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Exploring options for physician payment in Canada?

Pierre Thomas Léger, Ph.D.
HEC Montréal
CIRANO, CIRPÉE, CEPREMAP

Susan Fitzpatrick, ADM
Negotiations and Accountability Management Division
Ontario Ministry of Health and Long-Term Care
Introduction

• Lots of empirical evidence shows that:
  1. The fee-for-service system leads to excessive/inefficient care (see report).
  2. Physicians respond to financial incentives when making treatment decisions (see report).
• Not surprising as the FFS system rewards one thing and one thing alone: volume!
• Need to consider other forms of payment that will make physicians consider not only the benefits of treatment but also their costs.
Alternatives to FFS

- I will only consider systems which are income-neutral and thus can be on a purely voluntary basis → not about reducing income but rather altering how we pay it!

- Let's consider one such alternative, the mixed-payment system, where:
  1. A fixed up-front payment (exactly like a capitation payment) per patient enlisted.
  2. A marginal reimbursement (like a fee-for-service payment) which is equal or less than the marginal cost.
Mixed-Payment Systems:

• Let's examine one (of several) reasons why this might work!
• Consider an altruistic physician who is paid FFS who provides care to fully insured patients (like in Canada!).
• Physicians will want to provide lots of volume: doing so provides more income (FFS) & doing so makes the patient happy (altruism)!
• However, someone (i.e., the government) has to pay for this care (some of which is excessive).
• Want something to limit this excessive amount of provision associated with FFS, the presence of altruism and the presence of insurance.
Mixed-Payment Systems

• If we pay physicians a FFS rate which is less than its marginal cost:
  1. The physician will want to limit care (because each unit is provided at a loss).
  2. But not too much because he/she cares about the patient (altruistic).
• Reduction of excessive care (good thing) but physicians make negative income → not feasible.
• Solution: Can provide an up-front payment (like a capitation payment) per patient to cover these losses and provide net income!
• Modify the FFS and up-front components to get to the "right" amount of care.
Gainsharing

• Hospitals are paid independently from physicians.
• Hospitals (through global budgets, DRG...) must pay for all the non-physician-services costs.
• Even though hospitals pay for these non-physician-services, their use is often dictated by the physicians.
• This is especially true in specialties like orthopedics and cardiology where physicians have preferences over different devices.
• In areas like cardiology, drugs and devices (D&D) account for almost all of the rise in the cost per patient (i.e., not labour costs...) → big deal.
Gainsharing

- Hospitals buy D&Ds directly from vendors and bargain over prices.
- The contracts include quantity rebates (the more the hospital buys from one vendor, the less is the per-unit price).
- If physicians coordinate and standardize on particular D&Ds → get rebates → lower expenditures per-patient!
- So the costs of care depends on the collective actions of physicians (not just the sum of their independent actions).
- However, the hospital can't force the hand of physicians to do so.
Gainsharing

- Many hospitals (through special permission from the authorities) have participated in a pilot project of gainsharing.
- In gainsharing, physicians share in the savings on D&Ds and these are calculated based on the team's performance (group incentive).
- Gainsharing is a way to encourage standardization and thus face lower prices for D&Ds (because of rebates).
- Empirical evidence from KLL(2011) shows that (i) gainsharing leads to lower costs on D&Ds at the hospital level & (ii) these come mostly from lower prices per D&D (bargaining and rebates)!!!
PHYSICIAN PAYMENTS: THE ONTARIO EXPERIENCE

Susan Fitzpatrick, ADM
Negotiations and Accountability Management Division
Ontario Ministry of Health and Long-Term Care
OHIP PAYMENTS TO PHYSICIANS, 2000-2010

• Payments to physicians experienced a growth on average 7% annually for the last 10 years:
  • FFS payments – 4% annually and non-FFS payments – 22% annually
  • Non-FFS payments comprised only 9% of total payments to physicians in 2000/01 and 29% in 2009/10
  • Further analysis is concentrated on FFS professional payments as the main source of income for majority of physicians with data readily available for analysis

Source: Public Accounts
Note: FFS payments reported above include Technical Fees
DISTRIBUTION OF GPs and SPECIALISTS BY FFS INCOME IN 2009/10

- The total number of physicians with FFS income is 24,254 (11,549 GPs and 12,705 Specialists)
- The number of physicians with FFS income greater than $750,000 – 1,009 (92 GPs and 917 specialists)

Source: Claims History Database
3 specialties with the highest FFS payments per physician are: Ophthalmology, Diagnostic Radiology, and Thoracic Surgery with their practice overhead cost of 40%, 26%, and 28% respectively**
Practice type of the high earners usually falls under one or a few of the following categories: very specialized practice, high volume practice and/or practice related to one the Ontario’s Government priority areas (Wait Times, Chronic Disease Management, Diabetes, Mental Health). The physicians earning more than $750,000 are receiving most of their income from one or a few types of services listed below for each specialty.

<table>
<thead>
<tr>
<th>Practice Type</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Radiology</td>
<td>MRI, CT Scan, X-ray, ultrasound, consultation/assessment</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Hemodialysis, peritoneal dialysis, echocardiography, ECG, gastroscopy, colonoscopy, critical intensive care, sleep study, nerve blocks, consultation/assessment</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>Cataract surgery, photocoagulation, ophthalmic echography, laser iridotomy, and vitreous injection or aspiration, consultation/assessment</td>
</tr>
<tr>
<td>General Practice</td>
<td>Nerve blocks, addiction treatment, sleep study, hyperbaric therapy, abortion, ultrasound, assessment.</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>Prenatal care, delivery, postnatal care, IVF treatments, fertility tests, hysterectomy, ultrasound, consultation/assessment</td>
</tr>
<tr>
<td>General Surgery</td>
<td>Gastroscopy, colonoscopy, colecystomy, other surgical procedures, ultrasound, consultation/assessment</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Gastroscopy, colonoscopy, colecystectomy, ultrasound, consultation/assessment</td>
</tr>
<tr>
<td>Others</td>
<td>Nerve blocks, sleep studies, neurosurgeries, joint surgeries, cardiovascular surgeries, ultrasound, dialysis, consultation/assessment</td>
</tr>
</tbody>
</table>
The academic and non-academic alternative funding plans amounted to over 300 agreements payments of over $1 billion in 2009/10
Ontario’s Primary Health Care Models

The implementation of Family Health Teams (FHTs) is the central transformation strategy through which the government is providing more Ontarians with access to primary health care.

Improved Patient Outcomes:
- Chronic Disease Management Programs
- Health Promotion
- Disease Prevention
Monthly Physician Counts By Payment Model
Total Signed Physicians 7,575

*PCN and HSO amalgamated to the FHO model effective Nov 1, 2006.
*Information based on PHC Monthly Status Reports
PRIMARY CARE: AVERAGE PAYMENTS PER FTE* BY PAYMENT MODEL IN 2008/09

- Top 3 models with the highest average per FTE in 2008/09: FHO - $407K, GHC –$385K, FHG - $379K.
- Average payments per Fee-For-Service FTE** - $261K in 2008/09 based on 1,576 identified FTEs.
- In 2009/10 payments to General Practice from all sources increased by 9.5% and only 6.6% per GP physician due to increase in the total number of GPs.

Source: D’Amore. “Primary Care Mode Comparison of Payments, FY2008”. July 16, 2010
Note: *For the purpose of this analysis: 1 FTE in Primary Care setting is defined as a physician with at least 800 enrolled patients, at least $100,000 earnings from FFS and/or Primary Care, and at least 12 months affiliation with the same model. **1 FTE in FFS setting is a physician with at least $100,000 earnings from FFS program who billed any codes from the list of GP comprehensive care codes.
For FHG, CCM and “No Model” the largest percentage of earnings is derived from FFS billings.

*Note: Data on BSM exist from 2007 onwards when the model came into existence; for 2005 the FHO model is made up of PCN and HSO data as these models amalgamated into the FHO model effective Nov 1, 2006.

Note: “No Model”: There are primary health care physicians who are practicing outside the models and compensated mainly through fee for service plus some incentives and bonuses for primary care services.

*Note: Data on BSM exist from 2007 onwards when the model came into existence; for 2005 the FHO model is made up of PCN and HSO data as these models amalgamated into the FHO model effective Nov 1, 2006.

Source: Architected payments, CPDB, GAPP, KPAS, MPRO.
PRIMARY CARE PHYSICIANS WITH INCOME $\geq$ $750,000$ BY SHARE OF THEIR PRIMARY CARE EARNINGS IN THE TOTAL INCOME

- Majority of FHG physicians received less than 25% of their income from Primary Care and the rest from FFS.
- Majority of FHO physicians receive more than 70% of their income from Primary Care sources and the rest from FFS.

Source: PHCT (estimates)
Note: *Total Income= FFS + Primary Care. Technical fees and Commercial Lab fees excluded.
### PRACTICE OVERHEAD COST (PERCENTAGE OF TOTAL PRACTICE)

<table>
<thead>
<tr>
<th>OHIP SPECIALTY</th>
<th>1997 REVENUE CANADA</th>
<th>2005-07 OHRC PHYSICIAN SURVEY</th>
<th>CANDI/SAM METHODOLOGY*</th>
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<td>02 Dermatology</td>
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<td>03 General Surgery</td>
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<td>04 Neurosurgery</td>
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<td>06 Orthopedic Surgery</td>
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<td>07 Geriatric Medicine</td>
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<td>08 Plastic Surgery</td>
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<td>09 Cardiovascular and Thoracic Surgery</td>
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<td>13 Internal Medicine</td>
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<td>20 Obstetrics and Gynecology</td>
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<td>23 Ophthalmology</td>
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<td>31 Physical Medicine</td>
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<td>33 Diagnostic Radiology</td>
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<td>34 Radiation Oncology</td>
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<td>41 Gastroenterology</td>
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<td>47 Respiriology</td>
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<td>63 Nuclear Medicine</td>
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<td>14</td>
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<tr>
<td>64 General Thoracic surgery</td>
<td>33</td>
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Note: * CANDI/SAM methodology was used to allocate money by specialty in order to implement fee increases due to 2008 PSA Agreement.
How to ask a question...

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