Intelligence MEMOS

From: Åke Blomqvist and Colin Busby

To: Provincial Ministries of Health, The Ontario Medical Association and other Provincial Medical Associations

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Re: Physician Compensation: How We Pay Doctors Matters More Than How Much We Pay Them (Part II)

Binding arbitration can be very costly, which is one reason the Ontario government should not cave in its negotiations with the OMA, as we argued in Part I. However, the more important reason is that binding arbitration would likely put an end to any efforts to revamp the way in which physicians are paid: reforming the antiquated fee for service model of compensating physicians should be at the forefront of negotiations with doctors and payment reform can only happen after extensive negotiations.

The way in which physicians are paid has a major influence on overall health system performance. The incentives physicians face impact treatment decisions, the volume and range of services provided, and the overall value for each dollar spent within the health system. Further, as gatekeepers who use of services other than their own, doctors should have an incentive to be concerned with direct and indirect costs arising from referrals, requests for diagnostic testing, and use of prescription drugs. This is not the case under the current system.

Although we worry that binding arbitration would make it almost impossible for the government to implement payment reforms, so too would an agreement which incorporates a commitment by the government to give the OMA a role of "co-manager."

Alberta has recently experimented with "co-management" via a relatively new physician compensation committee. One of its recent tasks was to consider reduced fees for ophthalmologists and radiologists, which many deemed to be too high because new technology had made some of their procedures easier to perform. Although the committee suggested cutting certain fees in half, most were reduced by around 20 percent, and we have doubts that this committee will be effective more broadly within the system. Our biggest issue with this approach, however, is that it will further entrench the current fee-for-service compensation model as the norm, when fee-for-service might only be the best payment method in certain circumstances.

Payment reforms are some of the most promising approaches to making Canada's healthcare system more efficient, and improving our rankings in the international comparisons that lately have us placed pretty close to the bottom among comparable countries. If a method of paying family doctors, like blended capitation (per-patient payments based mainly on the number and needs of patients under a doctor's care), encourages better use of their time, the Ontario government should move toward applying that method more consistently than it has so far. And why not make family doctors more sensitive to the costs of their referrals and prescriptions by extending capitation payments and including these costs in annual physician budgets?

Further, if integrated funding for hospitals and hospital-based specialists makes more sense than the current model of paying them through separate envelopes, government should adopt this approach even if some specialists are opposed.

In many ways, the biggest shortcoming of the OMA deal was that it was almost entirely about the money: beyond "co-management", which has vague implications, it had little say on important structural issues, like new remuneration models.

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