How Should Physicians Be Paid?

Each year in New Brunswick the Department of Health publishes physician payments from Medicare, the responsible thing to do from a public accountability perspective. Physicians constitute a highly respected profession in which the public invests enormous trust in their practice and professional activity. That the majority of their professional billings come from the provincial government through the Medicare Branch suggests that public disclosure is essential. As a principle, all who draw income from the public purse should have their government-paid compensation fully disclosed.

The numbers reported in December 2019 had some unique characteristics because for the first time a family doctor was the leader in Medicare billings, reported at nearly $1.7 million. The public has come to anticipate billings by high-earning specialties in that range, but this was the first time for a family physician. The CBC report went on to note that this was the first year that a female physician led the earnings list.

In previous years, radiologists and other established high-earning specialties topped the list.

Physicians should be compensated fairly and the methods must be seen to be fair and competitive in order to attract and retain great physicians for New Brunswick.

The fee for service method of compensating doctors has been in place in Canada for generations and has been held as protected by the profession for very good reason. In the old days, long before government sponsored Medicare, physicians charged a fee for each service and if patients could not afford to pay, the physician would take what the patient could afford, if anything. There was a lot of free care in those days. Perhaps there would be no money, or payment might take the form of chickens and beef in exchange for medical service. Those were also the days of house calls being part of normal family practice.

In the early days of the fee schedules, it was recognized that in qualifying to practice medicine a physician will undergo a decade of education and training, and those in sub-specialties in the area of 12-14 years. So it was reasoned that physicians should be compensated well as a means of recognizing the many years of training, the cost of education, and the relative scarcity of doctors.

In the intervening years, though, there are many other professions in which professional education requires 8 years or much more, depending on the area of interest. Even properly trained health executives require 8-10 years or more to get to Certification and an additional several years, albeit work and education, to get to Fellowship with their professional College.

Physicians are able to bill at levels reported by Medicare for many reasons. Technology has been a great assist particularly in surgical specialties. In some specialties, procedures that once required hours in the operating room can now be performed in minutes, thus enabling large numbers of cases to be done in the same time slot that once was allocated for one or two cases.

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In Diagnostic Imaging, long gone are the days of film and view boxes, all of which consumed much time for placement, reading, interpretation and transcribing. Digital Imaging has changed the entire method by which this specialty operates to the extent that technically much of the interpretation can be done from the comfort of home with a high resolution lap top.

Some physicians tend to be what is referred to in the profession as “aggressive billers”, meaning that a claim is presented for each procedure and the time of office visits is strictly managed. As with any system in which government funds are dispensed, there are those who are aggressive and those who are conservative in claims. This is not to suggest lack of integrity but simply inconsistency in practice.

There are others who are simply more driven to see large numbers of patients with, perhaps, multiple service sites and a high volume of cases on their practice roster. In the old days, a busy family doctor would have 5-6,000 patients on the practice roster. I am told by my physician friends that family doctors now tend to carry about 2,000 patients on their roster, a reflection of the desire for work/life balance.

Some physicians do not prefer the fee for service system of payment, maintaining that it puts too much pressure on them to produce large numbers when they would prefer to spend more time with individual patients. So the province adopted a Salary System that is available to physicians who wish to function with a totally predictable annual income with fringe benefits and no office overhead to manage. Critics of the salary method of compensation suggest that it does not encourage physicians to see large numbers of patients or to be available in excess of 37.5 hour workweek.

Other jurisdictions have implemented variations on those themes. In Rural Northwestern Ontario, government authorized an Alternate Payment System that seems to have blended the best of the salary and fee for service systems in which physicians enjoy a predictable income but must account for patient volume thresholds.

Capitation is another method of paying physicians in which the doctor is paid a fixed amount of money to manage the health care of a given cohort of patients. With this method, the doctor has every incentive not to over-treat, over-prescribe, or over-use hospital facilities. Every time the doctor prescribes drugs, diagnostics, treatment or admission to hospital the payment comes from the funds entrusted to him or her. There are variations on this theme apparently in other countries.

Group practice, with income and expense sharing, is fairly common and particularly so in major teaching hospital facilities and clinics. In these models, physicians pool their professional incomes; pay all overheads from the pool, then divide up the remainder based on how they have already decided the group should function. For instance, in the group there would be a leader who would receive compensation from the group to account for time invested in managing the group.

There are several models, variations on the theme of fee for service, in which compensation is directly related to productivity. In these models, the group or the employing agency defines what is meant by productivity and compensation is based on that definition.

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In addition to Medicare billings, doctors in NB enjoy other sources of professional income not disclosed to the public. Other sources might include revenue from treating patients who are the responsibility of Worksafe. Some physicians may receive honoraria or contract income from drug companies for providing supervision of clinical trials or other expert advice. Insurance companies represent another source as does billing for services not covered by Medicare such as driver's license physicals, and such.

In teaching centres where doctors are involved either in the classroom, clinical supervision, departmental management or research activities, there are other sources of income. All these other sources may be negligible for some while significant for others.

The bottom line is that since a significant proportion of physician income is generated from the public purse, there is an obligation on the part of physicians for full disclosure and an expectation that government has the right to review and audit based upon sound business principles.

The profession has enjoyed the high respect of the public and all reasonable steps and controls must be maintained in order to continue to maintain that respect.

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January 8, 2020

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