The Economic Realities of Physician Compensation in Alberta

ECONOMIC BACKGROUNDER

PREPARED BY THE DEPARTMENT OF HEALTH ECONOMICS
ALBERTA MEDICAL ASSOCIATION

DECEMBER 16, 2019

EXECUTIVE SUMMARY

The intent of this paper is to provide an accurate picture of physician compensation in Alberta. When physician compensation is properly measured, and placed *in an appropriate context,* with due regard for other provinces' expenditures, including economic differences, a more accurate understanding of physician compensation is derived.

As will be evidenced in detail within this analysis, the *Report and Recommendations of the Blue Ribbon Panel on Alberta's Finances'* assertions regarding physician remuneration are largely misplaced in that the MacKinnon Panel's conclusions appear to be based on selective data and reported without sufficient contextual analysis.

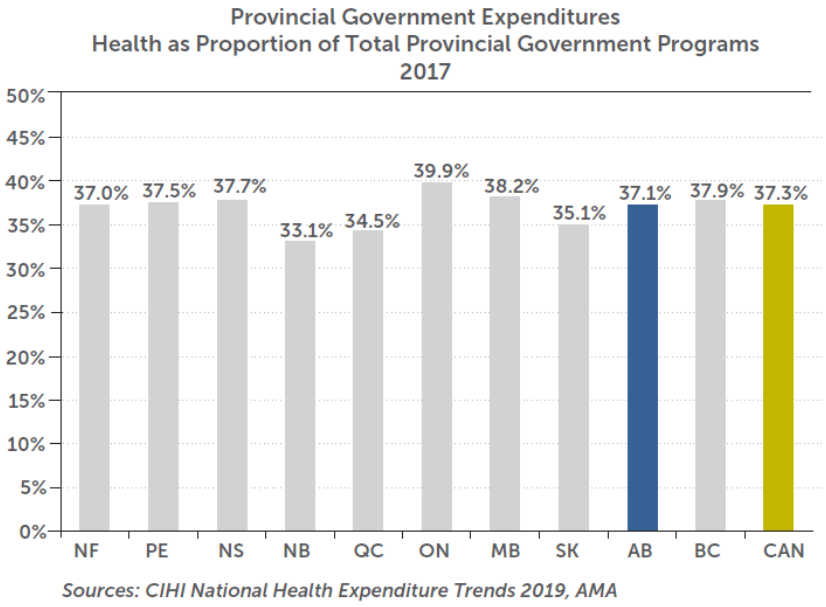
Physician compensation in Alberta is currently at a level that is competitive with other jurisdictions in Canada and largely provides the province with an appropriate supply of physicians in clinical practice. Rapid and broad sweeping changes to the physician compensation system in the province is unwise and cannot be justified on the facts. The AMA is very concerned that the Government of Alberta's current course of action will result in poorer outcomes within Alberta's health care system. As the decision-making and policy writing of Alberta's Government appears to be based on flawed assumptions and shaky conclusions, the AMA is worried that, ultimately, the burden of these changes will be borne by patients and their families.

We are calling for some sober second thought.

TABLE OF CONTENTS

I. Introduction

This summer, the Report and Recommendations of the Blue Ribbon Panel on Alberta's Finances (August 2019) tabled by a panel led by Dr. Janice MacKinnon and commissioned by the Government of Alberta ("the MacKinnon panel report"), had much to say about how spending in Alberta's health care sector – and, in particular – how expenditures on physician "costs" were out of control and out of sync with other provinces. It is certainly true that health care represents a significant portion (approximately 37.1%) of the Alberta Government's program expenditures. However, when considered in the Canadian context, Alberta's level of spending on health care is actually slightly lower than the national average (as shown in the chart above).



Sources: CIHI National Health Expenditure Trends 2019, AMA

PHYSICIAN COMPENSATION

Similarly, the Alberta Medical Association (AMA) disputes that Alberta's expenditures related to physician costs are out-of-step with other provinces, when these expenditures are considered in the appropriate context and with finer regard to interprovincial differences and contributing factors. The purpose of this report is to provide a more accurate picture of Alberta's spending on physician services than that which was outlined in the MacKinnon panel's report.

As this report will demonstrate, physician compensation in Alberta is currently at a level that is competitive with other jurisdictions in Canada and provides the province with an appropriate supply of physicians in clinical practice (although some deficiencies still remain, particularly in rural areas). When comparing earnings with other provinces, it is important to consider Alberta's high cost of practice relative to other provinces, as well as the positioning of physician remuneration within the overall level of wages and salaries in the province (industrial aggregate). The MacKinnon panel report quickly dismissed these factors as being *no longer the case* in Alberta and discarded these considerations as *irrelevant*. As we will point out, that assertion is simply untrue.

Physician engagement is critical if the Alberta government wants to effectively manage our province's health care costs.

While it is an important component, the physician services budget is not the only major driver of health care costs in Alberta. Individual physicians make decisions every day that impact costs across the system, including for example: patient hospitalization and treatment, diagnostic testing, laboratory, and drug utilization. As such, they have an important stewardship role to play in the responsible, effective and efficient use of health system resources. Multiple strategies can be employed to contain costs and improve quality, including realigning compensation to meet these strategic system goals and engaging physicians and patients to choose appropriate and effective treatments. *Meaningful engagement can occur only when a commitment to the fair treatment of physicians within the health system is endorsed by all parties.*

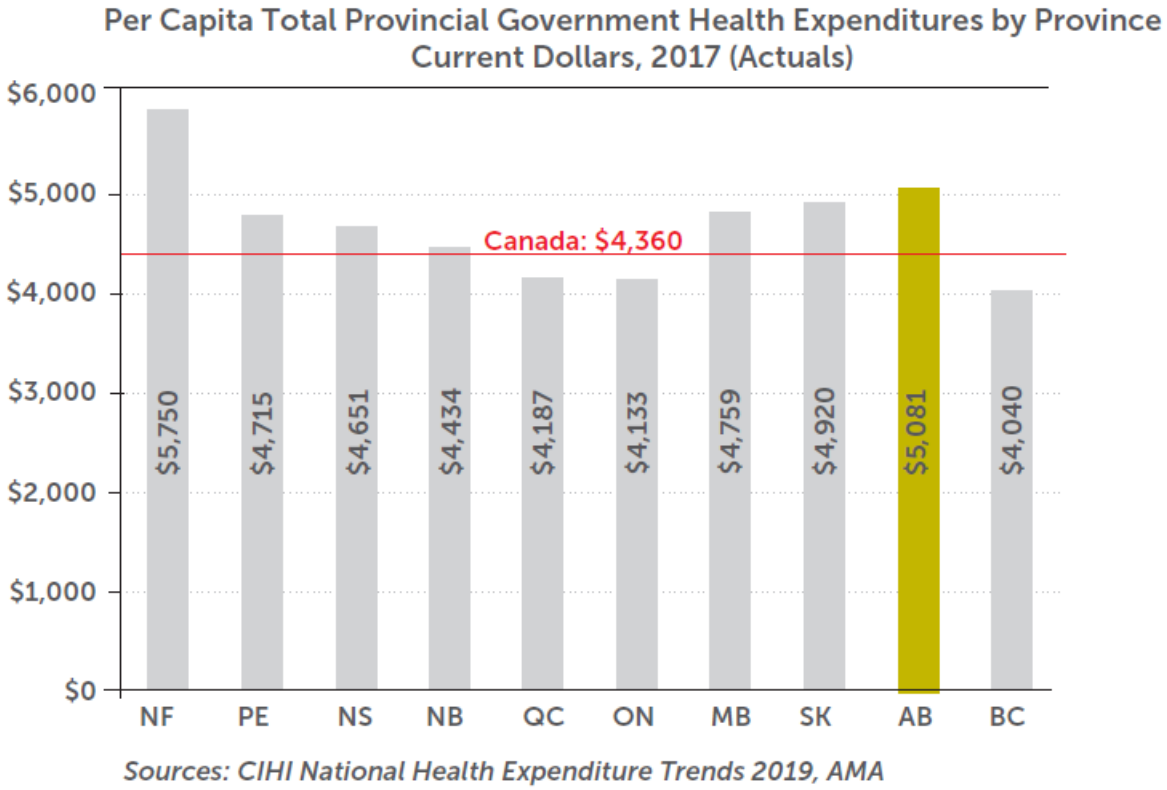
Physicians - by nature of their professional roles and responsibilities - are well positioned to serve as key stewards of our limited health care resources. Indeed, this role has been emphasized starting with the implementation of the first AMA Amending Agreement which was made effective November 1, 2016, and it continued to be carried forward within the second AMA Amending Agreement effective April 1, 2018. The parties' shared encouragement of physician stewardship has already proven successful at effectively controlling the growth of physician related expenditures.

Fundamentally, the AMA believes that aligning payment models with overall health system objectives (including quality, access and sustainability) is beneficial and should be pursued. However, unilateral solutions that have not adequately explored the unintended consequences are not the answer. Creative solutions, such as sharing savings of net reductions in health costs or population-based models such as capitation – developed jointly with the AMA – are a far better option to ensure a successful result over the long run.

II. Health Expenditures

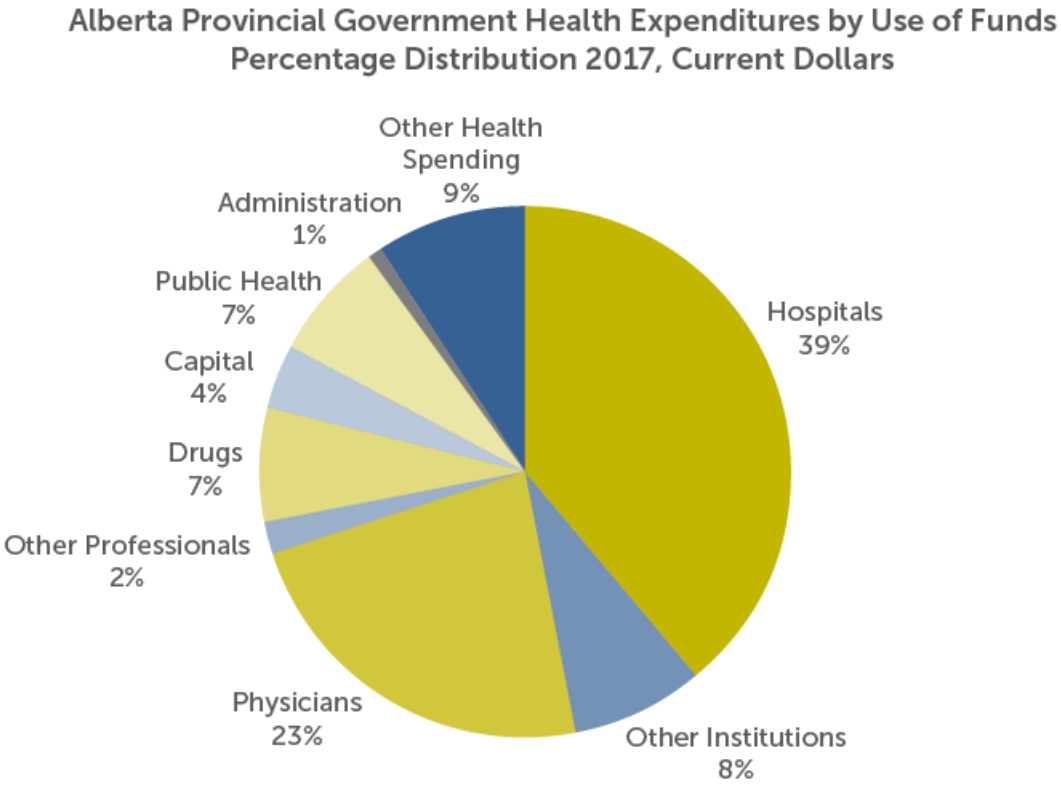
PER CAPITA SPENDING ON HEALTH CARE PUT INTO CONTEXT

In 2017, Alberta's health expenditures were $5,081 per capita, which was 16.5 percent higher than the national average of $4,360 per capita. However, Alberta's per capita spending was exceeded by Newfoundland, which spent $5,750, and very closely followed by Saskatchewan at $4,920 and Manitoba at $4,759. Of note, seven (7) out of the ten (10) provinces listed in the chart below spent *over* the national average. As we look to compare physician compensation, we should consider what expenditure data is missing from those provinces, British Columbia, Ontario, and Quebec - which appear far below national averages.



When analyzing our province's health care expenditures, it is important to understand the components of these expenditures. In Alberta in 2017, hospitals represented the largest cost category at 39 percent of total health spending. Physician compensation represented 23 percent of spending; other institutions were the third highest component at 8 percent; and drugs at 7 percent. Other categories, including

administration, public health, capital, other professional providers billing on a fee-for-service (FFS) basis collectively represented 23 percent of remaining costs.

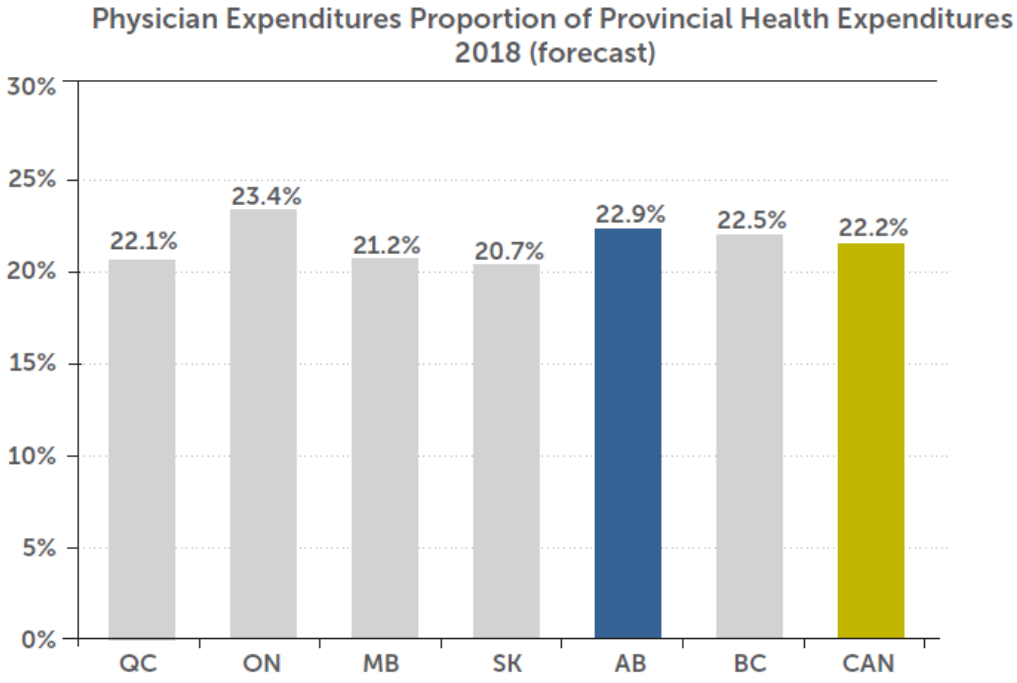


Sources: CIHI National Health Expenditure Trends 2019, AMA

Similarly, when placed in context, Alberta's physician expenditures are not far beyond the national average

In the MacKinnon paper, the proportion of physician expenditures, at 23.3%, is reported to be the second highest component of health care in Alberta. What MacKinnon fails to do is to put this piece of data into perspective.

Interestingly, Alberta is not unique when it comes to physician expenditure as a proportion of health expenditure - as can be seen in the chart below, which uses the latest available CIHI health expenditures data, the proportion (forecast for 2018 at 22.9%) of health care funding spent on physician services in Alberta, is very much in line with other provinces across Canada. Clearly, the health care equation is far more complicated than the MacKinnon panel attempts to portray.



Sources: CIHI National Health Expenditure Trends 2019, AMA

Of note, the proportion of the total provincial health expenditures spent on physicians in Ontario is greater than that of Alberta's. Yet Alternative Relationship Plan (ARP) arrangements, lauded by the MacKinnon panel as the panacea for Alberta's budgetary concerns, are used far more extensively in Ontario than Alberta (see discussion below).

III. Alberta's physicians are not paid disproportionately when compared with other Canadian physicians

ALBERTA DOCTORS ARE NOT PAID 35% HIGHER THAN COMPARATIVE PROVINCES

The MacKinnon panel's report states:

> *"In 2016/17 the average fee-for-service earning for all Alberta physicians was $413,000. That is $107,000 or 35% higher than the average in comparator provinces."*

This assertion fails to take into account all relevant factors, and is therefore an inaccurate depiction of the total picture. Unfortunately, this statement has since been repeated, and relied upon to write policy, develop budgets, and shore up other proposals and assertions that are being made to Albertans, ultimately attempting to sway the public towards a flawed conclusion.

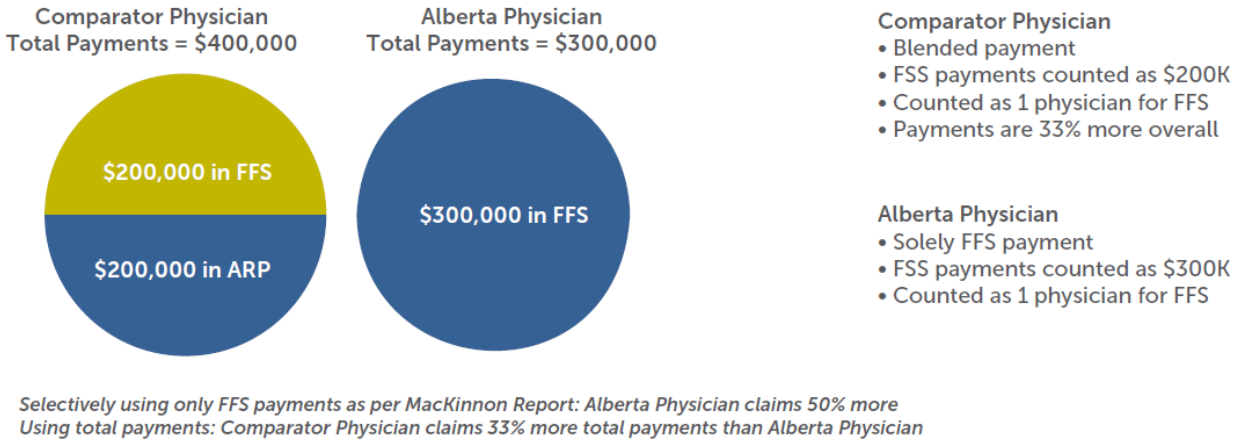
The MacKinnon panel's analysis of physician compensation relies solely on fee-for-service (FFS) payment data published by the Canadian Institute of Health Information (CIHI). However, CIHI itself cautions against using this specific data to compare physician payments across provinces. CIHI states:

> *"Due to the variation in the proportion that fee-for-service expenditure is of total physician compensation in each jurisdiction, comparisons across jurisdictions should be made with caution."*

It appears that the MacKinnon panel disregarded this cautionary note in relation to its report.

The critical flaw in this comparison - relying on pure FFS payments to suggest physician earnings are disproportionately large in Alberta - is that it neglects to consider the sizeable proportion of non-FFS payments earned by physicians in other provinces. Alberta historically (and presently) has the lowest percentage of physician compensation coming from alternative funding sources. Alberta also has the highest percentage of physicians relying solely on FFS as their only source of income.

Consider the following comparison:



Selectively using only FFS payments as per MacKinnon Report: Alberta Physician claims 50% more
Using total payments: Comparator Physician claims 33% more total payments than Alberta Physician

In the above example, payments for the comparator physician, from another province, would be counted (using the MacKinnon methodology) as $200,000 while payments for the Alberta physician, are $300,000. The MacKinnon type analysis as portrayed in the hypothetical example above, erroneously results in the Alberta physician's payments appearing to be 50% more than the comparator physician's payments. This assertion is simply not the case. It is evident that when both FFS and Alternative Relationship Plan (ARP) payments in the above example are considered, it is actually the comparator physician with the higher total payment amount of $400,000 vs $300,000 (33% more). As a result, it cannot reasonably be concluded – contrary to what the MacKinnon panel's report suggests - that physician compensation in Alberta is significantly higher than elsewhere (without accounting for all components of physician compensation across the country).

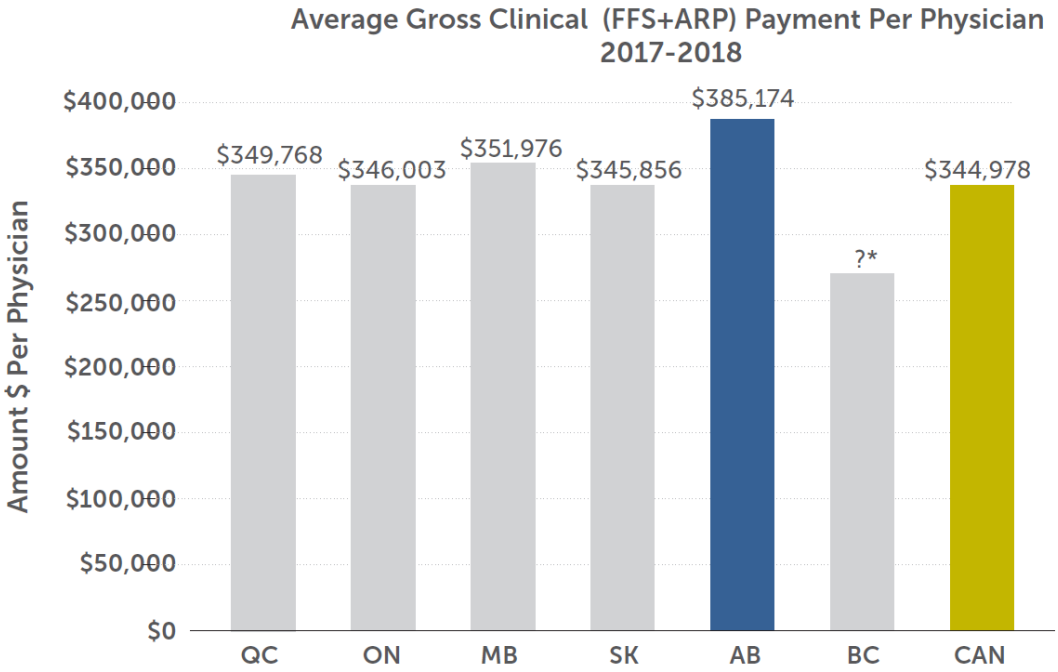
Using the method used by the MacKinnon panel, this error is magnified as ARP proportion of total payments by province increases. The higher the proportion of physicians receiving blended (FFS and ARP) payments in a province, the higher the error. Alberta's proportion of payments that are ARP, as reported by CIHI for 2017/18 (see table below), is the lowest of all the provinces:

ARP as Proportion of Total Payments 2017-18	
AB	13.0%
BC	19.5%
QB	20.1%
MB	29.0%
ON	35.8%
SK	37.1%

Interestingly, Ontario, which has nearly 3 times the percentage of ARP payments than Alberta, many of which include some form of blended (FFS + ARP) payment, appears lower in relation to Alberta when FFS-only comparisons are made.

A more accurate comparator measure is available from CIHI

Of critical note, CIHI produces provincial-level physician compensation measures that include a more comparable set of data than was used by MacKinnon. Using this more comparable payments measure, with both FFS and ARP payments included, a different picture emerges; as the graph below demonstrates. Using the latest data and best available methodology, ***CIHI shows that average gross payments to Alberta physicians were 11.7% above the national average in 2017/18,*** not 35% as purported by the MacKinnon report.



Sources: CIHI National Physician Database 2017-2018, AMA

**BC data does not appear to account for significant clinical services-related payments to physicians that are neither FFS nor ARP (that is, payments from other programs).*

The MacKinnon analysis should have recognized this obvious difference and should have gone further to consider a number of other payment variability factors that are unique to Alberta physicians. *Put simply, the MacKinnon panel's report cannot be relied upon to accurately assess physician expenditures within the national context.*

PAYMENT VARIABILITY FACTORS

The 11.7% difference in gross clinical payments between Alberta and the national average cannot be used as a stand-alone set of information to compare physician compensation because it does not take into account significant differences between the provinces in regards to several factors which impact payments:

1. REPORTING DIFFERENCES

The AMA believes that CIHI still undercounts clinical services payments in some provinces relative to Alberta.

For example, data reporting issues for physician payments include but are not limited to:

a. The AMA understands that a significant amount of payments made to British Columbia physicians are not accounted for in CIHI's payments data. A large proportion of these expenditures are payments for the provision of direct clinical care. This exclusion makes physician compensation in British Columbia appear artificially lower than Alberta, drawing down the national average.

b. For Ontario, technical fees, where they can be identified and separated, are not included in CIHI payments data. In contrast, similar payments to physicians are included in the CIHI provincial comparison data for Alberta. This exclusion makes physician compensation in Ontario appear artificially lower than Alberta, drawing down the national average.

2. ON A SERVICE-BY-SERVICE BASIS, ALBERTA'S FEES ARE IN-LINE WITH OTHER PROVINCES

Alberta's Schedule of Medical Benefits (SOMB) rates form the basis of Alberta's physicians' overall FFS billings, and in turn, the FFS component of physician compensation. As the table below clearly demonstrates, individual SOMB rates in Alberta are relatively similar to those in other Canadian Provinces.

Over the years, the AMA has conducted numerous inter-provincial comparisons on total cost of its physician services on a service-by-service basis. Assessing the comparability of Alberta's rates ensures not only that our province's physicians are paid equitably, but also that Albertans are getting the most for their tax dollars.

An interprovincial fee comparison for 19 common services and procedures was recently undertaken by the AMA. Using an aggregate set of Alberta Health Claims data for the year ending March 31, 2019, the subset shown in the table below represents 15 of the 31 economic sections of the AMA. The chart includes high volume codes, based on the number of claims, service volumes or amounts paid. In addition, a few codes were selected based on earned attention in regards to AHS- and CIHI- reported

surgical wait times. Some codes were also the focus of previous fees-related work, such as the Physician Compensation Committee Individual Fee Review or political mention in the current ministry's platform.

As fee schedules are not standardized across the country, comparing individual fee items province by province is a very complex and difficult challenge. In addition, the level at which services are inclusive of all components of a service (e.g. pre and post procedure visits, the inclusion or exclusion of technical components, etc.) varies greatly. Recognizing the above-noted limitations, the purpose of this comparison is to demonstrate how common services performed by Alberta physicians are compensated in line with other provinces.

Fee comparison

		Rate					
Section	Description	AB	MB	ON	SK	BC	Avg*
Allergy & Clinical Immunology	Lung function test - forced expiration measuring FVC,FEV/1,FEV/1/FVC. MMEFR	$51.17	$34.55	$17.15	$62.90	$22.22	$34.21
Cardiology	Electrocardiogram, interpretation and report	$9.83	$10.85	$4.45	$18.10	$24.68	$14.52
Dermatology	Plantar warts, removal	$34.87	$68.80		$28.60	$31.46	$32.22
Gastroenterology	Colonoscopy	$180.21	$196.00	$166.70	$203.00	$231.61	$199.33
General Schedule	Resuscitation including cardiac arrest, each additional 15 minute period or portion thereof	$96.52	$63.05	$110.55	$102.00	$105.26	$95.22
General Schedule	Psychotherapy - Individual per 15 minutes or major portion thereof	$47.54	$40.00	$62.75	$37.50	$54.76	$48,75
General Schedule	Office visit	$38.03	$37.40	$38.35	$35.00	$31.46	$35.55
General Schedule	Hospital Daily Care	$44.37	$41.35	$58.80	$34.90	$31.93	$41.75
Nephrology	Weekly provision of support/supervision to physicians caring for a patient at a Local Centre Dialysis Unit	$131.51	$156.15	$127.20	$52.20	$61.40	$99.24
Obstetrics & Gynecology	Hysterectomy	$632.45	$560.70	$463.00	$540.00	$653.87	$554.39
Obstetrics & Gynecology	Routine vaginal delivery without manual removal of placenta	$447.34	$553.80	$498.70	$609.30	$581.87	$560.92
Ophthalmology	Cataract removal and lens insertion	$409.90	$450.00	$397.75	$397.50	$352.63	$399.47
Ophthalmology	Intravitreal Injection of medication into eye	$111.98	$133.75	$90.00	$102.00	$134.43	$115.05
Orthopaedics	Total Hip Replacement	$1,054.82	$901.80	$696.00	$1,015.60	$802.93	$854.08
Plastic Surgey	Small Wound Closure	$57.05	$54.40	$35.90	$37.50	$35.44	$40.81
Plastic Surgery	Carpal Tunnel Release	$233.09	$231.10	$156.75	$327.30	$254.92	$242.52
Psychiatry	Psychotherapy, Individual, per 15 minutes or major portion thereof	$55.92	$49.40	$80.30	$56.10	$53.61	$59.85
Radiology	Ultrasound of Shoulder or Extremity	$115.23	$37.10	$40.45	$115.90	$59.13	$63.15
Urology	Cystoscopy	$85.56	$91.30	$71.00	$108.80	$101.51	$93.15

*Avg=Average of MB/ON/SK/BC

Note: The intent of this comparison was to find commonly billed procedures that are comparable across provinces. The analysis presented here, contains 4 of the top 10 utilized codes in Alberta. The comparison was not intended to locate all of the highest paid procedures.

3. Specialty mix

Average payments are higher for specialists than generalists. This difference is due mainly to variation in training requirements but also due to unique types of overhead associated with necessary medical equipment. *Alberta's proportion of physicians who are specialists is 49% which is equal to the national ratio but higher than British Columbia's (46%) and Saskatchewan's (45%). (Source*: Supply, Distribution and Migration of Physicians in Canada, 2018).

Alberta's specialty mix is influenced by its unique geographic location. Edmonton and Calgary are tertiary centres for Northern Canada, including Northern Saskatchewan, Northeastern BC, and the Territories. For this reason, the expertise for heart transplants, lung transplants, liver transplants, islet cell transplants, small bowel transplants, kidney-pancreas transplants, pediatric transplants, pediatric cardiac surgical care, extracorporeal life support and other programs are not distributed equally among provinces.

Evidence for Alberta physicians providing a higher proportion of services to out of province patients comes from CIHI's measure of reciprocal (out-of-province patients) billings across Canada. Alberta accounts for 36.5% of all reciprocal billings in Canada, and 38.5% of all specialist reciprocal billings in Canada. According to CIHI, these reciprocal billings are included in the physician payments comparisons – so the payment data which is used for the CIHI comparison also includes Alberta physician compensation for out of province patients. The total reciprocal payments included in Alberta's physician payments, is the highest of all provinces, at $59.8 million or about 1.6% of total physician payments. The Alberta government recovers these claims in a separate accounting (not included in the CIHI comparisons).

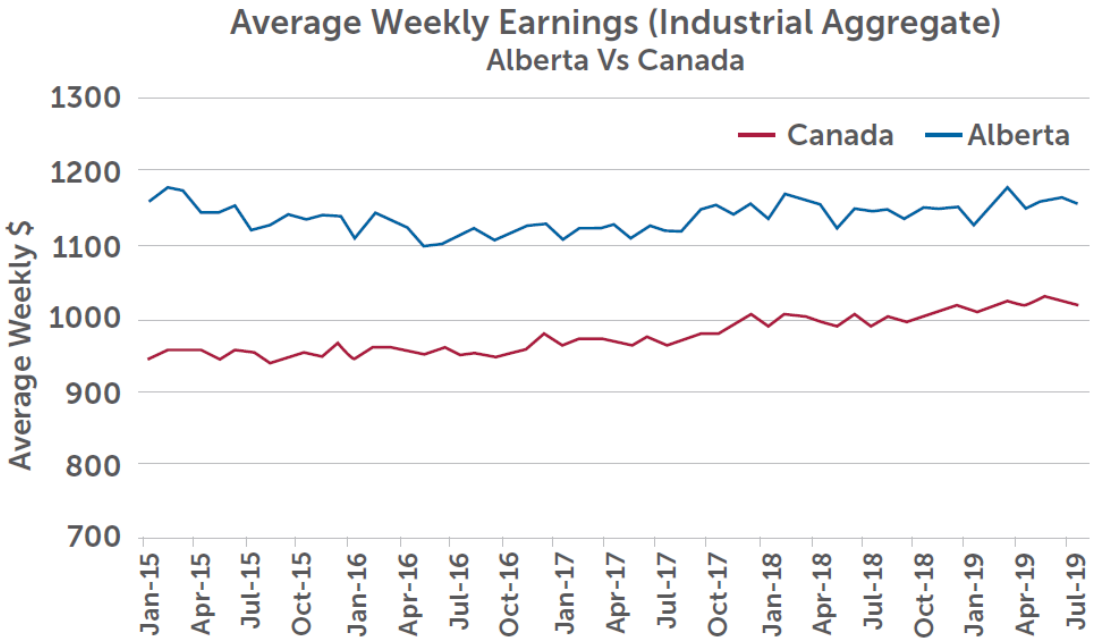
Since Alberta has built a number of exceptional programs for Alberta and Western Canada, policy-makers looking at the 11.7% difference must also consider the fact that a significant amount of these physician expenditures are compensating physicians for services that are provided to other provinces on a cost recovery basis.

4. Higher Overhead Costs for Alberta's Physicians

Physician payments do not equal physician net income. Payments to physicians include costs for overhead, including staffing, leases, equipment, etc. On average, Alberta's physicians use an estimated 40% of their payments (total physician payments from Alberta Health), towards overhead costs (Physician Business Cost Model). It is important to note that in Alberta, these overhead costs are higher compared to other provinces' costs.

Staffing

The largest component of physician overhead - staff wages and benefits - are relatively higher in Alberta compared to other provinces, as shown in the chart below, which demonstrates the gap between Alberta employee earnings and Canadian employee earnings.



Sources: AMA, Statistics Canada
Notes: All average weekly earnings are for the industrial aggregate
SEPH is the Survey of Employment Payrolls and Hours an employer-based survey

Over the last four years, average monthly reported weekly earnings for the industrial aggregate range from 12% to 24% higher in Alberta than the national average.

Unlike most other health providers, physicians are directly impacted by the level of provincial wages and salaries in the economy due to their overhead costs. Physicians are significant employers of clinic staff, ranging from clerical employees to highly-skilled (and high-priced) technologists. Alberta's physicians compete with other industries in the province to hire staff and therefore, are susceptible to higher overall costs associated with overhead when compared with other provinces.

Office Leases

Physicians are also generally responsible for the costs of leasing their clinics and business overhead. Until recently, rapid growth in Alberta's economy had the effect of driving up lease costs which, along with lease operating costs, represent the next greatest portion physicians' overhead costs. Additionally, most physicians sign long-term rental agreements. Many of these were signed at times that peak business cycle

rates were occurring, therefore, some physicians may not have yet been able to take advantage of lower lease rates.

Additional overhead factors

Another factor (omitted from the panel's report) is the reduced value of the Canadian dollar, which has driven up the cost of medical equipment (e.g. imaging equipment), usually priced in US dollars.

Service mix between hospitals and offices also varies by province. In Alberta - unlike most other provinces - a higher proportion of services from specialist sections with high overhead costs are performed in the community (e.g. pulmonary function testing; nuclear medicine cardiology services). Therefore, a higher overhead amount is captured in physician payments for these services for Alberta (whereas for other provinces, the payments would be captured in the hospital category of health expenditures rather than in physician expenditures).

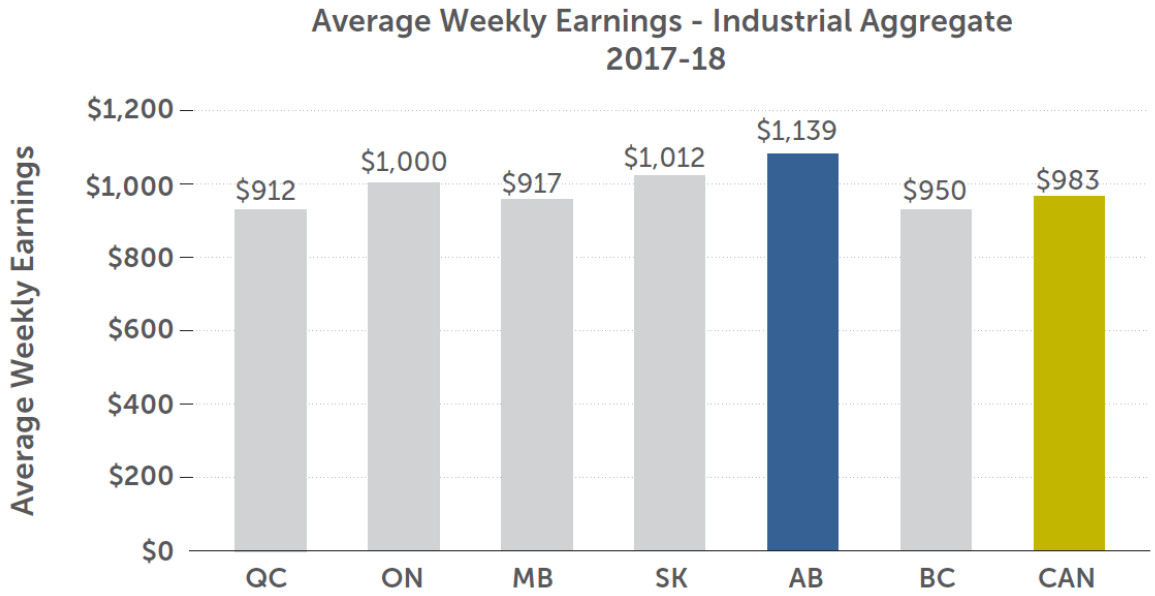
The MacKinnon panel's report did not account for relative differences in overhead expenditure in its considerations nor does the 11.7% CIHI comparison. Policy-makers looking at the 11.7% difference must also consider the significant difference in overhead costs including details of staffing, office leases and other factors such as service mix that are unique to Alberta physicians.

Increases to physician overhead costs are higher than CPI

Until very recently, according to the Physician Business Cost Model, increases to physician overheads have exceeded CPI by an average of 0.7 percentage points due to wages and lease costs rising faster than CPI.

5. COMPARISON TO OVERALL PROVINCIAL WAGE LEVELS

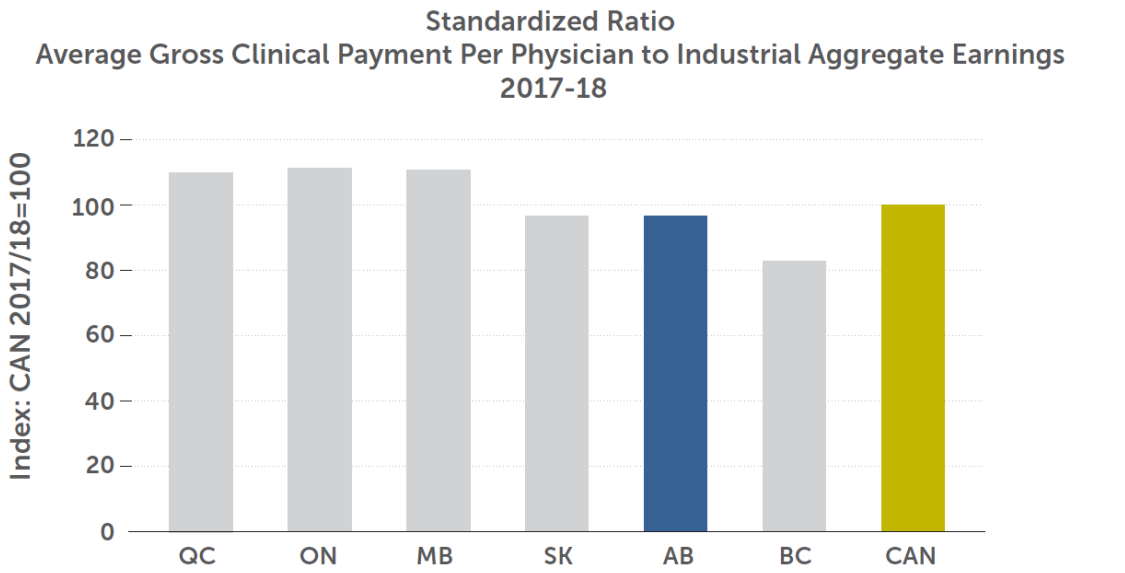
The MacKinnon report misleadingly makes claims about Alberta's physician payments, and health spending in general, in comparison to other provinces, without accounting for the differences between provincial economies. The Average Weekly Earnings for All Industries, from the Survey of Employment Payrolls and Hours (SEPH), published monthly by Statistics Canada is a well-known indicator used to compare provincial earnings. The chart below shows the Statistics Canada Industrial Aggregate Earnings measure for the fiscal year of 2017-18. Alberta, at 15.9% higher than the national average, is the highest among all provinces.



Sources: Statistics Canada, Survey of Employment Payrolls and Hours, AMA
Note: Data shown is the average of the monthly measures for Apr 2017 to Mar 2018

There is a relationship between the variation in physician payments among provinces and the variation of all workers' earnings among provinces, as measured by Statistics Canada's Weekly Earnings measure for All Industry (SEPH). This measure can be used to inform the comparison of provincial physician payments by considering the wage levels in the provinces more generally.

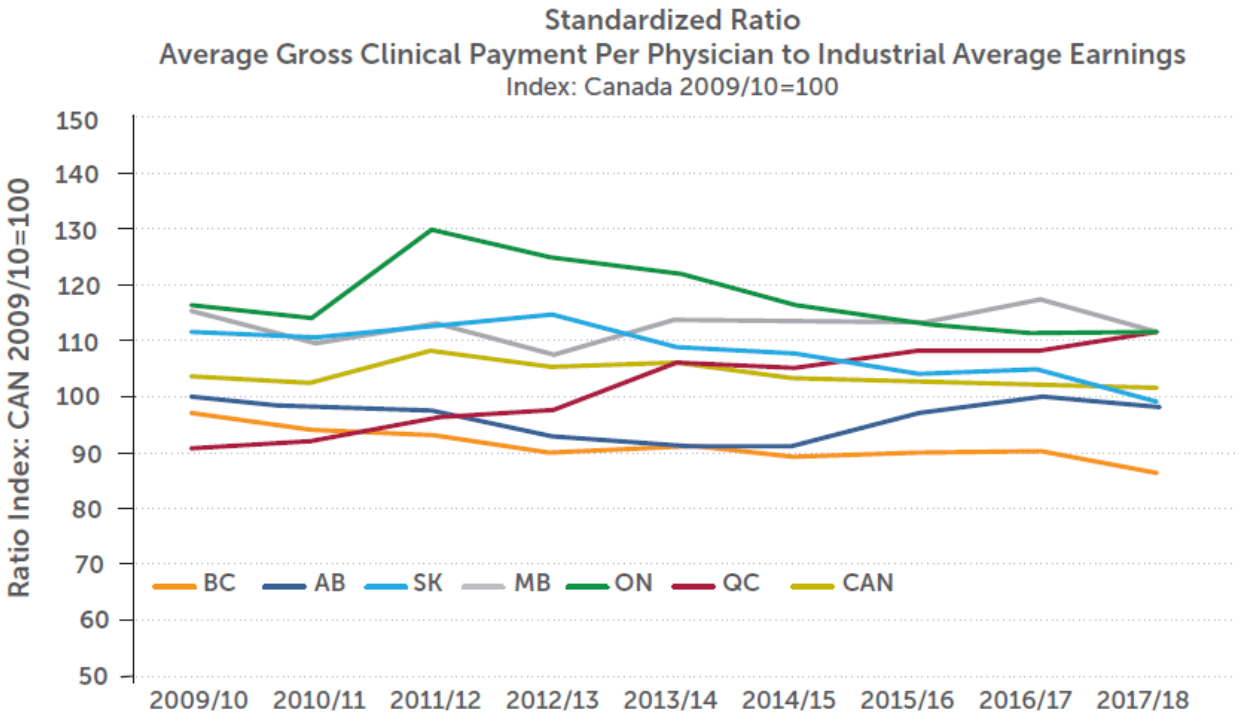
The ratio, shown in the graph below for 2017/18, of "Gross Clinical Payment per Physician" to "Weekly Earnings in the Industrial Composite" allows for comparison, province by province, of physician payments in relation to the province-wide wage level.



Sources: CIHI NPDB 2017/18; Statistics Canada, Survey of Employment Payrolls and Hours Apr 2017 to Mar 2018; AMA

The higher the ratio, the higher the level of physician payments when compared with the overall level of wages for the province. Alberta's ratio is at the lower end of the range. This means that although compensation for physicians, *when examined out of context*, may appear to be generous in comparison to other provinces, it is actually relatively lower after taking into account the overall level of workers' earnings for each province. Payments to physicians in Alberta are higher compared to other provinces in part because the general earnings level in Alberta is higher compared to other provinces. *Considering the overall proportionality of physician payments to the province's general wage levels better informs the analysis, producing a more accurate picture than the one portrayed in the MacKinnon report. To do otherwise is like comparing apples to oranges.*

The above analysis was repeated for the past nine years, resulting in a similar pattern. The chart below demonstrates, using the ratio comparator described above, that physician payments in Alberta are not out of line with other provinces. In fact, we are below the national average for the past nine years as shown in the following chart:



Sources: CIHI National Physician Database 2019, Statistics Canada, Survey of Employment Payrolls and Hours, AMA

IV. Physician payments per capita in Alberta are growing at a similar pace as in other provinces

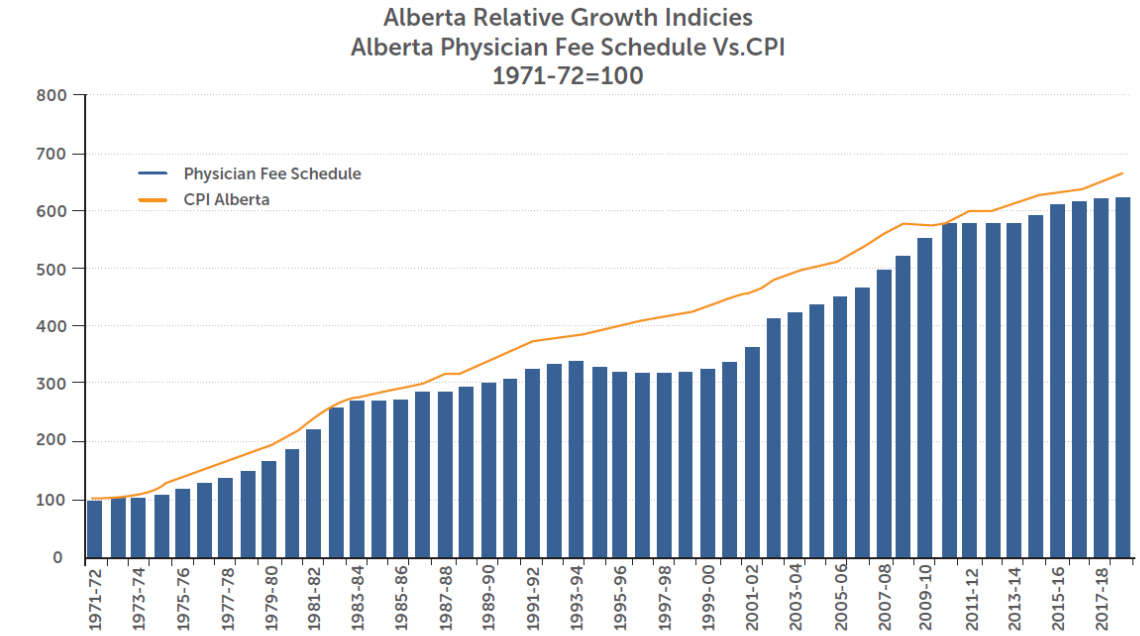
Cuts in the 1990s led to a necessary increase in the rate of growth in the early 2000s

The AMA's (Health Economics) studies of physician overhead costs consistently show that the year-over-year cost of **physician overhead** increases at a rate that *surpasses* the Alberta Consumer Price Index (CPI), while **physician fees** (i.e., the amount paid for each service) in Alberta have increased roughly in line with inflation over the years.

Ongoing pressures, including increasing staffing costs, as well as overhead costs for equipment and office space continue to threaten the viability of physician practices in Alberta and elsewhere. Health care spending analyses must take these factors into account if they are to be found to be *valid* and *reliable*.

The AMA has tracked Alberta's Consumer Price Index (CPI) against the negotiated fee schedule increases since 1971 (see chart below). However, it also must be understood that the fee schedule in Alberta has not increased in five (5) out of the last nine (9) years, and in the remaining four (4) years, increases were CPI or less.

The growth in Alberta's physician fees is certainly not out of control.

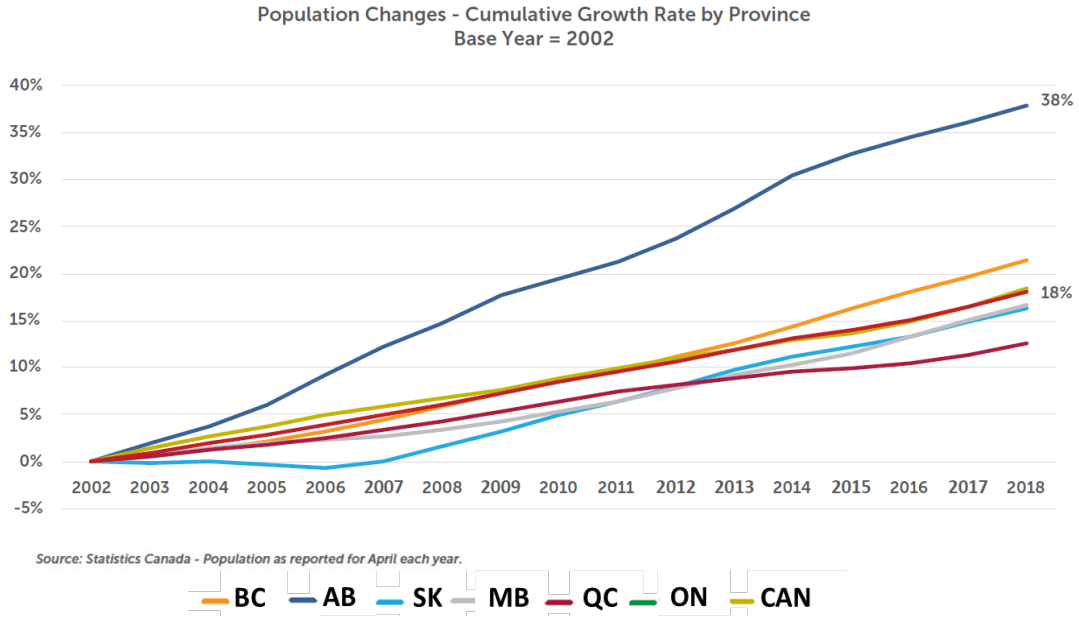


Sources: Alberta Medicial Association, Statistics Canada

Measurement of physician payment growth across provinces

The MacKinnon panel's report suggests that the rate of growth in physician expenditures in Alberta is significantly out of line when compared to the same in other provinces. This is simply not true for three reasons:

- The report fails to account for the difference in the rate of population growth between Alberta and other provinces, which was significant during the reporting period (as illustrated in the chart below, Alberta's cumulative population growth rate was double to that of Canada);



- The report selects 2002 as the base year for comparison of growth in physician expenditures relative to other provinces. However, choosing this year as a base year is misleading in that the years immediately following 2002 showed a period of higher growth in expenditures following the long period of "Klein cuts." These additional expenditures were necessary to help offset Alberta's difficulties in recruiting and retaining physicians at the time that had resulted from those cuts. As a result, MacKinnon's base year overstates long-term growth rates in Alberta's physician expenditures relative to other provinces; and

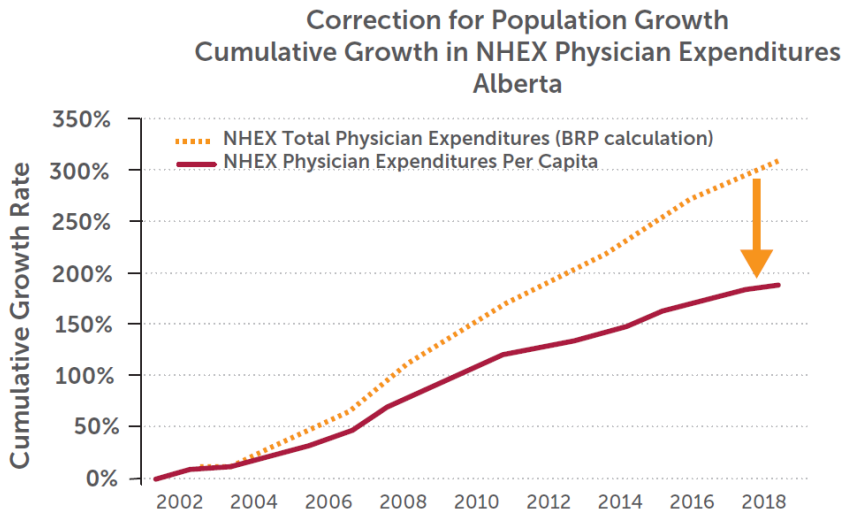
- The report uses growth in NHEX Physician Expenditures to frame its discussion around physician payments, but payments are not the only component of the NHEX physician expenditures measure. It is comprised of physician payments (FFS and ARP payments), other types of payments and other provincially funded programs. There are significant reporting inconsistencies among provinces for this data (e.g., different types of program funding), resulting in an analysis that may

be skewed. When a more specific measure is selected (physician payments from FFS and ARPs), Alberta growth in physician payments is on par with the rest of Canada (excepting Quebec which is an upward outliner).

The following charts show how results change, comparatively, when corrected for these three factors.

The MacKinnon panel's report fails to consider per capita considerations when contemplating overall expenditure growth

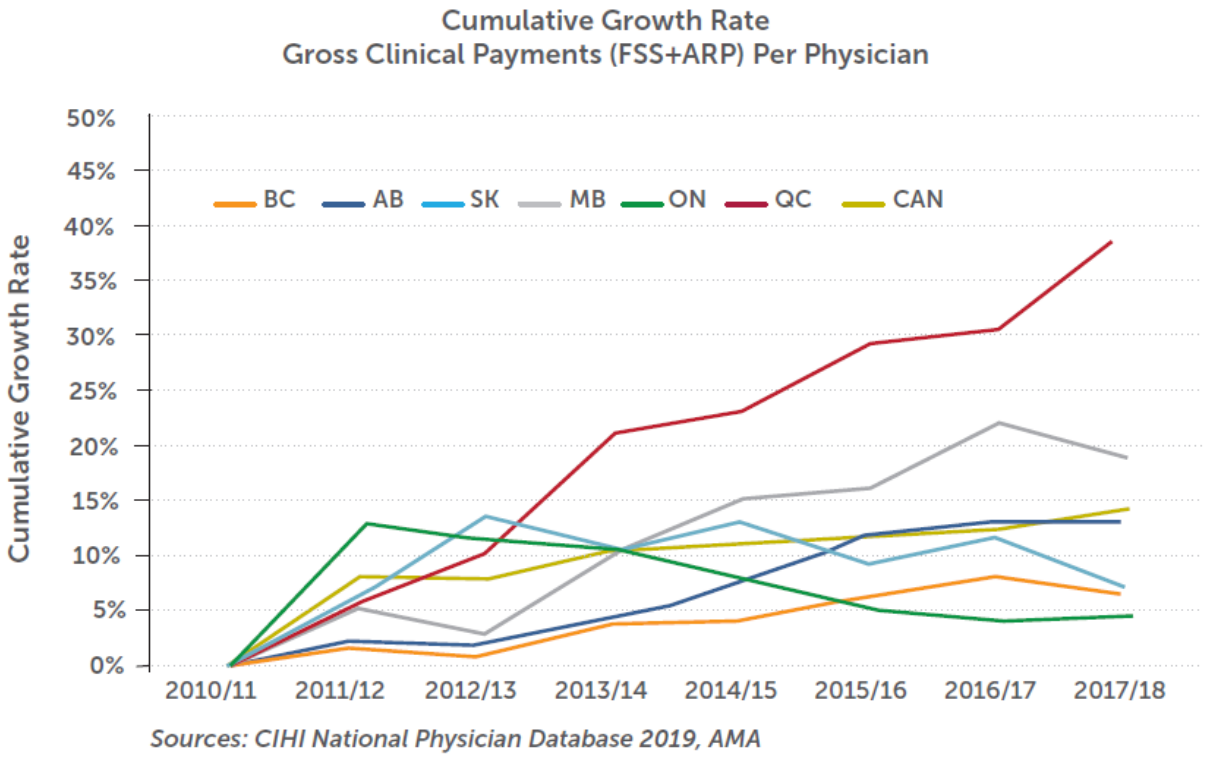
The chart below shows how, when appropriately contextualized by accounting for our province's population growth (even when using MacKinnon's problematic base year), Alberta's physician expenditure growth rate is substantially reduced.



Sources: CIHI National Health Expenditure Trends 2018, Blue Ribbon Panel Report - Gov of AB, AMA

A TRUER MEASURE OF DIRECT PHYSICIAN EXPENDITURE GROWTH RATE RESULTS IF TANGENTIAL PROVINCIALLY FUNDED PROGRAMS ARE EXCLUDED, AND THE POPULATION VARIABLE IS ACCOUNTED FOR

By using 2010 as a more appropriate base year (given the lack of surge funding in surrounding years); accounting for growth as measured on a per physician basis; and including relevant and direct expenditures (FFS and ARP payments) while excluding more tangential and indirect, inconsistently reported programming funds, a far more accurate picture of the cumulative growth in physician expenditures emerges. In this analysis, Alberta is far more in line with the growth seen in other provinces, with Quebec standing out as the upper outlier:



V. Physicians as employers

Significant downstream economic effects will likely be seen if payments for physician services are lowered

Government policy that reduces or constrains physician compensation is likely to have negative repercussions on Alberta's Gross Domestic Product (GDP). Reducing physician payments will necessarily and predictably lead to physicians reducing their staff complement. This, in turn, will add to Alberta's unemployment rate, thus reducing the overall purchasing power of Alberta's population.

Currently, Albertans have high debt loads and debt financing is a serious issue. At the same time, Alberta's current economic equilibrium is based upon an expected level of remuneration, e.g.; base price for housing, vehicle sales, minimum wage, etc. Deep and rapid public sector spending cuts will likely impact the ability of many debtors to maintain payments. Such cuts could likely have repercussions on other economic activity such as retail sales - leading to a downward spiral in economic activity.

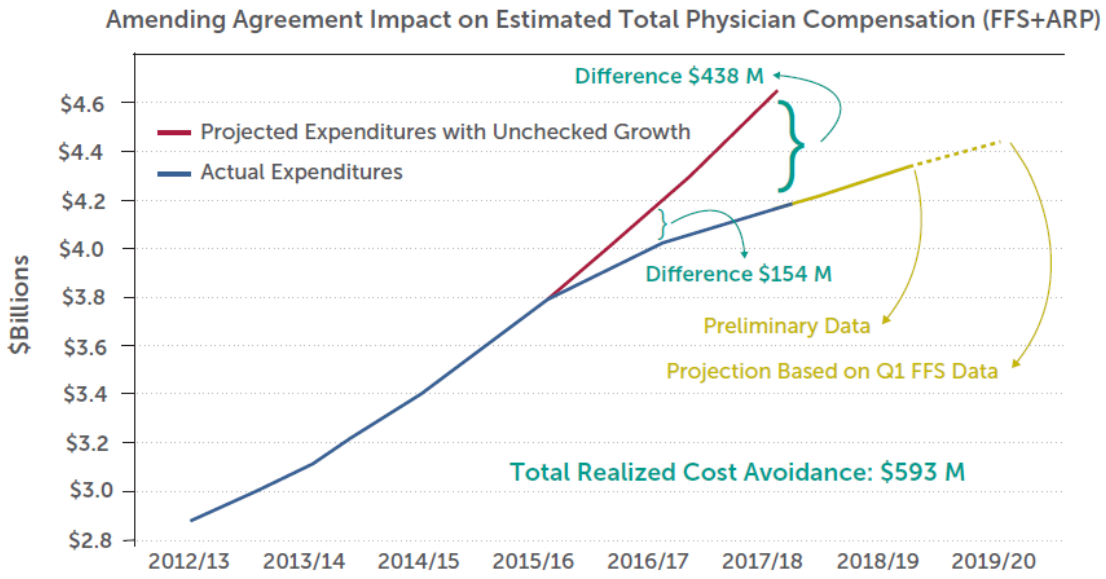
If negotiated increases to physician compensation are less than rising labour input costs (as they have been for the past 2 years), physicians experience a rollback in their incomes. From 2017-2019, physicians were earning less after overhead and, with rising prices in the economy, they were also able to purchase less with their incomes.

Misinformed and misguided spending restraint has the potential to generate an unintended, government-induced Alberta recession. At best, a lengthy period of economic stagnation would reasonably be expected.

VI. Alberta's year-over-year total costs for physicians have stabilized and are tracking to population + ageing + CPI

Accounting for population growth, aging and CPI is crucial if a true picture of Alberta's physician expenditures is to emerge. The previous two AMA Amending Agreements have included physician stewardship as a core theme and this approach has significantly bent the cost curve (including $593M in the first two years alone). Several collaborative initiatives have proven successful in identifying savings:

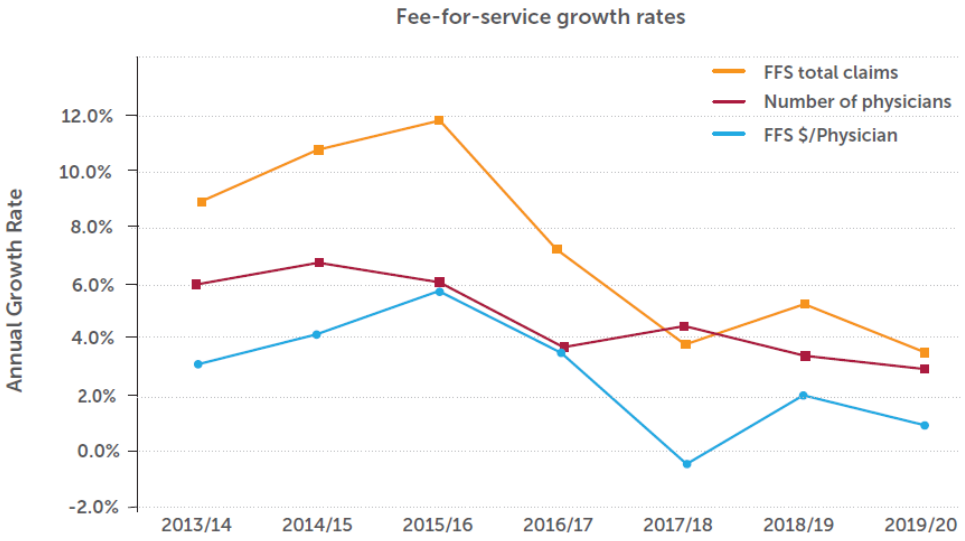
Working with physicians on these initiatives has significantly altered the trajectory of physician spending in Alberta to the extent that we are now tracking cost growth in line with growth in population plus ageing plus CPI:



Sources: AMA, Alberta Budget, FFS claims data, AH projections
Notes: Unchecked growth is assumed to be 9.7% based on 2015/16 growth in primary and specialist care renumeration and physician benefits between 2014/15 and 2015/16 (source Alberta Statistical Supplement)

The total growth in FFS has been reduced due to physician stewardship activity and is now tracking much closer to population growth plus ageing plus negotiated increases (which has traditionally kept pace with CPI).

As a consequence, the number of net new physicians in Alberta accounts for nearly all growth in expenditure:



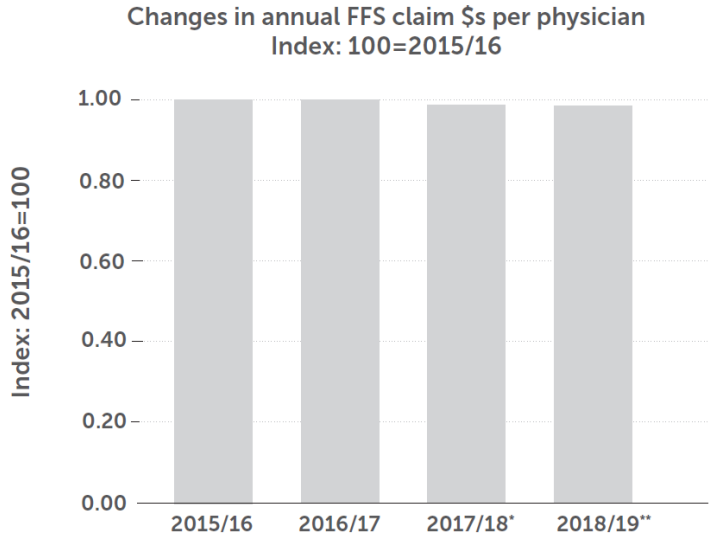
Sources: 2013/14 to 2017/18: AH Statisitical Supplement; 2018/19 to 2019/20; AH preliminary claims data; AMA calculations
**FFS total plus manual payment for retroactive COLA increases*
***FFS total plus adjustment for retroactive COLA increase for Apr-Oct (may not match AH Statistical Supplement)*
^Estimated Q1 growth rate for FFS $ and physician counts 2018/19 and 2019/20 used as estimates for annual growth rates

VII. FFS claims per physician has been declining for two straight years

There is a view that Alberta physicians have been intentionally increasing utilization year-over-year and that individual physicians behavior is therefore the main cause for any increased cost pressures (growth).

The AMA has examined the year-over-year changes to the amount of FFS claims per physician (without the impact of new and exiting physicians). A group of 4342 physicians were selected based upon certain characteristics including a minimum amount of FFS billing activity (see notes below). 2015/16 is selected as the base year for comparison because 2016/17 was the first year of the first Amending Agreement where physicians agreed to address the growth in utilization.

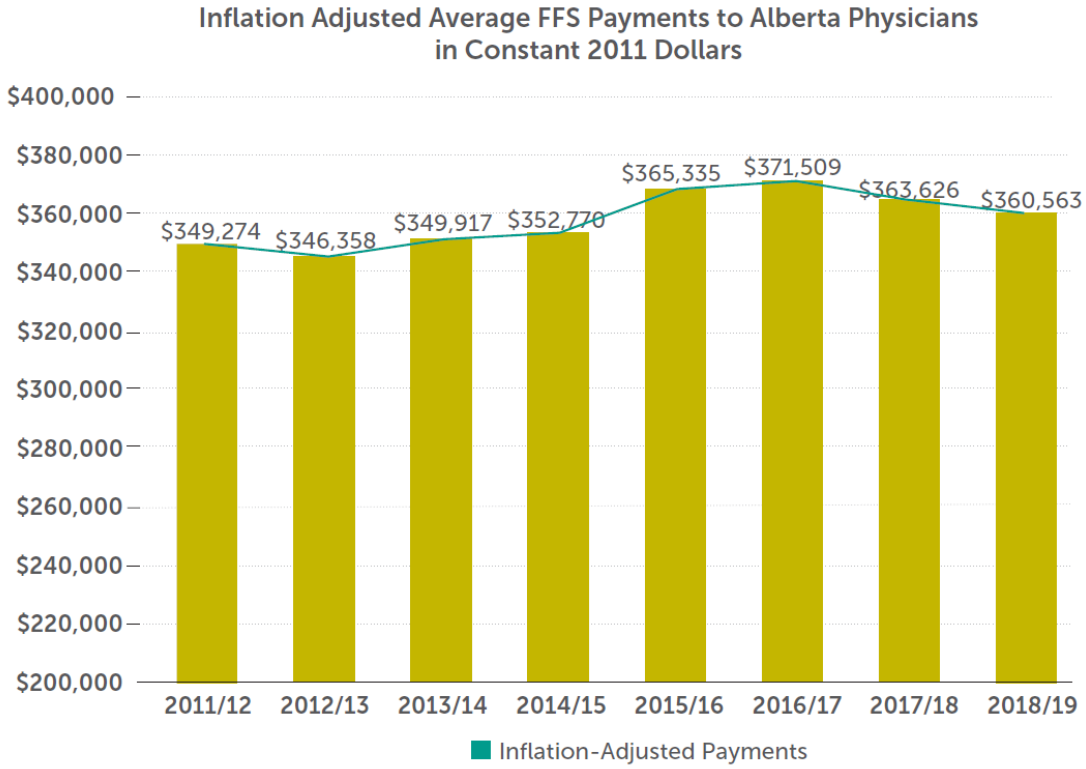
Results show that these individual physicians experienced a downward trend in earnings over the past two years, most likely as a result of the various stewardship/ cost-saving initiatives.



**1.05% increase applied at summary level for Apr 2017 to Mar 2018*
***1.05% retro increase applied at summary level for Apr 2018 to Oct 2018*
Sources: AH Claims 2013/14 to 2019/20 (preliminary claims dataset for 2018/19 and Q1 2019/20). Includes FFS physicians who claimed at least $100,000 annually for all years from 2013/14 to 2018/19, and at least $15,000 for Q1 2019/20.

It is notable that the fee for service claims of this cohort over the four years remains stable – supporting AMA's claim that individual physicians are not driving utilization growth year over year to make up for any loss in income (e.g., associated with the loss of retention benefit).

Furthermore, if all Alberta physician FFS payments are included and then adjusted for inflation, the chart below demonstrates how (inflation adjusted) FFS payments have declined over the last three years for the average Albertan physician:



Sources: 2011/12 to 2017/18 payments from AH Statistical supplement, 2018/19 payments from AMA analysis of AH preliminary claims file; CPI from Statistics Canada Consumer Price Index, Alberta All Items Annual Average not seasonally adjusted, Table 18-10-0005-01 .

VIII. What is actually happening in other provinces?

The MacKinnon panel's report doesn't have much to say about fee increases currently occurring in other provinces. In actuality, physicians in some provinces are currently negotiating, and as the chart below shows, others have recently seen negotiated or awarded increases in their agreements. Given the new physician agreements in other provinces, *a focus on restraint in Alberta is very likely to reduce Alberta's ability to attract and retain physicians.*

Comparability

Other provinces have recently negotiated new physician agreements that will impact interprovincial comparisons. Saskatchewan increases for 2017/18 onward are unknown as negotiations are ongoing. However, British Columbia estimates, based on $331M over three years ($121.6M in 2019/20, $103.66M in 2020/21 and $105.76M in 2021/22) represent a mix of fees, business costs and some program increases over the FFS and ARP base.

Other increases awarded in Ontario and Manitoba have recognized physicians for the value they provide and the rising overhead costs they are incurring.

Estimated interprovincial increases are as follows:

Negotiated Increases Since 2017/18 - Ontario West (plus Nova Scotia)						
Province	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
ON	0.75%	1.25%	4.95%	1.00%		
MB	2.40%	2.60%	0.00%	0.00%	0.75%	1.00%
SK*						
AB	1.05%	0.00%	0.00%			
BC	1.46%	0.50%	3.23%	2.67%	2.65%	
NS**			4.00%	4.00%	4.00%	4.00%

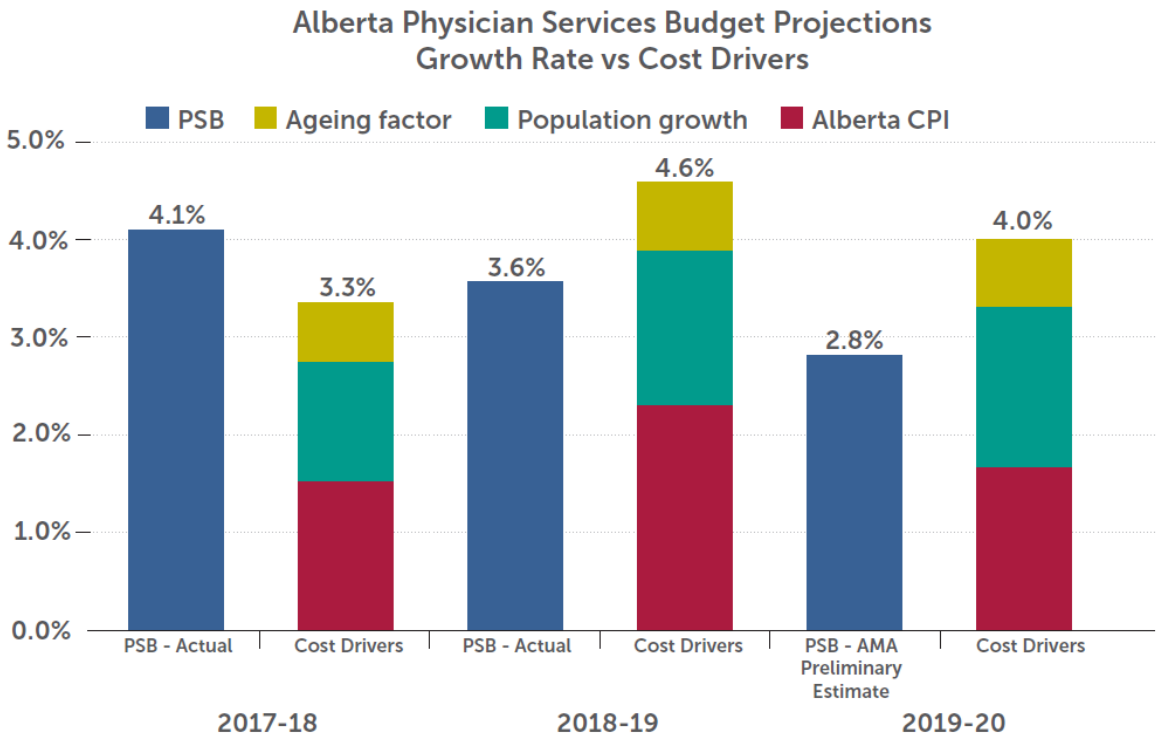
*SK Unknown

** Nova Scotia's awarded increase is effective April 1, 2019, and GPs in this province will see an increase of at least 23% per FTE

IX. Cost drivers in Alberta

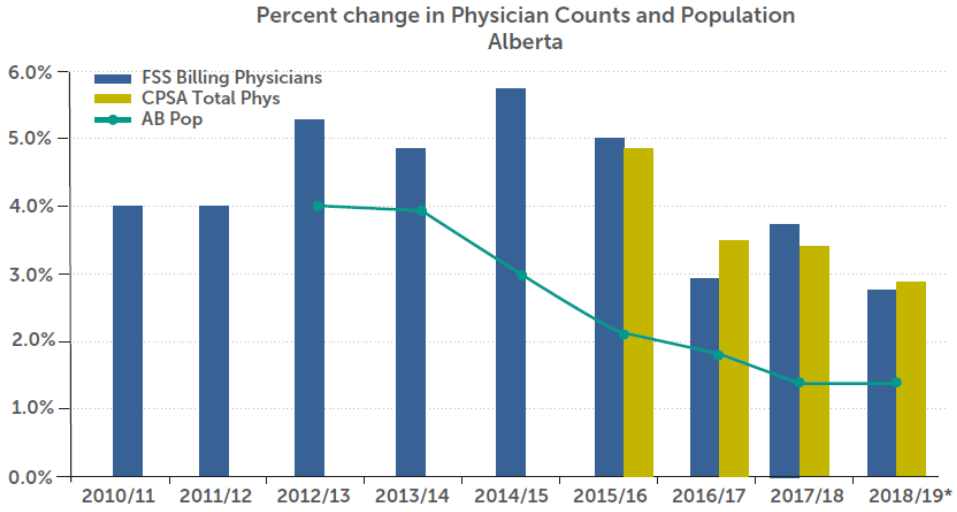
As for the 11.7% comparison, using nominal earnings as a comparator amongst provinces is problematic since prices in Alberta (due to a higher Consumer Price Index) exceed (past and present) all other jurisdictions. This is likely to remain so, particularly since the strength of Alberta's GDP and earnings outweighs all other provinces.

Looking ahead, the natural cost drivers associated with the physician services budget will be population plus ageing plus CPI. (CPI is necessary to address the increasing pressures associated with overhead).



Notes: 2019/20 growth estimated using AH FFS claims Apr-Jul; 2019/20 claims are preliminary
2017/18 and 2018/19 data have been adjusted to include fee increases
Sources: AB budget 2019, Oct 2019 PCC presentation, AMA

As mentioned above, the total growth of physician expenditures in Alberta over the past 4 years has been almost entirely associated with net new physicians:



Sources: AH Statistical Supplement, AH Claims Data, CPSA Physician Count Data, Stats Canada Population counts, AMA
**Notes: (1) 2018/19 Claims Data is Preliminary; (2) 2018/19 AB pop estimates growth rate calculated from Stats Can data*

MacKinnon has suggested that the AMA Agreement is an impediment when dealing with physician expenditure in Alberta under difficult economic times. Would MacKinnon had reached the same conclusion if she had understood that our previous two agreements have included physician stewardship initiatives and this has limited physician expenditure growth down to the cost of net new physicians entering Alberta – something government has always had the tools and levers to control (physician resource planning is not part of our agreement)?

X. Concluding Comments

THE CONCLUSIONS STATED WITHIN THE MACKINNON PANEL'S REPORT ARE NOT APPROPRIATELY CONTEXTUALIZED AND ARE OVERSIMPLIFIED. AS A RESULT, THEY CANNOT SAFELY BE RELIED UPON AS THE BEST EVIDENCE TO INFORM SOLID BUDGETARY DECISIONS. A THOUGHTFUL AND BALANCED SECOND LOOK IS REQUIRED IF THE GOAL IS TO ENSURE PAYMENTS TO PHYSICIANS ARE ON PAR WITH OTHER PROVINCES.

Alberta's payments to physicians are not 35% higher than those made to physicians by other provinces when a more complete analysis is undertaken. CIHI data and a thorough understanding of how different payment configurations (FFS and ARP) account for calculation differences actually narrows the gap to 11.7%; but as we have demonstrated in this paper, *when inter-provincial economic differences are also taken into account, payments to physicians in Alberta are on par with those made by other provinces.*

Physician payments in Alberta are largely in-line with other provinces when due consideration is given to the:

- Data reporting differences between provinces as reflected within the CIHI data;
- Similarity between provinces when individual service fees for common services are compared;
- Higher overhead and staffing costs that Alberta physicians must cover;
- Differences in physician specialty mix between the provinces;
- Industrial aggregate wage comparisons between the provinces; and
- Recent positive fee increases seen in other provinces.

Further, growth rates in physicians expenditures are not increasing more rapidly in Alberta than in other provinces when our population growth is taken into account and an appropriate base year (that will not selectively skew the data) for comparison between provinces is selected.

To ensure that the quality of the health care provided in Alberta does not suffer, the AMA emphasizes that government planning on a go-forward basis must not only take into account bottom lines, but rather consider other factors of critical importance such as population aging; population growth; and CPI.

If we assume that physician stewardship activities continue, we accept that the growth in the number of net new physicians in Alberta (which should appropriately be aligned with overall population growth) will be one of the primary factors predicting physician expenditures in the future.

A necessary caution

Initiatives cannot be 'cherry-picked' in isolation of the whole. They may not be the correct things to target – not the most important or most beneficial or the least harmful. A shared understanding of both policy objectives and determining how best to meet them - while avoiding unintended consequences such as worsened inequity - *requires a cooperative effort.*

Ultimately, collaborative negotiations towards a shared compensation strategy is a powerful instrument to achieve these goals that should not be dismissed. That is what is truly in Albertans' best interests.

Given the high risk of unintended consequences, it is critical for all stakeholders to work collaboratively on the expenditure restraint and stewardship initiatives required in light of the current fiscal situation. Government and physicians both have a role in ensuring that Albertans have timely access to quality health services and that the health system is affordable and sustainable.

Let's work together

Financial cost pressures are nothing new. Given these ongoing pressures on the health care system, the AMA is willing to explore new opportunities that support equity, access, productivity and quality. Let's do it together to achieve the best health care outcomes for Albertans.

In a time of economic constraint when the funding envelope is limited, we have to be even more careful to assure that spending meets the most important intended purposes. Limited resources require stewardship. In partnership with the AMA, Alberta Health has the opportunity to focus on any shared objectives by collaborating. Aligning these objectives can be accomplished through a collaborative provincial strategy on physician compensation.

Synergy results in magnified successes. Antagonistic relationships, the opposite.

Government has the tools and levers, including publicly-signaled limits and policy direction that can help the medical profession deliver ideas and support for the appropriate distribution of funds. Physicians' knowledge helps the parties align actions to meet population health needs and understand potential unintended consequences for the delivery of care that might arise from those actions. The AMA can marshal that knowledge to help the parties meet their shared responsibility to spend the available dollars most beneficially.

We look forward to meaningful discussions to best achieve our collective goals.