

Operational Limitations and Regulations on Canadian Walk-In Clinics

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Abstract

The Canadian healthcare system provides episodic, or walk-in clinics in each of its Provinces. These are funded by Canadian tax dollars which are allocated by Provincial government. This paper was written to identify and elaborate on how Walk-in Clinics are created, who can own and operate one, how said owners hire their physicians, and how the physicians are compensated. To identify the relevant information, I searched government and organizational websites, academic research and journal articles, and finally corresponded with contacts within each Province's governing bodies to find relevant policy data and documents. Anything related to the key questions was synthesized into this research. There are no limitations to who can open a clinic or where, except in Prince Edward Island. Physicians can be hired through postings similar to other professions. Finally, Physicians are compensated through a Fee-for-Service method in Walk-in Clinics. Further explanation of these findings is discussed at length throughout this work, and limitations, recommendations, and important data is included.

Keywords: walk-in, clinic, fee-for-service, rate, regulation, limitation, compensation

Introduction

Walk-in Clinics are a service provided to Canadian citizens with the purpose of providing episodic care. Episodic care refers to a single encounter with a patient-focused on a presenting concern(s), identified medical condition(s) or referred consultation, where neither the regulated member nor patient have the expectation of an ongoing care relationship (College of Physicians and Surgeons of Alberta, 2019). Walk-in Clinics can be owned and operated by either the Provincial Health Region or privately. These clinics are funded as part of Canada's public health care system via its citizens' tax dollars. The tax dollars are allocated to each Provincial Government and then they compensate health care professionals.

The primary focus of this research will be on the operational regulations and limitations set on Walk-in clinics, as well as the process of opening one, hiring physicians to work there, and compensating those Physicians. The goal is to provide the reader with an understanding of how Walk-in Clinics operate in general and provide them with the information they'd need to optimize the Walk-in's operation. With this knowledge future researchers could generate forecasts for the cost of episodic care that could benefit all the involved parties by efficiently spending the countries tax dollars, respecting patient satisfaction, and providing ethical episodic care to Canadian citizens.

The lack of controls dictating how many and where Walk-in Clinics are opened in Canada would imply a high supply and low demand for that service. However, patients attending a Walk-in Clinic can only be seen one-at-a-time and if their medical issue is complex, that means their appointment may take longer. Despite the lack of controls for the number of clinics, however, there are still issues in the care provided by walk-ins. Namely, the "one issue per visit" problem was detailed by the College of Physicians and Surgeons of Manitoba in 2012. In this article by the CBC, the College made their concerns on limiting patient time in a Walk-in Clinic known. A 60-

year-old woman went to a Manitoba Clinic to discuss her back pain and her chest pain. However, allegedly, the doctor told her “one appointment, one issue”. Two weeks later, the woman died of a heart attack.¹ In 2016 the College of Physicians and Surgeons of British Columbia warned against their physicians from posting signage and promoting a “one issue only policy”.² This problem came up again in 2019 when a woman’s teenage son, suffering from dyslexia, autism spectrum disorder, and mental health issues and recovery from leukemia was limited to “one issue per visit”³ Forcing patients to prioritize their concerns or triage unrelated medical concerns can lead to misdiagnosis, increased cost to the health care system, and potentially death.

Key Questions

- How are Walk-In clinics started? Are there any limitations on who can open and operate one?
- How are Physicians hired? What allows them to work in their respective Province?
- How are Physicians compensated?
- Are there any limitations on the amount of time a physician must spend with a patient?

Research Methodology

To identify the relevant information, I searched government and organizational websites for relevant policy data and documents. In addition, academic research and journal articles were analyzed. Finally, when it was necessary for explanation or elaboration on a subject,

¹ Retrieved on March 3, 2021, from URL: <https://www.cbc.ca/news/canada/manitoba/manitoba-mds-warned-about-limiting-patient-complaints-1.1260643?cmp=newsletter-Second+Opinion+-+March+16+2019>

² Retrieved on March 3, 2021, from URL: <https://www.cbc.ca/news/health/second-opinion-one-problem-visit-1.5061506>

³ Retrieved on March 3, 2021, from URL: <https://www.cbc.ca/news/health/second-opinion-one-problem-visit-1.5061506>

correspondence with contacts listed on Government and organizational websites would be emailed. Anything related to the key questions was synthesized into this research.

Research Limitations

When historical information, operating practices, or any other key information was not made accessible to the public there was a need to begin correspondence with the contacts made available to the general public online. On occasion, attempts to make contact would be unsuccessful, or those contacted would not have the answers to the research inquiries. If they were not able to or chose not to recommend an alternative contact, then the inaccessible information would remain unavailable, barring an alternative development in the research. Information surrounding the Walk-in Clinics in Quebec was particularly difficult to find and the multiple attempts to contact different members of the Quebec health care system were unfruitful.

Governing Bodies and Their Role in Health Care

The Federal Government

The Canadian Government's role in health care is detailed on the Government of Canada's website as:

The federal government's roles in health care include setting and administering national principles for the system under the Canada Health Act; financial support to the provinces and territories; and several other functions, including funding and/or delivery of primary and supplementary services to certain groups of people. These groups include: First Nations people living on reserves; Inuit; serving members of the Canadian Armed Forces; eligible

veterans; inmates in federal penitentiaries; and some groups of refugee claimants.

The Canada Health Act establishes criteria and conditions for health insurance plans that must be met by provinces and territories in order for them to receive full federal cash transfers in support of health. Provinces and territories are required to provide reasonable access to medically necessary hospital and doctors' services. The Act also discourages extra-billing and user fees. Extra-billing is the billing of an insured health service by a medical practitioner in an amount greater than the amount paid or to be paid for that service by the provincial or territorial health insurance plan. A user charge is any charge for an insured health service other than extra-billing that is permitted by a provincial or territorial health insurance plan and is not payable by the plan.

The federal government provides cash and tax transfers to the provinces and territories in support of health through the Canada Health Transfer. To support the costs of publicly funded services, including health care, the federal government also provides Equalization payments to less prosperous provinces and territorial financing to the territories.

Direct federal delivery of services to First Nations people and Inuit includes primary care and emergency services on remote and isolated reserves where no provincial or territorial services are readily available; community-based health programs both on reserves and in Inuit communities; and a non-

insured health benefits program (drug, dental and ancillary health services) for First Nations people and Inuit no matter where they live in Canada. In general, these services are provided at nursing stations, health centres, in-patient treatment centres, and through community health promotion programs. Increasingly, both orders of government and Aboriginal organizations are working together to integrate the delivery of these services with the provincial and territorial systems.

The federal government is also responsible for health protection and regulation (e.g., regulation of pharmaceuticals, food and medical devices), consumer safety, and disease surveillance and prevention. It also provides support for health promotion and health research. In addition, the federal government has instituted health-related tax measures, including tax credits for medical expenses, disability, caregivers and infirm dependants; tax rebates to public institutions for health services; and deductions for private health insurance premiums for the self-employed (2020).

The Provincial and Territorial Governments

The Provincial and Territorial Governments role in health care is detailed on the Government of Canada's website as:

The provinces and territories administer and deliver most of Canada's health care services, with all provincial and territorial health insurance plans expected to meet national principles set out under the Canada Health Act. Each provincial and territorial health insurance plan covers medically necessary

hospital and doctors' services that are provided on a pre-paid basis, without direct charges at the point of service. The provincial and territorial governments fund these services with assistance from federal cash and tax transfers.

- *The roles of the provincial and territorial governments in health care include:*
- *administration of their health insurance plans;*
- *planning and funding of care in hospitals and other health facilities;*
- *services provided by doctors and other health professionals;*
- *planning and implementation of health promotion and public health initiatives; and*
- *negotiation of fee schedules with health professionals.*

Most provincial and territorial governments offer and fund supplementary benefits for certain groups (e.g., low-income residents and seniors), such as drugs prescribed outside hospitals, ambulance costs, and hearing, vision and dental care, that are not covered under the Canada Health Act.

Although the provinces and territories provide these additional benefits for certain groups of people, supplementary health services are largely financed privately. Individuals and families who do not qualify for publicly funded coverage may pay these costs directly (out-of-pocket), be covered under an

employment-based group insurance plan or buy private insurance. Under most provincial and territorial laws, private insurers are restricted from offering coverage that duplicates that of the publicly funded plans, but they can compete in the supplementary coverage market.

As well, each province and territory has an independent workers' compensation agency, funded by employers, which funds services for workers who are injured on the job. (2020)

The Canadian Colleges of Physicians and Surgeons

The Royal College of Physicians and Surgeons of Canada (RCPSC) (2020) accredits the residency programs at 17 universities across Canada and also accredit the learning activities that physicians pursue in their continuing professional development programs. Then to practice in Canada, all postgraduate residents and all practising physicians must hold an educational or practice licence from the medical regulatory authority in the province in which they study or practise (Royal College of Physicians and Surgeons of Canada, 2020).

The Canadian Medical Association

The Canadian Medical Association (CMA) is made up of 11 Provincial/Territorial Medical Associations (PTMA). Each Province and Territory's medical associations function independently of the CPS's, but they work with them to govern the medical practices of their Province or Territory. These associations are the:

- Alberta Medical Association (AMA),
- Doctors of BC,
- Doctors Manitoba,
- Medical Society of Prince Edward Island
- Doctor Nova Scotia,

- New Brunswick Medical Society,
- Newfoundland and Labrador Medical Association,
- Northwest Territories Medical Association (NWTMA),
- Ontario Medical Association (OMA),
- Saskatchewan Medical Association (SMA), and the
- Yukon Medical Association (YMA)

The CMA's (2020) primary focuses are: building a dedicated team of Canadian Physicians, speaking up for health in the Federal Elections, co-leading Canada's "Virtual Care Task Force", shaping Canada's Health Policies, holding forums for Physicians to meet face-to-face, spotlighting Physicians achievements, funding grassroots programs, and seeking patient input.

Health Regions

Health Regions, also known as Health Authorities, are a provincial healthcare governance model utilized by each of Canada's provinces and territories. They are geographically determined by the provincial government to best administer healthcare to its citizens. Health regions hire their physicians and open their clinics as government-owned and operated facilities. Health Regions are responsible for coordinating healthcare within their borders and collaborating with the Provincial Government for resource allocation. There are currently 54 provincial and 10 territorial health regions in Canada. In 2008 and 2017 Alberta and Saskatchewan, respectively, transitioned to a single health region system for their entire province.

Canada's Territories

The Canadian Territories have a system of Medical Centres that cover a larger array of health issues than a typical Walk-in. Due to the remote nature of a stand-alone walk-in clinic, and

the population and needs of the Northwest Territories, the Yukon Territory, and the Nunavut Territory, it makes more logistical sense to have a single point of contact with the community that provides a large array of services, rather than a small facility with only General Practitioners. As such, and given the scope of this research, the Canadian Territories' Health Care system will be omitted from the research.

Opening A Walk-In Clinic in Canada

How to Open A Clinic in Canada's Provinces

Walk-in Clinics can be opened as either a private business or by a Provincial Health Regions/Authority. It is common in Canada for clinics to be opened and operated by Physicians, but it is not necessary. Whether or not a Walk-in Clinic is privately owned and operated, or provincially owned and operated, they follow the same regulations. To open and operate a Walk-in clinic in Canada, one requires a location, the accompanying licenses and registrations to practise medicine in that location, and practitioners.

Choosing a Suitable Location

The Canadian Medical Association's company Joule offers a free "Practice Management Resources" set of 15 modules.⁴ These provide an in-depth guide to the management of their practice. Although there is no legislation stating one must be a practicing physician to own and operate a Walk-in clinic in Canada, it is typical for the owning and operating of the practice to be done by a Physician or partnership of Physicians. Module 14: Setting Up Your Medical or Clinical Office, provides an in-depth checklist and tips sheet for the locations and the setup of a Clinic.⁵

⁴ <https://joulecma.ca/practice-management-resources>

⁵ <https://joulecma.ca/sites/default/files/2019-01/3973-PMC-Module-14.pdf>

When creating a clinic, the RCPSC also provides resources on the standards on patient safety⁶⁷⁸⁹ and quality improvement¹⁰.

The Clinic's Connection to the HealthCare System

Once a location has been chosen, the clinic must become part of the greater Health Care System in Canada and its Provinces. The RCPSC provides a module on keeping medical records physically and electronically. The onus falls on each Province's CPS to provide guidelines on caring for a patient in a Walk-in Clinic. Walk-ins differ from other clinics in the sense that they are not meant to provide continuous care, they are meant to function episodically. As the patient is received and cared for, steps are taken to acquire all the information necessary to handle the administrative duties of the clinic. That way, the notes and documents for the visit can be added to the patient's provincial medical files and their doctor, if they have one.

The accessibility to one's medical files is achieved with electronic medical records (EMR). An EMR is a computer-based patient record specific to a single clinical practice, such as a family health team or group practice (Canada Health Infoway, 2021). Each province has its own EMR system and software adapted to their needs, but each system's development is assisted by Canada Health Infoway Inc., a not-for-profit corporation. Infoway works with the provinces and territories to set a national direction and to ensure that provincial and territorial strategies are aligned with national priorities (Office of the Auditor General of Canada, 2010). The provinces and territories are responsible for developing their EMR strategies and for proposing projects to Infoway that

⁶ https://www.who.int/patientsafety/safesurgery/ss_checklist/en/

⁷ <https://www.patientsafetyinstitute.ca/en/Pages/default.aspx>

⁸ <https://www.who.int/patientsafety/safesurgery/en/>

⁹ <https://www.royalcollege.ca/rcsite/documents/health-policy/getting-it-right-e.pdf>

¹⁰ <https://www.royalcollege.ca/rcsite/documents/health-policy/quality-improvement-e.pdf>

align with the Electronic Health Record Solution Blueprint, the standards, and the eligibility criteria. (Office of the Auditor General of Canada, 2010). Then the cost of implementation and operation of their EMR systems are owned by the provincial and territorial governments (Office of the Auditor General of Canada, 2010).

Licensing and Registration of a Walk-in Clinic

To operate any form of business in Canada, a Provincial/Territorial business license is required. The Canadian Government provides a tool called Bizpal that helps one find the permits and licences possibly required when starting and/or operating a business (BizPal, 2020). Once the municipality and industry are defined, links to every necessary permit are provided. These links provide the cost, renewal period, waiting period, and inspection requirement for both medical and non-medical permits. BizPal does not cover and medical practice insurance or licenses, however. To be covered to practice medicine in any province or territory, you will need to register yourself with that province's CPS and the provincial health region they wish to operate in.

Regulations on Time with Patients

The services provided by Physicians at a Walk-in Clinic are provided on a fee-for-service basis. As such, there is no expressed limitation or maximum amount of time that a patient can spend with a physician. This research yielded no written law or regulation against limiting a patient visit to a certain timeframe, inferring that no regulation existed. Correspondence with each of the province's medical associations displayed contacts confirmed that no regulations existed.

One Visit, One Issue

However, it is not uncommon for Physicians to create a “one issue per appointment” rule. Although they are obligated to hear of the patient and do their very best to meet the health needs,

some Physicians choose this method of encouraging the patient to prioritize their issues so that the appointment is more concise. This could be because physicians are paid per visit, so they want to maximize their number of visits by rushing their patients. It could also be out of respect for the patients in the waiting room and their time and personal health issues. Unfortunately, there is no way to make that determination between greed and empathy. On top of the significant ethical issues involved in only addressing a fraction of a patient's concerns, the Canadian Medical Protective Association, which represents doctors in legal matters, warned that such a policy could be "risky" because it forces patients to "triage their own symptoms without the knowledge, skills, and judgment to do so" (Adhopia, 2019).

Hiring Physicians

When a Physician wished to practice in a specific Province or Territory, they register with its respective CPS. Once registered, they are licensed and insured to practice medicine independently or as an employee of a clinic. Once they are registered to practice, a Physician can begin searching job boards for clinic postings. Although positions in the medical field can be posted anywhere, a universally successful route is searching for opportunities on the respective PTMA's website. There, a clinic can contract the website and have their posting placed there. This is true in every Province; Prince Edward Island (PEI) uses a system called "The Complement", detailed below.

In some cases, hiring Physicians is not necessary because the owner-operator(s) are physicians themselves, and they are the only practicing staff they wish to employ. This way, they all have a stake in the success of the clinic, and business decisions are made by a collective of experienced, practicing Physicians. In the case of the owner-operator(s) all being practicing

physicians, they can choose to bill independently or to create a system in which they accumulate their timesheets and they are sent in on behalf of the clinic.

Prince Edward Island and “The Complement”

The exception to the aforementioned method of hiring a physician exists in PEI. PEI utilizes a system called “The Complement”. Under the complement, the Government of Prince Edward Island creates a maximum number of working physicians in the Province. Any physician who wishes to practice in PEI must be invited by the Government of Prince Edward Island. Any Physician that worked at a family practice and a Walk-in Clinic before the introduction of “The Complement” is permitted to continue working at that Clinic until their retirement or when they choose to no longer work at that Walk-in Clinic. Any new Physicians can put in a request to the Government of Prince Edward Island to work at or operate a Walk-in, but they cannot work or operate a Walk-in Clinic without the express permission of the Provincial Government. This system was created by the PEI Government to control the costs of their healthcare system, not to respond to the supply and demand of health care.

Compensation Models

In Canada, each province’s physicians use a “Fee-for-Service” system or an alternative compensation model presented by the local health region to collect money for their work from the Government. Alternative models are not uniform across each of the Provinces, and fee-for-service rates differ. Please see Appendix J for a comparison of the current fee-for-service rate utilized for Walk-in Clinics in each province. According to a report by the Canadian Institute for Health Information (2019), 72.6% of all clinical payments to physicians in Canada were via the fee-for-service payment model, and 27.4% of all gross clinical payments were via an alternative payment plan (p. 32). Over 96% of all physicians in 2018–2019 were paid a portion of their total payments

via the fee-for-service model (Canadian Institute for Health Information, 2019, p. 33). According to the McMaster Health Forum, Ontario, Alberta, Quebec, Manitoba, and Saskatchewan walk-in clinics rely on fee-for-service compensation models, with budgets for staff and operations being paid out of the clinic revenue (Waddell, Scallan, & Wilson, 2018). Correspondence with contacts from the remaining Provinces confirmed the remainder of Canada utilized fee-for-service models exclusively as well. Please, see table 1 detailing the Compensation Model and Compensation Requirements for each Province. Appendices A-I detail the Walk-in rates available to the public.

Table 1*Provincial Walk-In Clinic Compensation Model and Requirements*

| Province | Compensation Model | Compensation Requirements |
|------------------|--|---|
| British Columbia | <ul style="list-style-type: none"> • Fee-for-Service • Physicians are responsible for paying other staff and operating costs out of revenue generated from fee-for-service billing • Uninsured patients are required to pay out-of-pocket | <ul style="list-style-type: none"> • No policies have been put in place to limit compensation at walk-in clinics (1) |
| Alberta | <ul style="list-style-type: none"> • Fee-for-Service • Physicians are responsible for paying other staff and operating costs out of revenue generated from fee-for-service billing (1) • Uninsured patients are required to pay out-of-pocket (1) | <ul style="list-style-type: none"> • If an affiliated patient receives an in-basket service at another clinic, the home clinic receives a financial deduction (or negation) for the value of the service provided. The home clinic is negated at 100% of the service cost but is not negated more than 85% of the capitation rate for that patient. (2) • There is a limit on the number of services that can be provided in the community on a given day. The max number of services is 50, these are not specific to patient encounters but patient services. Reductions in payments occur at service 51, 50% reduction, and again at 66, 100% reduction. (3) |
| Saskatchewan | <ul style="list-style-type: none"> • Fee-for-Service • Physicians are responsible for paying other staff and operating costs out of revenue generated from fee-for-service billing (1) • Uninsured patients are required to pay out-of-pocket (1) | <ul style="list-style-type: none"> • No policies have been put in place to limit compensation at walk-in clinics (1) |
| Manitoba | <ul style="list-style-type: none"> • Fee-for-Service • Uninsured patients are required to pay out-of-pocket (1) | <ul style="list-style-type: none"> • No policies have been put in place to limit compensation at walk-in clinics (1) |

| | | |
|---------------------------|--|---|
| Ontario | <ul style="list-style-type: none"> • Fee-for-Service (1) • Physicians are responsible for paying other staff and operating costs out of revenue generated from fee-for-service billing (1) • Uninsured patients are required to pay out-of-pocket (1) | <ul style="list-style-type: none"> • Physicians with a patient roster are paid a bonus for ensuring patients' access to care (calculated as 0.1859 of a physician's monthly base rate payment), but any billings for services for a rostered patient by an outside primary-care physician (e.g., at a walk-in clinic or other primary-care clinic) are subtracted from this access bonus (1) |
| Quebec | <ul style="list-style-type: none"> • Fee-for-Service • Uninsured patients are required to pay out-of-pocket (1) | <ul style="list-style-type: none"> • No policies have been put in place specifically to limit compensation at walk-in clinics (1) • However, there is a quarterly and annual cap applied to fee-for-service payments, and if this cap is met, remuneration for any additional services rendered is reduced to 75% (1) |
| Newfoundland and Labrador | <ul style="list-style-type: none"> • Fee-for-Service • Uninsured patients are required to pay out-of-pocket (1) | <ul style="list-style-type: none"> • No policies have been put in place to limit compensation at walk-in clinics (1) |
| New Brunswick | <ul style="list-style-type: none"> • Fee-for-Service • Uninsured patients are required to pay out-of-pocket (1) | <ul style="list-style-type: none"> • No policies have been put in place to limit compensation at walk-in clinics (1) |
| Prince Edward Island | <ul style="list-style-type: none"> • Fee-for-Service • Uninsured patients are required to pay out-of-pocket (1) • PEI uses a code designed specifically for Walk-In Clinics | <ul style="list-style-type: none"> • No policies have been put in place to limit compensation at walk-in clinics (1) |
| Nova Scotia | <ul style="list-style-type: none"> • Fee-for-Service • Uninsured patients are required to pay out-of-pocket (1) | <ul style="list-style-type: none"> • No policies have been put in place to limit compensation at walk-in clinics (1) |

1. Waddell, Scallan, & Wilson (2018)
2. Government of Alberta (2021)
3. Alberta Medical Association (2020)

Table 2

Compensation Schedule Public Accessibility, How Often They Are Re-Negotiated, And How Many Previous Versions Are Publicly Available

| Province | Compensation Schedule Publicly Available | Compensation Schedule Link If Publicly Available | Renegotiating Frequency | Number of Previous Versions Publicly Available |
|---------------------------|--|---|-------------------------|--|
| British Columbia | Yes | https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/physicians/payment-schedules/msc-payment-schedule | Semi-Annual | 10 |
| Alberta | Yes | https://www.albertadoctors.org/fee-navigator | N/A | 1 |
| Saskatchewan | Yes | https://www.ehealthsask.ca/services/resources/establish-operate-practice/Pages/Physicians.aspx | Semi-Annual | 10 |
| Manitoba | Yes | https://www.gov.mb.ca/health/manual/index.html | No Noticeable Pattern | 2 |
| Ontario | Yes | http://www.health.gov.on.ca/en/pro/programs/ohip/sob/ | N/A | 1 |
| Quebec | No | N/A | N/A | N/A |
| Newfoundland and Labrador | Yes | https://www.gov.nl.ca/hcs/mcp/providers/ | N/A | 1 |

| | | | | |
|----------------------|-----|---|-----------------------|---|
| New Brunswick | Yes | https://www2.gnb.ca/content/gnb/en/departments/health/healthprofessionals.html | No Noticeable Pattern | 2 |
| Prince Edward Island | Yes | https://www.princeedwardisland.ca/en/publication/master-agreement | N/A | 1 |
| Nova Scotia | Yes | https://doctorsns.com/contract-and-support/master-agreement | N/A | 1 |

Recommendations

Keep Historical Records for Forecasting

To make proper forecasts regarding the cost of episodic care in the future researchers will require data. Statistics Canada has a Projection of Mortality chapter where they keep the population projections for Canada (2018 to 2068) and the Provinces and Territories (2018 to 2043)¹¹. If the Federal Government mandated keeping a semi-annual record of the fee-for-service payment structure then forecasted future costs against the mortality projection then future taxpayer expenses could be predicted and budgeted for, even roughly. Each Province, excluding Newfoundland and Labrador, and New Brunswick, has their definition of geriatric, and a rate modifier that provides extra compensation for caring for the elderly. In Saskatchewan, the modifier needed to be adjusted in 2020 to create a new modification structure to include a “75-84” and “85+” to replace the sole “75+” category. In Canada, life expectancy at birth for males is projected to increase from 79.9 years in 2016 to 83.9 years in 2043 and 87.0 years in 2068 under the medium mortality assumption (Zhang, Galbraith, & Dion, 2019). Given that positive projection of mortality, each Province will likely follow Saskatchewan’s example. As the average human lives longer, caring for them at relatively younger ages will call for less of a premium. Forecasting age and cost of episodic care will allow for better planning and allocation of tax dollars.

Improve Transparency and Accessibility

Gathering the information detailed in this report was not simple, time-effective, or consistent across Provinces. Since health care is a public industry, funded by the Canadian tax-

¹¹ Chapter 4: Projection of Mortality: <https://www150.statcan.gc.ca/n1/pub/91-620-x/2019001/chap04-eng.htm>

payer, information on the operation of health care facilities should be easily accessible information. Having either one federal webpage or provincial webpages that houses historical records of fee-for-service payment schedules to provide Canadian citizens with a hub of data. Also, operational overviews should be available. This allows Canadians to know how their tax-funded facilities are operated, and how their health care is administered. It will also provide a written standard of care for the Government and health care providers to reference. This could include a walk-in clinic's first-come-first-serve policy, but also an overview for hospitals and emergency rooms. If the process for administering, prioritizing, and potentially limiting patients is articulated for every Canadian to see, then it provides the current state. From that point, changes can be administered and compared against the current operating structure or regulations.

Recommendation Limitations

The cardinal limitation to the above-mentioned recommendations is the administration of the health care information. The Federal or Provincial Governments would need to allocate tax dollars to hire additional resources to maintain these data sets and information pages. In the grand-scheme, an additional resource per province would make up a fraction of Canada's gross tax dollars, but it is still an expenditure. This research can be time-consuming but once a system was implemented, the upkeep cost should be minimal. If the expectation of sharing fee schedules and operational regulations semi-annually, or annually as set forth by the Federal and Provincial governments then summarizing it online for the public to see should take minimal effort.

Conclusion

This paper's resulting research found that there are no time constraints on physician's appointments in Canadian Walk-in Clinics. There are also no limitations on how many clinics can

exist, the number of operating physicians in these Walk-in clinics, or who can own and/or operate a Walk-in clinic, except in PEI. Alberta, Ontario, and Quebec restructure their fee-for-service payments depending on the utilization rate in those provinces. Each Provincial Government negotiates these fees with their Provincial Medical Associations. There is no universal re-negotiating schedule across Canada.

References

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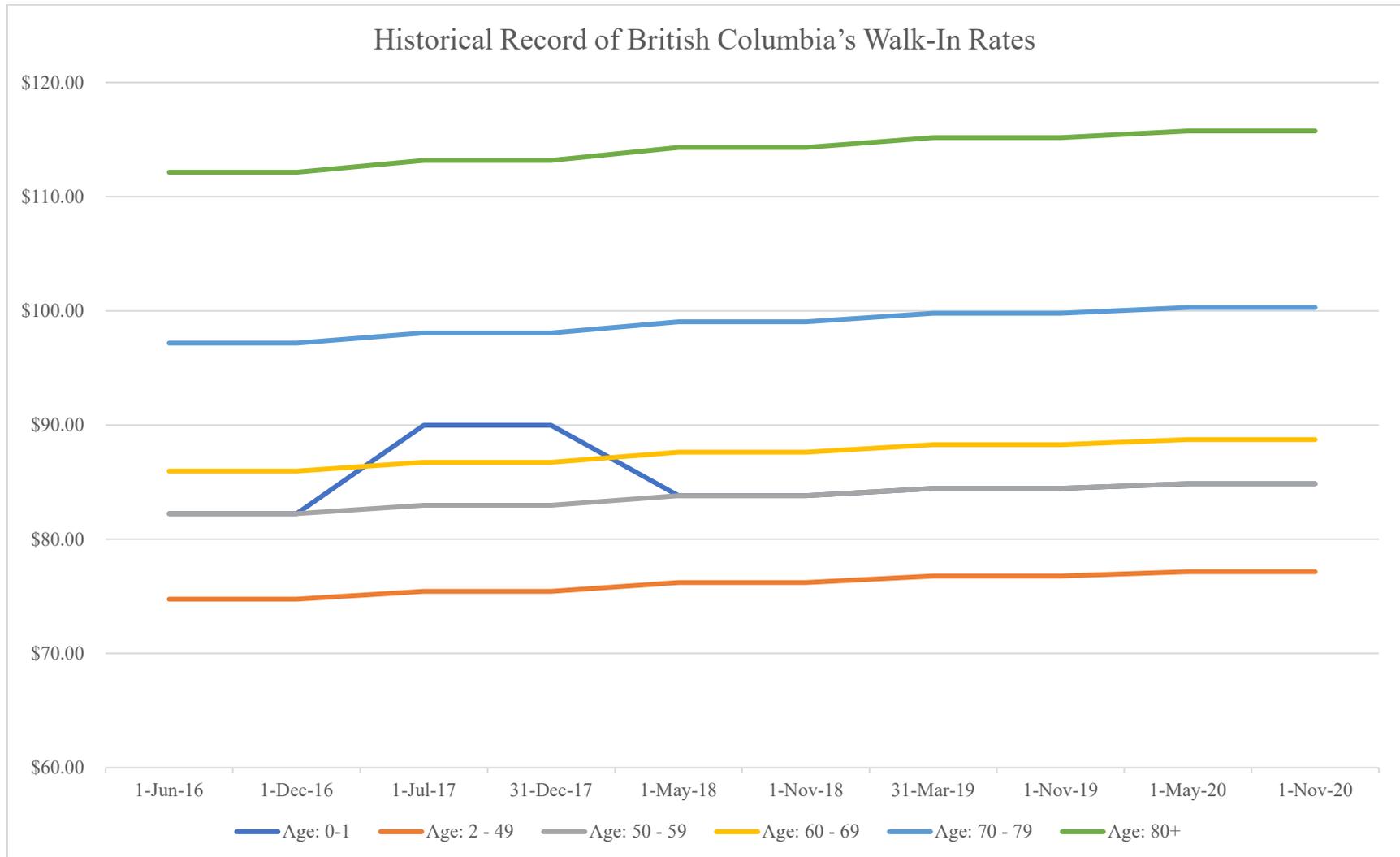
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Appendix A

Historical Record of British Columbia's Walk-In Rates

| In-Office Consultation/Visit | | | | | | | | | | |
|------------------------------|---|---|---|---|---|---|---|---|---|---|
| Age Range | 01-Jun-16 | 01-Dec-16 | 01-Jul-17 | 31-Dec-17 | 01-May-18 | 01-Nov-18 | 31-Mar-19 | 01-Nov-19 | 01-May-20 | 01-Nov-20 |
| Age: 0-1 | \$ 82.24 | \$ 82.24 | \$ 89.98 | \$ 89.98 | \$ 83.82 | \$ 83.82 | \$ 84.45 | \$ 84.45 | \$ 84.87 | \$ 84.87 |
| Age: 2 - 49 | \$ 74.75 | \$ 74.75 | \$ 75.44 | \$ 75.44 | \$ 76.20 | \$ 76.20 | \$ 76.77 | \$ 76.77 | \$ 77.15 | \$ 77.15 |
| Age: 50 - 59 | \$ 82.24 | \$ 82.24 | \$ 82.98 | \$ 82.98 | \$ 83.82 | \$ 83.82 | \$ 84.45 | \$ 84.45 | \$ 84.87 | \$ 84.87 |
| Age: 60 - 69 | \$ 85.97 | \$ 85.97 | \$ 86.75 | \$ 86.75 | \$ 87.63 | \$ 87.63 | \$ 88.29 | \$ 88.29 | \$ 88.73 | \$ 88.73 |
| Age: 70 - 79 | \$ 97.18 | \$ 97.18 | \$ 98.06 | \$ 98.06 | \$ 99.05 | \$ 99.05 | \$ 99.79 | \$ 99.79 | \$ 100.29 | \$ 100.29 |
| Age: 80+ | \$ 112.14 | \$ 112.14 | \$ 113.17 | \$ 113.17 | \$ 114.31 | \$ 114.31 | \$ 115.17 | \$ 115.17 | \$ 115.75 | \$ 115.75 |
| Payment Schedule: | https://www2.gov.bc.ca/assets/gov/health/practitioner/pro/medical-services-plan/msc-payment-schedule-june-2016.pdf | https://www2.gov.bc.ca/assets/gov/health/practitioner/pro/medical-services-plan/msc-payment-schedule-december-2016.pdf | https://www2.gov.bc.ca/assets/gov/health/practitioner/pro/medical-services-plan/msc-payment-schedule-july-2017.pdf | https://www2.gov.bc.ca/assets/gov/health/practitioner/pro/medical-services-plan/msc-payment-schedule-december-2017.pdf | https://www2.gov.bc.ca/assets/gov/health/practitioner/pro/medical-services-plan/msc-payment-schedule-may-2018.pdf | https://www2.gov.bc.ca/assets/gov/health/practitioner/pro/medical-services-plan/msc-payment-schedule-november-2018.pdf | https://www2.gov.bc.ca/assets/gov/health/practitioner/pro/medical-services-plan/msc-payment-schedule-march-2019.pdf | https://www2.gov.bc.ca/assets/gov/health/practitioner/pro/medical-services-plan/msc-payment-schedule-november-2019.pdf | https://www2.gov.bc.ca/assets/gov/health/practitioner/pro/medical-services-plan/msc-payment-schedule-may-2020.pdf | https://www2.gov.bc.ca/assets/gov/health/practitioner/pro/medical-services-plan/msc-payment-schedule-nov-2020.pdf |
| Page on PDF: | 91 | 90 | 96 | 97 | 97 | 99 | 100 | 104 | 106 | 107 |



Appendix B

Alberta's Walk-in Rates

| "Comprehensive consultation - in office" | | |
|---|-------------------|---|
| Age Range | Multiplier | 2021 |
| Age: 0-74 | 0% | \$ 79.23 |
| Age: 75+ | 20% ¹² | \$ 95.08 |
| Payment Schedule: | | https://www.albertadoctors.org/fee-navigator/hsc/03.08A |

¹²<https://open.alberta.ca/dataset/568f8505-2304-4ce2-882c-2bbbc314b739/resource/628a0f3a-ac55-4e34-9662-b0694c327e81/download/health-somb-fee-modifier-definitions-2020-05.pdf>

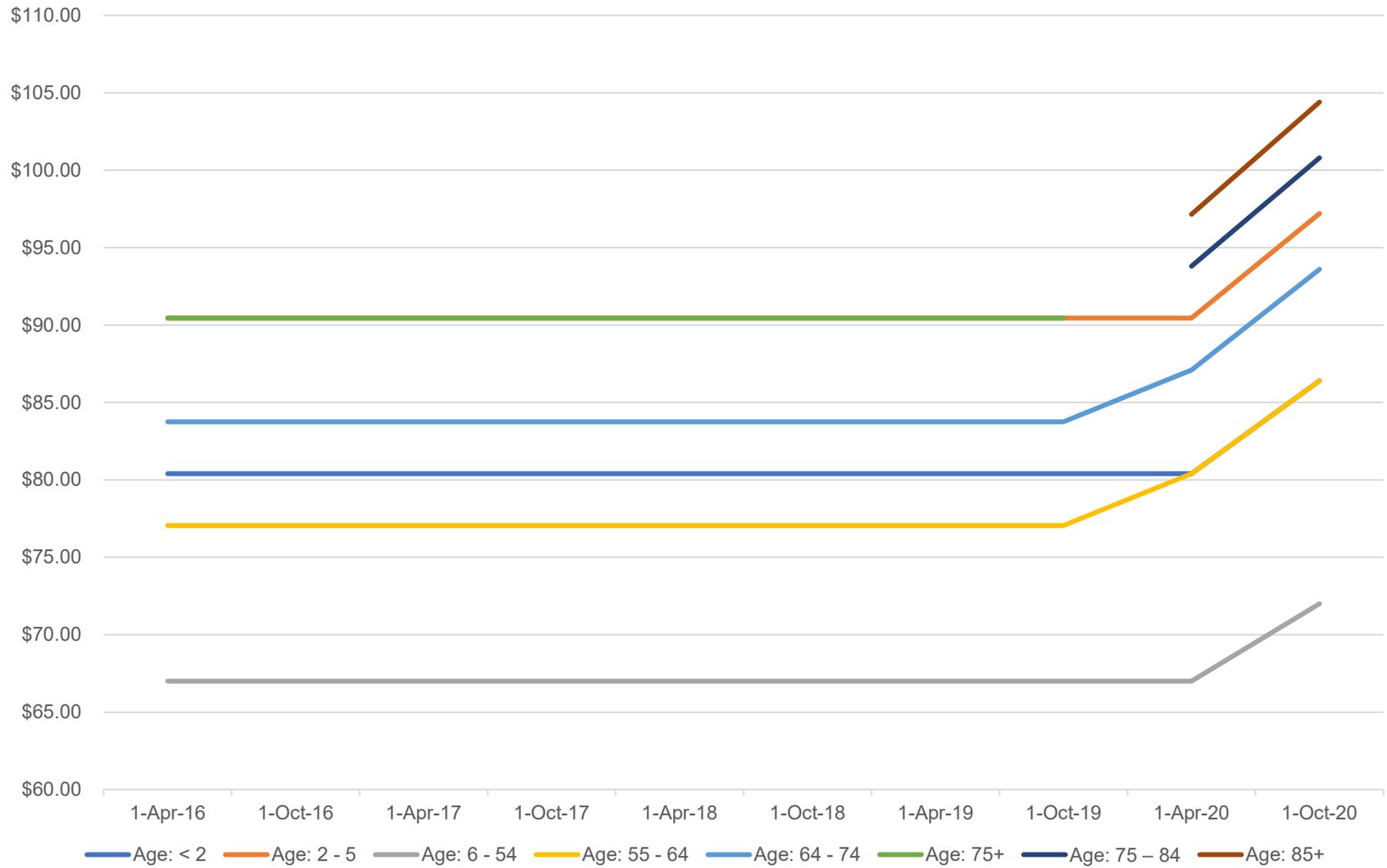
Appendix C

Historical Record of Saskatchewan's Walk-In Rates

| "Complete Assessment" | | | |
|------------------------------|-------------------|---|---|
| Age Range | Multiplier | 1-Apr-20 | 1-Oct-20 |
| Age: < 2 | 20% | \$ 80.40 | \$ 86.40 |
| Age: 2 – 5 | 35% | \$ 90.45 | \$ 97.20 |
| Age: 6 – 54 | 0% | \$ 67.00 | \$ 72.00 |
| Age: 55 – 64 | 20% | \$ 80.40 | \$ 86.40 |
| Age: 64 – 74 | 30% | \$ 87.10 | \$ 93.60 |
| Age: 75 – 84 | 40% | \$ 93.80 | \$ 100.80 |
| Age: 85+ | 45% | \$ 97.15 | \$ 104.40 |
| Payment Schedule: | | https://www.ehealthsask.ca/services/resources/establish-operate-practice/Documents/Payment%20Schedule%20-%20Final%20-%20October%201%202020.pdf | https://www.ehealthsask.ca/services/resources/establish-operate-practice/Documents/Payment%20Schedule%20-%20April%201%2c%202020%20-%20Final.pdf |
| Page on PDF: | | 82, 101 | 82, 101 |

| "Complete Assessment" | | | | | | | | | |
|--------------------------|---|--|---|---|---|---|---|---|----------|
| Age Range | Multiplier | 1-Oct-19 | 1-Apr-19 | 1-Oct-18 | 1-Apr-18 | 1-Oct-17 | 1-Apr-17 | 1-Oct-16 | 1-Apr-16 |
| Age: < 2 | 20% | \$ 80.40 | \$ 80.40 | \$ 80.40 | \$ 80.40 | \$ 80.40 | \$ 80.40 | \$ 80.40 | \$ 80.40 |
| Age: 2 - 5 | 35% | \$ 90.45 | \$ 90.45 | \$ 90.45 | \$ 90.45 | \$ 90.45 | \$ 90.45 | \$ 90.45 | \$ 90.45 |
| Age: 6 - 54 | 0% | \$ 67.00 | \$ 67.00 | \$ 67.00 | \$ 67.00 | \$ 67.00 | \$ 67.00 | \$ 67.00 | \$ 67.00 |
| Age: 55 - 64 | 15% | \$ 77.05 | \$ 77.05 | \$ 77.05 | \$ 77.05 | \$ 77.05 | \$ 77.05 | \$ 77.05 | \$ 77.05 |
| Age: 65 - 74 | 25% | \$ 83.75 | \$ 83.75 | \$ 83.75 | \$ 83.75 | \$ 83.75 | \$ 83.75 | \$ 83.75 | \$ 83.75 |
| Age: 75+ | 35% | \$ 90.45 | \$ 90.45 | \$ 90.45 | \$ 90.45 | \$ 90.45 | \$ 90.45 | \$ 90.45 | \$ 90.45 |
| Payment Schedule: | https://www.ehealthsask.ca/services/resources/Payment%20Schedule%20-%20October%201%2c%202019%20-%20FINAL.PDF | https://www.ehealthsask.ca/SiteCollectionDocuments/Payment%20Schedule%20For%20Insured%20Services%20Provided%20by%20a%20Physician | https://www.ehealthsask.ca/services/resources/Physician-payment-schedule-oct-2018.pdf | https://www.ehealthsask.ca/services/resources/Physician-payment-schedule-apr-18.pdf | https://www.ehealthsask.ca/services/resources/Physician-payment-schedule-oct-17.pdf | https://www.ehealthsask.ca/services/resources/Physician-payment-schedule-apr-2017.pdf | https://www.ehealthsask.ca/services/resources/Physician-payment-schedule-october19-2016-revised.pdf | https://www.ehealthsask.ca/services/resources/Physician-payment-schedule-apr-2016.pdf | |
| Page on PDF: | | 80, 97 | 80, 97 | 80, 97 | 76, 93 | 82, 99 | 80, 97 | 80, 97 | 80, 96 |

Historical Record of Saskatchewan's Walk-In Rates



Appendix D

Manitoba's Walk-In Rates

| "Office, Home Visits - Complete History and Physical Examination" | | |
|--|---|---|
| Age Range | 1-Apr-20 | 1-Jan-21 |
| Age: 0 - 64 | \$ 85.25 | \$ 85.25 |
| Age: 65 - 69 | \$ 91.95 | \$ 91.95 |
| Age: 70 + | \$ 101.75 | \$ 101.75 |
| Payment Schedule: | https://www.gov.mb.ca/health/documents/p_hysmanual.pdf | https://www.gov.mb.ca/health/documents/p_hysmanual.pdf |
| Page on PDF: | 156 | 156 |

Appendix E

Ontario's Walk-in Rates

| "General Listings - Consultation" | |
|--|---|
| Age Range | 1-Apr-20 |
| Age: 0-17 | \$ 175.40 |
| Age: 18-64 | \$ 84.45 |
| Age: 65+ | \$ 183.30 |
| Payment Schedule: | http://www.health.gov.on.ca/en/pro/programs/ohip/sob/physserv/sob_master20200306.pdf |
| Page on PDF: | 129, 227, 269 |

Appendix F

Newfoundland & Labrador

| "General Assessment" | |
|-----------------------------|---|
| Age Range | 4-Nov-19 |
| Pediatrics | \$ 98.72 |
| General | \$ 82.46 |
| Payment Schedule: | https://www.gov.nl.ca/hcs/files/Combined-Medical-Payment-Schedule.pdf |
| Page on PDF: | 12, 84, 103 |

Appendix G

New Brunswick Walk-in Rates

| Walk-in Clinic - Visit | | |
|-------------------------------|---|---|
| Age Range | 13-Feb-20 | 03-Mar-15 |
| N/A | \$ 28.00 | \$ 28.00 |
| Payment Schedule: | https://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/en/Physicians/new_brunswick_physicians_manual.pdf | https://www.gnb.ca/0394/pdf/2015/physician_manual-e.pdf |
| Page on PDF | 112 | 97 |

Appendix H

Prince Edward Island Walk-in Rates

| "Walk-In Clinic visit" | | | | | |
|-------------------------|---|-----------|-----------|-----------|-----------|
| Age Range | 01-Apr-19 | 01-Apr-20 | 01-Apr-21 | 01-Apr-22 | 01-Apr-23 |
| N/A | \$ 25.61 | \$ 25.91 | \$ 26.54 | \$ 27.20 | \$ 28.00 |
| Geriatric Premium (75+) | 25% | 25% | 25% | 25% | 25% |
| Geriatric Premium (75+) | \$ 32.01 | \$ 32.39 | \$ 33.18 | \$ 34.00 | \$ 35.00 |
| Payment Schedule: | https://www.princeedwardisland.ca/sites/default/files/publications/master_agreement.pdf | | | | |
| Page on PDF: | 152, 204 | | | | |

Appendix I

Nova Scotia Walk-in Rates

| Office Visit (ME=CARE) | | | | | |
|----------------------------------|---|----------|----------|----------|----------|
| Age Range | 2019 | 2020 | 2021 | 2022 | 2023 |
| N/A | \$ 36.60 | \$ 38.64 | \$ 41.15 | \$ 44.64 | \$ 45.54 |
| Geriatric Office Visit (ME=CARE) | \$ 45.28 | \$ 47.81 | \$ 50.91 | \$ 55.23 | \$ 56.33 |
| Payment Schedule: | https://doctorsns.com/sites/default/files/2019-12/MA-Execution-Copy-SIGNED-Dec_9_2019.pdf | | | | |
| Page on PDF: | 51 | | | | |

Appendix J*Current Fee-for-service Rate Utilized in Walk-in Clinics*