SMA Intersectional Allocation Process

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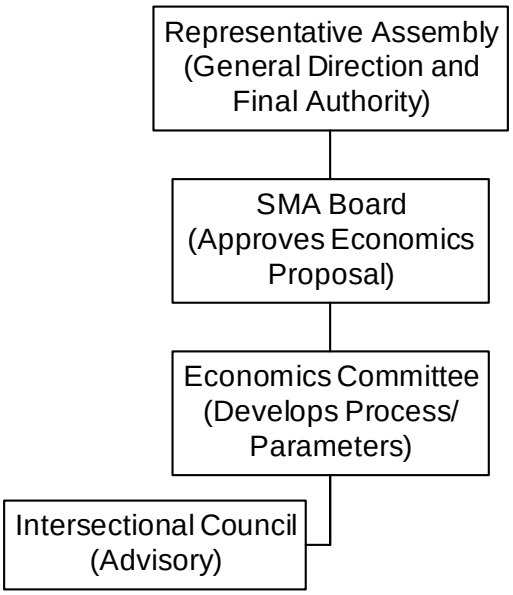
I. Overview

The Saskatchewan Medical Association is the organization primarily responsible for the allocation of funding among Saskatchewan's specialties. The SMA's Economics Committee, working under the advice of its Intersectional Council, is responsible for developing and managing the process for such allocations.

The SMA's governing body, the Representative Assembly, often provides general direction regarding disparity correction, and has ultimate authority over the allocation. However, it is typically the SMA Board of Directors that provides final approval of allocation decisions.



The Allocation is based upon a statistical process developed and refined by the Economics Committee over the past 15 years. Supporting data is drawn from a number of sources including the Ministry of Health Medical Services Branch (for insured income/payments data), the Workers' Compensation Board (for WCB Payments data) and the Canadian Institute for Health Information (for fee schedule comparisons with other provinces.

Before an allocation is carried out, the Economics Committee first develops a model to measure the disparity among sections. This involves the creation of three separate components:

1. Income index
2. Payment Schedule index
3. Workload index

II. Income Comparison

An income index is developed by comparing average payments, by specialty. Several considerations are taken into account when selecting the base data:

- Incomes of physicians working in community clinics and the College of Medicine are excluded, as they may not give a true indication of the fee-for-service earning potential in a specialty.

- Out of hours premiums, surcharges and on call payments are excluded from income. However, the base payments that physicians earn after hours are included.

- The SMA uses the average income of the 50th to 75th percentile for each specialty, as a "first adjustment" for workload differences. This factors out part-timers, and uses only the incomes of physicians who are in "busy practices" within their specialty. Where numbers are insufficient to draw from the 50th to 75th percentile, an average may be taken of physicians working in full-time practice.

- Payments from the Workers' Compensation Board are added. Depending on the specialty, WCB income can account for between 0 to 10 percent of a section's income.

- Payment data is adjusted for differences in overhead costs by specialty. Overhead proportions can vary significantly, ranging from 15 percent for Anaesthesia to 72 percent for non-hospital based radiology. These ratios are estimated using the average of Ontario, BC and Alberta estimates.

- Before comparing to specialist income, General Practitioner income is netted up by 10 percent. The notion is that, if equity were achieved, a specialist should still earn 10 percent more than a general practitioner. This is to reflect differences in training, skill level and lifetime earning potential (because of differences in residency requirements, a specialist will enter the workforce later than a general practitioner).

Adjusted incomes are compared to General Practitioners working in urban group practices to arrive at an Income index.

III. Payment Schedule Comparison

The second component in the disparity model is an index comparing each Section's fees with those in neighboring provinces. Such comparisons account for the fact that the physician market is highly competitive and, because of our relatively small market, Saskatchewan fee-for-service rates of payment must be competitive with other jurisdictions.

The Canadian Institute for Health Information develops a weighted payment schedule comparison for each specialty and province. Since the data is generally 3-4 years out of date, the SMA projects the data forward using recent interprovincial fee schedule increases by specialty and by province. The comparative group of provinces used in the model is Ontario, Manitoba, Alberta and British Columbia, as these are the main provinces with which we compete for physicians.

The resulting index is normalized so that GP's=1.0.

IV. Workload Index

A third component is an FTE or Workload Index, to measure the workload of our specialty groups (at the 50^{th} to 75^{th} percentile) in relation to their colleagues in the rest of Canada.

The SMA obtains from CIHI the upper and lower provincial benchmarks used for their most recent FTE study (usually 5 or 6 years out of date). These are the income thresholds used by CIHI to count the number of Saskatchewan full time equivalent physicians. They're based upon national practice volumes adjusted for provincial differences in Payment Schedule rates.

The SMA projects these benchmarks forward to the current date using using intersectional increases over the intervening period.

The payments to each section's average 50^{th} to 75^{th} percentile physician are then evaluated against these upper and lower benchmarks to obtain an FTE estimate. In most years, all exceed 1.0, for two reasons:

1. Saskatchewan physicians are in relatively short supply and consequently their workloads exceed the national average; and

2. We are evaluating our 50^{th} to 75^{th} percentile group against the FTE benchmarks which are based upon a lower 40^{th} to 60^{th} percentile group.

The raw index created is in the opposite direction to the income and payment schedule indices. We therefore invert it (and measure physicians per FTE) so that it can be combined into the overall parity index.

Finally, the FTE index is normalized so that Urban Association General Practitioners=1. This is consistent with the approach taken with income and payment schedule indices.

V. Overall Disparity Index

An Overall Disparity Index is created by weighting the above three indices as follows:

Income Index – 30 percent
Payment Schedule Index – 50 percent
Workload Index – 20 percent

By design, General Practitioners in urban group practice have a index of 1.0. The higher the index, the more well-off the section.

VI. Allocation Parameters

The Economics Committee considers and uses a number of parameters when developing an allocation. Some are fixed (e.g. the total dollars available to the profession), others come from directions of the Representative Assembly, and some are developed in consultation with the Intersectional Council.

A typical set of parameters would be as follows:

- Every section receives an "overhead" increase according to the CPI increase over the past year, and according to the percentage of their income that is attributable to overhead costs.

- The least disparate section (ie. the most well-off) receives a percentage increase of "x", while the most disparate receives "3x".

- All other sections in between these two bounds receive an increase according to their disparity index.

VII. Limitations

The SMA recognizes a number of data limitations in its allocation model. These include:

- For many specialties, there are very small samples, especially when using 50th to 75th percentile. In some cases such as neurosurgery, it's necessary to use the average payments of all the non-university section members. Because of small numbers, income and workload may not always be reflective of a typical busy practice.

- The income data does not account for income earned through private sources (e.g. cosmetic surgery, etc.), or hospital contracts such as radiological contracts. In the case of Radiology, the Economics Committee attempts to work around this limitation by considering only clinic-based physicians working under pure fee-for-service.

- Payment Schedule comparison data is generally 3-4 years out of date. Current year projections are developed, but these do not account for utilization increases or decreases over the estimation period.

VIII. Further Information

For further information regarding the intersectional allocation process, contact Mark Ceaser, Director of Economics (mark@sma.sk.ca) or Viktoriia Didkovska, Senior Compensation Analyst (viktoriia@sma.sk.ca).