



Dr. Darryl D. LaBuick

The President's Letter

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March 27, 2008

Dear Member:

Physician Compensation Strategy

As I mentioned in my March 14 *President's Letter*, the Alberta Medical Association's (AMA's) Representative Forum (RF) discussed and approved a new Physician Compensation Strategy at its March meeting.

In September 2007, the RF directed the Board of Directors to bring a strategy and timelines for achieving intra- and inter-sectional relativity (fee equity) to the Spring 2008 RF. The board subsequently established a working group of board members – Drs. Daniel J. Barer, G.N. (Gerry) Kiefer, Carolyn A. Lane – and AMA staff to determine how to move ahead on this challenging issue.

The working group recognized that fee equity is just one small piece of a much bigger picture and that strategizing about just this one element would not ultimately lead to an effective outcome. By defining aspects of physician compensation, the group developed a framework for a comprehensive Physician Compensation Strategy. This will ensure a thorough approach to this issue going forward.

Strategy objectives are to recruit, retain, innovate and offer incentives.

Components of physician compensation

Some of the major components of physician compensation are:

- After-hours' payments
- Allocation
- Alternate Relationship Plans

- Benefits
 - Continuing medical education
 - Medical liability reimbursement
 - Parental Leave Program
 - Others
- Clinical Stabilization Initiative
 - Business Costs Program
 - Rural, Remote, Northern Program
 - Communities in Crisis
- Fee schedule (through the Schedule of Medical Benefits)
- Incentives e.g., payments for comprehensive care
- Programs
 - Physician On-Call
 - Physician Office System Program
 - Primary Care Initiative
- Retention Benefit
- Uninsured services

There are a number of current activities underway to address various components in the list above. Some of these include the After-hours' Working Group looking at surcharges and call-back payments; the Business Cost Study looking at overhead costs; rules redevelopment through the allocation process and other avenues; and work on intra- and inter-sectional relative value, etc.

Fee equity

To effectively implement fee equity within a section (intra-sectional relativity or INRV), individual sections must establish relative values for their commonly billed health service codes. Sectional relativity is a building block that must be in place before we can begin to address relativity between sections (inter-sectional relativity).

Of the 29 sections with a primary economic role (i.e., those sections that have funds allocated to, and by, them):

- 8 sections have revised the INRVs for their commonly billed health service codes.
- 21 sections need to either update or begin to fully develop their INRVs.

Spring 2008 RF resolutions

RF delegates unanimously approved resolutions supporting the Physician Compensation Strategy working group recommendations. RF directed the group to:

1. Develop and implement the AMA's Physician Compensation Strategy with a one-year, three-year and five-year business plan approach to the allocation process.
2. Implement an April 1, 2009 deadline for sections to finalize their functional intra-sectional relative values (INRVs), and to impose conditions if the INRVs are not completed.
3. Develop the prioritization process and the criteria to be used for future macro-allocations. (The macro-allocation assigns funds negotiated for the Schedule of Medical Benefits to three separate funding areas: priority items for targeted funding, the same dollar value per full-time equivalent physician for each section and funds allocated to each section for overhead costs.)

The AMA will seek funding to support these activities.

Sectional INRV work

As noted, sections must complete their *functional* INRVs within the next year. Intra-sectional relative values are considered functional when a section uses the INRV in its allocation process to apply new funds to undervalued fees, new fee items and rule changes.

To ensure the April 1, 2009 deadline is met, AMA staff will contact all sections to confirm the status of their INRVs and the work that may need to be done to comply with RF direction.

I will keep you informed as the Physician Compensation Strategy is further developed and as milestones are established and met.

Clinical Stabilization Initiative updates

Rural, Remote, Northern Program (RRNP)

Earlier this month, Alberta Health and Wellness mailed application forms to physicians who provide services in RRNP-eligible communities. For the first-year payments, a signed application is needed to process payments for both the premium and flat-payment components of the RRNP. It is imperative that eligible physicians complete and return the application form, in order to receive the RRNP payments.

The President's Letter
March 27, 2008
Page 4

Application forms must be submitted to Alberta Health and Wellness by April 14. Application forms are also available on the AMA website at www.albertadoctors.org/FeesNegotiations/RuralRemoteNorthernProgram.

Business Costs Program

Some AMA members have written to the AMA asking who should receive payments from the Business Costs Program – a clinic owner who shoulders the responsibility for expenses, or the physicians who have a cost-sharing arrangement with the clinic owner.

Because circumstances and business considerations vary from practice to practice, we cannot provide a definitive answer to this question. While intended to help offset overhead and business costs, the Business Costs Program payments are provided to individual physicians.

It is up to all physicians in a clinic (including the clinic owner) to determine a cost-sharing arrangement for expenses. It would be useful to review business arrangements and expense sharing among colleagues. As well, it would be appropriate to discuss positions, concerns, operating costs, etc., and to come to an agreement that should then be formalized to include these issues. In the absence of some other agreement, current cost-sharing arrangements should continue.

As always, I welcome your feedback and comments.

Yours truly,

Darryl D. LaBuick, MD, CCFP
President