More power, bonuses proposed for GPs; Doctors who improve patients' health could get extra cash, document suggests

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Alberta Health Services is looking at handing more power to family doctors to run health services and to give them financial bonuses for improving patient health.

The proposals, in a Discussion Paper on Primary Care Models obtained by The Journal, aim to reduce use of hospitals and improve disease prevention. The paper has circulated quietly for several months inside Alberta Health Services and among doctors.

Front-line family doctors would be put in charge of a much wider range of services, including mental health and some public health services and home care, in a "cradle-to-grave" model of primary-care networks, the paper says. Many of those services are now provincially administered.

Alberta has 33 primary care networks in which doctors work in teams with other professionals, including dietitians and physiotherapists. About two-thirds of family doctors are involved in these type of networks, which were launched in 2003 as a way to overcome the shortage of family doctors.

Alberta's health superboard is looking at expanding the role of the medical networks because its fee contract with Alberta Medical Association expires this year, says Richard Lewanczuk, senior medical director for primary care and chronic disease for the health authority. Alberta Health Services hopes to use the new fee agreement, currently under negotiation, to move the networks "to the next level."

Family doctors "are keen to take on the extra responsibilities," says Lewanczuk, adding that the health authority met privately with 200 doctors and nurses this week in Edmonton to discuss the proposals.

By strengthening primary care, Alberta Health Services hopes to develop better disease prevention programs and to promote wellness, which in turn will reduce the burden on acute-care hospitals, Lewanczuk says.

The health services' discussion paper describes as "particularly appealing" the model of primary care in the United Kingdom. There, patients in a given geographic area are assigned to a local doctors' group, called a primate care trust. The doctors are given a per-capita budget from the

government and are responsible for purchasing services at competing hospitals, labs and other providers. In effect, the doctors' group operates like a "miniature health-care system."

This model provides good opportunity for incentives to save money. If the doctors manage to keep costs down, they can keep a portion of their budget surplus, the report says.

"Doctors become accountable for improving the health of a population in a given geographic area," says the report.

But this approach would be a "radical departure" for Alberta's primary care networks. It would also restrict patients' choice of doctors.

Instead, the paper says an enhanced primary care network model would be easier to implement here.

That means giving the networks additional responsibilities for chronic disease management, mental health, public health services such as administering flu vaccines -- all of which are done on a province-wide basis.

Lewanczuk says the funding for this model -- whether fee-for-service, salaries or some alternative -- is under discussion.

But incentives for good performance would be likely.

Doctors would measure their own performance against others. For instance, if one primary care network is sending patients to emergency wards or for certain kinds of tests more often than others, that would be noted, he added.

There would also be additional costs for administration and new facilities if the networks take on these extra duties. "Capital investment is necessary."

The report notes that only larger primary care networks in Alberta would have the administrative capacity to handle taking on a wider range of services.

Offering financial incentives for doctors to be efficient can result in lower health-care spending. But the report also notes "that prescribing patterns and ultimately quality of care may be compromised if providers chose to withhold services to stay within budget or in some cases to make a profit."

John Church, a political scientist at the University of Alberta specializing in primary care health policy, says in some cases, these financial incentives -- known as pay for performance -- can also encourage doctors to take on only healthier patients and avoid sicker patients who can't improve as quickly.

Church says Alberta's primary care networks have been a successful innovation in the last five years, though not all doctors have signed up.

However, doctors generally don't like the increased paperwork that would come with new duties, he says. It would likely require them to hire professional managers.

Church also questioned why the report didn't look at using the model of community clinics that have been around for 50 years. These are similar to existing medical networks, but members of the public have input into running the organizations, Church says.

"We should have a public discussion about these proposals," he says.

In an interesting development this week, the British government said it plans to go even further in devolving most health care -- and most of the United Kingdom's $120-billion Cdn health-care budget -- directly to doctors' groups to decide how the money will be spent. To be efficient, these doctor groups will have to oversee a large number of patients, between 30,000 to 100,000.