Physician pay should reflect workloads, say economists

Canada will face a cost crisis unless compensation schemes for physicians are retooled to account for declining workloads, warn health economists.

Doctors have "chosen to have a better lifestyle, and the system in which we work has allowed them to make that choice while still paying them the same or more," says Stephen Birch, a professor at the Centre for Health Economics and Policy Analysis at McMaster University in Hamilton, Ontario. Unchecked, the trend could "threaten the sustainability of a publicly funded system," as government and patients become dissatisfied with the balance of access for dollars spent.

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Doctors work fewer hours today than in the past but are paid the same or more, and that may not be sustainable, warn some health economists.

Birch and others are responding to a recent commentary in the *Huffington Post* by Livio Di Matteo, an economics professor at Lakehead University in Thunder Bay, Ontario, who argues that physicians doing less and costing more "may be seen as a luxury" in an era of tight public budgets. Physician groups, however, disagree that their members are overpaid, and argue that lighter workloads mean healthier doctors, which makes for better patient care.

Payments to physicians have risen over the past decade at rates outstripping inflation. Not adjusting for inflation, physician payments rose 6% in 2010–11, after increases of 9.7% in 2008–09 and 7.9% in 2009–10, according to the Canadian Institute for Health Information. This was preceded by "relatively flat" expenditures in the 1990s, when provinces capped payments and controlled physician supply.

Physician workloads, by contrast, have declined. The 2010 National Physician Survey found that 24.2% of Canadian physicians reduced their work hours during the previous two years (excluding on call) and 37.9% planned further reductions in the near future. (The 2012 edition, the latest published, surveyed only residents and medical students.)

Part of the decline in hours has been attributed to generational differences, as younger and middle-aged physicians typically carry smaller workloads than older doctors did at the same age, Birch says. Paying physicians more for the same services may also incent them to "work less to achieve [their] income expectations."

Others attribute the decline to an increasing proportion of female physicians, whose hours typically go down when they marry. "When male physicians get married, their hours go up or are unaffected," says Arthur Sweetman, Ontario Research Chair in Health Human Resources at McMaster.

Meanwhile, Sweetman and Birch say provinces have been generous in the shift to capitation and salary-based funding schemes, without imposing sufficient strictures on the hours of work provided under those models. If contracts don't specify clinic hours, it shouldn't be surprising that some physicians opt for less demanding schedules, Birch explains.

In theory, patient choice should keep this in check, "so if you don't like the fact that you can't see your doctor on a Wednesday or Friday, you can move to another practice, taking your entire annual budget or capitation fee with you," he says. However, "that check … is lost if physicians are able to close their lists, because I'm not going to leave my family physician if I can't find another one."

Premiums above normal capitation rates to encourage physicians to provide more after-hours care have also been provided "on a reasonably generous basis," says Sweetman, meaning provinces are potentially paying more to maintain the levels of access enjoyed in the past, when doctors carried larger workloads.

However, physician groups argue that the system receives better value from doctors who balance work and home life.

"It's very difficult to argue that being up all night, then working the next morning, leads to good quality care," says Dr. William Cunningham, president of the British Columbia Medical Association. "We're getting better value with people who live the life they're encouraging their patients to live."

Alberta Medical Association President Dr. R. Michael Giuffre says it doesn't follow that physicians who are working less are underworked, or that physicians who are earning more for their time are overpaid. He argues that, from a physician point of view, the compensation increases in recent years are "not out of line," particularly as provinces must compete to attract and retain physicians, and practices face growing overhead costs.

Physician office-staff costs — which account for about 60% of total overhead expenses — have increased 75% since 2003, reports the Ontario Medical Association. Other expenses include occupancy costs, equipment, insurance, utilities, property taxes, and professional fees, licensing and memberships.

However, Sweetman contends that recent wage freezes in Ontario and Alberta indicate "this is clearly some-

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thing where many governments feel they went a step too far."

Physician groups and some economists say that the way to address declining workloads is to train more physicians. Sweetman suggests increasing trainees by about 1% every five or six years to replace the hours lost.

According to Giuffre, increasing the number of family physicians could "dramatically" improve patient satisfaction and reduce unnecessary utilization, as patients with family doctors use 30% fewer services, on average.

However, Steve Buick, director of policy and communications for the Institute of Health Economics in Edmonton, Alberta, said in an email that a "perceived shortage" is why physician compensation "went out of control in the first place."

"We're so anxious to keep all the docs we train and avoid stories about new grads being 'turned away' from the system, that we're distorting it to keep them. We have a lot of surgeons in Alberta who'd love to do more surgery, but we can't afford the OR [operating room] time; we can't cut their pay rates, so we just keep splitting the ORs among more and more guys."

An alternative may be to stretch the current supply further through more team-based care, telemedicine and group visits — initiatives that Cunningham says have helped contain per capita physician spending in BC.

As physicians cost more per service provided, Di Matteo predicts "there will be a greater incentive to find lower-cost substitutes, whether that means more online medicine or nurse practitioners and pharmacists doing more."
— Lauren Vogel, *CMAJ*

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Mount Pleasant Village: planned for public health

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The typical suburb is built for cars. It discourages active forms of transportation, like walking, by making the path meandering and monotonous.

When residents finished moving into the Mount Pleasant Village development in Brampton, Ontario, they joined their new neighbours in one of the first urban communities in Canada designed to improve public health by reducing diabetes and obesity through healthy living.

Physicians continually advise their patients to be more active and manage their weight to prevent the growing problem of chronic obesity-linked conditions, including type 2 diabetes and cardiovascular disease. For many patients, however, being active is difficult because of the way the environments in which they live are built, as Dr. Richard Jackson, a professor at the UCLA's Fielding School of Public Health points out.

"We're giving them advice they can't act on," he says.

In Brampton, a sprawling city west of Toronto that is home to more than 500 000 people, public health officials and city planners recognized that neighbourhoods built more for cars than for people work against public health goals. They were also conscious of their area's specific health challenges.

"Generally, suburban areas have a problem, but we have an even bigger problem here in Brampton because of our tremendous rates of diabetes," says Alex Taranu, Brampton's manager of architectural design services.

In Ontario's Peel Region, where Brampton is situated, 1 in 10 adults has diabetes, and 47% of residents were overweight or obese as of 2005. This is a higher prevalence of diabetes than the national estimate by Statistics Canada, which found that 6.5% of Canadians over age 12 had diabetes and 52.5% of Canadians were overweight or obese in 2012. Many of Brampton's residents commute by car or train to Toronto, and the city is not particularly pedestrian- or cyclist-friendly.

In 2009, Peel Public Health commissioned guidelines for building healthy neighbourhoods from Toronto's St. Michael's Hospital. The hospital produced a report called the *Peel Healthy Development Index*. The index provides specific recommendations to lay foundations for communities that give people a better chance to live actively.

Planners designed Mount Pleasant Village specifically around the *Healthy Development Index*'s recommendations. Taranu describes the community as an "urban transit village," because at the core of the community is a public transit hub where Peel Region bus lines and a commuter train intersect. Residences, schools, services and transit are all within a five-minute walk of each other.

The *Healthy Development Index* emphasizes walkability and proximity to services and employment. The index also urges planners to build on a human, not automotive, scale.

Often, developers build serpentine suburbs and big box stores with cars in mind. This can make incorporating active forms of transportation like walking, cycling, or even using public transit, difficult. Many suburbs are imperme-

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