

Practice and payment preferences of newly practising family physicians in British Columbia

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Abstract

Objective To examine the remuneration model preferences of newly practising family physicians.

Design Mixed-methods study comprising a cross-sectional, Web-based survey, as well as qualitative content analysis of answers to open-ended questions.

Setting British Columbia.

Participants University of British Columbia family practice residents who graduated between 2000 and 2009.

Main outcome measures Preferred remuneration models of newly practising physicians.

Results The survey response rate was 31% (133 of 430). Of respondents, 71% (93 of 132) preferred non-fee-for-service practice models and 86% (110 of 132) identified the payment model as very or somewhat important in their choice of future practice. Three principal themes were identified from content analysis of respondents' open-ended comments: frustrations with fee-for-service billing, which encompassed issues related to aggravations with "the business side of things" and was seen as impeding "the freedom to focus on medicine"; quality of patient care, which embraced the importance of a payment model that supported "comprehensive patient care" and "quality rather than quantity"; and freedom to choose, which supported the plurality of practice preferences among providers who strived to provide quality care for patients, "whatever model you happen to be working in."

Conclusion Newly practising physicians in British Columbia preferred alternatives to fee-for-service payment models, which were perceived as contributing to fewer frustrations with billing systems, improved quality of work life, and better quality of patient care.

EDITOR'S KEY POINTS

- Despite considerable investment in primary care reform in Canada, few Canadian studies have looked at remuneration preferences among family physicians.
- Results of this survey showed that the remuneration model and the ability to choose the type of practice and payment model were important considerations for newly practising family physicians in British Columbia. This suggests that policy makers need to address not only the amount paid to family physicians, but also *how* they are paid.
- This survey demonstrates that newly practising family physicians in British Columbia had a strong preference for alternative, non-fee-for-service remuneration. Such models were perceived as contributing to fewer frustrations with billing systems, improved quality of work life, and better quality of patient care.

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Les types de pratique et de rémunération que préfèrent les médecins de famille de Colombie-Britannique en début de pratique

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Résumé

Objectif Déterminer les types de rémunération que préfèrent les médecins de famille en début de pratique.

Type d'étude Études par méthodes multiples incluant une enquête transversale via le Web de même qu'une analyse de contenu qualitative des réponses à des questions ouvertes.

Contexte La Colombie-Britannique.

Participants Résidents en médecine familiale de l'Université de la Colombie-Britannique ayant obtenu leur diplôme entre 2000 et 2009.

Principaux paramètres à l'étude Les modèles de rémunération que préfèrent les médecins en début de pratique.

Résultats Le taux de réponse à l'enquête était de 31 % (133 sur 430). Parmi les répondants, 71 % (93 sur 132) préféreraient un modèle autre que la rémunération à l'acte et 86 % (110 sur 132) déclareraient que le type de paiement était très ou relativement important pour le choix de leur pratique future. L'analyse de contenu des commentaires des répondants aux questions ouvertes a fait ressortir trois thèmes principaux: des frustrations en lien avec la facturation pour la rémunération à l'acte, par exemple le fait d'accentuer l'aspect « affaire » de la pratique et l'idée que cela fait obstacles à la « possibilité de se concentrer sur la médecine »; la qualité des soins aux patients, qui comprend l'importance d'un mode de paiement compatible avec « une approche holistique du patient » et avec une préférence pour « la qualité plutôt que la quantité »; et la liberté de choisir, qui correspond à la diversité des choix de pratique pour ceux qui s'efforcent de prodiguer des soins de qualité aux patients, « quel que soit le modèle dans lequel ils travaillent ».

Conclusion Les médecins de la Colombie-Britannique en début de pratique préféreraient des modèles de paiement autres que la rémunération à l'acte; selon eux, les autres modèles génèreraient moins de frustration relative à la facturation, et favoriseraient une amélioration du climat de travail et de la qualité des soins.

POINTS DE REPÈRE DU RÉDACTEUR

- Même si on a beaucoup investi dans la réforme des soins primaires au Canada, peu d'études se sont penchées sur le type de rémunération que préfèrent les médecins de famille.
- Les résultats de cette enquête révèlent que le type de rémunération et la possibilité de choisir son type de pratique sont des considérations importantes pour les médecins de famille de la Colombie-Britannique en début de pratique. Cela suggère que les responsables des politiques doivent tenir compte non seulement de la somme payée aux médecins de famille, mais aussi de la façon dont ils sont payés.
- Cette enquête montre que les médecins de famille de la Colombie-Britannique en début de pratique ont une forte préférence pour des modes de rémunération autres que la rémunération à l'acte. Selon eux, ces autres modèles permettent de réduire les frustrations liées au système de facturation et d'améliorer le climat de travail ainsi que la qualité des soins.

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Over the past decade there has been a growing recognition of the positive association between the robustness of a health system's primary care and overall improved quality of care, access, and cost control.¹⁻⁴ The policy response in Canada has been increased expenditure on primary care with substantial money transferred to the provinces for primary care reform.^{5,6} Family physicians have a considerable role in primary care delivery, and attention to recruitment, retention, and engagement of this group in the reform process is warranted.

Despite growing attention to primary care renewal, there is evidence that fewer medical students are opting to practise family medicine.⁷⁻¹⁰ Furthermore, upon graduation, many of those who train in family medicine choose to work in walk-in clinics, become hospitalists, or enter family medicine subspecialties as opposed to engaging in comprehensive practice, including "access to and use of first-contact care, patient-focused care over time for defined populations, services that are comprehensive and timely, and coordination of care when patients need services elsewhere."¹¹ Governments remain challenged to address the problem of more than 4 million Canadians who do not have family physicians.¹²

As part of primary care reform, some provinces have elected to expand opportunities for family physicians to provide primary care supported by remuneration that is not based on fee-for-service (FFS) payment. In Canada, FFS remuneration is a common form of service-based physician payment, whereby a fee is attached to each service and physicians then bill the public insurance plan once a service is rendered. In a move away from this form of remuneration in Ontario, there are now 5 different models of primary care physician remuneration involving capitation of some or all of a practice population.¹³ By 2006, FFS remuneration alone had become the least common model for family physicians in Ontario.¹⁴ Other provinces, such as British Columbia (BC), chose to focus on enhancing the FFS model rather than introducing or expanding capitation and other payment options.

Few Canadian studies have looked at remuneration preferences among family physicians. Green and colleagues found that family physicians who worked in non-FFS models in Ontario had higher levels of satisfaction compared with those in FFS models; however, it was unclear whether this satisfaction was driven by an increase in income or the form of remuneration itself.¹³ Furthermore, this study was performed in the context of government efforts to transition Ontario physicians from FFS to alternative remuneration models; the financial incentive provided in the context of this transition is unique to that province and not generalizable.

The 2010 National Physician Survey found that the percentage of all Canadian physicians preferring FFS payment as their sole source of income declined from 50%

in 1995 to 23% in 2007, and this pattern was even more pronounced among female and younger physicians.¹⁵ The same survey found that the most popular response for Canadian family medicine residents and practising family physicians was for a blended model that combined elements of FFS payment with other remuneration forms.^{3,16} However, the definition of *blended* is vague and it remains unclear to what extent remuneration type "matters" to newly graduating physicians.

Given the current challenges with recruiting and retaining sufficient family physicians for comprehensive primary care provision, a better understanding of new graduates' views on payment preferences is important to inform policies that support practice environments that address these preferences. Our primary goal for this study was to survey newly practising physicians in BC about their preferences for remuneration and practice type.

METHODS

A 10-item, anonymous, online survey was collaboratively created and informed by, but not replicated from, items from the National Physician Survey. Items included basic demographic information (including past residency, current practice, and locum experiences), as well as questions about practice and remuneration preferences. Language in the survey items was specifically designed to avoid inconsistent understanding and definitions of the term *blended model* by choosing a more explicit differentiation of payment options as FFS, enhanced FFS, and any alternatives to these 2 most common forms of remuneration in BC. Respondents were given the option to choose from multiple answers and provide further comment in a response section that followed. Survey items were pilot-tested on a small group of newly practising physicians, but were not formally tested for validity and reliability.

Surveys were distributed by e-mail to an administrative list serve of 430 graduates from the University of British Columbia (UBC) family practice residency program, which includes training sites in rural and urban centres throughout the province. This list serve is primarily used for locum advertisements and includes those who graduated between 2000 and 2009; it is the most comprehensive e-mail contact list available for UBC family practice residency graduates. An initial e-mail invitation was circulated, followed by 2 short reminder e-mails at 1-week intervals. Approval for the study was received from the UBC Behavioural Research Ethics Board.

Results were collaboratively reviewed by study team members. Responses to questions were described using summary statistics. Percentages were calculated for each question based on the number of respondents

for individual questions. Although designed primarily as a quantitative descriptive survey, 62% of respondents provided detailed written comments when asked to “explain the rationale for your choice.” The comments were analyzed using content analysis, a widely used qualitative method, to provide further insight into survey responses.¹⁷ Comments were read independently by each author and relevant statements were collectively extracted, parsed into clusters of meaning, and summarized into broad themes, using direct quotes as data. Initial summaries were circulated to all authors for corroboration.¹⁷

RESULTS

Respondent characteristics

There were 133 surveys completed, resulting in a response rate of 31%. Eighty-two respondents (62%) provided detailed written comments.

Most survey respondents were women (65%) and younger than 35 years of age (67%). Compared with a similar subset of National Physician Survey respondents (BC family physicians who graduated between 2000 and 2009), the current survey respondents were younger overall, and a greater proportion were locum physicians, women, and working in rural settings.

Most respondents were working as locum physicians (n=82, 69%); 39% (n=47) reported having their own practices. Forty-eight percent (n=57) worked in rural settings and 60% (n=72) in urban settings, with some physicians working in both urban and rural settings. Twenty-four respondents volunteered descriptions of their practice type, which represented a full scope consistent with family medicine.

Most respondents were primarily exposed to FFS practices during both residency and locum work. Exposure to both the enhanced FFS and the alternate payment or non-FFS remuneration models was higher after graduation from residency (Table 1).

Payment and working environment preferences

When respondents were asked, “Is the payment model an important factor for you in your choice of future practice?” 86% rated the payment model as very or somewhat important, 9% as neutral, and 5% as somewhat unimportant (Table 2).

When we asked respondents, “What payment model would you prefer?” 71% (n=93) preferred non-FFS (alternative payment) remuneration, including salaried, capitation, or blended models (Table 2). Thirty-two percent (n=42) of survey respondents identified enhanced FFS (including new fee initiatives and incentives) as a preferred remuneration model, with some overlap between the 2 groups (5%; n=7). Three percent (n=4)

Table 1. Current practice and remuneration exposure of respondents

CURRENT PRACTICE AND REMUNERATION EXPOSURE	RESPONDENTS (N = 133*), N (%)
Current practice of respondents, [†] N = 119	
• Locum	82 (69)
• Own practice	47 (39)
• Enrolled in third-year residency program	9 (8)
• Other	24 (20)
Remuneration exposure as locum, [†] N = 129	
• Fee-for-service	106 (82)
• Enhanced fee-for-service	50 (39)
• Alternative model	73 (57)
• Not applicable	14 (11)
Remuneration exposure in residency, [†] N = 129	
• Fee-for-service	61 (47)
• Enhanced fee-for-service	11 (9)
• Alternative model	21 (16)
• Both	48 (37)

*Total unique survey respondents.

[†]Total respondents for each question was used to calculate percentages. Respondents could select more than 1 answer.

Table 2. Importance and preferences of physician payment options

SATISFACTION AND PREFERENCES	RESPONDENTS (N = 133*), N (%)
Importance of payment model in future practice, [†] N = 128	
• Important	110 (86)
• Neutral	12 (9)
• Not important	6 (5)
Preferred payment model, [†] N = 132	
• Fee-for-service	10 (8)
• Enhanced fee-for-service	42 (32)
• Alternative model	93 (71)
Satisfaction with available payment options, [†] N = 132	
• Satisfied	66 (50)
• Neither satisfied nor dissatisfied	15 (11)
• Dissatisfied	51 (39)
• Not applicable	2 (1)
Preferred practice environment, [†] N = 129	
• Group	89 (69)
• Interdisciplinary	68 (53)
• Solo	4 (3)
• Other	13 (10)

*Total unique survey respondents.

[†]Total respondents for each question was used to calculate percentages. Respondents could select more than 1 answer.

identified FFS as their only preferred remuneration model (Table 2).

Nearly all respondents who offered qualitative comments explained the rationale for their choice of preferred payment model (n=75, 57%). Of these comments, 6 were in support of FFS remuneration, and 69 were in support of alternative remuneration models. Most respondents in all groups (urban, rural, own practice, locums, male, and female) preferred non-FFS remuneration.

Respondents were also asked to do the following: "Rate your current satisfaction with available options for being paid as a family physician." Respondents were fairly evenly divided in their satisfaction with available payment options: 39% (n=51) were somewhat to very dissatisfied, 11% (n=15) were neither satisfied nor dissatisfied, and 50% (n=66) were somewhat to very satisfied with available payment options (Table 2).

When respondents were asked, "What kind of practice environment would you prefer?" most (69%, n=89) preferred a group practice and more than half (53%; n=68) preferred interdisciplinary practice models (Table 2).

Content analysis of written comments

Key findings from the content analysis of respondents' written comments comprised 3 main themes: frustrations with FFS billing, quality of patient care, and freedom to choose. Here we present sample quotations, which represent the themes, from respondents.

Frustrations with FFS billing. This theme encompasses all issues related to aggravations with "the business side of things," which were seen as impeding "the freedom to focus on medicine."

Some people play the game better than others, so if you're ... money-focused, you make more money than other people doing the exact same job.

I am exceedingly frustrated with MSP [the Medical Services Plan] and the amount of billings that get held back. I know how much I bill, but I have no idea how much I will get paid.

Nevertheless, there was also the opinion that the FFS model can serve as a motivation to work. One respondent explained: "I like knowing that when I work hard and efficiently I am rewarded for it. I prefer the FFS model, as it seems to work best for me."

In locums thus far, I have billed an average of \$1100/d FFS as opposed to receiving \$800/d in sessional fees. Thus, as a new graduate with significant debt, there is a strong incentive to practise FFS, even though this leaves me feeling frantic, and with 4-6 hours of leftover charting and paperwork to do by the end of a typical 35-40 patient day.

In contrast, one respondent described less frustration in a non-FFS model: "I have enjoyed an extremely positive experience in a salaried locum, with less time stress and an ability to deal with medically complicated patients in a comprehensive way."

Quality of patient care. This theme developed from respondents describing the importance of a payment model that supported "comprehensive patient care" and "quality rather than quantity."

Right now it pays to see as many people as possible regardless of the quality of care given. It literally pays to practise poor medicine.

I would like to remove the pressure of having to see a patient every 5-7 minutes to enhance quality and thoroughness of the clinical encounter [I]t's very rewarding to identify a serious and complex issue in someone presenting with a seemingly simple problem; this is the art and beauty of medicine.

I have worked as a locum in a variety of family practice and walk-in settings and, now, as a permanent family doctor in a rural full-service family practice. I was always amazed to find that doctors who saw less complicated patients, spent less time with patients, and who discouraged consistent follow-up actually made the most money (ie, easy patients = more patients/day = more \$\$). On the other hand, physicians who had complex patient loads emphasizing comprehensive care and continuity often billed far less, as they simply didn't have the time to see the same volume of patients. The usual FFS model encouraged high volume, low accountability practice (ie, bad medicine).

I am a new graduate in family medicine and, as such, I have been taught in the new culture of improved patient-centred communication. This means I will take longer per patient than a graduate from past years—with a large body of evidence supporting the fact that these patient-doctor interactions have potential to have larger positive impact—and I thus require an innovative way of receiving remuneration for my work. Family medicine in modern times requires alternative models of funding.

Freedom to choose. This theme supports the plurality of practice preferences among providers who strive to provide quality care for patients, "whatever model you happen to be working in."

I would like to do more chronic pain but it doesn't pay.

I have worked in essentially all 3 models. I think it's important to be able to work within a system that acknowledges the inherent practice preferences of all doctors—and all of us simply do not work the same.

I wish that the province would throw out the traditional FFS model and introduce a whole new system of innovative funding models that will give us like-minded new family physicians much more choice and freedom in choosing our place for clinical practice. Should the province do this, one would certainly see a lot more new graduates move into setting up a practice, rather than remaining in the locum pool. As it stands now in the FFS climate, setting up a practice and being tied to the clock is an onerous and very unattractive option for most of us new family physicians. I never wish to put up a sign on my clinic door saying "one complaint per visit, please." Fee-for-service must go.

DISCUSSION

This survey of new UBC family medicine graduates found that most respondents preferred non-FFS remuneration. These results are consistent with the 2007 National Physician Survey, in which 21% of BC family physicians preferred FFS only and 52% preferred blended payment remuneration for their work.³

The research evidence for one form of payment over another in relation to quality of care is weak and inconclusive.^{6,18} However, there is evidence that work satisfaction among general practitioners is positively associated with quality of care.^{19,20} In this survey, the importance of the remuneration model and the ability to choose the type of practice and payment model in which to work emerged as an important theme. Such choice would likely be one element of work satisfaction. Although the perception of FFS remuneration being associated with lower quality of care emerged as a theme, this was likely reflective of the experiences of young physicians "taught in the new culture of improved patient-centred communication" rather than of an existing evidence base.

In both residency and locum work, most respondents primarily worked in FFS clinics. This, according to the Negotiations Analyst of the BC Medical Association (T. Keefe, oral communication, June 2010), is in keeping with the current climate of practice in BC, where an estimate of only 2.5% of all family physicians provide longitudinal primary care in non-FFS settings. However, exposure to non-FFS practices increased substantially after residency (57% vs 37%) despite few non-FFS practice opportunities in the province, suggesting that recent graduates were seeking practice opportunities in alternately funded settings.

Most survey respondents (69%) were working as locums, compared with only 23% of BC primary care physicians overall. According to the Postgraduate Program Director in the Department of Family Practice at

UBC (Dr J. Kernahan, e-mail communication, September 2010), this is likely an accurate representation of recent residency graduates, many of whom practise as locum physicians in their first years in practice. The locum physician's freedom to choose practice type (including the non-FFS Rural Locum Program) might in part explain why 50% of respondents were somewhat to very satisfied with available payment options despite the lack of non-FFS practice opportunities. However, the qualitative comments highlight an important limitation to this question, which might have been misinterpreted by some respondents as assessing satisfaction with *amount* rather than *model* of payment.

The survey also found that most respondents favoured interdisciplinary group practices. This is particularly important owing to the relatively strong evidence for the association of this component of primary care reform with improved quality of care.⁶ Although group practice is becoming more common in the province, interdisciplinary practice opportunities remain sparse and tend to be restricted to non-FFS settings, which facilitate collaborative practice.¹³ This finding is echoed by several of the qualitative comments that revealed a desire for interdisciplinary practice opportunities, but a lack of support for establishing or working in such environments.

Primary care reform has, thus far, been restricted to enhanced FFS in BC, where currently only 125 of the 5000 physicians in the province are providing longitudinal primary care in non-FFS settings. Given the results of this survey, there appears to be some misalignment of policy in addressing the needs of a substantial proportion, however few, of newly practising family physicians who prefer non-FFS remuneration. Greater choice of payment model is a policy option that might begin to address the apparent preferences of this group. The survey showed that 81% of respondents reported that payment models were important to their choice of future practice, which suggests that policy makers need to address not only the amount paid to family physicians, but also *how* they are paid. Further study could explore specific preferences for interprofessional working environments, as well as the perceived connection between remuneration type, quality of patient care, and best models to meet both physician and patient needs.

Limitations

This study has several limitations. First, although comparable to similar surveys of family physicians, the response rate was low.²¹ Despite numerous strategies to increase response rates identified in several systematic reviews,²²⁻²⁴ there has been a steady downward trend in clinicians' response rates to surveys.²⁵ Second, it is possible that survey respondents were disaffected with FFS remuneration compared with nonrespondents, thereby

introducing responder bias. Third, questions were not formally validated before implementation. A final limitation is that the initial study design did not encompass qualitative methods. However, the richness of comments offered by the respondents offered insight in the interpretation of the survey results, thereby warranting inclusion.

Despite these limitations, this survey demonstrates a considerable preference for alternative, non-FFS remuneration by almost 100 young family physicians (N=93; 71% of respondents) regardless of what proportion of the total this number represents. Furthermore, the study adds rich descriptive data to our understanding of the practice and payment preferences of newly practising family physicians in BC.

Conclusion

This survey found that the preference of newly practising family physicians in BC was for alternative remuneration models, which were perceived as contributing to fewer frustrations with billing systems, improved quality of work life, and better quality of patient care.

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Contributors

All authors contributed to the concept and design of the study; data gathering, analysis, and interpretation; and preparing the manuscript for submission.

Competing interests

None declared

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