. Increased Private Healthcare for Canada: Is That the Right Solution? Healthcare Policy 2021; 16: 30-42.

65. McKee M, Edwards N, Atun R. Public-Private Partnerships for Hospitals. Bulletin of the World Health Organization 2006; 84(11): 890-894.

66. Canadian Agency for Drugs and Technologies (CADTH). 2022. Managed Equipment Services. Available at https://www.cadth.ca/sites/default/ files/attachments/2022-09/managed equipment_ services.pdf

67. CBC. Supreme Court dismisses B. C. doctor's appeal in challenge over to private health care. April 6, 2023; https://www.cbc.ca/news/canada/british-columbia/private-health-care-dr-day-supreme-court-appeal-dismissed-1.6803463

68. McPake B, Hanson K. UHC: markets, profit, and the public good 4. Managing the public-private mix to achieve universal health coverage. Lancet 2016; 388: 622-30; http://dx.doi.org/10.1016/50140-6736(16)00344-5.

69. Morgan R, Ensar T, Waters H.UHC: markets, profit, and the public good 2. Performance of private sector health care: implications for universal health coverage. Lancet 2016; 388: 606-12; http://dx.doi.org/10.1016/50140-6736(16)00343-3

70. CIHI: A profile of physicians in Canada. https://www.cihi.ca/en/a-profile-of-physicians-in-canada. Accessed March 16, 2024

71. CIHI: A lens on the supply of Canada's health workforce. https://www.cihi.ca/en/health-workforce-in-canada-in-focus-including-nurses-and-physicians/a-lens-on-the-supply-of-canadas. Accessed March 16, 2024

72. CMA Commentary: 4 ways governments can improve health care in 2024. https://www.cma.ca/about-us/what-we-do/press-room/commentary-4-ways-governments-can-improve-health-care-2024. Accessed March 16, 2024.

73. Boozary A, Laupacis A. The mirage of universality: Canada's failure to act on social policy and health care. CMAJ 2020; 192(5): E105-6. doi: 10.1503/cmaj.200085

74. Wendt C, Frisina L, Rothgang H. Healthcare System Types: A Conceptual Framework for Comparison. Social Policy & Administration 2009; 43(1): 70-90. DOI: 10.1111/j.1467- 9515.2008.00647.x

75. Böhm K, Schmidt A, Götze R, Landwehr C, Rothgang H. Five Types of OECD Healthcare Systems: Empirical Results of a Deductive Classification. Health Policy 2013; 113(3): 258-269. Available at http://dx.doi.org/10.1016/j. healthpol.2013.09.003

76. Marchildon G. Comparative Healthcare Systems in North America and Europe: Similarities and Differences. 2022. In Katherine Fierlbeck and Joaquín Cayón-de las Cuevas, eds. Health Law and Policy from East to West: Analytical Perspectives and Comparative Case Studies. Pamplona: Thomson Reuters/Editorial Aranzadi S.A.U., 37-54.

77. Persaud N, Sabir A, Woods H, Sayani A, Agarwal A, Chowdhury M, et al. Preventive care recommendations to promote health equity. CMAJ 2023; 195: E1250-73. Doi: 10.1503/cmaj.230237.

78. Galholtra S, Smith RB, Norton T, Mahnert ND. The surgical gender gap: the impact of surgeon gender in medicine and gynecologic surgery. Curr Opin Obstet Gynecol 2022; 34: 256-261. Doi: 10.1097/GCO.0000000000000788

79. Dosa F, Zeltzer D, Sutradhar R, Simpson AN, Baxter NN. Sex Differences in the Pattern of Patient Referrals to Male and Female Surgeons. JAMA Surg 2022; 157: 95-103. doi: 10.1001/jamasurg.2021.5784

80. Hwang H, Barton A, Jenkin D, Scott TM. The impact of targeted fee increases on the pay disparity between female and male general surgeons in British Columbia. Can J Surg 2023 November 1; 66(6). doi: 10.1503/cjs.000922

81. Dossa F, Simpson AN, Sutradhar R, Urbach DR, Tomlinson G, Detsky AS, Baxter NN. Sex-Based Disparities in the Hourly Earnings of Surgeons in the Fee-for-Service System in Ontario, Canada. JAMA Surg 2019; 154: 1134-1142.doi: 10.1001/jamasurg.2019.3769.

82. Merali Z, Malhotra AK, Balas M, Lorello GR, Flexman A, Kiran T, et al. Gender-based differences in physician payments within the fee-for-service system in Ontario: a retrospective, cross-sectional study. CMAJ 2021; 193: E1584-91; DOI: 10.1503/cmaj.210437

83. Koussa ME, Atun R, Bowser D, Kruk ME. Factors influencing physicians' choice of workplace: systematic review of drivers of attrition and policy interventions to address them. JOGH 2016. doi: 10.7189/jogh.06.0200403

84. CIHI's Information Quality Plan 2017. www.cihi.ca. Accessed March 16, 2024.

85. Jiwani I, Fluery MJ. Divergent modes of integration: the Canadian way. Inter J Integrated Care 2011. URN: NBN: NL:UL;10-1-101421.

86. Wiseman SM, Sutherland JM. Improving the quality of care of Canadians waiting for elective surgery: an important health care priority. Can J Surg 2023; doi: 10.1503/cjs.015922.

87. Shahaed H, Glazier RH, Anderson M, Barbazza E, Bos VLLC, Saunes IS, et al. Primary care for all: lessons for Canada from peer countries with high primary care attachment. CMAJ 2023; 195: E1628-36. Doi: 10.1503/cmaj.221824

88. Banaszek D, McIntosh G, Charest-Morin R, Abraham E, Manson N, Johnson MG, et al. Practice Variation between Salaried and Fee-for-Service Surgeons for Lumbar Surgery. Can J Neurosurgical Sciences 2023; 50: 604-611. Doi: 10.1017/cjn.2022.259

89. Vimalananda VG, Gupte G, Seraj SM, Orlander J, Berlowowitz D, Fincke BG, et al. Electronic consultations(e-consults) to improve access to specialty care: A systematic review and narrative. J Telemedicine Telecare 2015; 21: 323-330. doi: 10.1177/1357633X15582108

90. Tian PGJ, Harris JR, Seikaly H, Chambers T, Alvarado S, Eurich D. Characteristics and Outcomes of Physician -to-Physician Telephone Consultation Programs: Environmental Scan. JMIR Form Res 2021; 5: e17672. doi: 10.2196/17672

91. Islam R, Kralj B, Sweetman A. Physician workforce planning in Canada: the importance of accounting for population aging and changing physician hours of work. CMAJ 2023; 195: E335-40. doi: 10.1503/cmaj.221239

92. Kis A, Razek T, Grushka J, Boulanger N, Watt L, Deckelbaum D, et al. Surgical, trauma, and telehealth capacity in Northern Quebec: a cross-sectional survey. Can J Surg 2023. doi: 10.1503/cjs.013822

93. Wilson RD. Toward a Policy Framework for Sustainable Rural Obstetrics and Surgical Care in Canada. Canadian Health Policy 2023. https://doi.org/10.54194/GTEX1486 www.canadianhealthpolicy.com

94. The Physician Talent Crisis. https://www.g-med.com/page/view-post?&id=221182 Accessed October 30, 2024

95. Which countries in Europe rely the most on foreign doctors and nurses? https://www.g-med.com/page/view-post?&id=220773. Accessed October 30, 2024.

96. Highest Paid Medical Specialties in 2024. https://www.g-med.com/page/view-post?&id=220557. Accessed October 30, 2024.

97. Joss Reimer Why we need to track health-care funding – and hire a chief accountability officer. https://healthydebate.ca/2024/10/topic/health-care-funding-accountability-officer/#msdynttrid=QA0KTxSbWTrJPnzTgVbyZAd3tVzMaJoaaNmV53mhSTk ; Accessed October 30, 2025

98. Harvey EJ, Ball CG. Patient care has taken a back seat. Can J Surg 2024; doi: 10.1503/cjs.005824.

99. Langer M. A system oin the brink. CMAJ 2024; 196(38): E1295-6; doi: 10.1503/cmaj.241114.

100.CMA, Draft CMA Policy. Managing the Public-Private Interface to Support Quality Care. 2024-90-21; https://policybase.cma.>link.policy 14519. Accessed November 18, 2024.

FIGURES AND TABLES

Figure 1: Basic concepts (regulation, financial, delivery) for a physician remuneration model (Salary or APM with Contract / Hourly / other option) for provider to increase access, accountability and patient quality outcomes.

True North: Every province wants high quality healthcare at a reasonable cost, for as many people / patients and services as required, in a manner that is consistent **with fair and equitable human resource sustainability using mutually agreed to service-based principles for efficiency, equity of access, accountability for quality outcomes, and fiscal responsibility.**

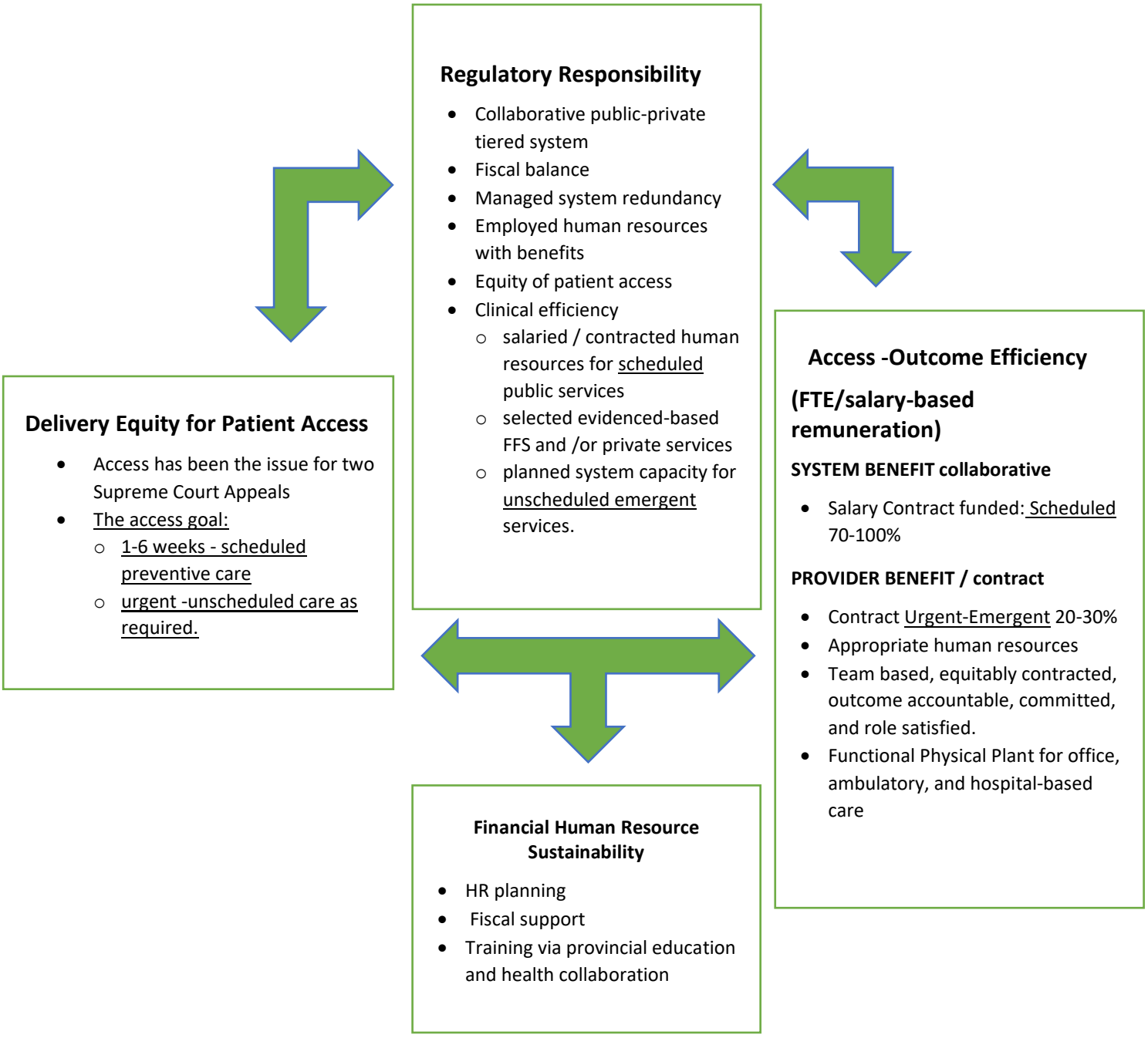

Figure 2: Clinical Delivery Processes required for a Collaborative and Equitable Healthcare System using both public and private healthcare services and providers.

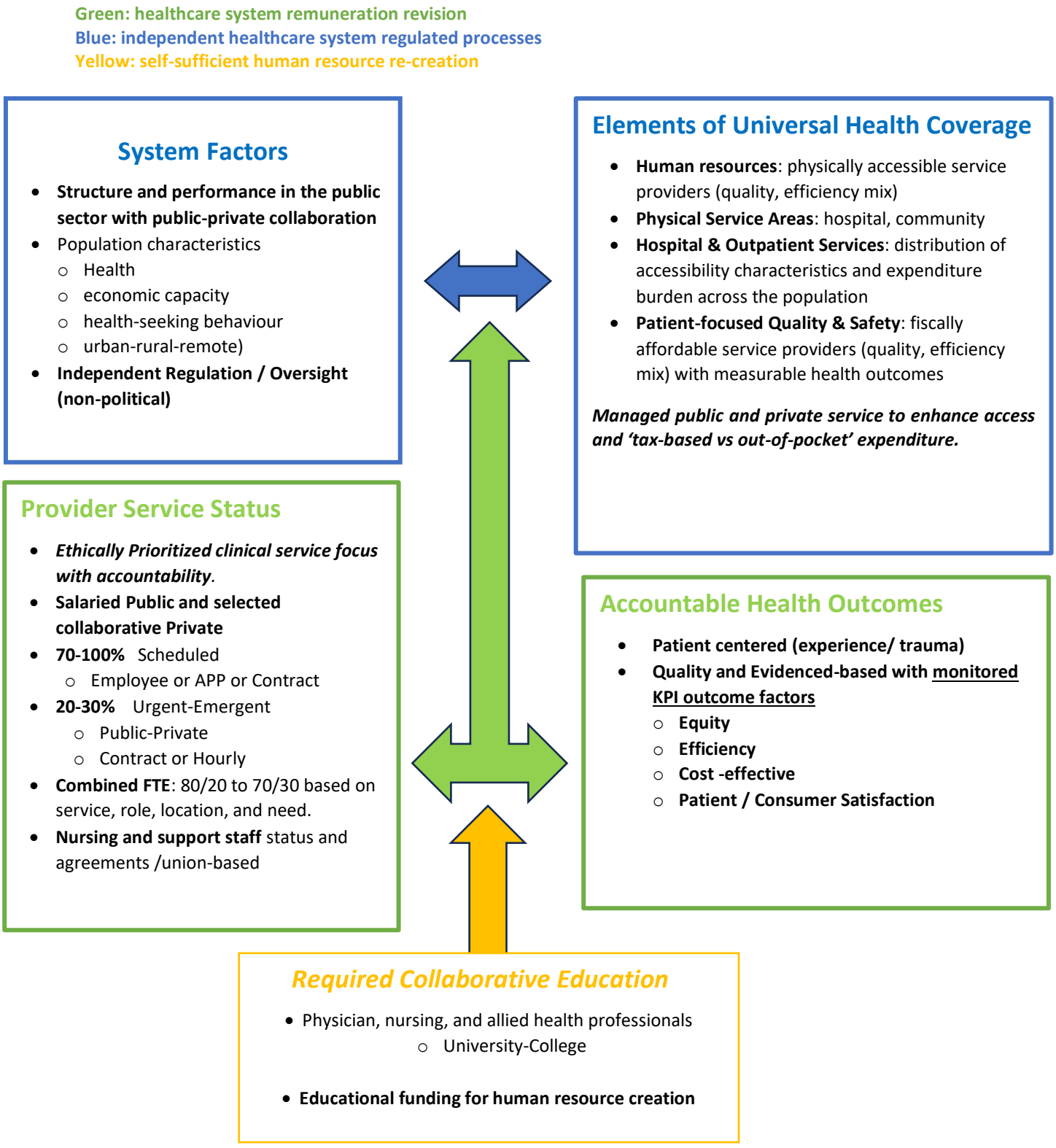

Table 1: Four Issues that Impact the collective Canadian Healthcare Quality [6-17].

Issue	Report or Evidence	Comment
Healthcare Reform	**Picard** July 2023: implement reform instead of just asking for more funding; tackle the root causes of non-existent human resources policies and fundamentally flawed structures [7,8]. **Angus Reid** August 2023: 'Canadians not convinced that money is enough to solve the crisis'; 50% of Canadians struggle with access as 19% have no primary care access and 29% have difficulty getting access to the provider they have; 70% of Canadians feel their province does a poor or terrible job and 70% are pessimistic that the province will be able to make any improvements [9].	Shows the lack of leadership in provincial vision, innovation, priority, and ability to manage the system.
	Persaud N September 2023: Proven preventive care interventions can address health inequities if people experiencing disadvantages are prioritized [10]. **Ma O** August 2023: Canadian rural general surgeons (760) were identified; a prediction model was used to estimate future workforce needs [11].	Avoidable disparities in health outcomes persist in Canada despite substantial investments in a publicly funded healthcare system that includes preventive services. 370 rural surgeons will be required over the next 10 years = 43% of all general surgery graduates will need to enter rural locations.
System	**CMA** August 2023: the debate re public and private access to healthcare; CIHI public funding 72% and private 28%; private healthcare is that for profit or not-for-profit models; these models have not helped with primary care access; then comes wait times [6]. **Varner C** September 2023: capital and human resource expenditure for new acute hospital beds and extended hours for ORs is required for waiting lists and ER barriers [12]. **Varner C** June 2023: Emergency departments are in crisis now and for the foreseeable future [13].	Appropriate and defined accountability and 'expected' clinical outcomes are required in any public or private clinical care agreement.
	Pace D December 2023: high-quality surgical care in Canada; challenges: wait times, travel distances, human resource issues, equitable access issues, limited data collection, lack of transparency re surgical outcomes, lack of incentives to achieve high-quality outcomes. [14]	Suggested solutions: centralized referral intake and wait-list management strategies, increase use of enhanced recovery pathways, systematic data collection to optimize outcomes, incentivize hospitals and surgeon to improve quality.
Human Resources Funding	Models / methods of funding for primary care, midwifery, specialist (generalist vs sub-specialist), other medical or nursing professions, and additional support staff roles. **CMA** December 2023: too much paperwork is hurting physicians and healthcare [15] **Islam et al**. 2023; the changing demographics and hours of work for the clinical care workforce cannot be ignored as this will have an impact on the ability to provide the clinical care, education, research, and administration; work-life balance may be important but then other decisions are required [16].	This HR issue requires important and necessary change with revision as there should be one 'viable and accountable' healthcare business model not the thousands of MD small business entities we have now. The 'unequable' fee distribution requires new evidenced-based business solutions.
Education	**Rosenbaum** 2024; reports that the trainee's need to be a part of the solution as they are part of the future[17].	There has been no or very little discussion at any of the federal-provincial transfer funding discussions related to more educational support and positions for MDs and nursing; the lack of provincial political oversight and management for healthcare human resource planning is a major barrier.

Table 2: The Big Picture - Canada (OECD member) compared to other OECD Countries [2]

Health Measurement Category	Canada mean	OECD mean	OECD Low range	OECD High range
Green better than OECD mean Red worse than OECD mean	9/25 16/25			
Country Health Status / Access/Quality				
Life expectancy in years ***Canada in Large OECD group high $; greater life expectancy***	81.6	**80.3**	73.1 Latvia	84.5 Japan
Avoidable mortality rate using deaths per 100,000 ***Canada in Large OECD group higher $; less mortality***	171	**237**	133 Switzerland	665 Mexico
Population care satisfaction ***Canada in Small OECD group higher $; less access***	56	**67**	39 Chile	94 Switzerland
Effective preventive care using % of mammogram-2 yrs. ***Canada in Larger OECD group higher $; greater quality***	59.7	**55.1**	20.2 Mexico	83.0 Denmark
Chronic conditions % of adults	7.7	**7.0**	3.0 Ireland	16.9 Mexico
Safe primary care antibiotics per 1000	9.0	**13.1**	7.2 Austria	21.7 Greece
Effective primary care to avoid hospital /100,000	388	**463**	195 Mexico	827 Turkey
Effective secondary care 30-day mortality per 100 AMI	4.7	**NA**	1.7 Iceland	23.7 Mexico
Health system capacity / resources				
Health spending US $ per capita	6319	**5000**	1,200 Mexico	12000 USA
Health spending %GDP	11.2	**9.2**	4.3 Turkey	16.6 USA
Doctors per 1000 population	2.8	**3.7**	2.2 Turkey	6.3 Greece
Nurses per 1000 population	10.3	**9.2**	1.6 Columbia	18.9 Finland
Hospital beds per 1000 population	2.6	**4.3**	1.0 Mexico	12.8 Korea
Health Status				
Maternal mortality per 100,000 LB	11.0	10.9	1.7	126.8
Infant mortality per 1000 LB	4.5	4.0	1.6	27.0
Access				
Average length of stay	7.8	7.7	18.5	4.4
Emergency use / access visits	37	27	63	6.0
Hip Surgery =/- 2 days	93	80	99	47
PE /100,000	659	467	1192	57
Quality				
MD consultations per year				
Per patient	4.7	6.0	0.6	15.7
Per MD	1734	1788	428	6113
Hospital beds per 1000	2.6	4.3	1.0	12.8
Occupancy	87%	70%	52%	90%
ICU per 100,000	12.8	16.9	4.8	45.5
30-day mortality per 100				
Myocardial infarction	4.7	7.0	1.7	23.7
Ischemic Stroke	7.7	7.9	2.9	20.5

Table 3A and B: Canada compared to Economically Comparable International Countries: Healthcare Key Performance Indicators (KPI) - Overall and Focused [2, 31, 32]

Comparison Factor											
Table 3A	***Canada***	***Netherland***	***Norway***	***Sweden***	***France***	***Germany***	***Aus***	***NZ***	***Switzerland***	***UK***	***USA***
Overall Country Ranking	**10**	**2**	**1**	**7**	**8**	**5**	**3**	**6**	**9**	**4**	**11**
Access to Care	9	1	2	6	7	3	8	5	10	4	11
Care Process	4	3	8	11	10	9	6	1	7	5	2
Equity	10	5	8	6	7	2	1	9	3	4	11
Health Care Outcomes	10	4	2	5	6	7	1	8	3	9	11
Administrative Efficiency	7	8	1	5	6	9	2	3	10	4	11
MD remuneration primary $$	FFS / regional ARPs	salary public-private	salary public-private	salary public-private	salary public-private	salary public-private	FFS &/or private care	FFS &/or private care	salary public-private	salary &/or private care	salary / FFS via insurance private

Table 3B				
Focused toward High Functioning Countries	1.	Netherlands	Norway	Sweden
Demographics				
Population million	37	17.5	5.4	10.5
>65 years %	20.0	19.8	17.9	20.1
Fertility /# of children	1.43	1.54	1.48	1.67
Health Spending				
GDP%				
Per capita USD	11.2 6339	10.2 6729	7.9 7772	10.7 6438
Health Care Utilization				
Beds per 1000	2.6	3.0	3.4	2.0
MDs per 1000	2.8	3.9	5.2	4.3
Patient satisfaction %	56	70-90	70-90	70-90
Quality				
Primary care per 100,00				
Prevention	388	318	477	361
Secondary 30-day mortality per 100 for AMI / Stroke	59.7% 4.7 /7.7	72.7% 2.9 / 4.9	65.5% 2.6 /3.1	80.0% 3.6 /5.5
Avoidable deaths per 100,000	171	161	156	150

Table 4: Canada and the OECD Remuneration Comparisons [2, 45-51]

Canada and OECD: Models of Care	OECD Remuneration	OECD Quality with mixed Public Private models
Canada: Fee for Service (FFS)/Alternate Payment Plan (APP) via a fixed provincial process. *CIHI average gross income $343,500* Gross income range: 2020-2021 (NL $275,000 – PEI $400,000) *70 % FFS / 30% APP* *with 66% receiving some APP $* **FFS** use highest BC, AB, QC **APP** use highest NS, SK, YT, NB Consultation and office visits are the largest billed services via either the FFS 75% / APP 66% processes. *Canada 2022 Average payment:* Family Medicine $299,000 Medical Specialist $382,000 Surgical Specialist $507,000 B.C. in 2022 negotiated a new physician payment agreement that means a full-time family physician working 1,680 hours a year, who handles 1,250 patients, will earn at least $385,000 (overhead to be deducted).	In many countries, governments can determine or influence the level and structure of physician remuneration by regulating their fees or by setting salaries when doctors are employed in the public sector. In most countries, specialists earned more than GPs. In Australia, Belgium and Korea, the income of self-employed specialists was at least double that of self-employed GPs. In Germany, the difference between self-employed specialists and self-employed GPs was much smaller, at about 12% In about half of countries, the remuneration of specialists has risen faster than that of generalists since 2011, thereby increasing the remuneration gap between the two professional categories. In some countries, including Portugal, Costa Rica and the United Kingdom, the remuneration of both GPs and specialists fell in real terms between 2011 and 2021. In the United Kingdom, the remuneration of doctors has fallen slightly in real terms over the past decade. When comparing doctors' income, it is important to bear in mind that the remuneration of different categories of surgical or medical specialties can vary widely within a country. In Canada, ophthalmologists and many surgical specialists had at least twice the income of paediatricians and psychiatrists in 2018/19.	Only Australia has below average primary care (effective) with all other country comparisons at the OECD average. Sweden, Norway, Denmark, and Finland have their majority of categories as better or equal to the OECD average. Belgium, France, Germany each have one category below the OECD average, otherwise categories at the OECD average. Poor performances equal to or below the OECD average are in Poland, Turkey, Mexico, and Latvia.
OECD identified: **Salaried / Public-Private Funding** Sweden, Norway, Denmark, Finland, Netherland, Belgium, France, Germany, Austria UK, Switzerland Korea, Israel, Australia NHS doctors are paid a basic starting salary equivalent to $55,000, the entry-level salary for medical residency, ranging up to $170,500 with about 28 years experience.	**Alternative Payment Plan (APPs)** are central to the efforts to reduce the growth in healthcare costs and improve outcomes for patients. 1. *Density and scale*- the model must be sufficiently large (high density) to motivate providers to change, justify investments, and adopt dedicated clinical-operational workflows. 2. *Strategic leverage* - the leverage available to APP contractors varies considerably. 3. *Skin in the game* - financial accountability for losses ensures providers' organizational commitment. 4. *Focus on the forest* rather than the trees - rewarding value is possible only when costs can be juxtaposed with quality of care that meaningfully reflects the patient's journey.	

Canada and OECD: Models of Care	OECD Remuneration	OECD Quality with mixed Public Private models
	5. *Calibration of risks and rewards* - successful APPs are built upon design choices that balance the payer's interest in reducing medical costs and the provider's interest in minimizing risk and maximizing retained savings. 6. The *right mix* of incentives, motivation, and feasibility - successful APPs combine financial incentives with two other key behavioral modification drivers: professional motivation and feasible targets. 7. *Accounting for consumer behavior* - APP contractors can identify and target specific value "leaks" and introduce initiatives to improve consumer behaviors, treatment adherence, and referrals to high-value providers. **Fee for service (FFS)** is the most traditional payment model of healthcare with reimbursed based on the number of services or procedures provided; the coverage is expensive but provides complete independence and flexibility. This payment model rewards physicians for the volume and quantity of services provided, regardless of the outcome. **True salaries** are an uncommon form of payment for physicians. Salary payment is more likely in academic, administrative, and government roles. The salary model would include health benefits, vacation / meeting time, and other employee compensation components. These salary arrangements are required where FFS and APP are not appropriate.	

Table 5: A Starting Point: Generic 'Straw Dog' Provider FTE and Support / Benefit Distribution for Clinical Hospital -Ambulatory based and Primary Care Services: For Public and Private Services.[5]

Healthcare Clinical Factors	**Public Funded Care (goal: no waiting lists)**	**Public / Private Funded Care Scheduled -Elective with waiting list of 1-6 weeks**	**Public / Private Funded Care (urgent component) Scheduled within 1-3 weeks**	**Public Funded Emergent**	**Public Funded On call: nights weekends**
FTE Full Time Equivalent Hours per week TBD 45-50 hrs.	Public FTE 1.0	Public FTE 0.7-0.8 Private TBD Clinic visit 3-10 days Procedure 1-6 weeks	Public FTE 0.7-0.8 Private TBD	FTE 0.2 - 0.3	TBD **Public requirement as service needed**
Providers	Primary Care 0700-1900 ***Hospital-based 24 hour*** Emergency Obstetrics Labor Delivery NICU ICU / Cardiac ICU Anesthesia Pathology-Laboratory Imaging Internal Med (no procedures)	7 days per week Medical Ambulatory and Procedures Surgical Ambulatory and Procedures Reproductive and Gynecology / MIS **Private Care Services TBD**	Surgery +++ depts Gynecology / MIS Oncology Cardiology (procedures) **Private Care Services TBD**	**Emergent Care 24 hours** Trauma Surgery Orthopedics Surgery +++ Neurosurgery Vascular Oncology Cardiology Neurology	***Hospital-based*** Obstetrics 24/7 ICU/Cardiac 24/7 NICU 24/7 Anesthesia 24/7 Imaging 24/7 Emergency 24/7 **Urgent: On call** Other services
Remuneration Model and Support	Contract Payment Model (CPM) Office / admin Clinic: service dependent	CPM or Insurance / Out of Pocket Physical plant (public / private)	CPM or Insurance / Out of Pocket Limited /designated hourly $ procedures Office / admin Clinic	Hourly $ / Contract	Hourly $ / Contract
Benefits	**Public Package**: 15-20% ($) of CPM total ($ service dependent) Health / Dental / Disability CMPA Vacation starting at 3 weeks. CME 2 weeks Pension Funding for professional expenses Union/ Societies TBD **Private Package TBD**	**Public Package:** Shared: Physical plant [Office/ admin support/ clinic] (provided public/rented private)			
CMA 2024[93] **Very limited approach**	**Public healthcare** Hospitals Physicians Diagnostics Long-term care 43% public Home care: public gate keeper	**Overlapping publicly funded, privately delivered** cataract surgeries walk-in clinics	**Private healthcare** many drugs therapies community-based rehab/physio dentistry counseling for mental health / addiction		**CMA Guiding Principles for Public and Private care:** Timely access Equity Accountability

Supplementary Table 1: Remuneration models comparison [62, 63]

Model	Positives	Negatives	Other Issues
CIHI estimates a 30% use in Canada.			
Salaried as true salaries are an uncommon form of payment for physicians.	Academic or hospital-based roles Predictable income Work/life balance Less fiscal complexity Benefit: leave/pension	Inequity in income Less autonomy Less tax and fiscal advantage	Re-negotiation on a regular basis for maintenance of an Independent market value Accountability
Alternate Payment Model /APP Is central to the efforts to reduce the growth in healthcare costs and improve outcomes for patients.	Predictable income Income for non-clinical work Time for complex care or prevention	Agreement may have some administrative complexity. Reduced autonomy with some clinical care choices Compensation inequity may occur	Capitation choice Blended choice Value-based choice Innovation Collaborative care Accountability Service equality for clinical, education, research, administration
Value Based Care focused on achieving better health outcomes for patients and improving the value of healthcare services delivered.	Shared Risk: Providers share financial risk with payers based on predefined quality and cost targets. Shared Savings: Providers receive a share of cost savings achieved by delivering high-quality care at a lower cost. Bundled Payments: Payers provide a single payment for a bundle of services related to a specific episode of care.	Global Capitation: Providers receive a fixed payment per patient, per period, regardless of the services delivered.	
Sessional Is a focused service role	FTE < 100% with clinical type or disease focus		Focused accountability
CIHI estimates a 70% use in Canada.			
Fee for Service is the most traditional payment model of healthcare.	Provider autonomy Understandable process See one; bill one. Fiscal benefits	Low volume is a barrier. Easy vs complex patients creates process difficulty Fiscal reward for volume over quality of care Expensive for the healthcare system	Limited accountability Trend is for decreasing FFS use except in focused clinical areas where care or procedure is repetitive and cost-effective.

Supplemental Table 2: Canada Revenue Agency definitions of employee and independent contractor [64].

Role	Independent contractor (IC)	Employee
	Provider control (self-employed)	***Healthcare System control***
Status	There is a personal choice for work type and location.	The provider works for and is managed by the healthcare system.
Financial risk	They will assume any possible fiscal risk.	The employer will be re-imbursed for workplace cost.
Profit option	There is an opportunity for profit or loss.	There is no opportunity for profit sharing.
Responsible for investment and management	A significant investment may be required, to receive, the designated fee-for-service payment.	No investment is needed to provide the required service.
Assistant / Subcontractor	The work can be done by an assistant or subcontractor and billed by the IC / the healthcare service has no human resource oversight or responsibility.	The work assigned to the employee by the employer is the employee responsibility.
Equipment	The purchase / repair of equipment required to complete the work is the IC responsibility.	The healthcare system provides the necessary equipment / tools for the employee to complete their work.
Benefits	None.	Benefits are provided: pension, vacation, educational leave, insurance coverage (liability, health, dental, accident).