ALBERTA MEDICAL ASSOCIATION

Patients First®

Alberta Physician Expenditures:
Macro and Micro Levels

January 2015

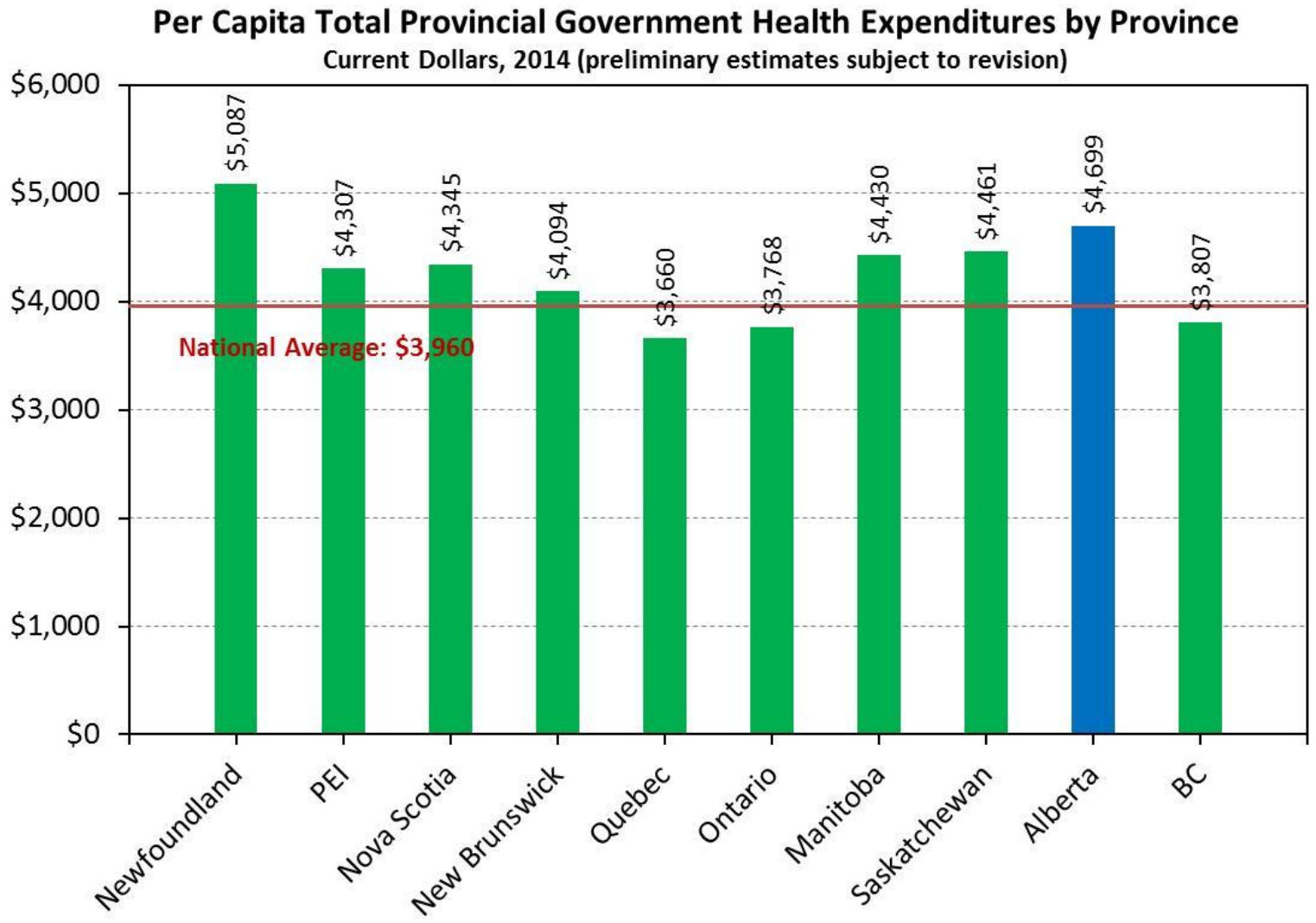
Outline

- Alberta physician expenditure background
- Macro adjustments to physician fees
- Micro adjustments to physician fees
- Improving relative values

Physician Spending: Observations

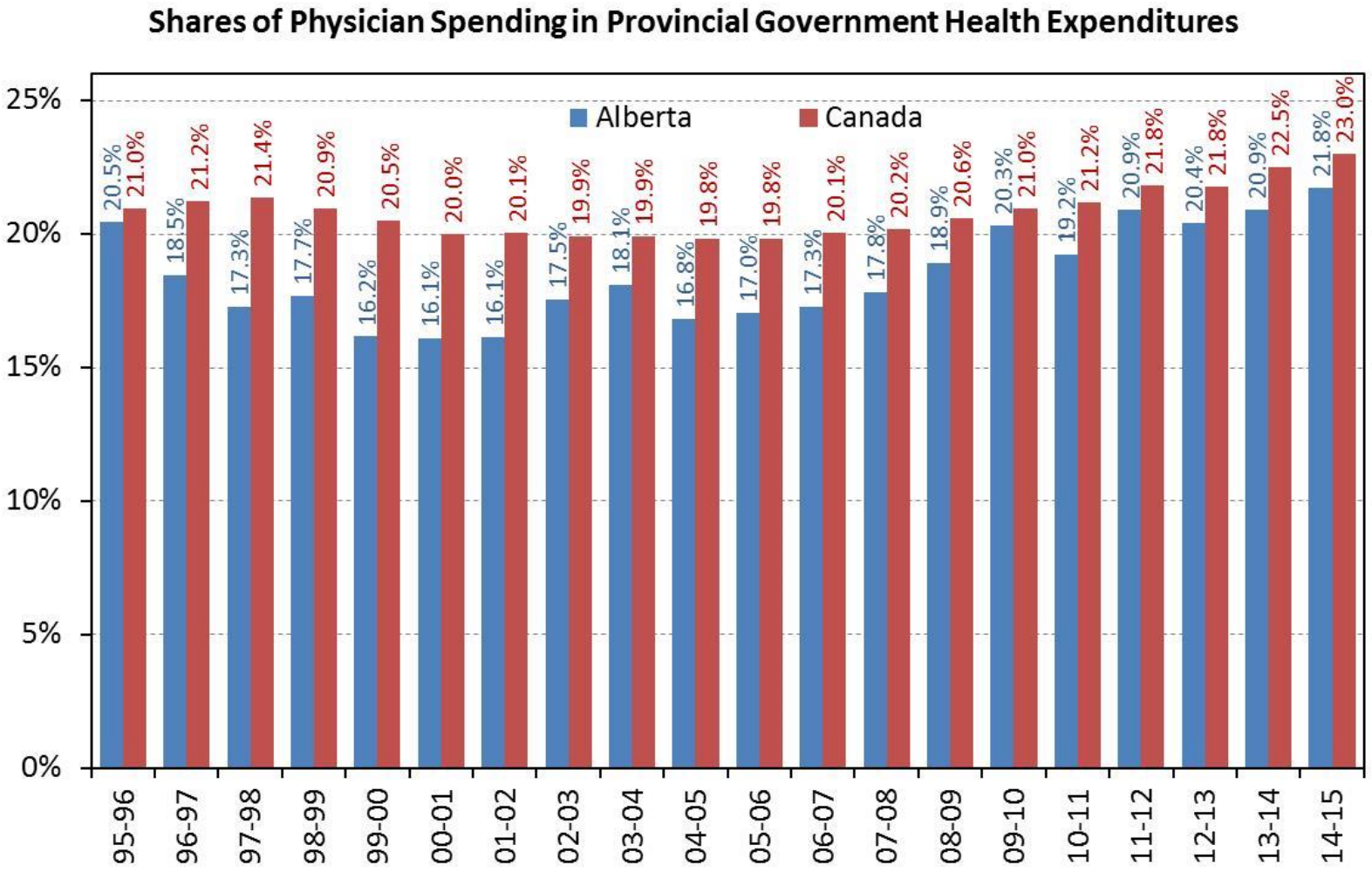
- Multiple measures typically required for understanding
- Difficult to make accurate interprovincial comparisons
  - Alberta has among the highest-health expenditures
  - Alberta has among the highest-physician compensation
  - Key pieces of data missing such as provincial purchasing power, hours worked, population morbidity
  - Comparability of some data not fully transparent (e.g., provincial cost accounting methods)

Health Spending by Province



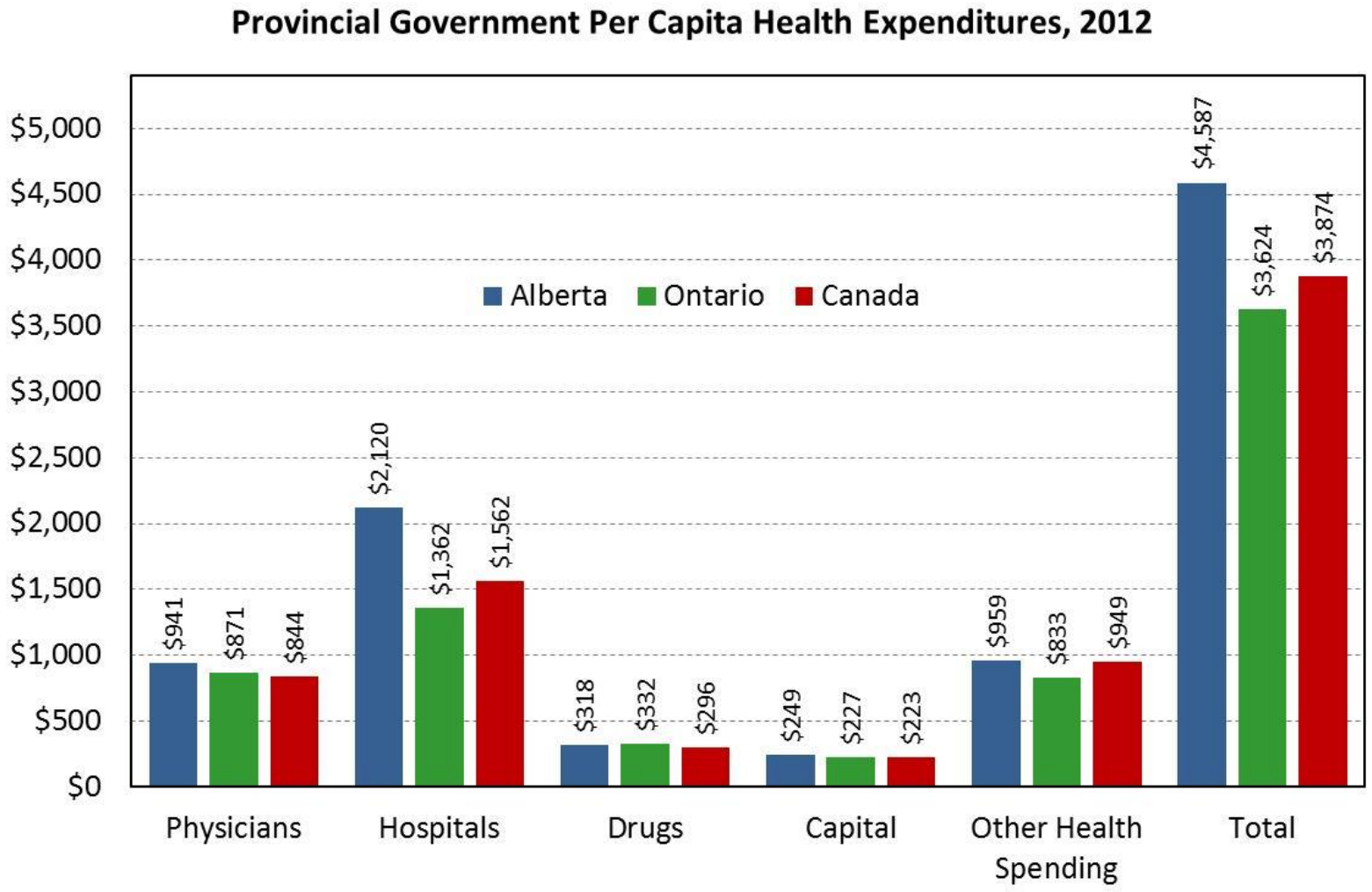
Sources: CIHI National Health Expenditure Trends 2014, AMA

Health Spending: Physician Shares



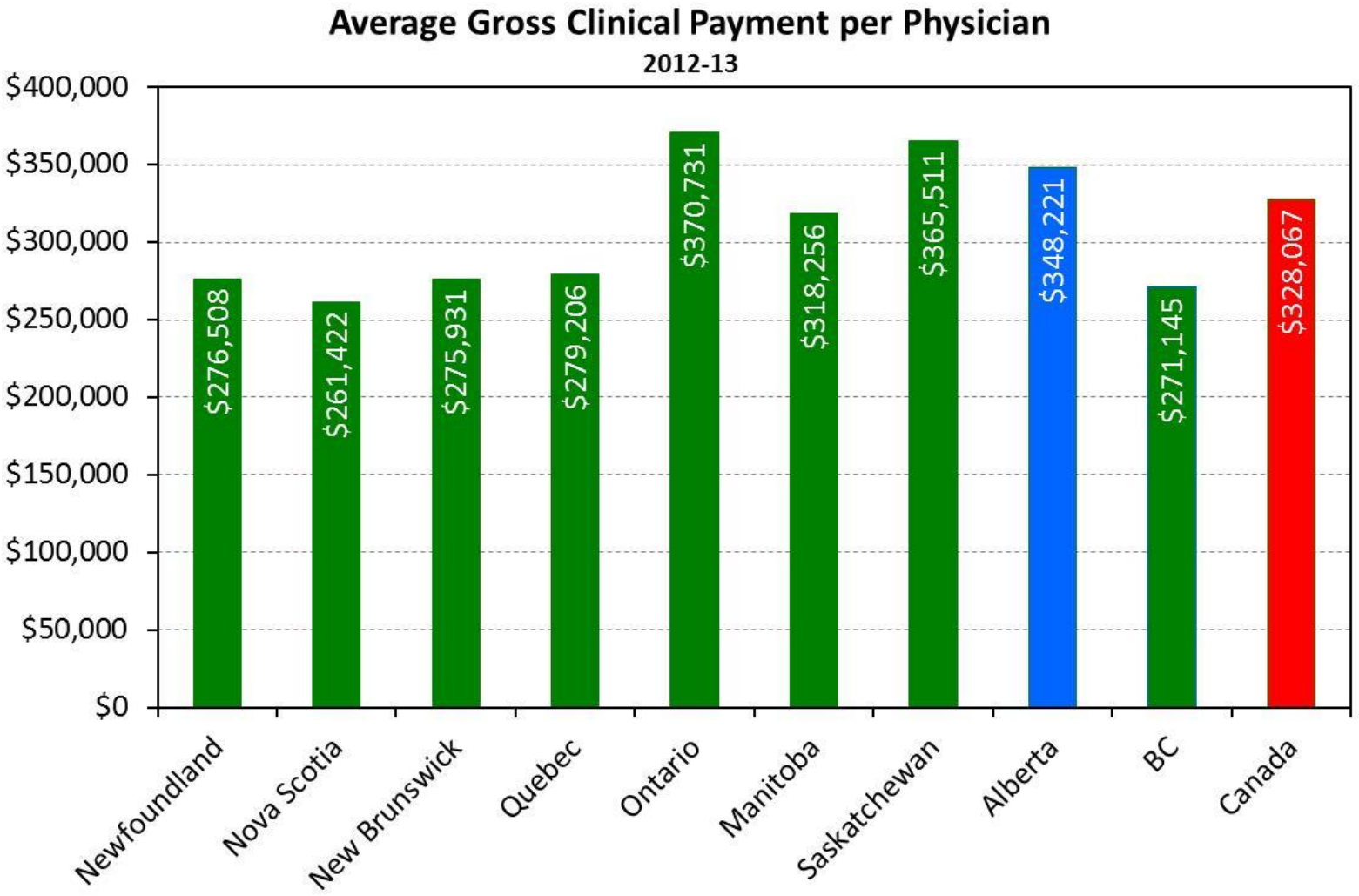
Sources: CIHI National Health Expenditure Trends 2014, AMA
Note: 2013-14 and 2014-15 data are forecast.

Health Spending by Envelope



Sources: CIHI National Health Expenditure Trends 2014, AMA

Physician Spending by Province

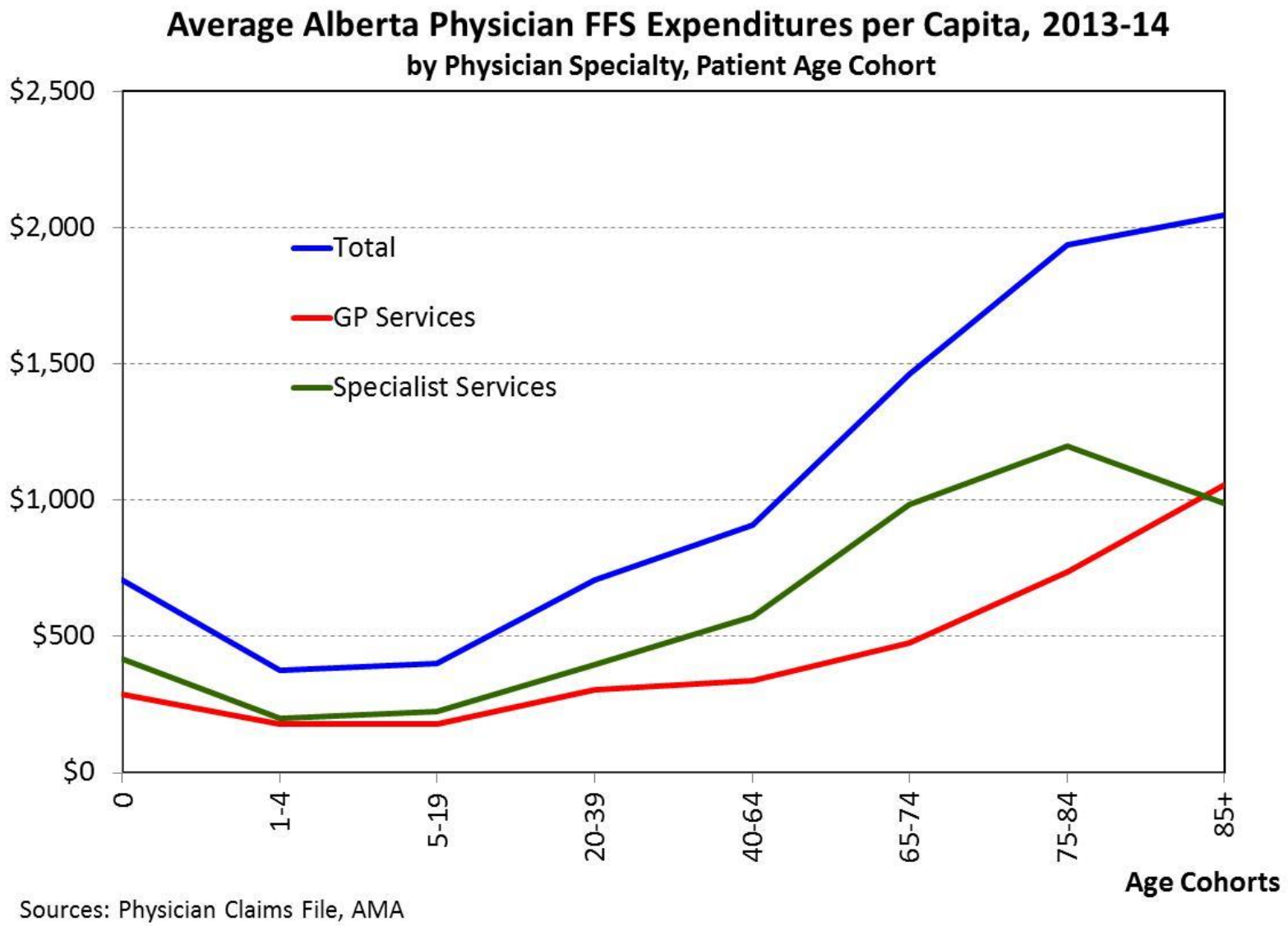


Sources: CIHI National Physician Database 2012-13, AMA

Alberta's Physician Payment Models

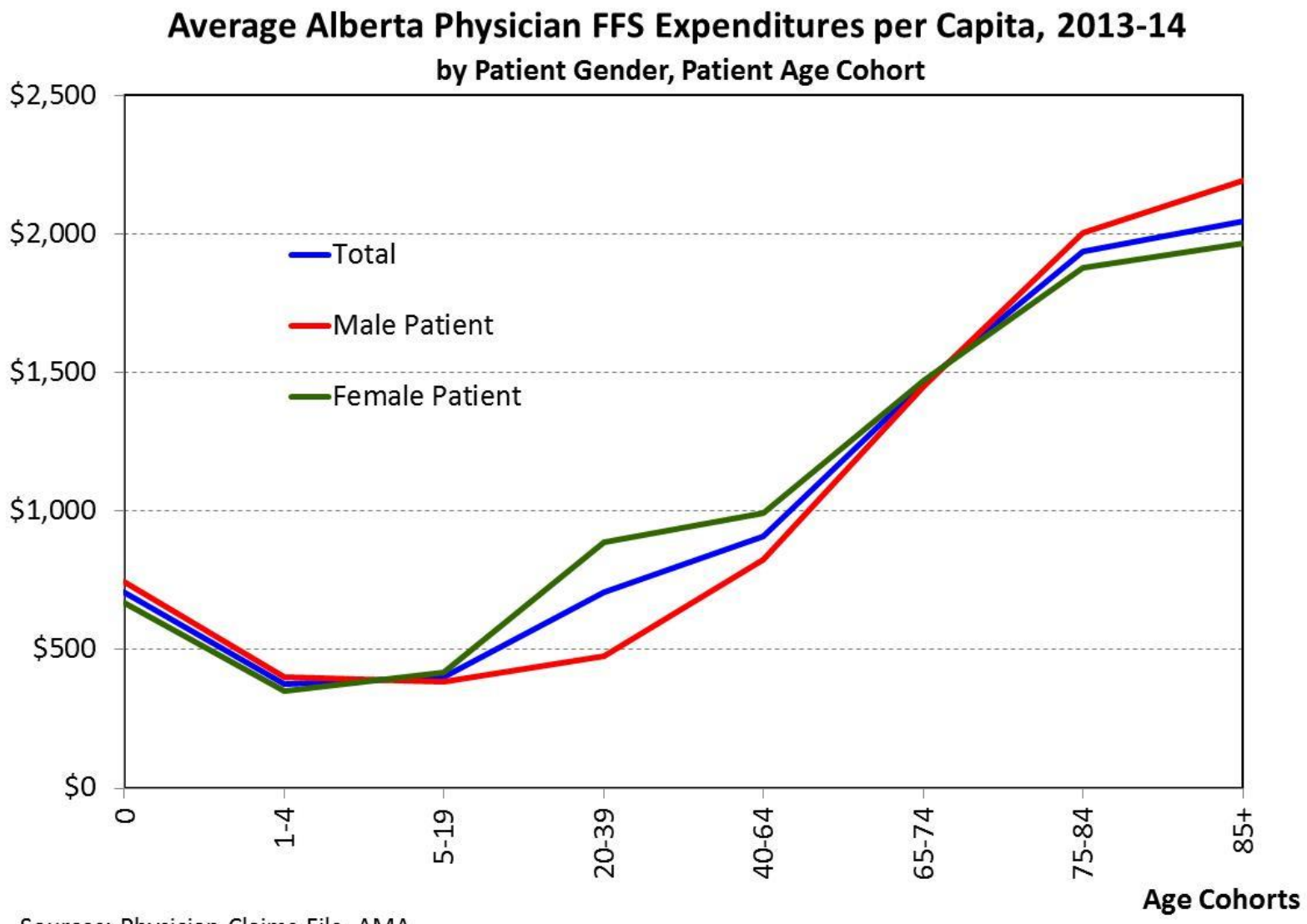
- Fee-for-Service (FFS)
- Alternate Relationship Plans (ARPs)
  - Clinical
  - Academic
  - Sessional rates
- Primary Care Capitation Models
  - Under development
- AHS Salary/Contract Models
  - Limited number (e.g. lab and cancer docs)
  - Outside of allocation

Physician Spending by Age Cohort



Sources: Physician Claims File, AMA

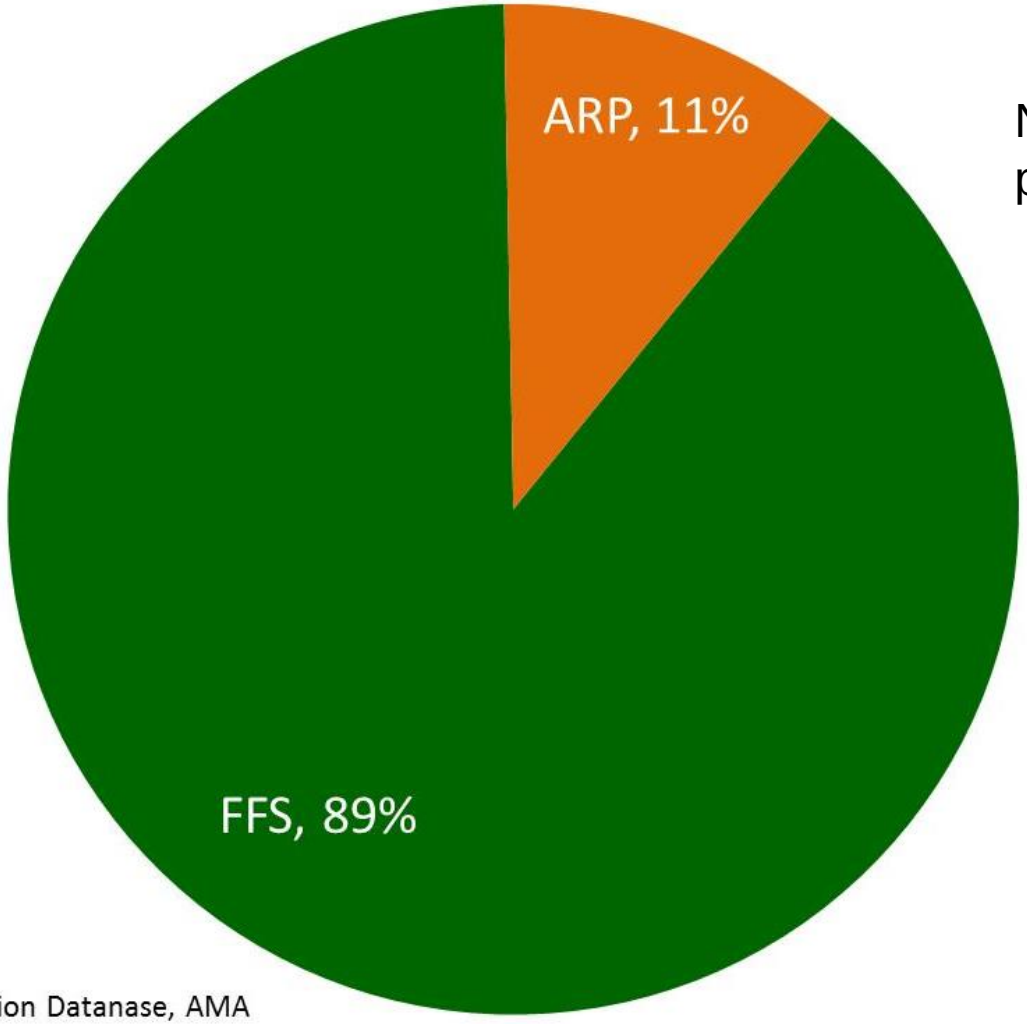
Physician Spending by Age Cohort



Sources: Physician Claims File, AMA

Physician Spending by Payment Model

Alberta Physician Expenditure Shares by Payment Type, 2013-14



Nationally, alternate payment share is 30%

Sources: Allocation Datanase, AMA

ARP Rates

- Base rates established when program was initiated in 1990s
  - Basis was Health Canada/CIHI FTE methodology
  - Base rates set at mean of FFS earnings for 1.0 FTE physicians (40^{th} to 60^{th} percentiles of annual physician claims) by section
- FFS percentage increases by section (allocation process) have been applied to rates for subsequent years
  - Unclear if ARP compensation remains consistent with FFS
- Incomplete activity data so difficult to micro cost individual ARP services
  - Shadow billing not comprehensive

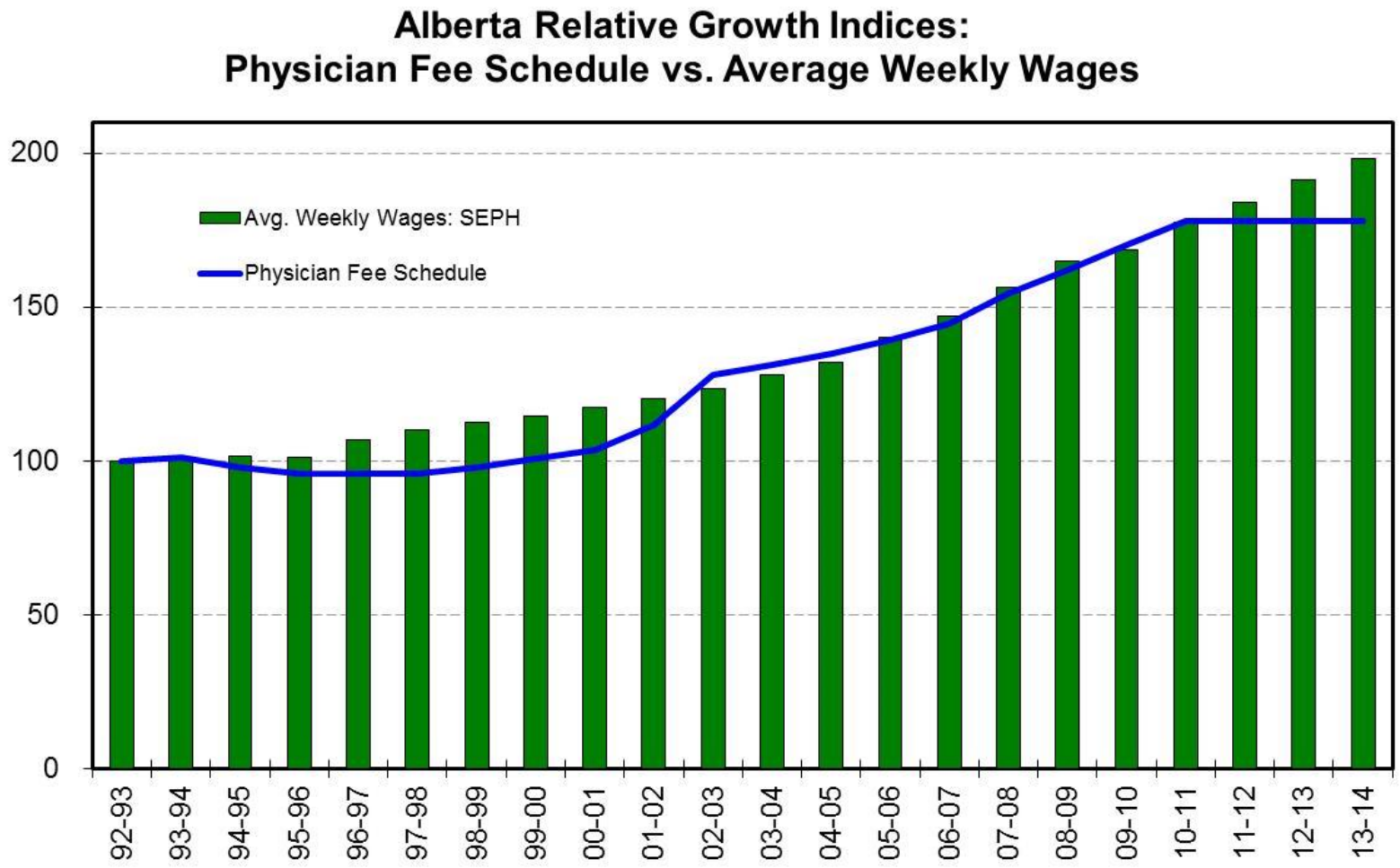
Physician Spending Adjustments

- Negotiations lead to "Agreement" which includes fee increases
  - Government responsible for utilization growth, physicians for calculation errors
- Allocation process distributes fee increases
- Macro allocation: changes to physicians fees are divided among the various AMA physician sections
  - 31 sections with an economic role
  - Apply to FFS and ARP
- Micro allocation: Sections then designate the allocated money to individual SOMB services for FFS
- Individual physicians receive funds for the medical services they provide based on SOMB payment rates

Physician Spending Adjustments

- Both AMA and AH recognize fiscal constraints and physician overhead expenses in negotiations and allocation
- Allocation shared process between AMA and AH (objectives and workload)
- Partnerships outside of allocation (e.g., System Wide Efficiency and Savings committee) also look for health system efficiencies

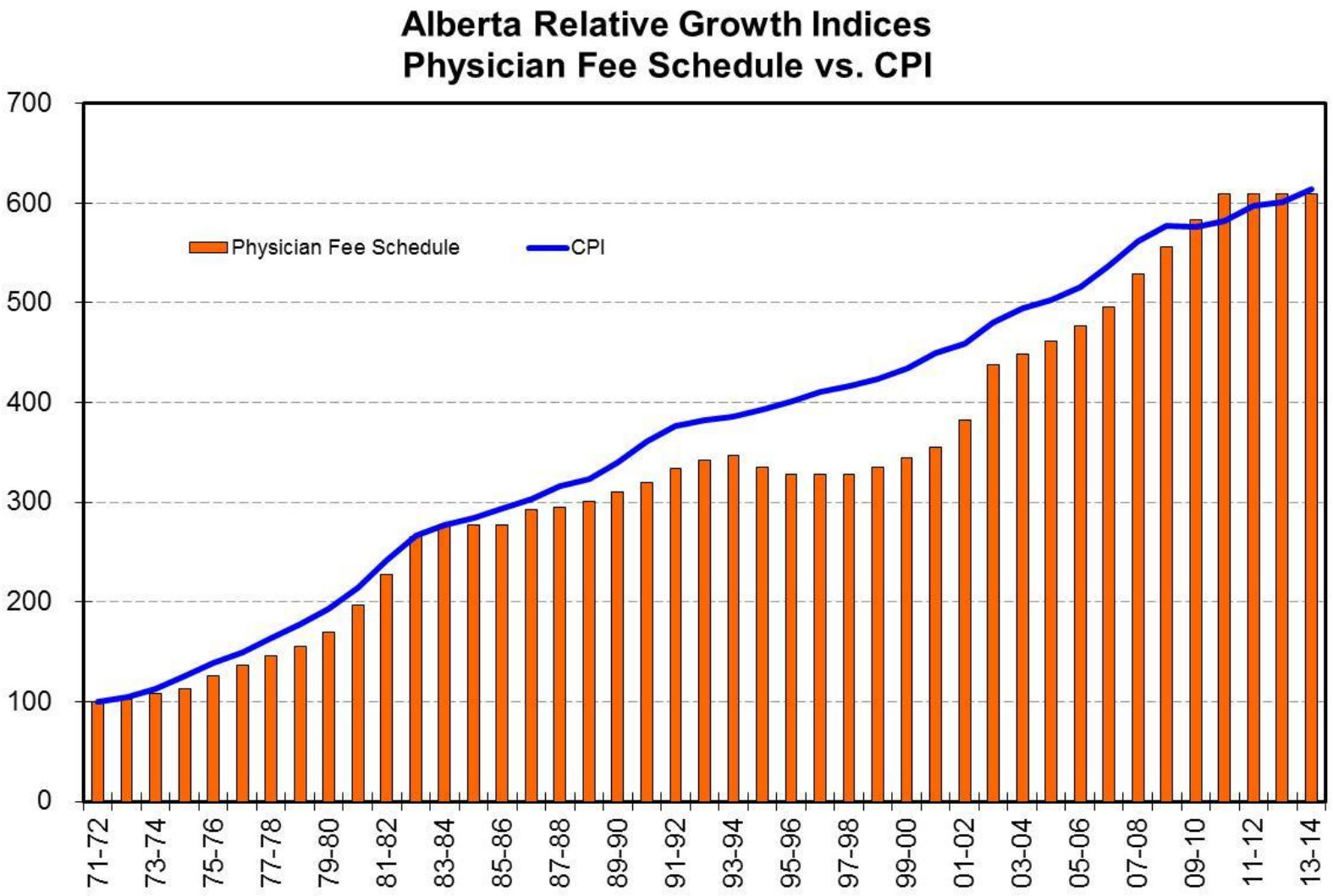
Physician Fee Increases



Sources: AMA, Statistics Canada

Notes: All average weekly wages are for the industrial aggregate.
SEPH is the Survey of Employment Payrolls and Hours an employer-based survey.

Physician Fee Increases



Sources: AMA, Statistics Canada

AMA Broad Allocation Objectives

- The key objectives of the strategy are:
  - Equity – improve relative fairness of physician compensation at fee and income levels
  - Access – ensure care available and timely
  - Productivity – support efficiency and cost-effectiveness in the use of physicians' time and skills
  - Quality – appropriate care (health outcomes)

AMA Specific Goals

- Relative fees reflect
  - Overhead expenses
    - Reasonable variable costs
    - Share of reasonable fixed costs
    - Return on large-scale capital investment (not universally agreed)
  - Professional components
    - Time, intensity, complexity
    - Inconvenience, after-hours work
    - Technical components / special training
- Relative incomes between sections reflect
  - Expenses (variable and fixed)
  - Hours of work
  - Work outside normal office hours
  - Investments in human capital
  - Location or other incentives

AMA Specific Goals

- Incomes between methods of payment are comparable
- Alberta physicians are paid competitively relative to:
  - Physicians in other provinces
  - Physicians in other countries
- Albertans have access to advances in medical science (new services and technology)

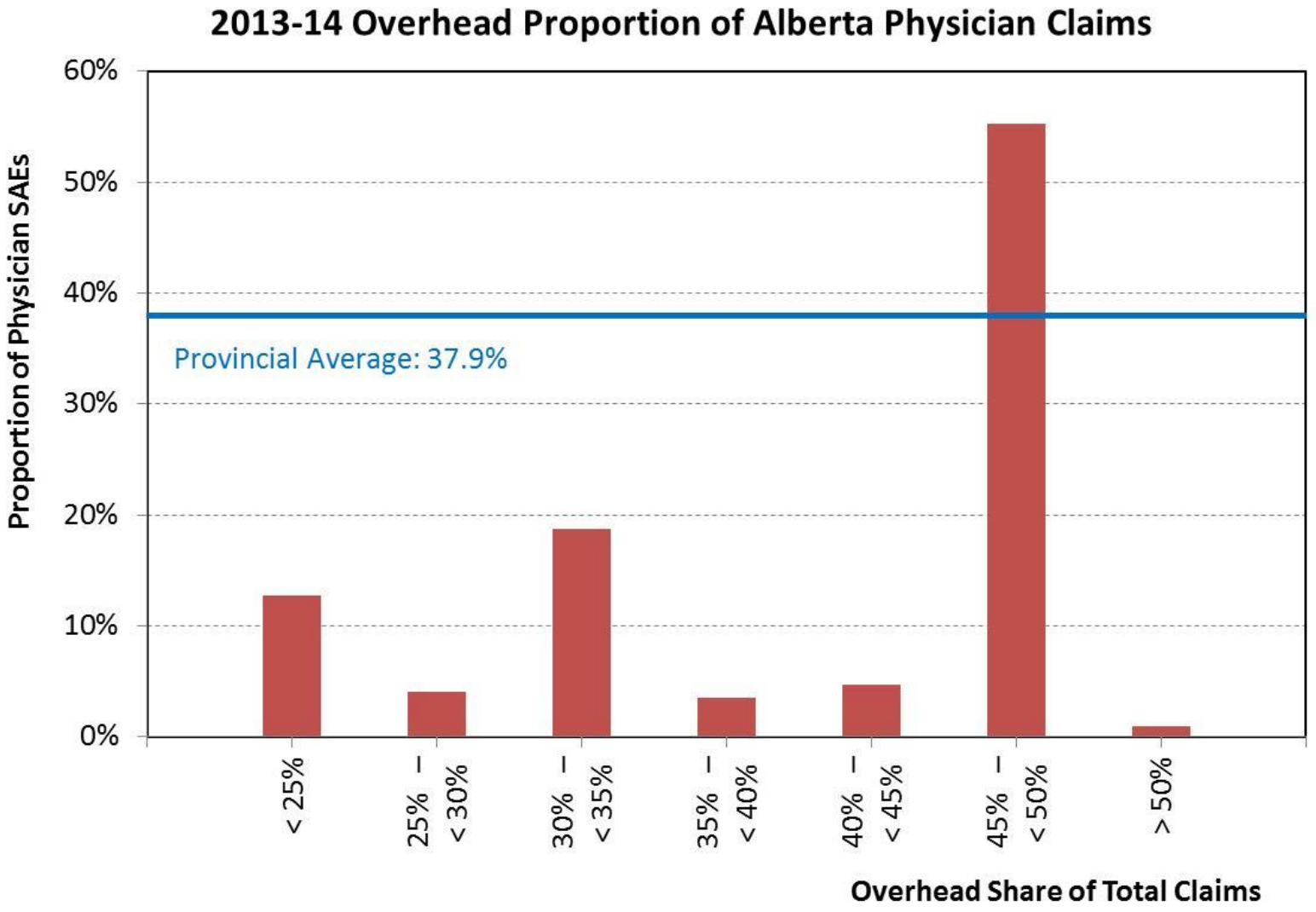
Macro Allocation

- Priority/targeted items:
  - Recognize identified areas of need in the health system (government direction or bilateral agreement)
  - First funded item
- Overhead adjustment:
  - Recognize changes in physician overhead costs
- Funding for each full-time-equivalent (FTE) physician in a section:
  - Remainder (if available funding not exhausted on priorities and overhead)
  - AMA developed FTE definition specific to allocation - SAE

Physician Overheads

- Alberta physicians' average overhead is 38% of billings
  - Specialty average range from 10% to 60% of billings
  - Average 2014 overheads: $159,000 for generalists, $173,000 for specialists
- Physician overheads rising by 0.8 percentage points faster than CPI annually
- Alberta has the highest wages in Canada
  - Salaries and benefits account for approximately 40% of overheads
- Alberta likely has the highest office lease rates in Canada
  - Accounts for approximately 25% of overheads
  - Cushman and Wakefield, October 2012 reported Calgary has the highest average city-wide office gross office lease rate among major Canadian cities, Edmonton was also relatively high

Overhead Distribution



Source: AMA Allocation Database

Micro Allocation

- Over 3,000 fee codes (with over 40,000 modifier combinations) to be adjusted so section increases match macro increases
  - Several rules to determine which fee codes are owned by a section
- Macro priorities funded first
- Remaining money distributed by intra-sectional relative values (INRVs) of owning sections
  - Weights/rankings attached to the health service codes used by a section
  - INRVs reflect the intensity and complexity of each medical service and the time it takes to complete it
  - Some INRVs also include a technical component – reflecting use of specialized equipment or supplies

Observations

- Allocation process distributes fee increases
  - Process not designed to address historical inequities in incomes
- Allocation process determine fees
  - Variable service provision in combination with fees determines gross income for most Alberta physicians
- Allocation process does not address financial disparities among sections. Joint fee review project (under PCC)

Potential Relative Value Methodology

- Building new approach based upon factors such as time, intensity, and past studies from Alberta, Ontario and the US

For More Information

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