



## **AMA President Dr. Neil Cooper: Thoughts on the Physician Compensation Strategy**

Hi everyone.

I'd like to spend a few minutes talking about the Alberta Medical Association's physician compensation strategy. I'd like to look at it in a broader context.

I'm AMA President, Dr. Neil Cooper, and for almost 20 years I've been involved in physician compensation work. I really love health economics, in fact, when I walk into the AMA building, I make a point of cutting through the Health Economics area so I can hang out with the staff who work on these projects.

One thing I've noticed is that we tend to focus in on a lot of really small details and have troubles seeing the big picture.

In 2012 our then-called Physician Compensation Committee developed the four pillars of our physician compensation strategy.

They are:

**Equity:** To improve relative fairness in physician compensation at a fee level and at an income level, within sections, between sections and between different payment methods.

**Access:** Where all Albertans have access to timely quality health care. This requires an appropriate supply of physicians by specialty and location and also requires an appropriate spectrum of services within groups or positions.

**Productivity:** Remuneration of physicians supports efficiency and cost-effectiveness in the use of physicians' skills.

And **Quality:** Our compensation strategies are used to enhance and align payment mechanisms with quality care and improved outcomes.

In 2017, our Representative Forum and AMA Board of Directors developed a new mission, vision and values statement.

Our mission states: The AMA advances patient centered, quality care by advocating for and supporting physician leadership and wellness.

The vision is for the AMA to be powered individually and collectively by physician leadership and stewardship in a high-performing health system. Member wellness and economic well-being in their practices and communities are supported by our comprehensive negotiated agreements and programs.

So what does this all mean? What is the goal? Well, it can be pretty easily summarized by saying we are looking for **value** for patients and **fairness** to physicians.

In order to get there, there are several things that we can measure – or metrics. We have started along the road to measuring many of those things already.

First, we can look at market forces – things like is there a clinic to work in or a hospital to operate in. We also need to look at comparisons between provinces and physicians' workloads in other places.

Of course we must consider the needs of the patient. Over the next few months, our new Needs-Based Physician Resource Committee will be measuring and giving us the results of their work in order to determine the future patient needs for the physician workforce.

We are also measuring some system and individual performance – things like referral wait times, emergency room waiting and the size of wait lists.

We also measure patient satisfaction with surveys, but instead of posting them on the Internet, the physicians could give their patients the opportunity to comment on how they're doing and the physician receives the feedback directly in order to improve their own practices. The CPSA is just sending out the Practice Checkup Report, with a personalized and confidential summary of potential risk factors for your practice.

We could also measure things that have been shown to make a difference, like the number of patients involved with patient medical home and levels of attachment.

The Alberta Medical Association is starting to gather data as part of our Income Equity Initiative. We are going to be looking and documenting overhead details, hours of work and years of training along with many other factors that act on physician income. This will give us great data and help us to calculate the Adjusted Net Daily Income, and then start to compare like levels of workload skills and hours of work to more fairly compensate physicians.

We are gathering a lot of information on physician compensation and we have developed many strategies and will develop many more on how physicians should be compensated.

We have a well-defined allocation process which allocates increases in the Physician Services Budget according to calculated overhead, targeted items and our section allocation equivalent.

Some sections are now working on their standardized Intra-Sectional Relative Values projects which will give sections a common method of assessing the relative value of their different fee codes, and once that is done allow comparisons between sections at a fee level.

Our Business Costs Program provides a strategy of applying extra payments for activities that occur where business costs are higher, and our Rural Remote Northern Program provides extra funding for physicians working in rural areas where it has been traditionally hard to recruit physicians.

Last year, the Physician Compensation Committee went through its process of individual fee review in order to address several codes that were identified as outliers. They were able to adjust the value of several fee codes.

Some new strategies are being developed. We are just beginning a process where our Peer Review Committee will begin looking at specific fee codes that may be being used incorrectly and instituting a series of educational processes in order to correct those billing practices. One of the strategies coming out of the Income Equity Initiative is the use of reallocation of funds if our data indicates that inequities exist.

Overall, we are looking forward to some schedule of medical benefit system reforms including eliminating inappropriate codes and developing new codes. Much of this work will depend on development of a new billing system that is greatly needed.

Outside of fee-for-service, there are new payment models and reassessments of some of the current models of payment including Academic Alternative Relationship Plans and Blended Capitation Models.

In the future, there are several potential strategies for improving physician compensation. These strategies are just in the conceptual stages but include things like individual performance and accountability measures, outcome measures, giving sections accountability for how their fees are distributed and models where savings are shared with the physicians involved.

As we look at all of these various metrics and strategies for physician compensation we must remember how they fit into the greater health care system. Important linkages like how information is shared between physicians and between patients and their physicians, and how our entire health system is integrated so that patients and caregivers have the ability to closely work together in order to make the patient's journey through the system easy and informative.

You may be thinking we have a lot of balls in the air and we do. There are literally hundreds of AMA staff, member physicians and consultants working on these projects. The thing is that for any system to undergo true reform we must work on all the pieces. As we continue to juggle all these balls, please support your representatives with suggestions and advice so we can make sure the end products are correct, and remember to give our Health Economics staff some love too.

So that's my thoughts on our entire physician compensation strategy. We have the great opportunity in Alberta to have influence over and mold our compensation systems so that they provide appropriate value for our patients and fair compensation for physicians.

I would really like to hear your thoughts on the big picture. Please write to me and let me know your impressions.