LAKE COUNTRY
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DISTRICT OF LAKE COUNTRY

Strategy Session Information

MEETING TYPE AND DATE: SPECIAL COUNCIL MEETING, FEBRUARY 22, 2022
AUTHOR: **REYNA SEABROOK, DIRECTOR OF CORPORATE SERVICES**
SUBJECT: **SILGA RESOLUTIONS**

ESSENTIAL QUESTION:
Subsequent to the discussion of Council on February 1, 2022 and February 15, 2022 regarding potential SILGA resolutions, staff have reviewed the topics noted and provided more information for Council's consideration.

OPTIONS (number as identified on Special Council Meeting Agenda) :

4.1 RCMP POPULATION THRESHOLDS FOR COST SHARING

WHEREAS during the 1992 negotiations between the federal Solicitor General and the provincial negotiating team it was agreed that the Province would be responsible for 90 percent of the share of the RCMP costs in communities with more than 15,000 residents and for 70 percent of the costs in communities with less than 15,000 residents;

AND WHEREAS there have been significant increases in RCMP costs as a result of the collective bargaining process that municipalities must pay since the thresholds were set in 1992;

THEREFORE BE IT RESOLVED that the Provincial and Federal Governments be urged to consider increasing the population thresholds to recognize the increased burden on emerging municipalities and inability for the current population thresholds to support the increasing costs of policing.

Additional Information:
It is recognized that the Police Act of British Columbia requires that municipalities of more than 5,000 residents provide their own policing services. In 1992, negotiations between the federal Solicitor General and the provincial negotiating team agreed that the Province would be responsible for 90 percent of the share of the RCMP costs in communities with more than 15,000 residents and for 70 percent of the costs in communities with populations between 5,000 and 15,000.

The District of Lake Country established its RCMP operations in April 1998. As a newly incorporated municipality, the District of Lake Country was provided a grant to phase in the costs of policing to ease the burden on taxpayers. However, no easing or phased increase in costs is available when municipalities reach the 5,000 and 15,000 thresholds.

The cost of a RCMP police member has increased drastically in the years since this negotiation was completed. These costs may now be too big a burden for those thresholds to bear. It may be timely to consider increasing the thresholds or adding additional thresholds for the sharing of policing costs in BC.

- May not get support from the municipalities that wouldn't see any benefit (either not close to any threshold or have significantly surpassed the 15,000) but are suffering with increased RCMP costs as well.
- May not even get to UBCM if supported by SILGA, may move over to the committee reviewing the RCMP contract.

4.2 WINTER TIRES MANDATORY FOR RENTAL VEHICLES

WHEREAS winters in many parts of British Columbia are subject to icy road conditions and snowfall accumulation;

AND WHEREAS most rental vehicles are only equipped with all season tires rather than winter tires;

THEREFORE BE IT RESOLVED that UBCM request the Province of BC to make it mandatory that winter rated tires be installed on rental vehicles during the winter months in those areas of BC that experience snow and ice conditions.

4.3 FAMILY DOCTORS

WHEREAS British Columbians are continuing to struggle to access primary care and establish relationships with a family doctor despite a Provincial commitment to a new primary care network model in 2018;

AND WHEREAS the Province of British Columbia offers limited alternatives with limited funding to the fee for service model for physician compensation;

THEREFORE BE IT RESOLVED that UBCM ask the provincial government to consider, implement and adequately fund alternative physician compensation models to replace the fee for service model to better support continuity of care and encourage doctors to practice family medicine.

Additional Information (See attachments A, B and C):

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8589129/
https://www.cbc.ca/news/canada/british-columbia/fee-for-service-model-family-doctors-1.6247049
https://news.gov.bc.ca/releases/2018HLTH0052-001043

4.4 OKANAGAN REGIONAL LIBRARY

WHEREAS libraries in British Columbia are largely financed by levies paid by local governments, and where provincial library funding has remained stagnant for the past 10 years;

AND WHEREAS public libraries are central to communities, providing equitable access to vial resources, including internet, computers, digital library tools, and in person services from expert staff;

AND WHEREAS public libraries provide British Columbians with low-barrier services, that support job seekers and small businesses, that increase literacy in communities, that advance reconciliation with Indigenous peoples, and that promote equity and inclusion;

THEREFORE BE IT RESOLVED that UBCM urges the Government of British Columbia to provide long-term sustainable funding for public libraries in BC;

AND BE IT FURTHER RESOLVED that the Province ensure that BC Libraires will henceforth receive regular increases to Provincial Government funding in subsequent years.

4.5 WATER SOURCE/WATERSHED CONTROL AND PROTECTION

Further to Council's discussion on February 15, 2022 it was established the direction of a proposed resolution to SILGA was associated with the ability for local governments to provide direct response and enforcement for contraventions taking place in the foreshore, watershed and riparian areas.

Staff reached out to the Ministry of Forest, Lands, Natural Resource Operations and Rural Development Contracts (FLNROE) and were advised that legislation already exists providing local governments with authority to enforce so long as local bylaws are in place. Staff propose not submitting a resolution on this topic to SILGA at this time until further research can be conducted into existing legislation and authority for local governments to enforce contraventions related to crown land and riparian areas.

This report has been prepared with the collaboration of the following individuals:

COLLABORATORS	
TITLE	**NAME**

This report has been prepared in consultation with the following departments:

CONCURRENCES	
DEPARTMENT	**NAME**
Chief Administrative Officer	Tanya Garost

ATTACHMENTS:

Attachment A - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8589129/
Attachment B - https://www.cbc.ca/news/canada/british-columbia/fee-for-service-model-family-doctors-1.6247049
Attachment C - https://news.gov.bc.ca/releases/2018HLTH0052-001043

Attachment A

CFP·MFC
CANADIAN FAMILY PHYSICIAN • LE MÉDECIN DE FAMILLE CANADIEN
Official Publication of
The College of
Family Physicians of Canada

Can Fam Physician. 2021 Nov; 67(11): 805–807.
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PMCID: PMC8589129
PMID: 34772705

Alternative payment models

A path forward

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> *Ironically, at the very time definitive data are confirming primary care's essential contributions to health care … practicing primary care physicians are demoralized, retiring early, and advising others not to go into the field.*
>
> *Allan H. Goroll et al*[1]

Most Canadian FPs would suggest that little has changed in the 15 years since the above statement appeared in a journal article calling for reforms to primary care remuneration.[1] Canada has a higher than ever ratio of FPs to the population, yet Canadians continue to struggle to access comprehensive primary care.[2,4] New-to-practice FPs are choosing hospital-based work and focused practice rather than comprehensive family medicine (FM), which we define as longitudinal primary care for a defined population of patients across the life cycle that addresses a spectrum of clinical presentations.[5] Many of these new FPs never venture into comprehensive FM and those who do often leave, citing the long-standing problems associated with fee-for-service (FFS) remuneration.[6] Most recently, the coronavirus disease 2019 pandemic has exposed additional problems with the FFS payment model.[7]

Attachment A

Increasing evidence suggests that the availability of remuneration models influences newly graduated FPs' decisions about future practice.[8] Payment model reform alone will not be enough to reinvigorate comprehensive FM, which requires other pillars such as engaged leadership, incentives for innovation, and continuous quality improvement.[9] However, it is one part of the solution that can enable team-based care and help address deterrents such as mounting administrative tasks and paperwork.[10] Governments and provincial and territorial medical associations would be wise to adapt payment systems accordingly.

Here we discuss the threat posed to longitudinal primary care by continued reliance on FFS payment models, and the payment reforms needed to maintain and expand the practice of comprehensive FM.

The remuneration issue in context

For more than 50 years, Canadian FPs have been primarily remunerated through FFS, wherein they are paid a predetermined amount for each service rendered for a patient. Fee-for-service remuneration has fallen out of favour as a preferred form of payment, particularly for those early in their careers.[8] Reasons include concerns about the quality of care provided to patients under this model, the negative impact of "one problem per visit" and time limitations commonly associated with FFS, and difficulties in serving marginalized or less advantaged patients.[8,11] While there are examples of interdisciplinary team–based primary care models that are funded through FFS, they tend to be the exception rather than the rule.[12]

The coronavirus disease 2019 pandemic has highlighted further problems with the FFS payment model, such as income instability and the need for rapid practice change that often outpaces fee schedule cycles.[7,13] As a result, the College of Family Physicians of Canada has renewed its call for the introduction of more alternative funding models.[14]

Taken together, these issues have led to heightened physician interest in alternatives to FFS such as salaried, capitation, and blended compensation models, collectively termed *alternative payment plans (APPs)*. Alternative payment plans have been implemented in a patchwork fashion in several Canadian provinces.[10] Capitated payment models pay physicians a fixed amount per patient per year for delivery of a primary care "basket" of services, with payment adjusted for factors such as age and patient complexity. Successful risk-adjusted capitated models have been piloted in British Columbia (BC)[15] and have been in widespread use internationally for decades.[16] Blended payment models often combine elements of both capitation and FFS.

Payment reform is an essential element of successful transition to a Patient's Medical Home model of care.[17–19] The shift to APPs allows increased ability to fund and support collaborative, team-based care because funding can flow independently from direct physician-patient interaction. Teams can be funded directly in a clinic managed by a health authority or community-governed not-for-profit organization. Alternatively, they can be funded in physician-owned practices through increased flexibility in delegation of patient care to nurses, pharmacists, and allied health care providers. Alternative payment plans also allow increased flexibility for FPs to spend more time with patients, when needed, to address increasingly complex health and social needs.

Across Canada, the limited introduction of APPs and innovations in team-based care have already helped recruit and retain FPs in longitudinal care.[8] Physicians remunerated through salary and capitation models report higher levels of satisfaction compared with those working in FFS settings.[20,21] Patient care delivered through an APP-funded Patient's Medical Home is also associated with a higher likelihood of preventive screening for diabetes and malignancy.[11]

Attachment A

Previous research suggests that payment models are important in guiding decision making about future practice among early career FPs, with most strongly preferring APPs.[6] Despite the emergence of APPs in some jurisdictions across Canada, FFS remains the predominant payment model. Ontario has several different payment models, including salary and capitation, resulting in the lowest rates of FFS-funded FPs. Unfortunately, the availability of these payment models has been curtailed by the province in recent years.[22] At the other end of the spectrum, BC has only limited alternatives to FFS and has the lowest levels of primary care reforms to date.[23–25]

Recent movement toward payment reform in several provinces has fueled conversations about optimal payment schemes. For example, BC recently developed new contracts for FPs,[26] Ontario is examining cross-organizational funding options for the recently implemented Ontario health teams,[27] and Nova Scotia is developing a blended capitation funding model.[28]

Understanding potential solutions

Initial results from our pan-Canadian study of early career FPs in BC, Ontario, and Nova Scotia[29] are helping us better understand this issue. Our research, to be fully reported in a future publication, points to a preference for alternatives to FFS and suggests that a lack of alternatives shifts practice preferences away from longitudinal comprehensive primary care.[30]

Our team conducted in-depth semistructured interviews with 63 FPs across the 3 provinces, all in their first 10 years of practice. Participants were recruited to explore a range of personal characteristics and practice settings. Of our participants, 41% exclusively practised comprehensive FM, while the remainder spent either part or all of their time in a focused area of practice. Fifty-one percent of the practice settings in which they worked were urban or suburban.

Our data suggest that the availability of remuneration models is an important factor shaping the practice choices of early career physicians. In areas of the country where FFS was the only payment option, some FPs were deterred from practising comprehensive FM. In these settings, many opted for serial locums or focused areas of practice, despite a desire to provide longitudinal primary care. A BC-based physician told us, “We want to set up practices; we want to care for a set population; we want to follow them. This is why we went to school; this is what we went into residency for. [Yet] a lot of us don’t do that work because the system in BC is not set up to do that.” Participants shared serious concerns about burnout, viewing a career in a hospital-based or focused area of practice as a way of protecting themselves from the unsustainable demands of FFS-based comprehensive FM.

For the early career FPs interviewed, it was not simply a dislike of the FFS model that was driving their decision making. Rather, FFS impeded their ability to provide high-quality medical care in alignment with their values. A physician from Ontario shared, “I will never work in a fee-for-service clinic because I just know that the approach I have towards medicine and what I want to focus on doesn’t co-align with the values you need to be financially successful in those models.” Participants compensated through FFS noted that it compelled them to see high volumes of patients without sufficient time with each patient to address their increasingly complex needs.

Finally, many participants believed FFS afforded limited options to establish interprofessional primary care teams. Despite many completing their residency training in interprofessional team settings under APP models, they expressed concerns that these models of care were not later available to them as they entered practice.

The path forward

Attachment A

While we continue to graduate large numbers of FPs, we will not solve the problem of dwindling comprehensive FM practices without introducing more alternatives to FFS. Even when FM residents are trained in interprofessional teams and under APPs, upon graduation they have few options to enter similar models of practice. In Ontario, where there have been the greatest payment reforms to date, graduates interested in comprehensive FM are left either to purchase a practice from a retiring physician at substantial cost or to start up an FFS clinic. Instead, they are choosing other forms of practice that are well supported by interprofessional teams, do not require business ownership, and are more predictably remunerated.

There have been recent positive changes to remuneration models that will alter the landscape. The 2019 Nova Scotia Master Agreement includes a commitment to develop a blended capitation funding model, adding to existing FFS and APP options.[28] In BC, a process was outlined in the 2019 Physician Master Agreement for consultation with physicians around the development of APPs.[31]

Provincial governments and provincial and territorial medical associations across Canada need to carefully adapt how they fund primary care. There are existing Canadian models for viable and attractive APPs that do not substantially increase per-patient primary care costs compared with FFS. British Columbia has an ongoing pilot project for such a capitation model that adjusts for patient age and medical complexity, with per-patient payment indexed to FFS billing costs for patients with a similar health profile.[15] In addition, across the country there are physician contract and other salaried options that can allow for predictability in yearly income for FPs, with fewer administrative burdens.

As these important conversations continue, APPs need to be developed, expanded, offered widely, and carefully studied for patient-, physician-, and system-level outcomes. By doing so, we can ensure the provision of high-quality, accessible, team-based care while supporting FPs in practising comprehensive FM. Without APPs that acknowledge and value the foundational role that FPs play within our system, we risk eroding comprehensive practice even further.

Acknowledgment

We thank the Early Career Primary Care study team, our physician participants for sharing their time and experiences, and **Dr Lori Jones** for her assistance with data analysis. This research was supported by a Canadian Institutes of Health Research project grant. **Dr M. Ruth Lavergne** is supported by a Michael Smith Foundation for Health Research Scholar Award.

Footnotes

Competing interests

None declared

The opinions expressed in commentaries are those of the authors. Publication does not imply endorsement by the College of Family Physicians of Canada.

This article has been peer reviewed.

Cet article se trouve aussi en français à la **page 812**.

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Attachment B

British Columbia

Fee-for-service model is deterring aspiring family doctors from setting up practice: report

Model incentivizing high volume of patients is also contributing to B.C.'s family doctor shortage, report says

CBC News · Posted: Nov 12, 2021 12:02 PM PT | Last Updated: November 12, 2021

Attachment B

Under the fee-for-service model, doctors and hospitals are paid by the province for each office visit, test or operation. To stay afloat, doctors need to continuously work through a high-volume of patients and run a business at the same time. (Cryptographer/Shutterstock)

comments

The payment model for family doctors in B.C. is deterring aspiring physicians from pursuing the work and contributing to the ongoing family doctor shortage in the province, according to a report released Friday.

The report, published in the Canadian Family Physician Journal, found up-and-coming family doctors are choosing more hospital-based work and specialized practice rather than family medicine — in part because they're worried about the consequences of B.C.'s fee-for-service model.

Under the payment model, doctors and hospitals are paid by the province for each office visit, test or operation. To stay afloat, they need to continuously work through a high-volume of patients and run a business at the same time.

"The problem with this type of payment is that it requires the family doctor to do everything related to the patient's care — the medical care, the nursing care and the administrative work," said Dr. Goldis Mitra, a family physician and assistant professor who co-authored the report.

"As patients have become increasingly complex, it's becoming clear that it's not working for patients or for providers."

- **Nurse practitioners say they can help fill gaps in B.C. physician shortage**

Most family doctors in B.C. are paid about $30 per patient visit — whether they're treating a straightforward common cold or a complex chronic health problem.

Physicians run their practice as a business, paying out overhead costs like staff and office space at an average rate of about $60 per hour or more.

Many would prefer to be part of a team: report

The report — which interviewed 63 young doctors across three provinces, including B.C. — found many respondents would prefer alternative funding models.

Attachment B

"Many of the doctors we spoke to said they wanted to go into [an] office-based practice — so, they wanted to be what we think of as the traditional family doctor — but they avoided going into this type of practice because fee-for-service, in some ways, prevented them from providing the care they felt their patients needed and deserved," said Mitra.

She said many would prefer to work as part of a team of health-care practitioners like nurses, physiotherapists and social workers.

They would also have help from administrative workers to take care of tasks that come with running a business. The province would fund the clinic and the health practitioners would be paid a salary.

"This allows the family doctor to focus on the medical care: prevention, diagnosis and treatment of disease," said Mitra, who is also a clinical assistant professor in the Department of Family Practice at the University of British Columbia.

- **Calls for action grow as B.C. hospital diverts maternity patient because of pediatrician shortage**

In the places where these models have worked well, Mitra said, there are risk-adjusted payment models in place, meaning the clinics are funded and supported more to care for more complex patients.

"We know that everybody needs a family doctor, but especially some of the patients who are sickest and needs the most care," she said.

The authors of the report, including Mitra, are part of a team of health policy researchers who are looking at how early-career family doctors are choosing to work and why. The doctors they interviewed were from B.C., Ontario and Nova Scotia.

In May 2020, the College of Family Physicians of Canada also called for alternative funding models to replace the fee-for-service method to better support continuity of care and stop family doctors from leaving their jobs.

In a statement, the Ministry of Health said there are alternative physician compensation models available to B.C. doctors, like contracts with the ministry and health authorities. It

Attachment B
said the budget for alternative funding represents about 20 per cent of the overall compensation available for physicians in B.C.

Mitra said that was a good step, but the province needs more "clear and sustained" investments.

LISTEN | Dr. Goldis Mitra explains the fee-for-service model and its shortcomings:

7:59

Why B.C.'s fee-for-service payment system is failing health care

Dr. Goldis Mitra speaks with Stephen Quinn about the case for changing British Columbia's fee-for-service model for family doctors 7:59

With files from CBC's The Early Edition

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Attachment B

Attachment C

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British Columbia News

New strategy unveiled to recruit and retain more graduates in family medicine

https://news.gov.bc.ca/17254

Sunday, May 27, 2018 1:15 PM

Vancouver - Resident medical graduates and graduating nurse practitioners will be offered positions in the new primary care networks, announced Adrian Dix, Minister of Health.

"To address the gap in primary care, we are recruiting 200 nurse practitioners and 200 family doctors, including new graduates and residents of family medicine," Dix said. "Through implementing team-based practices, we're making sure new doctors are supported to focus on diagnostic medicine and developing strong relationships with their patients, and receive a good salary while they are also paying down their student debt. This kind of support can encourage more residents educated and trained in B.C. to stay and serve in the province's primary-care system."

Through the provincial health authorities, the Province will offer graduating medical residents and nurse practitioners the opportunity to start their careers within primary-care networks in team-based practices on alternative payment arrangements, instead of the traditional fee-for-service payment plan. This means new doctors can benefit from the experience and knowledge of other health-care professionals, receive a steady level of compensation to offset any student debt they may have, and access benefits.

As part of addressing some of the factors underlying the current gap in primary care, this model answers the need for change articulated by resident doctors. A recent survey conducted by the Society of General Practitioners of BC found a majority of resident doctor respondents felt that changes are required in how primary care is delivered in British Columbia, including that an alternative physician-payment model could promote the delivery of comprehensive patient care.

The survey also found that work-life balance, including being part of a group practice or team-based care, access to vacation and parental leave, and the ability to reduce debt, were all considered important factors that would influence decisions to practise family medicine.

"Resident physicians have completed medical school and hold educational licences to deliver medical services, under the supervision of fully licensed practising physicians, and use their resident placements to gain valuable experience to determine their areas of expertise," said Dr. David Kim, president, Resident Doctors of BC. "Having comprehensive support to experience family medicine within a team can mean greater success for new physicians, such as myself, as well as meeting the needs of primary care patients in British Columbia."

A new outreach team is being established to begin the work of recruiting for the 200 recently announced positions for doctors, and 200 positions for nurse practitioners that are part of the Province's plan to increase access to primary care for all British Columbians. Outreach will commence this summer to current general practitioner and nurse practitioner graduates, and will provide personal support from the initial stages of expressing interest and through the first year of practice.

By supporting more doctors and nurse practitioners to join primary-care networks and team-based practices, more families will have access to a greater number of primary-care providers for their day-to-day health needs. This approach also addresses shortages faced with the growing number of doctors retiring, allowing for a gradual transition of patients and avoiding the loss of access to primary care for patients.

Attachment C

This supports the B.C. government's recently announced primary health-care strategy, which focuses on delivering faster and improved access to team-based health care for British Columbians in all parts of the province.

Quick Facts:

- In 2018, 170 family physicians will complete residency from the University of British Columbia.
- British Columbia has more than 1,300 medical residents providing care to patients in urban and rural communities throughout the province.

Learn More:

To learn more about the Province's Primary Care Strategy, visit: https://news.gov.bc.ca/releases/2018PREM0034-001010 (https://news.gov.bc.ca/releases/2018PREM0034-001010)

To learn more about the Society of General Practitioners of BC survey, visit: https://sgp.bc.ca/sgp-survey-of-family-medicine-residents/ (https://sgp.bc.ca/sgp-survey-of-family-medicine-residents/)

To learn more about the Province's strategy to increase the number of nurse practitioners, visit: https://news.gov.bc.ca/releases/2018HLTH0034-000995 (https://news.gov.bc.ca/releases/2018HLTH0034-000995)

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