Alberta Doctors' Digest

Seeing the Primary Care Physician Compensation Model put into practice

On April 17, 2024, then AMA President Paul Parks stood with Minister of Health Adriana LaGrange, to introduce a new physician compensation model framework intended to stabilize and strengthen family and rural community practices. The new model represented months of relentless work by the AMA Strike Team, which included primary care physician leaders and AMA staff, and aimed to make Alberta competitive with neighbouring provinces.

Almost exactly a year later, on April 1, 2025, the Primary Care Physician Compensation Model (PCPCM) went live with its first cohort of physicians. Dr. Lisa Stevenson, a family doctor at the Richmond Square Medical Clinic, was one of those physicians and, after the first few months, has found it to be a game-changer.

“I have a very traditional practice,” notes Dr. Stevenson, who has been a family doctor for 33 years. “I work four days a week, I have a panel of 900+ patients that includes everyone from babies to 90-year-olds. I don't do hospital work, and I don't deliver babies. I'm an urban, office-based fee-for-service physician, and a percentage of my billings goes to overhead payment for the clinic. It’s the way I’ve always worked.” Her clinic includes 12 other family doctors who all maintain individual practices. “We take care of our own patients on our own panels. We don't share an inbox and anything relating to our patient panel, we take care of ourselves, and that includes dealing with issues during evenings, weekends and holidays.”

The problem with that model, she explains, is that it is exhausting, and a lot of work is done for free. “I’ve been doing this for 33 years, and until this new model, I have worked every day, even on days that I’m not in the clinic. That includes weekends and vacations, because even when I’m on vacation, or not in the clinic, I am still taking care of my panel of patients.” And as those patients got older and became more complex, “my inbox became completely unmanageable. It took longer and longer each day, and all of this was unpaid work.”

Like many family physicians, even as the work took its toll, Dr. Stevenson was hesitant to limit her work. “I did it because it's the right thing to do and because we want to provide the best possible care for our patients, but when you think of it, it’s kind of crazy that we did it for free for so long.”

When the provincial government made changes to select family medicine billing codes just before the pandemic, it added insult to injury. “The big thing it did to family doctors was make us feel that all this hard work was not valued. We knew our patients valued us, but we felt very unvalued by government and that made it even more difficult to do the work we had to do. It was really crushing for a lot of us.”

She recalls that some colleagues folded and decided they were done. “There were many that said, ‘that’s it, I’m retiring’ or ‘I’m going to change my practice so I am not carrying this panel of patients around.’ A lot of people decided they just couldn’t do it anymore.”

The PCPCM offered a promise of change

While Dr. Stevenson continued to offer longitudinal family care, she was growing increasingly weary. When she heard the AMA was working to develop a new funding model that would provide an alternative to the traditional fee-for-service model, she was intrigued, but cautious. “After going so long with feeling undervalued and unappreciated, this new model seemed to offer some hope for tangible change. I’d heard about British Columbia’s new model and the impact it had on family physician compensation and thought it was promising.”

That optimism was tempered by the delays in seeing the PCPCM rolled out. Government had initially indicated the PCPCM would launch in the fall of 2024, but there were several delays as government worked through various processes. “It kept getting delayed and delayed,” recalls Dr. Stevenson. “And it just felt like government once again wasn’t prioritizing primary care. It seemed like it was never going to happen. I know of many practices that closed while waiting for changes that just never seemed to come.”

On December 19, 2024, the Government of Alberta and the AMA jointly announced that enrolment in the PCPCM would begin in January 2025 and the model would go live as of April 1, 2025. During the press conference, AMA President Dr. Shelley Duggan joined Premier Danielle Smith and Health Minister Adriana LaGrange in announcing a model that the accompanying press release promised would “make Alberta’s family doctors the strongest-paid and most patient-focused in the country.”

I remember thinking, “great, we’ve finally got it,” says Dr. Stevenson. She immediately began exploring the AMA’s various PCPCM resources, which include an Operations Manual, an FAQ document and a financial calculator that helps physicians estimate potential earnings under the PCPCM.

“I ran the numbers for my practice a few different ways, and I knew immediately that it would make a difference,” recalls Dr. Stevenson. She made the decision to submit her expression of interest (EOI) form on the AMA member dashboard, which is the first step in the application process. Once it was determined that she met the eligibility criteria, she received a personalized PCPCM application form and a copy of the Ministerial Order. “It wasn’t the easiest process, but it was worth the effort.”

Already having an impact

Dr. Stevenson officially joined the model when it went live on April 1, and so far has found the PCPCM delivers exactly what was promised. “It’s resulted in an increase in my payments, in large part because we now get compensated for indirect patient care, which we were doing previously without compensation. There’s so much indirect care that we have done for years without being remunerated, and that it made us practice in a way that wasn’t always ideal. There may have been times when we didn’t need to see a patient in person, but the only way to get paid properly was for an in-person appointment. Now it's possible to do a lot of care virtually to complement our in-person care, and the patients love it. The PCPCM hasn’t changed how I care for patients, but it makes it possible to be paid appropriately for more effective and efficient care. I don't have to worry about recording minute-by-minute in-person encounters anymore.

While the increase in compensation is welcome, she stresses that's not the biggest benefit of the PCPCM. "It's really about the fact that we feel valued. I finally feel like my time matters and that the work I do is seen and recognized for its value."

Still room for improvement

Dr. Stevenson is quick to note that there are shortcomings with the model, including the fact that the minimum 500-patient panel requirement excludes physicians with smaller, often complex panels. "It seems a bit shortsighted, because the needs of some patients really necessitate physicians to maintain smaller panels."

Dr. Steveson explains that she has a colleague who sees a very complex population of diabetic patients. "She's got a panel of just under 500 people, and she's 65 and she didn't want to take on another 50 patients, because she simply can't work harder than she already is. And so she couldn't join the model. That type of person is giving an amazing service to a huge number of complicated patients, and we'll lose her because this model doesn't accommodate her."

There has also been feedback that there needs to be other improvements to the PCPCM, including an improved mechanism for panel conflicts, better panel complexity rates, and expansion to other types of practices – such as pediatrics. The model also needs to adapt to work better for rural physicians, and work is underway to address those issues. It also provides no funding for team-based care which would help family physicians take care of more patients.

"There are definitely things the PCPCM could do better, and hopefully that will come."

Words of advice

As of mid-June, approximately 42% of eligible Alberta physicians have enrolled in the model – a number Dr. Stevenson thinks will grow as time goes on. "I hear from some people that they're not sure if the PCPCM is right for them, and there's still some mistrust of this government and what their intent is, but I tell them all the same thing – this is a good plan and if you have the right panel numbers, and you fulfil the practice criteria, you have nothing to lose and everything to gain. If you don't like it, you can go back to FFS, but I doubt you will. I tell them to take the plunge with me – you won't regret it."

While there are areas for improvement, Dr. Stevenson notes that there's no reason not to give it a try. "It will make a measurable difference." It has already changed her plans for the future.

"Before the PCPCM, I was seriously thinking that I didn't know if I wanted to keep practicing. Now I'm able to plan to be around for my patients for many more years to come."