

February 2014

OVERSIGHT OF PHYSICIAN SERVICES

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The Honourable Linda Reid
Speaker of the Legislative Assembly
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Dear Madame Speaker:

I have the honour to transmit to the Legislative Assembly of British Columbia my *Oversight of Physician Services* report.

The audit was conducted under s.11 (8) (b) of the *Auditor General Act* and the standards for assurance engagements established by the Chartered Professional Accountants Canada.

Part of Government's role is to assess whether the services provided by physicians are offering value and are high-quality. With this information, Government can prioritize funding choices to ensure value for taxpayers, and make informed decisions regarding how health care dollars are spent.

In this audit, we examined the quality and cost-effectiveness of services provided under the fee-for-service and Alternative Payment Program models, the two largest funding models of physician services for British Columbians. Our findings suggest that Government does not know if the services provided by physicians are high-quality and if they are providing value for British Columbians. In addition, the way that doctors receive payment for their services does not necessarily lead to value for taxpayers.

This report contains six recommendations to improve the oversight of physician services and assist Government with demonstrating that physician services are high-quality and providing value for British Columbians. Although Government has taken some steps to address the issues presented in this report, significant work is still needed.

I wish to acknowledge and thank the dedicated staff at the Ministry of Health, the six health authorities and the Medical Services Commission for their cooperation with this audit. I look forward to following up on our recommendations in spring 2015.

Russ Jones, MBA, CA
Auditor General
Victoria, British Columbia
February 2014

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GOVERNMENT HAS THE CHALLENGE of ensuring our health care system will remain strong and affordable for generations, in an environment with limited funding and continual demand. To be successful, Government must prioritize the funding available by making informed choices about health care service delivery now and into the future.

Physicians play a major role in providing health care services. They contribute to promoting, maintaining, and restoring our health, and can often save lives. At the same time, these services are a major cost to the system. In 2011/12, British Columbia paid its 10,346 physicians over \$3.6 billion dollars, approximately 9% of the entire provincial budget. To make informed choices, Government needs to know whether the services being provided are offering the best value and the highest quality for the money spent.

This audit examined the oversight of the quality and cost-effectiveness of physician services provided under the fee-for-service and Alternative Payment Program models, the two largest funding models of physician services for British Columbians.

We found Government is not ensuring that physician services are achieving value for money. Government is unable to demonstrate that physician services are high-quality and cannot demonstrate that compensation for physician services is offering the best value. Furthermore, there are systemic barriers that are hampering Government's ability to achieve value for money with physician services.

This report contains six recommendations to improve the oversight of physician services and assist Government with demonstrating that physician services are high-quality and providing value for British Columbians. This includes clarifying the roles and accountabilities of the entities involved with physician services and rebuilding the physician compensation model so that it aligns with the delivery of high-quality, cost-effective physician services. Although Government has taken some steps to address a few of the issues presented in this report, we believe that significant work is still needed.

I wish to acknowledge and thank the dedicated staff at the Ministry of Health, the six health authorities and the Medical Services Commission for their cooperation with this audit. My Office also worked with the British Columbia Medical Association and the College of Physicians and Surgeons of British Columbia in conducting this audit. I would also like to extend our gratitude for their contribution. Given the health sector accounts for more than 40% of the provincial budget and impacts everyone in the province, I plan to continue identifying opportunities for further work by my Office in the health sector.

I look forward to following up on our recommendations in spring 2015.



Russ Jones, MBA, CA
Auditor General
February 2014



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ANYONE WHO HAS had an illness or been affected by illness in their family understands the value of physicians. The services they offer can be life saving. Because of how valuable physician services are, it can be difficult to determine an appropriate cost. This is Government's responsibility. It has to manage healthcare spending.

The cost of paying for physician services is quite high. In 2011/12, British Columbia (BC) paid its 10,346 physicians over \$3.6 billion dollars, approximately 9% of the entire provincial budget. Almost all BC physicians receive their income from public health care dollars.

Given the limited amount of funding available for health care and Government's duty to protect and enhance the health care system, Government must make evidence-based funding decisions. To be successful, Government must understand and ensure that all health care services, including those provided by physicians, are high-quality and offer good value for the money spent.

This audit examined whether the Ministry of Health (the Ministry), the six health authorities and the Medical Services Commission (the MSC) (collectively known in this report as the Government) are ensuring that physician services are achieving value for money (i.e. the benefit gained from the money spent).

We examined the oversight of the quality and cost-effectiveness of services provided under the fee-for-service and Alternative Payment Program models, the two largest physician funding models in BC. This audit focused on the quality and cost-effectiveness of physician services and not the overall health care system.

RESULTS OF THE PERFORMANCE AUDIT

Overall, Government does not know if physician services are high-quality and offering good value for the money spent. This calls into question Government's ability to make informed decisions regarding physician services.

Government cannot demonstrate that physician services are high-quality

Government has not defined what it means by high-quality physician services even though the Ministry uses the words "high-quality" in two of its goals related to physician services in its [2013/14–2015/16 Service Plan](#). Government does not have a consistent, overall system for assessing and managing physician performance, which is important for identifying training and development needs, and setting goals for increasing motivation and professional satisfaction. Performance management is common for many professions and is not new to the provincial government. We recognize that these systems are complex and expensive, and many jurisdictions have difficulty defining and measuring quality of physician services. However, there are examples of jurisdictions that have established performance management systems for physicians.

Given how costly and complicated physician services are, we believe that Government needs a clear, consistent and continuous mechanism for managing individual physician performance and that there should be consistency across the health authorities, between like professionals (e.g. all orthopedic surgeons have a consistent performance review process). Only in this way can the Province fully understand what it is getting for the money spent on physician services and make informed decisions to ensure value for money is being achieved.

In addition, entities are working in silos, which is resulting in gaps in the oversight of physician services. The entities involved with physician services have significant differences in opinion regarding who is and who should be accountable for physician services. In some cases, those with the delegated responsibilities did not have the tools needed, or did not feel they were responsible. For example, the Province expects the College of Physicians and Surgeons of British Columbia (the College), the licensing and regulatory body governing physicians in BC, is ensuring quality of practice among all licensed physicians. According to the College, however, while its role is to regulate basic competence for safe practice, the Ministry is the body responsible for the oversight of physician services and the health authorities are the entities responsible for managing the delivery of the health care system and the day-to-day performance of physicians. This means that there is a gap in oversight of physician performance outside of health authority facilities. It is important that the entities involved with physician services, including physicians themselves, work together and accept their accountabilities for ensuring high-quality care.

Government cannot demonstrate that compensation for physician services is cost-effective

Government is also unable to demonstrate that compensation for physician services is offering the best value because it has not defined what “value” or “cost-effective” means as it relates to physician services. In addition, Government’s current physician compensation models and processes limit its ability to ensure value for money. This is specifically a concern given that the Minister of Health is accountable for ensuring the best possible value for taxpayers.

Government has two main models to pay physicians: fee-for-service and the Alternative Payment Program (APP). Both models are common throughout Canada and internationally.

The majority of BC’s physicians receive funding through the fee-for-service model, where a physician is paid per service provided. Although this model encourages physicians to provide a high volume of services, fees are not linked to patient outcomes. Because payment is provided for each service, there is a potential incentive to “over-service” (i.e. providing services that are not necessary and/or most appropriate based on patient needs). We were unable to determine if this is an issue in BC because this type of information regarding appropriateness of services is not collected consistently. Finally, physicians can only charge for services that they perform themselves. This restricts physicians from working in interdisciplinary teams, which have been shown to improve patient satisfaction, access and equity.

We also found that Government is not regularly reviewing the existing fee-for-service fee codes to ensure that the fees are appropriately matched with the service provided (with the exception of laboratory fees). Advanced technology can decrease the complexity and the amount of time needed to provide a service, thereby making an expensive fee

less appropriate. To manage the cost of physician services, it is important that fees are appropriately matched to the services provided.

Fee-for-service fees are also not linked to health needs of the general population. That is, fees for complex services that significantly improve a patient's quality of life are not necessarily higher than fees for services that do not make a significant improvement on a patient's quality of life. Historically, fee increases have resulted from organized groups of physicians (called Sections) advocating for higher pay.

APP, on the other hand, pays for a range of services through contracts, standard rates for half-day services or by fixed compensation (salary). APP can fund practices where the volume of services do not provide dependable physician income, such as in areas with a transient population. Physicians receiving APP choose how much time they spend with each patient, which can result in a lower number of patients having access to care. The research on this is mixed, particularly because physicians receiving APP usually have patients that require more clinical time or participate in other time-consuming measures for which fee-for-service has been found to be ineffective. It is difficult to determine whether this is an issue in BC because this type of information (e.g. patient volume) is not collected consistently.

We also found that Government is not reviewing or adjusting APP contracts to ensure they are cost-effective. In fact, half of the APP contracts we reviewed exceeded agreed upon compensation ranges or were so unclear, we could not reach a conclusion. Sometimes, the Ministry and health authorities agree to pay more than established ranges and rates (i.e. to obtain a sought-after specialist), which sets a precedent for negotiating higher rates.

Our audit also identifies several systemic barriers that make it challenging for Government to ensure quality and cost-effective physician services. One barrier is the information technology (IT) framework in the province's health care system, which was designed to capture billing data, not clinical data. As a result, the data needed to assess the quality of physician services and monitor improvements at the individual level is either not available or is fragmented, with some information held by health authorities and the remainder residing in community physician offices. In addition, aspects of work culture are impeding constructive engagement with physicians and current legislation is not adequately supporting entities overseeing physician services.

Some of these issues in this report were identified by Dr. Douglas Cochrane, Provincial Patient Safety and Quality Officer and Chair of the BC Patient Safety & Quality Council, in his 2011 investigation regarding the quality of the interpretation of computerized tomography (CT) scans and obstetrical ultrasound readings in the province. Government has taken steps to address some of the issues; however, progress has been slow and significant work is still needed. Government must continue to resolve these barriers to ensure effective oversight of physician services. We will be monitoring progress and following up on our recommendations in April 2015.

RECOMMENDATION 1:

We recommend that the Ministry of Health work with the College of Physicians and Surgeons of British Columbia and the health authorities to:

- 1.1** define and set measures and targets for high-quality and cost-effective physician services as part of a performance review process;
- 1.2** document and address barriers that are preventing timely action to ensure that a performance review process is implemented by December 2014 (target completion date of the current Physician Performance Enhancement Framework);
- 1.3** implement the Physician Performance Enhancement Framework and a performance review process for both community- and facility-based physicians;
- 1.4** use the information for the defined measures and targets, as part of the performance review process, to evaluate the quality and cost-effectiveness of physician services across BC and identify areas of improvement;
- 1.5** report results at an aggregate level so the Legislative Assembly and the public understand whether the services being provided are achieving value for money; and
- 1.6** require all physicians to participate in the process.

RECOMMENDATION 2:

We recommend that the Ministry of Health, the health authorities, the Medical Services Commission and the College of Physicians and Surgeons of British Columbia, in consultation with the British Columbia Medical Association, clarify:

- 2.1** the roles and accountabilities for ensuring that the health system supports quality and cost-effective physician services; and
- 2.2** the relationship and accountability of individual physicians to Government for the quality and cost-effectiveness of their services.

RECOMMENDATION 3:

We recommend that the Ministry of Health and the health authorities, in consultation with the British Columbia Medical Association and other health system partners, rebuild physician compensation models so they align with the delivery of high-quality, cost-effective physician services.

RECOMMENDATION 4:

We recommend that as long as fee-for-service and alternative payment remain significant funding models for physician services in British Columbia:

- 4.1** the Ministry of Health should ensure that it has the degree of influence necessary to align funding with health system priorities;
- 4.2** fees and contracts are adjusted on a regular basis so physician compensation reflects changes in the knowledge, skills, time and technology required to deliver a service; and
- 4.3** the health authorities adhere to negotiated ranges and rates, work as one entity to negotiate expectations, and document the rationale for any non-adherence to negotiated ranges and rates.

RECOMMENDATION 5:

We recommend that the Ministry of Health work with the health authorities, in consultation with the British Columbia Medical Association, to:

- 5.1** identify work environment barriers to physician engagement;
- 5.2** develop and implement a plan to improve the organizational culture between administrators and physicians so the focus is on delivering high-quality, cost-effective services that meet both individual patient and population health needs;
- 5.3** identify and implement performance measures and targets to evaluate physician engagement;
- 5.4** monitor and evaluate progress in addressing areas requiring improvements; and
- 5.5** report the results to physicians and health administrators.

RECOMMENDATION 6:

We recommend that the Ministry of Health:

- 6.1** work with the health authorities, health care facilities and the College of Physicians and Surgeons of British Columbia to identify regulatory framework barriers;
- 6.2** create and implement an action plan to address the barriers; and
- 6.3** work with the health authorities, facilities and the College of Physicians and Surgeons of British Columbia to ensure they are able to work collaboratively to maximize the quality and cost-effectiveness of patient care.

MINISTRY OF HEALTH, MEDICAL SERVICES COMMISSION, HEALTH AUTHORITIES

The Ministry of Health (the Ministry), Medical Services Commission (MSC) and Health Authorities (HA's) thank the Office of the Auditor General (OAG) for its report on Oversight of Physician Services.

The report focusses on quality and cost-effectiveness of physician services, a significant and complex subject that every jurisdiction in the developed world is challenged to effectively address. We appreciate the OAG's efforts, but also recognize the limitations inherent in any attempt to gain a comprehensive understanding of such a complex and nuanced topic within a relatively short timeframe.

Nevertheless, the Ministry, MSC and HA's welcome the recommendations of the OAG as an opportunity to continue to ensure public dollars spent on physician services in B.C. provide maximum benefit for patients and maximum value for taxpayers.

The OAG notes that the report is intended to address the quality and cost-effectiveness of physician services and not the quality and cost-effectiveness of the overall health care system. However, as the report also correctly points out, physician services represent a substantial part of government's annual expenditure on the overall health care system. In our view the two are inextricably linked, and as such, we think it important to say a few words about the quality and cost-effectiveness of our health care system in B.C.

It is important to recognize that British Columbians have thousands of successful interactions with the health care system every day, with multiple examples of excellent results: high quality maternity care; high quality acute, critical and trauma care services; excellent cancer care and treatment; high quality elective surgeries; high quality diagnostic services; and all of this delivered by a highly skilled health workforce that includes over 10,000 physicians. Citizens of B.C. enjoy some of the best health indicators in the world, pointing to the underlying strength of the province's social determinants of health and the quality of its health care system – including its physician services.

It is also important to recognize that B.C. has made meaningful progress across a range of areas over the past several years, including:

- Æ Putting in place a proactive chronic disease prevention framework;
- Æ Strengthening primary care and, in particular, improving care and treatment for a number of chronic conditions;
- Æ Improving patient flow within and between hospitals and the community;

- Æ Increasing the use of day surgeries;
- Æ An increasing focus on quality through strengthening clinical care management, physician quality assurance, and the establishment of the BC Patient Safety & Quality Council and the Patient Safety Review Boards; and,
- Æ Improving productivity and cost management.

In terms of cost growth, there is also the reality that, similar to other jurisdictions, B.C.'s health system has seen its expenditures for health services growing at an unsustainable rate. However, over the past few years, B.C. has successfully managed some of these pressures. First and foremost, with compensation for the workforce representing approximately 70 cents of every health care dollar spent in the public system, the government has been successful with professional associations and unions – including the B.C. Medical Association (BCMA) – in collaboratively negotiating agreements to manage compensation growth. Secondly, there have been significant efforts in driving efficiencies in how we deliver, administer and purchase services and supplies. Due to these efforts, B.C. now compares well with other provinces, with the second lowest per capita health spending in Canada.

Additionally, our province compares well against other Organisation for Economic Co-operation and Development countries for life expectancy and per capita spending. British Columbia has one of the longest life expectancies and is one of the lowest in per capita spending.

The aforementioned is important because progress over the past several years in terms of improving the quality and cost-effectiveness of the health care system overall is undoubtedly linked to efforts to address the quality and cost-effectiveness of physician services.

Although the report finds that “entities are not working together” there are numerous examples of the Ministry, MSC, HA's, B.C. Medical Association (BCMA), the College of Physicians and Surgeons of B.C. (CPSBC) and other health system partners working together to address issues raised in the report, for example, through a number of joint collaborative committees (some of which are noted in the report):

- Æ Physician Quality Assurance Steering Committee
- Æ General Practice Services Committee
- Æ Specialist Services Committee
- Æ Shared Care Committee
- Æ Joint Standing Committee on Rural Issues
- Æ Audit and Inspection Committee
- Æ Patterns of Practice Committee
- Æ Guidelines and Protocols Advisory Committee

We raise these examples specifically to acknowledge the many physicians, as well as staff in the Ministry, MSC, HA's, BCMA and CPSBC, who are committed and actively working to improve the quality and cost-effectiveness of services provided to citizens of this province.

Notwithstanding the above, we recognize that there continue to be persistent challenges across a number of areas in the health care system. We also recognize there are significant opportunities for improvement with respect to oversight of physician services. Government is currently in the process of refreshing its strategic agenda for the health care system and developing a three-year plan of action. The refreshed agenda and plan of action are intended to continue and incrementally improve upon what is working well and to identify new priorities. The plan will include key actions that will specifically address issues raised in the OAG's report on physician services.

For example, Recommendations 1 and 2 of the OAG's report suggest the need for improvements with respect to performance management for physicians, as well as clarification in terms of roles, responsibilities and accountabilities of entities involved in oversight of physician services. Government's three-year plan will include a clear performance management accountability framework built on public reporting and grounded in a clear understanding of the roles, responsibilities and accountabilities of the various individuals and organizations involved in the delivery of health services – including those of the Ministry, MSC, HA's, CPSBC and physicians as they relate to ensuring the quality and cost-effectiveness of physician services.

Government also intends to continue to develop and strengthen professional development and quality assurance mechanisms for physicians and other health professions. To this end we will continue to work collaboratively with the BCMA and CPSBC through the Physician Quality Assurance Steering Committee (PQASC) to develop and strengthen performance management for physicians.

Recommendations 3 and 4 suggest improvements related to current physician compensation models. Government agrees that as technology advances and patient and population health needs change, our approach to compensation for physicians must also change.

Of course, changes to physician compensation models require negotiation and agreement between government and the BCMA and they do not happen overnight. That is why as part of its three-year plan government will collaborate with the BCMA to develop a new agreement with physicians that builds on the significant progress of the last decade and drives a fresh contractual and partnership relationship with the health authorities.

As part of the collaborative process to reach this agreement, the parties will discuss significant short, medium and long-term policy issues, including internationally leading practices with respect to physician compensation, which will set the stage for the delivery of physician services over the next decade or longer in B.C. We believe the time is right for this type of fundamental and far-reaching policy discussion, and we believe we have a strong, constructive relationship with the BCMA and physicians that will serve as a foundation for creating new and innovative approaches to physician compensation models that serve the interests of patients, taxpayers and physicians alike.

In the interim, a major priority for government will be to work in consultation with the BCMA and health authorities to re-energize effective alternative funding mechanisms for physicians. Additionally, there are significant opportunities to improve upon and better utilize existing fee-setting processes in collaboration with the BCMA.

Recommendation 5 in the report recognizes that in a sector driven by the commitment and skills of its workforce, an engaged, skilled, well-led and healthy workforce is a critical strategic asset. Government is committed to developing a provincial engagement, influence and accountability framework in collaboration with health authorities, professional associations and unions to support the creation of inclusive, vibrant and healthy workplaces across the health sector. This framework will:

- Æ Ensure rigorous discussion with physicians, nurses, allied health workers, and health support workforce staff about health care practices and change.
- Æ Improve provincial-level analytics to better assess where teamwork and what skill mix is best for both quality patient care and cost-effectiveness.
- Æ Develop clearly articulated, specific, and measurable healthy workplace objectives in each health authority linked to the provincial framework that are monitored, measured, and reported to the board and ministry on a quarterly basis.

Finally, Recommendation 6 suggests improvements are necessary with respect to the legislative and regulatory framework governing physician services in B.C. As the report indicates, work is underway through the PQASC to review the legislative and regulatory framework for physician services, and government is committed to continue working collaboratively through the PQASC to identify opportunities for improvement with respect to provincial legislation and regulation.

Again, the Ministry, MSC and HA's would like to take this opportunity to thank the staff of the OAG for this ambitious report and its six recommendations. We believe we are doing many things well in this province with respect to the overall health care system, and with respect to oversight for physician services in particular; however, we also recognize there are opportunities for significant improvement. We are collectively committed to working with our health system partners to make these improvements, and look forward to discussing our progress with the OAG in April 2015.

BACKGROUND

Physicians play a vital role in our lives. Working alongside other health care professionals, they contribute to our improved well-being and to increased life expectancy.

However, the cost of providing physician services is high. This is a concern not only because of the limited amount of funding available for health care, but also because of impending and significant changes that will likely put greater pressure on health care spending decisions. These changes include: an aging population, greater use of health care services, and the rising rates of chronic disease.

In 2011/12, British Columbia (BC) paid its 10,346 physicians over \$3.6 billion dollars, approximately 9% of the entire provincial budget. Total government spending on the health care sector in 2011/12 was about \$17 billion (over 40% of the provincial budget), and Government estimates that will rise to about \$19.3 billion in 2015/16. Part of this growth will be due to increases in payments to physicians. Please see [Appendix A](#) for more information regarding payments to physicians in British Columbia.

The majority of physicians are independent practitioners who are paid on a fee-for-service or contract basis. Many own their own practice (e.g. a general practitioner, ophthalmologist or dermatologist) and/or work in publicly funded hospitals or facilities (such as cardiac surgeons in hospitals or geriatric psychiatrists in residential care facilities). Whether a physician is working outside government-run facilities (what we refer to in this report as a community-based physician) or inside (what we call a facility-based physician), or both, that individual receives the majority of his or her income from Government.

Thus, while physicians are not employees of Government, they are clearly linked with the health care system by virtue of being paid by public health care dollars. For this reason, all the entities involved with physician services, including physicians themselves, must accept their responsibilities and accountabilities for ensuring high-quality care. It is also important that the legislation affecting physician services reflects these responsibilities and accountabilities as well as appropriate practices and priorities of the system.

In British Columbia, payments to physicians increased from \$2.2 billion in 2001/02 to \$3.6 billion in 2011/12. During the same period, physicians worked less. According to Ministry analysis, the average number of days a year billed by physicians during this period declined from 193 to 179 days.

However, this is not necessarily a reflection of falling physician productivity. It depends on which output or outcome is being measured. This makes it important that Government is clear on what it is trying to achieve with regard to physician services,



Did you know?

Although physicians in BC receive most of their income from Government, physicians must pay for the costs of operating their practices such as staff wages, equipment, supplies, facilities, etc. See [Appendix B](#) for more information.

has agreement with key entities on roles and accountabilities, and has processes in place to understand whether the services provided by physicians are leading to improved health and value to taxpayers.

Although this audit focuses on physician services and not the overall health care system, readers may be interested in understanding how well BC and Canada compare with other jurisdictions in terms of their health outcomes, particularly given that physicians play such a large role in the health system. To this end, information is provided in [Appendix C](#).

We would like to highlight that the information in the Appendices has not been audited. Also, comparisons between jurisdictions should be made with caution.

There are no agreed-upon definitions for what information is included in the various physician payments models (e.g. part-time physicians versus full-time physicians) as well as for understanding the quality and cost-effectiveness of a health care system. This makes it challenging to gauge how BC truly compares with other jurisdictions.

AUDIT PURPOSE AND SCOPE

This audit was carried out to determine whether the Ministry of Health (the Ministry), the health authorities and the Medical Services Commission (the MSC) (collectively, the Government) are ensuring that physician services are achieving value for money (i.e. the benefit gained from the money spent). Government can then make choices on funding priorities to ensure value is achieved. The Nisga'a Valley Health Authority, the health authority that manages the delivery of health care in Nisga'a communities, was not included in the scope of this audit.

Our focus was on two questions:

1. Can Government demonstrate that physician services are high-quality?
2. Can Government demonstrate that compensation for physician services is cost-effective?

We examined the quality and cost of services provided under the fee-for-service and Alternative Payment Program models, the two largest funding models of physician services for British Columbians.

We developed the audit objectives using the Ministry's *Innovation and Change Agenda*, the Institute for Health Care Improvement's *Triple Aim* framework, guidance from the BC Patient Safety and Quality Council, consultation with our subject matter experts, and an understanding of the risks associated with physician services. Please see box 1 for more information.

The audit focused on the actions of the Ministry, the health authorities and the Medical Services Commission because of their shared responsibility for physician services. To get a more comprehensive picture of how the quality and cost of physician services is managed in BC, we also considered the role of the British Columbia Medical Association (BCMA) and the College of Physicians and Surgeons of British Columbia (the College). However, because the BCMA and the College are not part of the government reporting entity (GRE), we did not consider them to be direct auditees. The GRE is composed of ministries, Crown corporations and other public sector entities that are controlled by, or accountable to, the provincial government, which are subject to audit by our Office.

Box 1: Defining Quality and Cost-effectiveness

There are many ways to define high-quality services. We looked to Government to define it. The following five elements of quality are used in the Ministry's *Innovation and Change Agenda*, the BC Patient Safety and Quality Council's definition of quality, and the Institute for Health Care Improvement's *Triple Aim* framework:

- Æ **Safe:** Care provided does not result in harm.
- Æ **Appropriate:** Care provided is evidence-based and specific to individual care needs. This is particularly important because physicians directly influence the use of most health care resources.
- Æ **Patient-centred:** Care is respectful to patient and family needs, preferences and values.
- Æ **Effective:** Care produces or contributes to the intended results or outcomes.
- Æ **Accessible:** Care services are timely and geographically available and can be used by people with various limitations.

Similarly, the term "cost-effectiveness" can be defined in different ways, and we looked to see how Government defines it. We expected a definition that included paying the right price for the right service (not necessarily the lowest cost). Regarding the cost and value of physician compensation, we expected a definition that accounted for relevant factors such as the physician's skills and knowledge, the time and complexity of the procedure, the needs of the population, and the cost of the services in other jurisdictions. Instead, we found that the provincial government has not defined cost-effectiveness for physician services.

Although we did not survey physicians directly, our audit considered evidence provided by the BCMA, the association representing the voice of physicians. Also, some of the BCMA interviewees and many of the health authority interviewees were practicing physicians. In addition, we spoke to physicians as part of the planning for this audit.

We did not evaluate the quality or cost-effectiveness of the health system. Our focus was solely on physician services. Also, we did not investigate which physician funding model is best. Rather, we focused on examining the two largest models used in the province.

The audit was conducted under s.11 (8) (b) of the *Auditor General Act* and the standards for assurance engagements established by the Chartered Professional Accountants Canada.

We carried out our audit work between April and September 2013, and considered evidence from the 2012/13 fiscal year. We also considered documents outside this period if they were significant and if newer information was unavailable.

AUDIT CONCLUSION

We concluded that Government is not ensuring that physician services are achieving value for money.

1. Government cannot demonstrate that physician services are high-quality.
 - Æ Government is not consistently measuring and evaluating physician services at either the individual physician level or at the medical program level.
 - Æ BC's health care system is siloed; there is a lack of agreement regarding roles, responsibilities and accountabilities for the quality of physician services.
2. Government cannot demonstrate that compensation for physician services is cost-effective.
 - Æ Government has not defined what it means by cost-effectiveness for physician services.
 - Æ Government's current physician compensation models and oversight processes limit its ability to achieve cost-effective physician services.
3. Systemic barriers in the province's health care system are hampering Government's ability to achieve value for money with physician services.

KEY FINDINGS AND RECOMMENDATIONS

Government cannot demonstrate that physician services are high-quality

Government is not consistently measuring and evaluating physician services at either the individual physician level or medical program level

We expected Government to have clearly defined what it is trying to achieve with regard to physician services, including what it considers high-quality care. The Ministry uses the words “high-quality” in relation to physician services in its [2013/14–2015/16 Service Plan](#).

We also expected that Government would have defined what it is trying to achieve with regard to cost-effective physician services. This is discussed in the section [Government has not defined what it means by cost-effectiveness](#).

Furthermore, because physician compensation consumes approximately 9% of the entire provincial budget and physician decision-making drives health care spending (e.g. from prescriptions and referrals), we expected Government to be working proactively to ensure that the services provided by all physicians meet expectations for high-quality. This would involve measuring physician performance at the individual physician level, in addition to the medical program and health system level (see box 2).

Assessing and managing performance are also important means of:

- Æ identifying training and development needs;
- Æ setting goals, which can be used for increasing motivation and professional satisfaction; and
- Æ driving specific priorities.

We found that Government has not defined what it means by high-quality physician services, nor has it developed consistent measures for evaluating performance and identifying areas for improvement at either the individual physician level or the medical program level. Only at the broader health system level has Government defined quality health services, looking at the combined performance of various components of the health system (as explained in box 2).

Box 2: Physician Performance Measurement

The quality of physician services can be measured at three levels:

1. Health system level - This provides insight on the combined performance of the various components of the health system including: the individual and team performance of physicians, nurses, other health care professionals and other employees; and operations of facilities including availability of operating rooms, cleanliness, and medical equipment and supplies. It is difficult to analyze this data to understand which component is having which impact.
2. Medical program level - This provides information on how a group of physicians with similar training and scopes of practice is performing (e.g. gynaecology, radiology, etc.).
3. Physician level - This measures the performance of individual physicians.

Government has not implemented a performance management system at the individual physician level in part because physicians are a self-regulating profession. The Province's expectation is that the College of Physicians and Surgeons of British Columbia (the College), the licensing and regulatory body governing physicians in British Columbia, is ensuring quality of practice amongst all licensed physicians.

According to the College, however, while its role is to regulate basic competence for safe practice, the Ministry is the body responsible for the oversight of physician services and the health authorities are responsible for managing the delivery of the health care system and the day-to-day performance of physicians. (We discuss the College's legislated role in [BC's health care system is siloed](#) section of this report).

The College conducts assessments under its Physician Practice Enhancement Program (PPEP), which is aimed at proactively assessing and educating community-based physicians to ensure they meet standards of practice. According to the College, all community-based physicians undergo a periodic assessment. Based on the College's past experience, physicians working in isolated environments without the support of colleagues, as well as physicians over the age of 70 benefit more from assessments. The College, therefore, prioritizes the assessment of these practices. The majority of physicians, however, are randomly selected.

In 2012, PPEP completed 332 peer practice assessments comprised of General Practice, Methadone, Psychiatry and Diagnostic Radiology. For 2013, PPEP assigned 571 assessments and completed 410 as of November 27, 2013. However, the College does not have any performance measures for quality. There is therefore no information on overall performance or trends over time.

Although the College issues a [public report](#) that cites the number of assessments completed and the results of its other quality assurance programs, it does not report on the outcomes of the peer assessments to the public or to Government, even at an aggregate level.

We recognize that current legislation does not set an expectation that the College is involved with ensuring cost-effectiveness (such as determining what gets covered, who gets paid how much, etc.). However, we believe that the information collected through the College's quality assurance activities could be aggregated to help Government identify opportunities for making changes in current physician service delivery – changes that could further improve patient care, ensure more effective use of health care resources, and save money.

Lack of a consistent, overall system for assessing and managing individual physician performance

Several structures and initiatives are in place in BC for ensuring quality physician services; however, we found inconsistency.

The process of "privileging": The health authorities' medical staff bylaws state that each member of the medical staff must have his or her appointment and privileges reviewed annually. Privileges are a permit to practice medicine in facilities and programs operated by a health authority. Granting privileges is one of the systems in place for managing individual physician performance.

Did you know?

According to the *Council of the Federation*, there is mounting evidence that some patients receive treatments that may not be best suited to their actual needs. That results in less effective care for patients and wastes precious health care resources. The *Council of the Federation* comprises Canada's 13 provincial and territorial premiers who work collaboratively to strengthen the Canadian federation by fostering constructive relationships among the provinces and territories and with the federal government. For more information, please visit: <http://www.conseildelafederation.ca/en/featured-publications/75-council-of-the-federation-to-meet-in-victoria>.

In examining the “privileging” documentation and processes, we found that physician performance reviews were not done consistently as a condition for privilege reappointment across all health authorities. There are also no provincial standards for physician performance reviews to ensure continued physician competency.

This means that there is no system in place to consistently and continuously manage individual facility-based physician performance. Government, therefore, does not know what quality of services is being provided by individual physicians and whether it is getting the quality it expects for the money being spent.

Critical incident follow-up: Structures are in place to enable health authority staff and physicians to identify areas of concern and follow up when a critical incident has occurred (such as a death or near death) or when a patient complaint has been made (see box 3 for examples).

However, many of these structures are only for specific medical program areas and are not implemented consistently in all health authorities. In short, there is no consistent, province-wide management of physician performance.

We also found that for issues identified, it was not always clear what actions or recommendations were implemented in response and/or what follow-up was completed to ensure improvements. This concerns us because such oversights can result in preventable life-threatening incidents occurring again, and in duplication of effort to address a single issue, leading to inefficiencies and waste of funding.

Box 3: Quality Assurance Processes

Health authorities use a variety of structures to identify and address areas requiring improvements. However, many of these structures and processes are not implemented and/or operating consistently in the health authorities.

Examples of structures that identify and address areas requiring improvements and their purpose:

- Æ *Medical Advisory Committees* – All health authorities are required to establish a Medical Advisory Committee, which provides advice to the Board of Directors and to the Chief Executive Officer on a variety of areas including the quality and effectiveness of medical care provided by health authority facilities (including care provided by physicians).
- Æ *Mortality and Morbidity Rounds* – Discussions between medical practitioners regarding medical errors and/or difficult cases. This enables practitioners to identify areas for improvement in patient care.
- Æ *Patient Safety Learning System* – Web-based tool that enables the collection of patient safety data for follow-up when a critical incident occurs.
- Æ *Peer Reviews* – Joint peer review of professional decisions to increase accuracy of diagnosis.
- Æ *National Surgical Quality Improvement Program (NSQIP)* – Collection of surgical data to identify areas of concern and measure quality improvements.
- Æ *Managing Obstetrical Risk Efficiently Program (MOREOB)* – Continuous patient safety improvement program for physicians, midwives and nurses. The focus is on promoting a culture of patient safety.
- Æ *Patient Complaint Process* – All health authorities have a Patient Care Quality Office to assist in addressing patient complaints.

The proposed Physician Performance Enhancement Framework: The Province's Physician Quality Assurance (PQA) Steering Committee has been working to implement a Physician Performance Enhancement Framework (see box 4) and a common credentialing and privileging system for the province. However, progress in achieving this has been slow for several reasons, including the challenge of obtaining consensus with the many different entities involved, the significant cultural shift that is required to implement the initiatives, and the lack of clarity about roles and responsibilities.

Finally, we learned that there are barriers preventing information at the individual physician level from being collected and/or shared. This will be discussed in the [Information Systems](#) section.

Performance management systems for professionals do exist

Performance management beyond certification provided by professional bodies is common for many professions, including engineers and accountants. Furthermore, performance management is not new to the provincial government. For example, the *Employee Performance and Development Plan* (now referred to as *MyPerformance Profile*) applies to all BC's public sector employees, about 30,000 – three times the number of physicians in the province.

We found that only a few jurisdictions have established performance management systems for physicians due to the difficulty of defining and measuring quality in physician services. Examples include the National Health Service in England, Intermountain Health in Salt Lake City and the Cleveland Clinic in Ohio. Australia and New Zealand have also piloted a program called *Supporting Physicians' Professionalism and Performance* that consists of, among other things, monitoring and evaluating care, including patient feedback, peer review, promotion of best practices, and participation in analysis of adverse events.

Box 4: Cochrane Review

In 2011, Dr. Doug Cochrane, Chair of the BC Patient Safety and Quality Council, was appointed to investigate issues raised about the quality of the interpretation of computerized tomography (CT) scans and obstetrical ultrasound readings in the province. His review provided reassurance that all radiologists practising in the province (aside from those whose work triggered the review) were appropriately qualified. However, the review also found that quality assurance processes were limited. A range of recommendations resulted. In response, the Physician Quality Assurance Steering Committee was created.

Examples of specific initiatives and their purpose:

- Æ *Physician Performance Enhancement Framework* – To implement a consistent process for ongoing assessment of competency amongst physicians.
- Æ *Practitioner Credentialing & Privileging Project* – To implement a single provincial information technology (IT) system and related standard business processes across all health authorities, to ensure that medical staff have the credentials and privileges to provide appropriate and safe care to patients.
- Æ *Provincial Privileging Standards Project* – To establish discipline-specific core and criteria-based privileging dictionaries for BC.
- Æ *Provincial Credentialing Core Data Set* – To establish a common core data set for medical staff, including the use of forms for application and reappointment.
- Æ *Radiology Peer Review System* – Implementation of a timely radiology peer review system.

We understand that performance management systems are complex and expensive to set up. Nevertheless, given how costly and complicated physician services are, we believe that Government needs a clear, consistent and continuous mechanism for managing individual physician performance and that there should be consistency, between like professionals. Only in this way can the Province fully understand what it is getting for the money spent on physician services and make informed decisions to ensure value for money is being achieved.

RECOMMENDATION 1: *We recommend that the Ministry of Health work with the College of Physicians and Surgeons of British Columbia and the health authorities to:*

1. *define and set measures and targets for high-quality and cost-effective physician services as part of a performance review process;*
2. *document and address barriers that are preventing timely action to ensure that a performance review process is implemented by December 2014 (target completion date of the current Physician Performance Enhancement Framework);*
3. *implement the Physician Performance Enhancement Framework and a performance review process for both community- and facility-based physicians;*
4. *use the information for the defined measures and targets, as part of the performance review process, to evaluate the quality and cost-effectiveness of physician services across BC and identify areas of improvement;*
5. *report results at an aggregate level so the Legislative Assembly and the public understand whether the services being provided are achieving value for money; and*
6. *require all physicians to participate in the process.*

BC's health care system is siloed; there is a lack of agreement regarding roles, responsibilities and accountabilities

Given legislated roles and responsibilities, we expected that entities would be working together to ensure that physician services are high-quality. Rather, we found that entities are not working together, resulting in silos and gaps in the oversight of the quality of physician services.

There are several reasons for this poor coordination, including:

- Æ lack of clarity about what Government is trying to achieve;
- Æ lack of agreement on who is ultimately accountable for physician services;
- Æ physicians are not employees of Government; and
- Æ the system is complex with many entities.

The following entities are involved in physician services in BC (see [Exhibit 1](#)):

- Æ The **Minister of Health** is responsible for protecting and enhancing the health care system in BC while ensuring the best possible value for taxpayers. The Ministry, under the Minister's direction, is in charge of all matters relating to public health and government-operated health insurance programs. To that end, the Ministry has specific and final authority over various matters related to physician services.
- Æ There are **six provincial health authorities**. Under the *Health Authorities Act*,

five of these are responsible for health services provided in specific geographical regions. Each has a governing Board of Directors (reporting to the Minister of Health), a Medical Advisory Committee and various quality-of-care committees.

The Provincial Health Services Authority is not a health authority under the *Health Authority Act*, but a society under the *Society Act*. It is responsible for planning, managing and as appropriate, operating the integrated delivery of province-wide health care services and health protection services. Nevertheless, it is still responsible for oversight of health services, including physician services.

Æ The **Medical Services Commission** is an independent body created through the *Medicare Protection Act*. It is responsible for ensuring that all BC residents have reasonable access to quality medical care, and for managing the payment of medical services in an effective and cost-efficient manner.

This nine-member statutory body is made up of three representatives from Government, three representatives from the British Columbia Medical Association (the BCMA) and three members from the public who are jointly nominated by Government and the BCMA to represent Medical Services Plan beneficiaries. The Commission oversees a significant budget including fee-for-service and some rural program amounts. It does not have any full-time staff, relying instead on the Ministry and the BCMA to provide it with the information it needs to carry out its work.

Æ Under the *Health Professions Act*, the **College of Physicians and Surgeons of British Columbia** (the College) is the licensing and regulatory body governing physicians in the province. The College sets, monitors and enforces standards of practice to enhance the quality of practice by reducing incompetent, impaired or unethical practice among licensed physicians.

Æ The **British Columbia Medical Association** (BCMA) is a separate and distinct body from Government and the College. Its primary responsibility is to negotiate physician compensation with the Ministry, on behalf of the province's physicians. (This role is discussed further in the next section of the report.) However, it has partnered with Government to create three Joint Clinical Committees, whose mandate is to identify changes in current physician service delivery that could result in health care improvements (see box 5). The BCMA has also produced a number of papers focused on a variety of topics including prevention and health promotion, health information technology and access to care.

Box 5: Joint Clinical Committees

The Joint Clinical Committees are joint committees of the BCMA and the Ministry of Health. Although each of the three committees has its own focus, they all share a core mandate that includes identifying changes in current physician service delivery that could result in: improvements in patient care; more effective use of physician and other health care resources; and measurable savings that could be reallocated for more optimal health care. The three committees include:

1. *Specialist Services Committee* – to enhance and expand programs that support the delivery of high-quality specialist services to British Columbians.
2. *General Practice Services Committee* – to develop programs to enhance the role of primary care physicians, with the goal of supporting those currently on the frontlines of health care and medical students considering the specialty of family practice.
3. *Shared Care Committee* – to address the growing need for coordination of patient care and best use of health care resources. It works closely with the other two committees to address the care provided by both family physicians and specialists.

Although we did not include the Joint Clinical Committees within the scope of this audit, we reviewed committee documents and interviewed members about the committees' effectiveness. The Ministry and the BCMA have agreed to put funds into these committees instead of overall flat increases to physician compensation. The intention is that the committees will provide fee incentives linked to health care needs.

Practice differs from legislation

In practice, oversight of physician services has been divided into two components: oversight of facility-based physicians and oversight of community-based physicians. Health authorities are responsible for managing facility-based physicians. The College is responsible for ensuring all physicians meet basic practice expectations. Neither is currently managing the performance of community-based physicians to ensure that the services provided are high-quality.

This practice is different from what is in legislation. Under the *Health Authorities Act*, each health authority is responsible for the oversight of all physicians working in their region. Under the *Health Professions Act*, the College is responsible for the oversight of all licensed physicians in the province. Moreover, under the *Ministry of Health Act*, the Ministry has specific and final authority over various matters related to physician services.

In legislation, there is no division between community- and facility-based physicians. Although the *Hospital Act Regulation* states that a hospital's medical staff must participate in appropriate quality improvement activities (thereby implying that health authorities are responsible for the oversight of facility-based physicians), the regulation states nothing about the responsibilities of non-hospital facility administrators (such as a residential care administrator). It also does not mention the accountability of physicians to a health authority or hospital, and does not clearly outline who should be responsible for the management of physician performance. It is therefore difficult to see how this regulation comprehensively guides the current practice.

Even if the health authorities were able to accept their legislated responsibility, they do not have any tools to influence community-based physicians – that is, physicians who do not have hospital privileges. To fulfill this responsibility, the *Health Authorities Act* and the *Hospital Act* would need to be revised and aligned. Most health authorities have very limited communication with community-based physicians, other than through the recently created Divisions of Family Practice (see box 6).

Also of concern is that some key entities are unsure of the number of physicians that are community-based in the province versus facility-based. The College estimates there are 5,000–6,000 community-based physicians. The challenge in identifying a specific number is that many physicians are both facility- and community-based.

This calls into question how the health authorities and the College can ensure adequate oversight of physician services if there is uncertainty about which group some physicians fall under. The College told us it will rectify this uncertainty by capturing this information as part of the licence renewal process.

Box 6: Divisions of Family Practice

Divisions of Family Practice are groups of physicians organized at the local or regional level that work to address common health care goals. This initiative was designed to improve patient care, increase family physicians' influence on health care delivery and policy, and provide professional satisfaction for physicians. Each Division of Family Practice works in partnership with its health authority, the General Practices Service Committee and the Ministry of Health.

Overall, the differences between practice and the legislated responsibilities leave a significant gap in Government's ability to manage and ensure access to community-based physicians.

We found other instances where mandates and commitments are not being complied with, which has left gaps in oversight. For example:

Æ The Medical Services Commission is responsible for ensuring that BC residents have reasonable access to medical care. Access can be improved through tools such as Telehealth and rural funding incentives, which the MSC has supported by enabling special funding. However, this does not provide evidence that the MSC is ensuring reasonable access to medical care for British Columbians.

The agency is not able to ensure services are reasonably accessible for British Columbians due in part to not having any full time staff. We found evidence of the Commission monitoring selected areas of the accessibility of physician services through information provided by the Ministry (e.g. waitlists); however, there is no evidence of the MSC regularly facilitating accessible physician services. (The exception is the MSC's Advisory Committee on Diagnostic Facilities, which monitors accessibility of lab services.)

Æ We, therefore, expected the Ministry to be actively monitoring access to physicians – facility-based and community-based. This is not happening. In 2010 the Minister of Health announced a commitment to provide, by 2015, a physician for every British Columbian who wishes one (the [A GP for Me](#) initiative); however, we found that the Ministry is not actively tracking its progress in meeting this goal. The Ministry has only estimated the number of unattached patients prior to the initiative's launch, and plans to use the same estimation process in 2015 to look at the change.

Æ None of the entities are measuring the length of time patients have to wait for an appointment with a specialist once they have been referred.

Unclear roles and responsibilities

We found significant differences in opinion about who is and who should be accountable for physician services. In some cases, those with the delegated responsibilities do not have the tools to carry these out or the ability to influence physician practice, or they do not agree that they are responsible.

Some health authorities see themselves as having a limited ability to persuade physicians in their region to align their decisions with government priorities, as physicians are not government employees and the majority do not have contracts with health authorities. The primary lever that health authorities have in influencing physician behaviour (other than granting access to resources such as operating rooms) is modifying or removing the privilege to work in hospitals. In some instances, however, removing privileges would be too extreme: it could take away a physician's ability to earn a living, and may take away access to physician services.

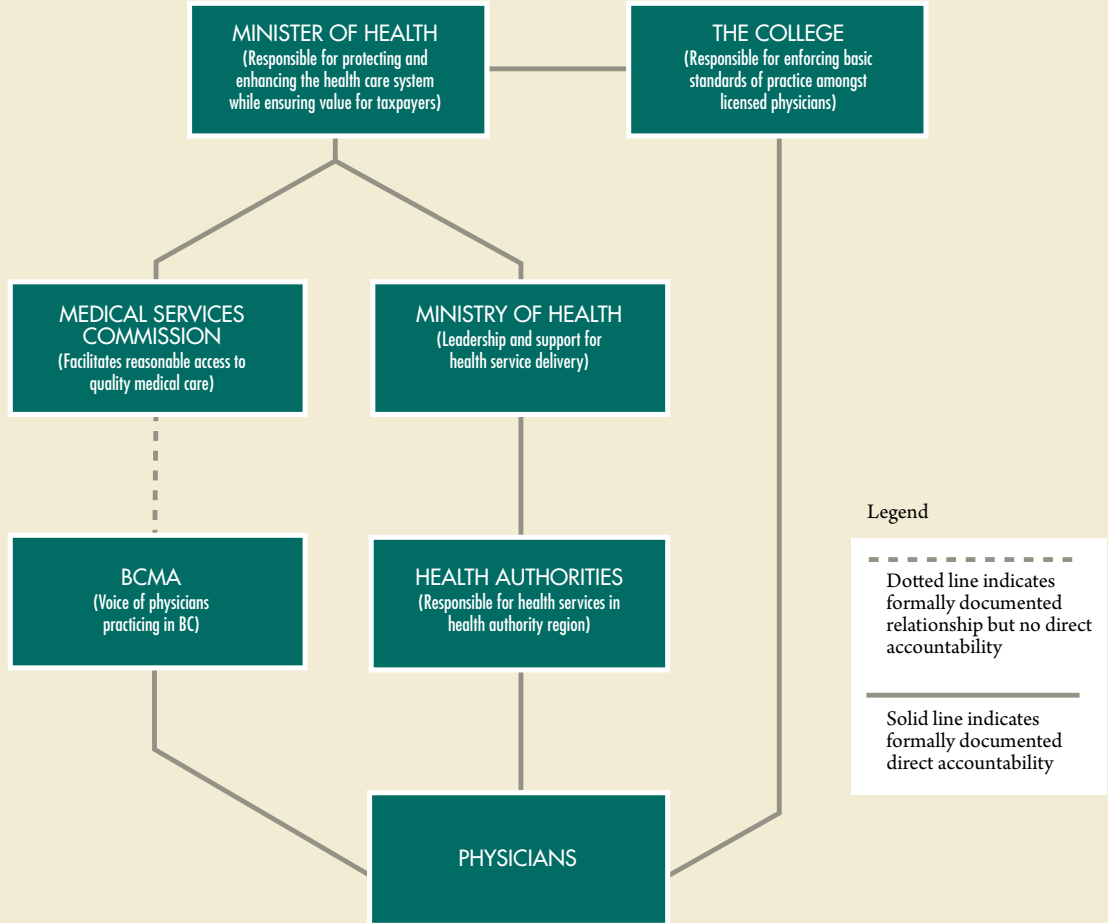
Where it would be appropriate to remove privileges (i.e. for significant unsafe practices), it can be difficult for some health authorities. As we noted above, health authorities do not generally collect performance information at the individual physician level; yet, individual physician performance information is required to modify, suspend or revoke a physician's privilege(s). Some health authorities told us that they want additional tools to help manage physicians. The Ministry believes that the consideration of other tools may be required and there are opportunities for health authorities to more effectively use available tools, such as controls over privileges, to ensure adequate oversight of physicians.

Overall, the lack of agreement on roles and responsibilities makes it difficult for Government to understand if high-quality physician services are being provided in the province. Until roles and accountabilities are clarified, progress in addressing issues and implementing improvements will be slow.

RECOMMENDATION 2: *We recommend that the Ministry of Health, the health authorities, the Medical Services Commission and the College of Physicians and Surgeons of British Columbia, in consultation with the British Columbia Medical Association, clarify:*

- 1. the roles and accountabilities for ensuring that the health system supports quality and cost-effective physician services; and*
- 2. the relationship and accountability of individual physicians to Government for the quality and cost-effectiveness of their services.*

Exhibit 1: Legislative Governance Framework*



* Diagram based on responsibilities outlined in legislation

Source: Office of the Auditor General of British Columbia

Government cannot demonstrate that compensation for physician services is cost-effective

Government has not defined what it means by cost-effectiveness for physician services

How we pay physicians directly affects how much of society’s resources go to the health sector. At the same time, the Minister of Health is responsible for ensuring the best possible value for taxpayers. We, therefore, expected Government to have defined what it means by cost-effective physician services and have processes in place for how it intends to achieve this. We also expected physician compensation to be linked to quality outcomes, as part of good practices for ensuring cost-effectiveness and value for money.

We found that Government does not have an agreed upon definition of cost-effectiveness for physician services and that the process of creating and adjusting service fees has many limitations.

Government’s current physician compensation models and oversight processes limit its ability to achieve cost-effective physician services

The two largest funding models of physician services for BC are fee-for-service and the Alternative Payment Program (APP) – both common in Canada. We examined the risks and benefits of these two models, and assessed whether Government can determine if physician fees being paid in the province are cost-effective.

Note: While other physician compensation models exist, we did not include them in the scope of our audit. In BC, for example, physicians can also receive funding through the Medical On-Call Availability Program, which compensates physicians for being on call; and through rural funding programs, which focus on recruiting and retaining physicians in rural practice. Some physicians also receive funding through their work at universities. For more information on BC’s physician funding models, see our Office’s [Health Funding Explained](#) report.

The benefits and risks of the fee-for-service model

About 70% of BC’s physicians receive compensation solely on a fee-for-service basis. In this model, each service has a specific fee code and the level of income a physician earns relates to the number and types of services he or she provides. As of March 31, 2012, there were 4,578 fee codes (see [Appendix D](#) for a list of the top 20 fee codes).

Fee-for-service encourages a higher volume of services, as physicians make more money if they provide more services. This can help reduce wait times. However, fees are not linked to patient outcomes. This means that physicians are paid regardless of whether the service provided is effective. Also, because payment is provided for each service, there is a potential incentive to “over-service” (i.e. providing services that are not necessary and/or most appropriate based on patient needs). Because there are few systems in place for monitoring whether services provided are appropriate at the individual physician level (see box 7), it is difficult to determine if this is an issue in BC.

Fee-for-service can also create an incentive to request that patients make appointments to discuss one issue at a time (helping physicians cope with increased workload and/



Source: Office of the Auditor General of British Columbia.

Box 7: Medical Services Commission Audit and Inspection Committee

The Audit and Inspection Committee, under the Medical Services Commission (MSC), approves audits of physicians' services and billing practices, reviews all audit reports and makes recommendations to the MSC with regard to whether recovery of funds should be pursued. However, the Committee does not regularly investigate whether the service being provided is high-quality (such as whether the care provided was specific to individual care needs, whether the service was performed correctly, or whether the service produced the intended result).

The Billing Integrity Program (BIP) provides audit services to the Ministry and the MSC, by monitoring billing and payment claims. BIP investigates billing patterns and practices of medical and health care practitioners to detect and deter inappropriate and incorrect billing of MSP claims.

The Patterns of Practice Committee – a joint committee of the BCMA and the MSC – conducts ongoing reviews of physician practice and flags outliers for follow-up by the MSC Audit and Inspection Committee. The focus of the Patterns of Practice Committee is on educating physicians regarding how they compare to their peers with regard to billings. Again, this committee does not look into whether the service being provided is high-quality.

or maximize the number of services that can be billed). Where this occurs, it could be contrary to high-quality practice and can put the patient at risk for not bringing forward issues that require immediate attention.

Finally, in the current fee-for-service model, physicians can only charge for services that they perform themselves. This restricts physicians from working in interdisciplinary teams, which have been shown to improve patient satisfaction, access and equity.

How the fees are set in the fee-for-service model

Every medical specialty in the BCMA is represented by a Section. Sections are groups of physicians that practice medicine with the same field of practice. For example, general practitioners form the Section of General and Family Practice.

How physicians are funded is outlined in the Physician Master Agreement (PMA). The BCMA negotiates the PMA with the Ministry (with input from the MSC and health authorities). Each year, the Ministry determines the amount available for funding physicians through fee-for-service and advises the BCMA through the MSC. In addition, the Ministry and the BCMA can negotiate an overall increase of fees (see box 8). The BCMA allocates this increase to the Sections based on their own allocation process. Neither Government nor health authorities allocate these public monies to different medical specialties.

To create a new fee or adjust an existing fee, Sections bring forward a proposal to the BCMA, which in turn shares the proposal with the Ministry's Medical Services Plan (MSP). When the Sections provide fee item information, limited verification is done by the Ministry. At the time of our fieldwork, the Ministry's Medical Services Branch did not have staff with the medical expertise to evaluate fee proposals.

Box 8: Fee Allocation in 2012/13 and 2013/14

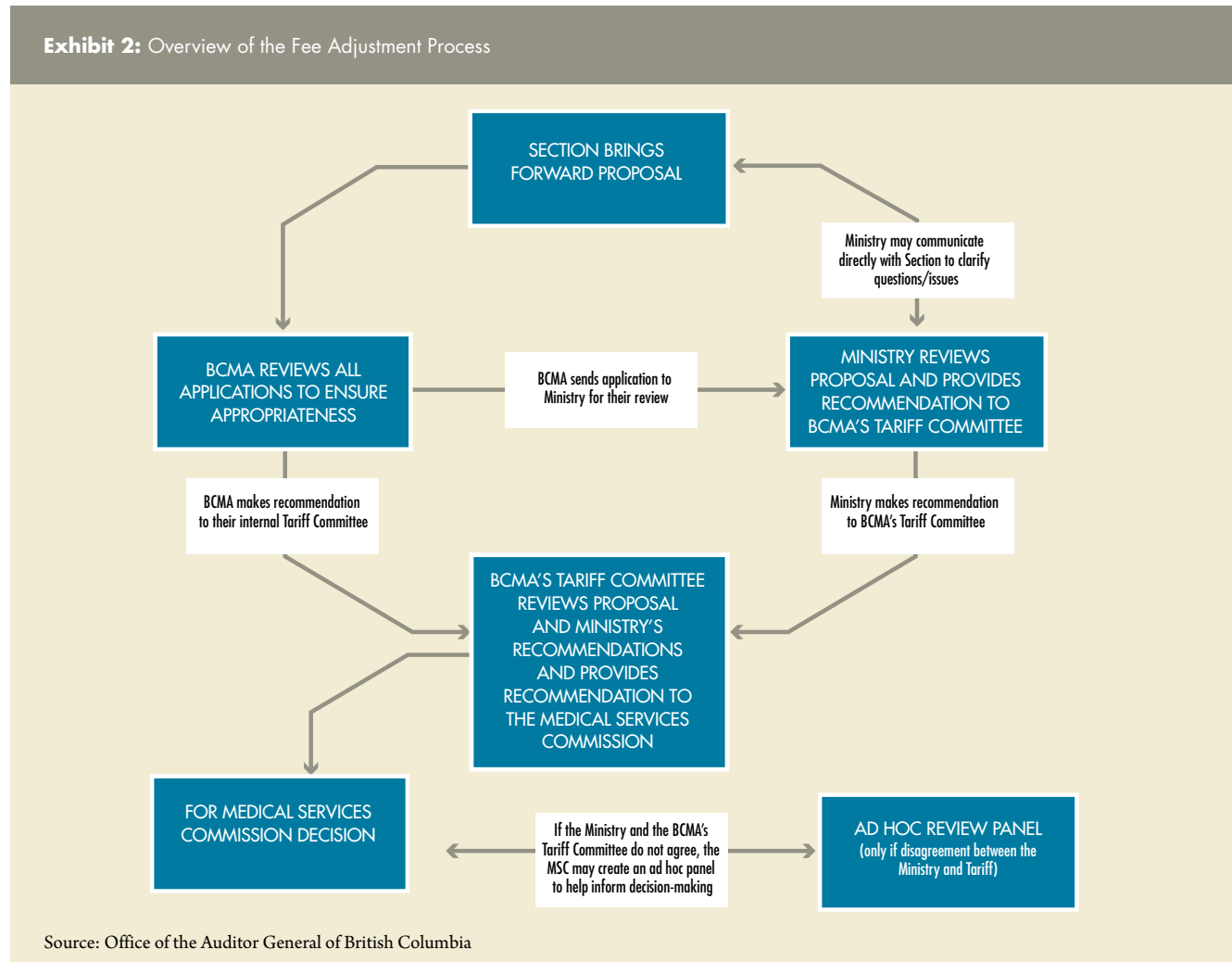
As part of the Physician Master Agreement negotiations, the Ministry of Health and the BCMA agreed to an overall increase in fees (excluding laboratory services fees) by an average of 0.5% in 2012/13 and 2013/14, to fund the increases in the cost of providing services. Those funds were allocated by the BCMA to its different Sections, and the Sections determined where to designate increases.

The Ministry can also submit fee change proposals. However, our audit found that during the 2012/13 fiscal year, all 25 applications received (not already in progress) by the BCMA's Tariff Committee were from the Sections. It is a concern that the Ministry is not regularly using the established mechanisms to ensure that fees are cost-effective. As a result, some fees may not be aligned with the significance and complexity of the task involved.

The Tariff Committee reviews the proposal as well as any concerns raised by the Ministry and provides a recommendation to the Commission. A key consideration for the Tariff Committee is "revenue neutrality" – whether the available funding covers the cost of proposed new or adjusted fee items. This places greater emphasis on where funding is coming from rather than whether the fee item is necessary or cost-effective. The exception is when new fees or proposed increases qualify for new funding (capped at \$1 million in 2012/13).

If the Tariff Committee and the Ministry disagree on the proposed change, an ad hoc review panel can be created to review the issue and make recommendations to the MSC. Ad hoc review panels are only created if the Ministry and Tariff Committee disagree. They are not created if there is a disagreement with the Sections. In that case, the disagreement goes straight to the MSC.

The MSC makes the final determination about whether the fee should be created or adjusted. Exhibit 2 provides an overview of the fee adjustment process.



Government does not know if fee-for-service fees are cost-effective

Given the significant amount of money spent on physician services, we expected the Ministry and the MSC would have a process for ensuring cost-effective physician services. We also expected a process to be in place for adjusting fees on an ongoing basis, and for reviewing fees frequently for cost-effectiveness (i.e. fees for procedures involving advanced technology).

We further expected that, through analysis, the general population health needs would be linked with payments to physicians (i.e. fees for complex services that significantly improved a patient's quality of life would be higher than fees for less complex services). Instead, we found:

- Æ Government is not reviewing existing fees on an ongoing basis to ensure that they are cost-effective (with the exception of laboratory fees).
- Æ Fees are not linked to health needs of the general population. Historically, fee increases have been the result of efforts by Sections advocating for higher pay – an approach that can create tension among the Sections when there is a limited available amount of funding.
- Æ The current physician compensation models are not linked to quality (so cost-effectiveness cannot be determined).

The MSC reviews fees only when there is disagreement between the BCMA and the Ministry. The MSC does not have staff or the tools to complete regular reviews, and it acknowledges this is a concern.

The Ministry, for its part, told us that it has not allocated resources to analyze how general population health needs are linked with payments to physicians because it sees the matter of changing fees as difficult. When the Ministry has used the process available, the undertaking has been resource intensive and the savings less than expected.

For example, when cataract fees were first introduced, the average duration for cataract extraction and lens implantation was one hour. By 2011, the procedure had decreased to approximately 15 minutes. Improvements in technology (specifically phacoemulsification – where the eye's internal lens is emulsified with an ultrasonic hand piece and aspirated from the eye) made cataract surgery easier and safer to perform. The Ministry, therefore, proposed reducing the fee, but it took six years to obtain approval and implement the change. The fee was reduced from a combined total of \$533.87 to \$420.

Without the Ministry or the MSC systematically assessing cost-effectiveness, there is no incentive to initiate changes to fees to ensure cost-effectiveness is maintained.

Pros and cons of the Alternative Payment Program

Because of the challenges of the fee-for-service model, the Ministry created an Alternative Payment Program (APP) for physician compensation. APP was established to maintain, stabilize and improve patients' access to medically necessary physician services.

APP is typically used to fund:

Æ practices where, under a fee-for-service model, the volume of services provided would not offer service stability or dependable physician income, such as in some rural and remote communities; and

Æ physicians' management of complex or time-consuming patient care.

In British Columbia, APP pays physicians for a range of services through three main approaches:

1. **Service contracts** – contracts for the delivery of services (service-based payment);
2. **Sessional agreements** – standard rates paid for each half-day session of a physician's time spent on medical services provided through a health care agency (time-based payment); and
3. **Salary** – fixed compensation paid to health agencies for their employed physicians (employee-based payment).

However, through our interviews, we were advised that the APP model often results in a decrease in the number of patients receiving care. The research on this is mixed, with some studies showing that salaried and fee-for-service physicians see similar numbers of patients and others validating the claim that salaried physicians see lower numbers. It is important to highlight that APP is specifically put in place to support physicians seeing patients who require more clinical time or other time-consuming measures for which fee-for-service has been found to be ineffective. It is therefore possible that the reduction of patient volume is appropriate. However, it is difficult to determine if (and if so, why) service levels do decline because this type of information is not currently being consistently collected.

Government does not know if physician alternative payment contracts are cost-effective

The Province spent approximately \$408 million on APP payments in 2011/12. We, therefore, expected the Ministry and health authorities to have a process for ensuring cost-effective APP ranges and rates. However, we found that none of the entities responsible are ensuring that physicians' contracts are adjusted to reflect changes that affect the cost-effectiveness of the services (i.e. advances in technology easing the complexity of the work).

We also identified these main problems:

Æ Although payment ranges are competitive with other jurisdictions, health authorities are paying some APP physicians outside the negotiated ranges/rates in the PMA (i.e. to obtain a sought-after specialist), which sets a precedent for negotiating higher rates for other contracts. Half of the APP contracts we reviewed exceeded established ranges or were so unclear that we could not reach a conclusion.

- ⌘ Deliverables outlined in the contracts were not clearly defined and were not connected to patient outcomes.
- ⌘ The BCMA and the Ministry do not agree on key contract terms, including whether the ranges and rates should include overhead and what the number of hours worked should be (there is a large range with no adjustments for significant volume decreases or increases).
- ⌘ In many cases, there is insufficient information to know whether value for taxpayers is being obtained.
- ⌘ The BCMA and the Ministry are engaged in a significant disagreement (described in box 9) that has prevented APP payment decisions. Retroactive payments are a concern because they impact operational costs and can affect physician engagement.

It is difficult to determine whether APP is achieving its intended purpose of improving access in areas where fee-for-service practices are not practical. This lack of sufficient information to assess cost-effectiveness means that the Ministry and health authorities do not know whether existing APP contracts are the best funding model for certain circumstances. In addition, many APP contracts do not adhere to the negotiated Physician Master Agreement, thus making future negotiations and management of cost-effectiveness even more challenging.

RECOMMENDATION 3: *We recommend that the Ministry of Health and the health authorities, in consultation with the British Columbia Medical Association and other health system partners, rebuild physician compensation models so they align with the delivery of high-quality, cost-effective physician services.*

RECOMMENDATION 4: *We recommend that as long as fee-for-service and alternative payment remain significant funding models for physician services in British Columbia:*

1. *the Ministry of Health should ensure that it has the degree of influence necessary to align funding with health system priorities;*
2. *fees and contracts are adjusted on a regular basis so physician compensation reflects changes in the knowledge, skills, time and technology required to deliver a service; and*
3. *the health authorities adhere to negotiated ranges and rates, work as one entity to negotiate expectations, and document the rationale for any non-adherence to negotiated ranges and rates.*

Box 9: Alternative Payment Program Negotiations at a Standstill

The BCMA and the Ministry have a disagreement about the interpretation of the Physician Master Agreement (PMA). The Government believes physicians should be paid within a practice category that aligns with the physician’s credentials recognized by the Royal College of Physicians and Surgeons of Canada. The BCMA believes that physicians should be paid within a practice category that aligns with the services that they are contracted, privileged and credentialed by the health authorities and licensed by the College of Physicians and Surgeons of British Columbia to provide. There is no disagreement that physicians should only provide services that they are credentialed to provide. We were told that the parties have recently agreed to accept the recommendations of a mediator and have referred the interpretation issue to the upcoming PMA negotiations for resolution.

Systemic barriers in the province's health care system are hampering Government's ability to achieve value for money with physician services

In conducting this audit, we identified several key systemic barriers that are hampering Government's ability to ensure the quality and cost-effectiveness of physician services in the province.

Systemic barriers are issues that are widespread or structural within a system and are difficult for a single organization to control or influence. Systemic barriers affect many organizations, and can make reaching consensus on how best to address the issues challenging. It is often easier to identify and address smaller, preventable issues than to try to correct broader, more deeply embedded issues.

The Physician Quality Assurance Steering Committee, created in response to Dr. Doug Cochrane's review (described in [box 4](#)), has identified many of these barriers and is working to address them. However, progress has been slow due to a variety of factors including the challenge of obtaining consensus with the many different entities involved, the significant cultural shift that is required to implement the initiatives, and the lack of clarity about roles and responsibilities.

It is essential that Government continues to examine and find ways to overcome these barriers. If it does not, it will not be able to ensure that it is providing effective oversight of physician services.

Information systems do not provide the data needed

The current information technology (IT) framework in the province's health care system makes measuring quality difficult. The IT systems were designed to capture billing data, not clinical data which facilitates performance measurement. As a result, the data needed to assess the quality of physician services at the individual level and to monitor improvements is either not available or is fragmented, with some information held by health authorities and the remainder residing in community physician offices.

Extracting this information and improving data collection are expensive undertakings, especially in the context of competing resource demands for direct patient care. The Province told us that it is continuing to move ahead with the eHealth initiative (i.e. implementation of Electronic Health Records and Electronic Medical Records), which could enable better performance measurement and oversight of physician services in the future.

Aspects of work culture are impeding constructive engagement with physicians

Health authority administrators face several work environment challenges, including the challenge of managing different health care approaches and cultures amongst service providers. Physicians are traditionally trained to be independent and accountable to their patients. Administrators are trained to run an organization and to manage processes to ensure efficient inputs and outputs. Because of these differences in focus, alignment of different approaches between physicians and administrators to achieve a common goal can be challenging.

Furthermore, some physicians see government health system priorities as constantly changing, often without adequate physician consultation on how best to meet those priorities. There are also no fee codes for administrative work, which makes it difficult for Government to obtain input from physicians. Physicians can make more money seeing patients than the amount offered to participate in these activities (if any). However, as physicians are integral to the successful implementation of improvements to health care, it is important that they and Government work together to achieve high-quality health outcomes.

The Physician Quality Assurance Steering Committee has identified physician communication and engagement as an action item. We encourage the committee to continue examining and addressing physician engagement and work environment barriers.

RECOMMENDATION 5: *We recommend that the Ministry of Health work with the health authorities, in consultation with the British Columbia Medical Association, to:*

1. *identify work environment barriers to physician engagement;*
2. *develop and implement a plan to improve the organizational culture between administrators and physicians so the focus is on delivering high-quality, cost-effective services that meet both individual patient and population health needs;*
3. *identify and implement performance measures and targets to evaluate physician engagement;*
4. *monitor and evaluate progress in addressing areas requiring improvements; and*
5. *report the results to physicians and administrators.*

Lack of clear, current legislation

Current legislation is not adequately supporting the entities involved with physician services to provide oversight of physician services. The College has also acknowledged the need to update relevant legislation in its [2012/13 Annual Report](#).

Decision makers require access to information regarding the quality of services being provided so they can make informed decisions to drive improvements. There are differing interpretations of whether legislation is preventing the College and health authorities from adequately sharing information. Based on our review, the legislation does not prevent the College and the health authorities from sharing physician performance information at an aggregate level. Currently, this is not happening.

Section 26.2 of the *Health Professions Act* (HPA) protects the confidentiality of the College's quality assurance activities from being disclosed to another person or committee unless the College determines the public is at risk. HPA outlines only limited obligations to report and only after an investigation is complete. This impedes the sharing of quality assurance information between the College and the health authorities until an investigation is complete, to protect the privacy of the physician. Therefore, health authorities may be unaware of ongoing concerns regarding a physician's practice and patients could be at risk until the College's investigation is complete.

Section 51 of the *Evidence Act* protects health care information and evidence collected by quality care committees from disclosure in civil court proceedings to ensure that

individuals are comfortable bringing forward concerns. In particular, this section limits the circumstances in which a quality assurance committee can disclose the results of a quality review. There is potential ambiguity in the interpretation of the Act, creating the risk of health authorities not using the results of reviews to identify trends that are important for improving performance for other physicians.

In addition, the *Evidence Act* does not speak to quality of care information collected by health care facilities such as community care facilities or mental health teams. This leaves a gap in guidance regarding what can and should be shared.

Health authorities view the *Hospital Act* as being out of date. The Act does not discuss patients in non-hospital facilities (such as residential care facilities), does not reflect recent changes in practice, and does not reflect the creation of the health authorities in 2001. This is clearly a concern, as the current practices and priorities of the system must be backed by relevant legislation.

As part of its work, the Physician Quality Assurance Steering Committee has identified many of these issues and will be conducting a comprehensive review of legislation, regulations and bylaws, including identifying opportunities to improve information sharing, clarify roles and responsibilities, and develop model clinician bylaws. However, the committee has only just begun this initiative and legislative changes can take years.

RECOMMENDATION 6: *We recommend that the Ministry of Health:*

- 1. work with the health authorities, health care facilities and the College of Physicians and Surgeons of British Columbia to identify regulatory framework barriers;*
- 2. create and implement an action plan to address the barriers; and*
- 3. work with the health authorities, facilities and the College of Physicians and Surgeons of British Columbia to ensure they are able to work collaboratively to maximize the quality and cost-effectiveness of patient care.*

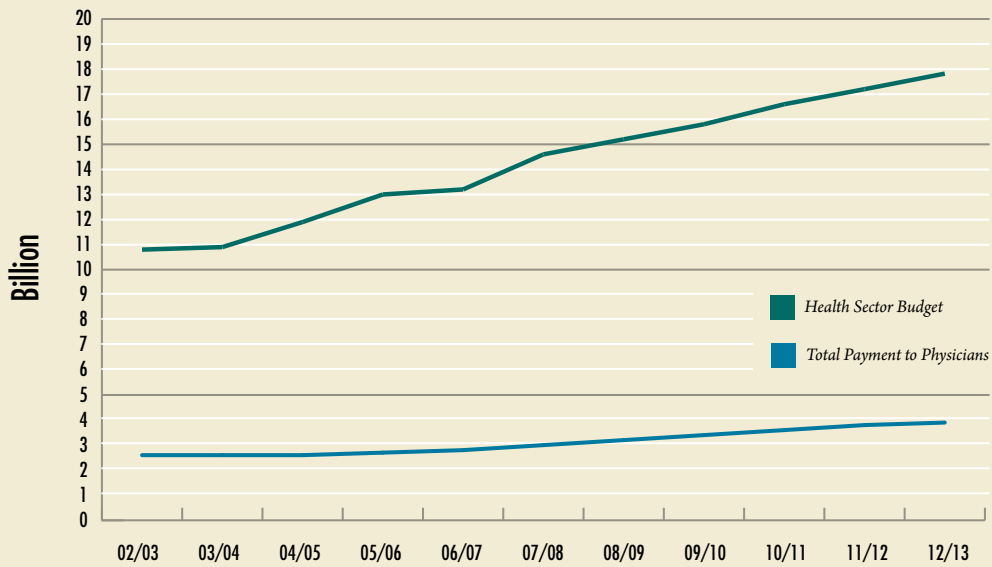
WE WILL FOLLOW UP in April 2015 by reporting on how Government has responded to the recommendations made in this report.

We were advised that the implementation of Electronic Health Records might enable Government to address some of the issues we have identified in this report, as more clinical data will be available to understand the services being provided. However, we know that progress has been slow and significant issues may hamper the success of implementation, including that of Electronic Medical Records. In addition, even where these records do exist, they are not linked to a central patient information system. Although this matter was not within the scope of this audit, it is an area we are considering for future audit.



According to Ministry of Health data, total payments to physicians over the past 10 years have steadily increased (52%) along with expenditures of the health sector. However, health sector spending has increased at a greater rate (66%).

Exhibit 3: Total Payments to Physicians Relative to Health Sector Expenditure, 2002/03 – 2012/13

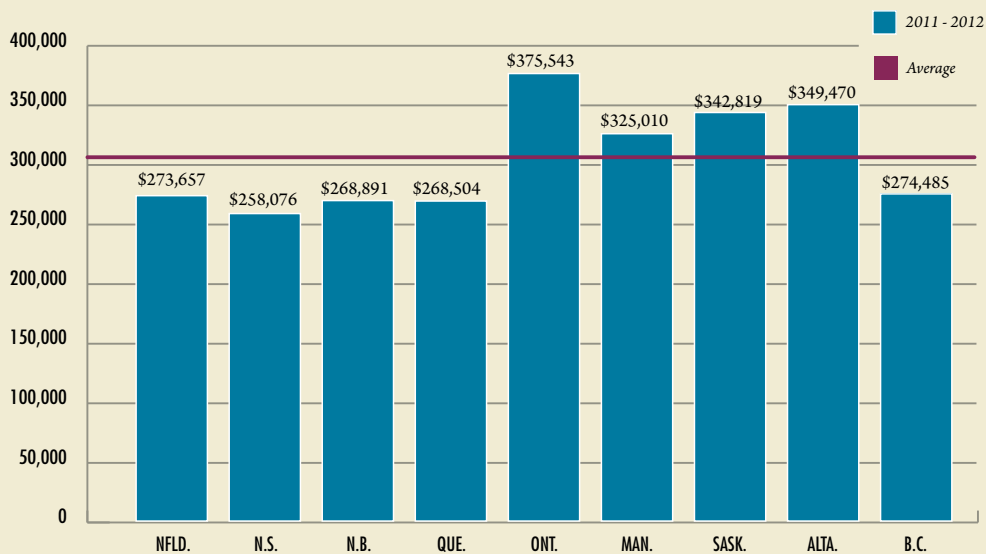


Source: BC Ministry of Health and BC Public Accounts Financial Statements
Please note: information is unaudited.

The Canadian Institute for Health Information (CIHI) indicates that BC is in the middle of the pack with regards to payments to physicians (see Exhibit 4), though the data does not account for the number of physicians working part-time.

Because of differences in the composition of the workforce (part-time versus full-time, primary care physicians versus specialists, etc.) and the different ways provinces pay physicians, comparing BC with other jurisdictions must be done with caution.

Exhibit 4: Average Annual Payment to Physician by Province*, 2011–2012



Source: National Physician Database and National Health Expenditure Database, Canadian Institute for Health Information
Please note: information is unaudited.

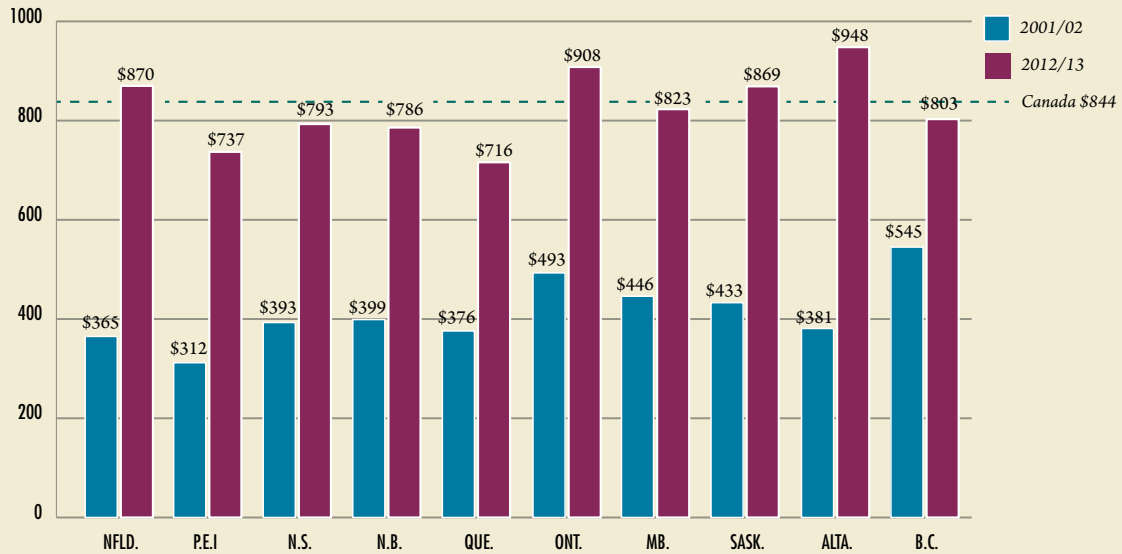
The above chart is the sum of each province’s expenditure for clinical payments (fee for service and Alternative Payment Programs) to physicians, divided by the total number of physicians as reported by each province, less imaging and laboratory specialists. Clinical payments are from fee-for-service and alternative payments based on gross payments.

Each physician receiving clinical payments was counted equally regardless of the amount of money he/she received or his/her level of activity (full-time, part-time or casual).

* Due to the significant skewing effect on physician counts and their associated payments caused by visiting specialists and locums, a comparable average physician payment is not included for Prince Edward Island.

According to information provided by the Ministry, the Government of BC has restrained the growth of physician compensation in recent years in comparison to some other Canadian provinces (see Exhibit 5). In 2001, BC had the highest physician expenditure per capita. By 2012, BC had moved to the middle compared to other provinces. Please note, the below information is unaudited.

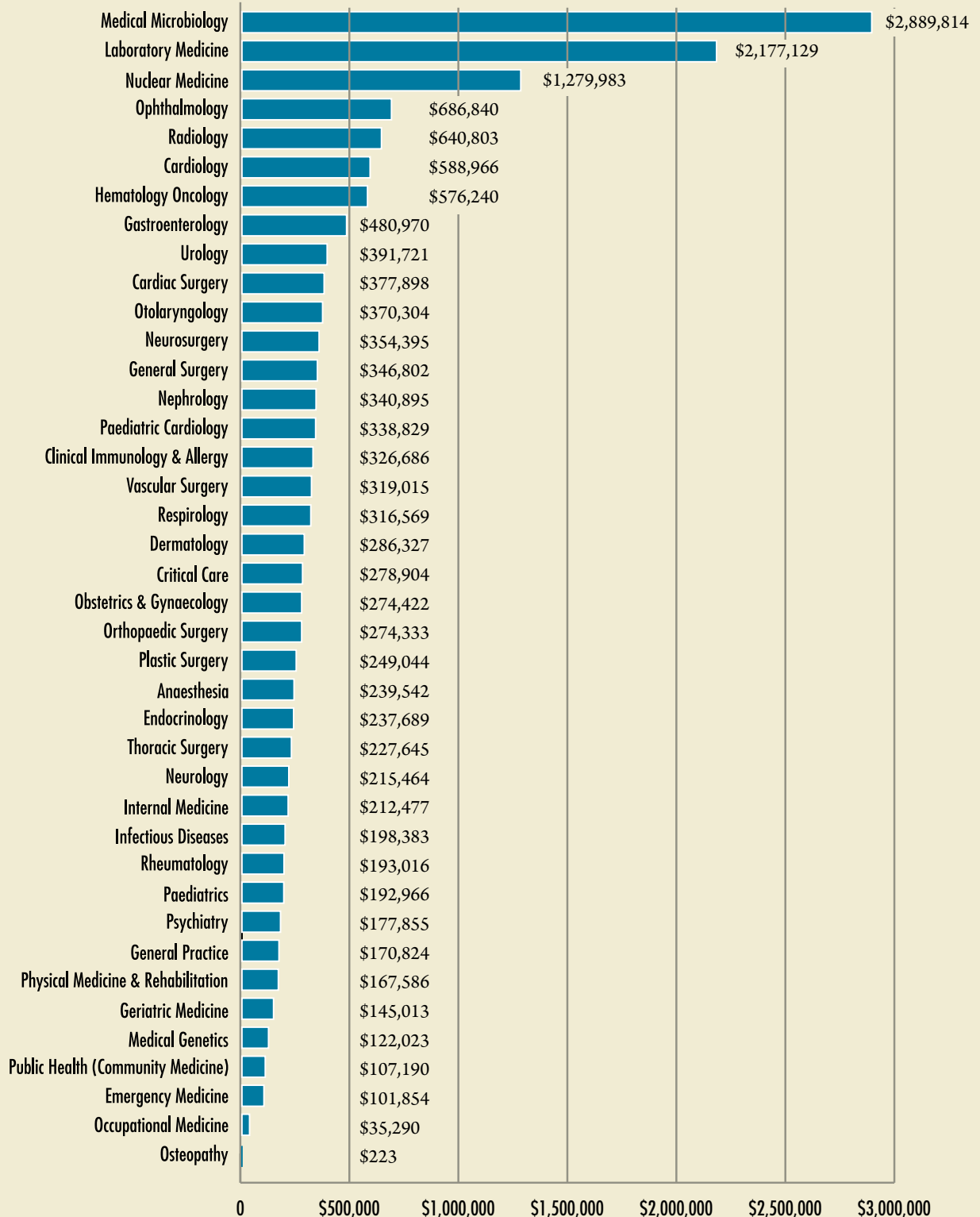
Exhibit 5: Physician Expenditure per Capita by Province 2001/02 and 2012/13



Source: BC Ministry of Health, Workforce Analysis Branch
Please note: information is unaudited.

Exhibit 6: Average Gross Fee-for-Service Payment by Physician Speciality in BC in 2012/13

According to Ministry of Health data, specialists generally earn more than general practice physicians.



Source: Ministry of Health
Please note: information is unaudited.

Exhibit 6 accounts for average gross fee-for-service billings only. The fee-for-service model is one of four physician-funding models, described in detail in the [Health Funding Explained](#) report. Fee-for-service is used to fund the majority of physicians in the province. This is explained further in the [Government cannot demonstrate that physician compensation is cost-effective](#) section. Fee-for-service fees include funding for overhead costs.

We were told physicians who provide osteopathy services are also general practitioner physicians and this graph would include the majority of their income under general practice. Professions such as emergency medicine are often paid through APP, which may be why they are significantly lower compared to the professions displayed in this graph.

According to the Ministry, the billings represented by medical microbiology, laboratory medicine and nuclear medicine represent billings made by facilities or agencies. These billings include a significantly higher percentage of overhead compared to other specialities. See [Appendix A](#) for more information regarding the estimated amount of payments that go towards practice expenses.

Exhibit 7: Physician 2011/12 Overhead Payments by Practice Category

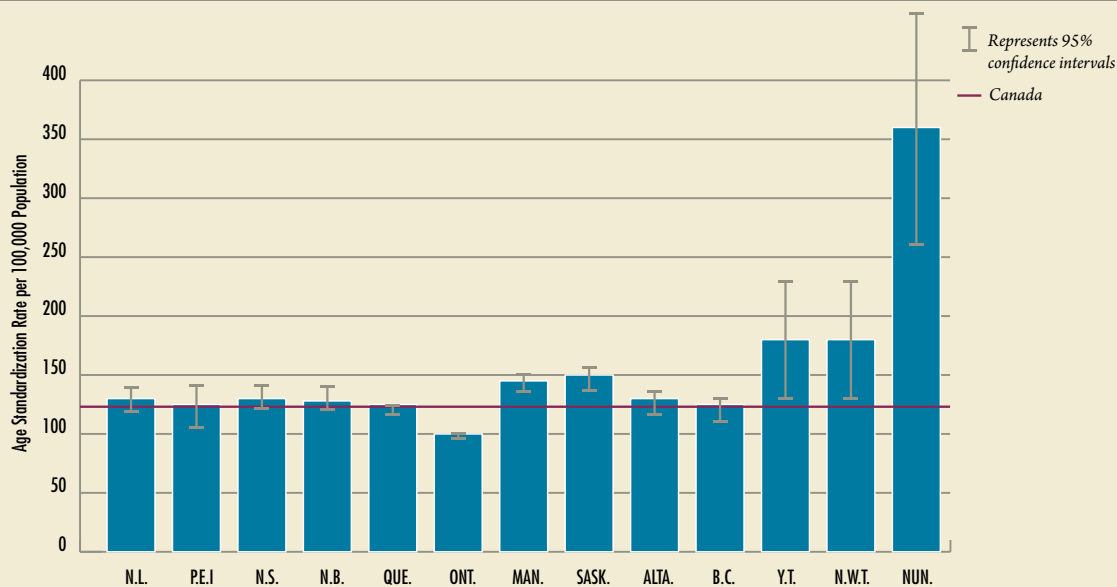
Practice Category	Payment (in millions)	Overhead Ratio	Total Practice Expenses (in millions)
General Practice	\$1,042.4	41.5%	\$432.6
Diagnostic	\$556.6	78.6%	\$437.3
Medical	\$663.1	33.9%	\$224.9
Surgical	\$493.3	39.2%	\$193.5
Total	\$2,755.4	46.85%	\$1,288.3

Source: BC Medical Association Economics Impacts of Physician Practice Expense Spending by BC Physicians, July 17, 2013.
Please note: information is unaudited.

APPENDIX C: HEALTH OUTCOMES AND SPENDING - BRITISH COLUMBIA AND CANADA COMPARED TO OTHER JURISDICTIONS

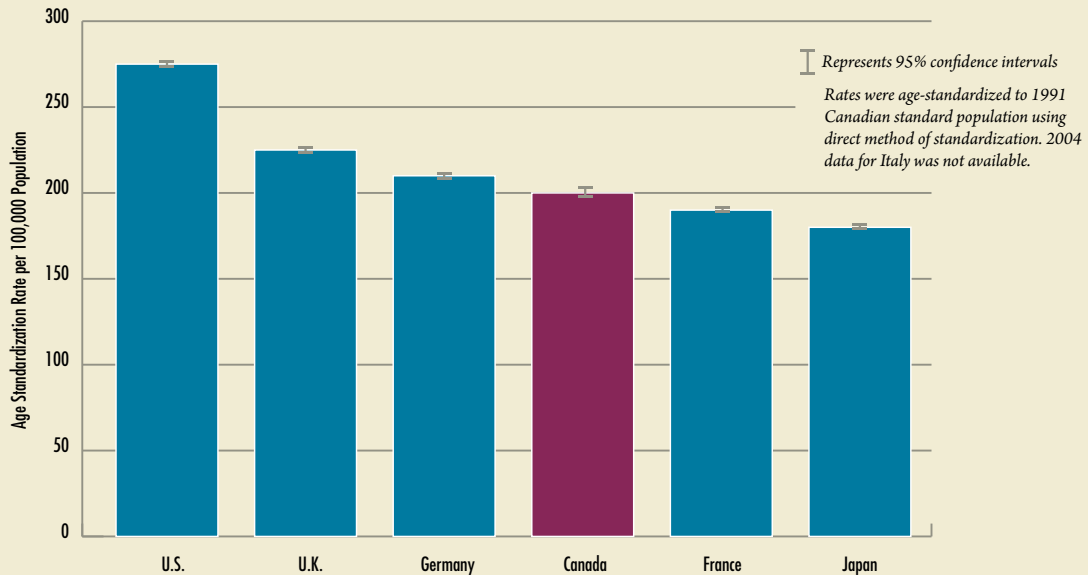
Although this audit focused on physician services and not the overall health care system, it is also important to know where BC's health system sits in terms of its health outcomes, particularly given that physicians play such a large role. For example, as the Canadian Institute for Health Information reports, BC has one of the lowest preventable mortality rates of all provinces in Canada (see Exhibit 8). Preventable mortality refers to deaths that could be avoided by preventing a disease from developing. A lower preventable mortality rate is better than a higher rate.

Exhibit 8: Preventable Mortality, by Province/Territory, 2006



Source: Health Indicators 2012, Canadian Institute for Health Information and Statistics Canada
Please note: information is unaudited.

Exhibit 9: Avoidable Mortality, G7 Countries, 2004



Source: Health Indicators 2012, Canadian Institute for Health Information and Statistics Canada
 Please note: information is unaudited.

Canada’s performance is in the middle of the G7 countries for avoidable mortality – that is, premature deaths that could potentially be avoided through prevention (see Exhibit 9). However, as discussed, comparisons must be made with caution. There are no agreed-upon definitions for preventable or avoidable mortality or for understanding the effectiveness of a health care system. There may also be differences in coding practices and timeliness of the data.

Other measures used to define the success of health systems do not put Canada in such a positive light. The International Profiles of Health Care Systems completed by the Commonwealth Fund in 2011, reported that Canada, compared with 13 other jurisdictions, ranked close to the bottom for access to care. Canada also ranked poorly on routinely receiving and reviewing clinical outcome data and patient satisfaction data. These are important aspects for ensuring quality care and, in particular, for ensuring the improvement of care provided by health care practitioners such as physicians.

Furthermore, Canada is spending more per capita compared to many other countries, including France, Japan, the UK, Sweden, New Zealand, Italy, Germany, Australia and Denmark.

Although this data is not specific to BC, it highlights the importance of Government understanding the results it achieves for the money spent so it can make informed decisions, especially given the significant role that physicians play and their cost to the health care system.

Exhibit 10: Top 20 Fee Items by Expenditure 2012/13

Rank	Fee Item And Description	Expenditure	% of Total	Cumulative %
1	100 - Visit In Office (Age 2 - 49)	\$226,459,288	8.04%	8.04%
2	15300 - Visit In Office (Age 50-59)	\$92,030,880	3.27%	11.31 %
3	16100 - Visit In Office (Age 60-69)	\$88,485,719	3.14%	14.45%
4	17100 - Visit In Office (Age 70-79)	\$71,530,475	2.54%	16.99%
5	18100 - Visit In Office (Age 80+)	\$55,699, 181	1.98%	18.96%
6	14033 - Annual Complex Care Management Fee	\$51,848,685	1.84%	20.80%
7	91000 - Primary Base Fee - Chemistry	\$45, 174,677	1.60%	22.41%
8	2010 - Consultation - Ophthalmology	\$32,244,494	1.14%	23.55%
9	632 - Psychotherapy Individ. (Off.,Out-Patient) Per Hour	\$31,989,788	1.14%	24.69%
10	90205 - Haematology Profile	\$28, 171 ,479	1.00%	25.69%
11	8695 - Tomography - Body Scan Double Scan Or Two Regions	\$25,7 18,847	0.91%	26.60%
12	4010 - Consultation, Ob&G	\$24, 121 ,917	0.86%	27.46%
13	14050 - Gp Annual Chronic Care Bonus - Diabetes Mellitus	\$24,051 ,400	0.85%	28.31%
14	510 - Consultation, Paediatrics	\$22,522,962	0.80%	29.11%
15	13008 - Community Based Gp: Hospital Visit	\$20,685,461	0.73%	29.85%
16	2188 - Cataract Linear Extraction, Congenital, Traumatic	\$20,505,810	0.73%	30.57%
17	7010 - Consultation- General Surgery	\$20,303,928	0.72%	31.29%
18	33010 - Consultation - Cardiology	\$19,831 ,848	0.10%	32.00%
19	310 - Consultation, Int. Med.	\$18,993,076	0.67%	32.67%
20	108 - Hospital Visit	\$18,496,350	0.66%	33.33%

Source: Ministry of Health, Business Analytics Strategies and Operations Branch.
Please note: information is unaudited.

These 20 fee items account for 33% of the fee-for-service payments.



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