April 2016

Dear colleagues:

Winston Churchill once said: I never “worry” about action, but only about inaction. These wise words have stayed with me over the past several weeks given recent presentations and discussions I have participated in at the Saskatchewan Medical Association Board of Directors table as well as Economics and Intersectional Council committee meetings.

The topic for these gatherings has been the current and emerging healthcare system trends and the leadership role physicians can and should play going forward. The impetus for these discussions began earlier in the year with the SMA Board of Directors as we reflected on some of the initial efforts underway with payment schedule modernization. We acknowledged that while there was and is necessary work to ensure fee codes are contemporary or “modernized”, bigger challenges or opportunities await us as a profession.

We asked our senior staff, with the help of a consultant, to pull together some information on the provincial, national and international health care landscape and began sharing it with the constituencies mentioned above. At each of these forums, vibrant discussions and debate ensued. The initial overview clearly whetted the appetite of Intersectional Council members for additional information. They indicated that “even better” would be more in-depth information to inform subsequent discussions.

We took that to heart and have prepared the attached discussion paper: The Future Physician Role in a Redesigned and Integrated Health System. The purpose of this document is to launch and inform a dialogue among our members about the compelling reasons for change and how we as a profession want to participate in the change process. Like good medicine, it begins with observation and diagnosis – agreement on the issues and problems is essential if we are to come up with the right solutions. It outlines trends, supplies some data but does not end with a solution, but with questions. The perspective is global rather than local, and grounded in one overarching ambition: to make Saskatchewan the best place in the world to practise medicine.

The document is a clear, evidence-based summary. In places it challenges longstanding approaches to how we work, including how we are paid. If you are like me, you may find some of these discussions uncomfortable. However, I recognize that the intent of the paper is to support doctors and make our professional practice more rewarding. It starts from the premise that doctors make enormous contributions to the well-being of Saskatchewan. However, as the paper outlines, the world of today is different from that of even ten years ago, and we have an enormous opportunity to shape a better future.

Each and every day, individual physicians work tirelessly to make care better and safer. Now our profession is being called to collectively step up as effective stewards of healthcare resources. Strong, effective physician leadership is necessary for any healthcare system to achieve its full potential. By virtue of our history and our position, we, as physicians, have a disproportionate impact on the healthcare system when compared to any other provider group. We are the point of first contact for most patients as they seek care. We have multiple roles across the entire spectrum of the healthcare system including caregiver, teacher, advocate, and leader. The privilege of power carries with it both great responsibility and the opportunity to not only treat our individual patients, but to better understand and improve our province’s healthcare system. It is important to note that this multivariate role of the physician is acknowledged in the SMA’s strategic priorities.
We believe significant change within the healthcare system is coming. These changes will likely happen whether we are involved in the change or not. Ideally physicians will be actively participating in the design and planning of a new system. To be effectively involved will mean having to be better informed. The kind of positive, physician-focused discourse proposed by the discussion paper is a good place for physicians to start re-imagining healthcare.

Our healthcare system is in a state of constant change; the medical profession must also evolve in order to not only survive, but thrive. The SMA can take full advantage of an opportunity to redefine our professional role and responsibilities. I can see a future where the SMA has, through effective leadership and partnership, pulled our system to a higher level of performance than ever imagined. Through advocating for a more transparent, patient-centred, evidence-based health system, Saskatchewan physicians, through the SMA, will lead the ongoing transformation of aspects of the quality of care provided to our public.

We have the need, expertise, leadership and the relationships necessary to create a better system. We as a profession have a choice: we can cling to the status quo and react to changes proposed by others, or we can embrace the prospect of a transformation that will improve the lives of our patients and our profession.

As you read the discussion paper, think about the Churchill quote I shared above. Reflect on the future of our profession – will we be leaders or followers in the creation of tomorrow’s healthcare system?

I look forward to the discussions we will have in the weeks and months ahead.

Dr. Mark Brown, President

On behalf of the SMA Board of Directors
The Future Physician Role in a Redesigned and Integrated Health System

April 2016
Fulfilling Our Ambitions, Transforming the System

For at least three decades, reviews of the Canadian health system by government-sponsored commissions and task forces, think tanks, and professional associations, including the Canadian Medical Association and the Canadian Nurses Association, have called for health system transformation. There is widespread consensus on what needs to be done. In broad strokes, the goals for the system are succinctly defined by Saskatchewan’s version of the Institute for Healthcare Improvement’s (IHI) Triple Aim. Saskatchewan has adapted these goals, as illustrated below.

Figure 1. Saskatchewan’s Vision for the Saskatchewan Health System (IHI’s “Triple Aim” Adapted)

Yet these aspirations have not been realized despite the pursuit of several different strategies:

- Invest massive amounts of new money: from about 1997 to 2010, healthcare spending across the country doubled in real terms.
- Change organizational and individual behaviours through financial incentives such as pay-for-performance (P4P), activity-based funding, and bonus payments for certain types of care and achieving certain targets.
• Reorganize, with provinces regionalizing and de-regionalizing, creating or modifying structures, and creating new administrative portfolios. While there have been some improvements, nothing has had transformative effects.
• Produce more clinicians. Collectively, Canadian medical schools have almost doubled enrolment since the turn of the 21st century, and international medical graduates add to the growing supply.

Our system was designed in the mid-20th century for a younger population, when inpatient care was the norm for most serious conditions, there were relatively few effective drugs, and healthcare technology was far less advanced than it is now. It was assumed that better healthcare meant better health; the population health research enterprise that has illuminated the primacy of the non-medical determinants of health gathered steam in the late 1970s and early 1980s. Demographically, the population aged, with many more people living into their late 80s and early 90s. Epidemiologically, many previously fatal conditions such as heart disease and cancer have become chronic conditions. With old age comes a much higher risk of cognitive decline.

The work of today’s health system is therefore very different from fifty years ago. Health science educators, practitioners, managers, and governors have been struggling to adapt to new needs and new complexities. Healthcare consumes at least 40 percent of provincial government revenues, crowding out other expenditures. The workforce is more highly trained than ever. There have been some magnificent technological advances, particular in diagnostic imaging and laboratory testing. Surgery has become much more efficient and effective. While the components of healthcare advance continuously, the system is less than the sum of its parts. We remain vexed and frustrated by long waits, breakdowns in communication, uneven chronic disease management, caregiver burden, and poor value for money.

These shortcomings explain why our health system performs poorly by international standards. The Commonwealth Fund is perhaps the world’s leading organization that compares health system performance across countries via analyses by examining performance data, and conducting clinician and public surveys. In its 2014 report, Canada placed 10th of 11 countries in overall performance.

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The term “health system” is deliberately broad, spanning the continuum from health promotion and population health improvement to specialized acute care.
Physicians are central to the health system. Its successes are our successes, and its failures are our failures. Saskatchewan has always been a can-do province in healthcare. We invented Canadian medicare, and we have an opportunity to reinvent it. The status quo appears to be no longer an option: the combination of increasing technical capacity, growing numbers of practitioners, high costs, government fiscal challenges, and external examples of high-performing systems creates a compelling case for change. Successful change is built on introspection, open-mindedness, evidence, collaboration, and commitment.

The purpose of this discussion paper is to launch a dialogue among our members about the compelling reasons for change and how we want to participate in the change process. Like good medicine, it begins with observation and diagnosis; without agreement on what the issues and problems are, no course of action or prescription is likely to lead to the desired outcome. The perspective is global rather than local, and grounded in one overarching ambition: **to make Saskatchewan the best place in the world to practice medicine.** If we achieve this goal, Saskatchewan will be the best place in the
world to stay healthy, and the best place to receive healthcare. Our professional ambitions are indistinguishable from our ambitions for our province and our people.

Importantly, there is nothing in this paper that has not been known for years. What is new is the notion of physicians playing a central leadership role in creating a system that improves health outcomes. We are inspired by integrated health systems like Kaiser Permanente, Group Health Cooperative, and Intermountain Health – systems where physicians play leadership roles and have the authority to work with colleagues to deliver high quality, efficient care.

The remainder of the paper describes the factors that will affect health and healthcare in the foreseeable future, and their implications for physicians (numbers, distribution, payment). The discussion is aligned with the SMA Strategic Plan’s 4 pillars:

- Continue to be a strong, member-based organization
- Enhance physician well-being
- Enhance the physician role in the healthcare team model
- Improve physician participation and leadership in healthcare design

**New Realities’ New Approaches**

Health systems are a paradox: they combine dynamic changes in technology and capability on the one hand, and inertia resulting from complexity and ingrained patterns on the other. In every sector, practice must respond to new science, changing demographics, and broader societal trends and expectations. Medicine is dealing with an older population living with chronic conditions. In the United States, people with one or more chronic conditions account for an estimated 86 percent of health care spending. In Canada and elsewhere, research has revealed major quality problems despite a highly skilled workforce. These and other factors have led to repeated calls for health system delivery and payment reform.

Table 1 summarizes these major cultural shifts inherent in these developments. Together they suggest a fundamental re-examination of healthcare delivery. In Canada, an additional catalyst for change is our comparative performance; other rich countries do a better job of providing timely, efficient, and high quality care. The problem is not a lack of money; Canada usually ranks in the top five in per capita spending. Put simply, we are trying to run a 2016 health system with the approaches developed half a century ago. The common thread that runs through the dozens of healthcare reports produced over the years is that we need a population health-focused, primary care-based, team-based, patient-centered system. Yet by objective measures we have not achieved it.
Funding, Payment, and Practice

Physician payment does not exist in a vacuum; it is part of and influences the overall system. How physicians are paid affects more than physician incomes. It affects the organization of healthcare work and the use of healthcare resources. It encourages some practices while discouraging others. There is no perfect way to pay physicians; what is important is aligning the payment system with the goals of the system.

In Canada and Saskatchewan’s fee-for-service (FFS) comprises slightly over 70 percent of all payments. Both the benefits and the critiques of FFS are well-known. Recent analyses and policy discussions have almost universally concluded that on balance, FFS on its own is not, and cannot be made to be, compatible with contemporary health and health system goals. If we were starting the health system with a blank slate today, it is unlikely that either physicians or governments would choose it as the principal payment method. But it is the system with which we are familiar, and physicians have organized their practices and their practice styles around its structures and incentives. Even so, in surveys a strong majority of Canadian doctors favour a blended payment system, and younger physicians in particular are open to different mechanisms.

Thus far changes have been incremental; the FFS/non-FFS proportions of total payments have been stable for about five years. But a number of factors – financial, structural, and cultural – suggest that the status quo will not continue indefinitely. Perhaps the main pressure comes from simple arithmetic: the forces that drive up healthcare spending may exceed the capacity or willingness of government to accommodate them.

How we fund programs and pay providers is part of the health system culture. For payment systems, like other structures and mechanisms, form should follow function. The logical sequence is to get consensus on health system and physician goals and then develop payment mechanisms to align with them. Currently, physicians work under a collective agreement that has to be renewed and updated every few years. It is by no
means a certainty that physicians and the government can create a new collective agreement that addresses long-standing issues. A perfect payment system does not exist, and no one approach will be embraced by every doctor. What is certain is that unless there is a willingness to imagine a different collective agreement in an unconstrained environment, we will never know what is possible and whether it is a significant improvement over the status quo.

What would a different kind of agreement try to accomplish? There are many critical issues to explore, including:

- How can physicians become more fully integrated into the system?
- What does enhanced accountability for performance mean?
- How do we optimize the scope of practice of all physicians in healthcare teams?
- How do we shift the focus of the system toward areas of greatest need – frailty, mental health, chronic disease management?
- What does equity among physicians mean – what degree of income inequality is acceptable?
- What mechanisms best encourage the shift from volume to value, and the elimination of waste?

A. Physician Supply: How Many Do We Need?

There are more doctors per capita in Canada than ever before: 224 per 100,000 in 2014. After a no-growth period between 1992 and 2006, the last decade has seen supply increase sharply. This trend is likely to continue because medical schools are producing nearly double the number of graduates than at the beginning of the century.

Saskatchewan’s trend is similar, rising from 154 to 189 per 100,000 in the past decade. To get to the national average of 224, we would need an additional 400 doctors\(^b\) for the current population. It is highly probable that we will reach this figure (and that the national average will continue to rise as well). Enrolment at the U of S medical school has risen from 60 to 100. Retention rates are rising for three main reasons. Saskatchewan’s economy has boomed for a decade and out-migration rates have declined significantly. Opportunities to move elsewhere are shrinking because the historically favoured destinations of Alberta and British Columbia have even higher physician: population ratios. And other provinces’ medical schools are also taking in far more students than a decade ago, which creates an overall supply bulge.

\(^b\) The current population is 1.14 million. We currently have 1,890 physicians per million. To get to 2,240 per million, we would need \((2,240-1,890)\times1.14 = 399\) more physicians.
More doctors results in more spending. Average gross billings per active physician (billings at least $60,000) in Saskatchewan were **$363,000 in 2012-13** and are in the order of $375,000 now. Presuming the province continues to add at least 50 new doctors annually, and if these additional doctors would bill at current rates, an additional $150 million to the physician compensation envelope would be required over the next eight years. But the impact on the system would be far greater because the physician “footprint” on total system costs includes lab tests, diagnostic imaging, drugs, hospitalizations, and other services. If we assume that all prescription drug and hospital costs are attributable to physician decisions, doctors drive about 70 percent of total system costs. Another 400 doctors, then, could be expected to increase total system costs by about $525 million. This may be understated in that it does not account for major new facilities and other forms of capital that may be required to accommodate the new activity.

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The calculation is $400 \times \$375,000 \times 2.5$ – the 2.5 is the multiplier to account for the additional drug and hospital expenditures.
There is nothing intrinsically meaningful about national averages, nor is there an objective formula for calculating how many doctors are needed. The recently released planning tool for physician supply in the province illustrates how projected requirements depend on models of care. In one scenario there are already too many primary care physicians; in others there are not enough. Even having the right number overall does not mean that they will be evenly distributed to meet population needs locally.

Internationally, there is very little relationship between the number of physicians per capita and health status (see Fig. 4 below). This is hardly surprising in that the Canadian Medical Association (among others) estimates that only 25 percent of health status is attributable to healthcare. Large variations in physician supply by region do not predict either patient satisfaction or health outcomes. Based on this research, the authors of the Dartmouth Atlas of Healthcare, which reports on geographic variation in physician supply, system expenditures, and health outcomes for the US Medicare (65+) population, concludes:

*Increasing the number of physicians will make our health system worse, not better. First, unfettered growth is likely to exacerbate regional inequities in supply and spending; our research has shown that physicians generally do not choose to practice where the need is greatest. Second, expansion of graduate medical education would most likely further undermine primary care and reinforce trends toward a fragmented, specialist-oriented health system. Current reimbursement systems strongly favor procedure-oriented specialties, and training programs would almost certainly respond to these incentives. Third, workforce expansion will be expensive. If outcomes and patients' perception of access improved as supply increased, then we could debate whether an expansion of training offers better value than investments in preventive care, disease management, or broader insurance coverage, which have known benefits. Instead, the costs of expansion will limit the re-

![Figure 3. Cost of Adding 50 MDs/Year To 2026](image-url)
There are many explanations for the apparent disconnect. One is that beyond a certain level, healthcare, like any other service, yields diminishing returns. Physician groups have recognized that while there is a scarcity and underuse of some services (mental health, geriatrics), there is also growing abundance of others, especially in the areas of diagnostics (lab tests, diagnostic imaging), drugs (polypharmacy in the elderly, overuse of antibiotics), and some interventions (knee arthroscopy, cataract surgery). This phenomenon underlies the Choosing Wisely Canada movement, widely endorsed by provincial medical associations, including the SMA.

The notion that there may be an adequate or even surplus supply of physicians would appear to fly in the face of common experience, e.g., the large numbers of Canadians without a regular source of care, and the long waits to see a specialist. But there are paradoxes here as well. The proportion of Canadians without a regular family physician is similar in large urban areas with high physician: population ratios and rural areas with lower ratios.\(^d\) Ontario enrolled more than a million previously unattached patients in primary care practices without a major increase in supply. Family medicine has changed: a British Columbia study showed that only a quarter of family physicians are

\(^d\) For example, Vancouver in 2014 had 168 family doctors per 100,000, compared to 122 in the rest of the province and 109 in Canada. Yet there are a reported 100,000 people in the city without a family doctor – about 15 percent.
full-service practitioners for the great majority of their patients. Specialist wait times are often unacceptably long, but again, it is not simply a question of physician numbers. A system of pooled referrals could even out wait times and shorten many.

Finally, health human resource needs depend on the model of care. In Canada and Saskatchewan, there is one family physician for about every 1,000 people. But there are huge variations among physicians in the number of patients for whom they are the primary provider. Systems like Group Health Cooperative in Washington State have one family physician for every 1,800 patients. The model works because of the team-based structure where other professionals work to their maximum scope of practice and many office visits are avoided by the use of telephone and email.

Hence how many physicians Saskatchewan needs depends on how we organize and distribute the work of healthcare. If current practice cultures and patterns remain largely intact, and if there are few barriers to entry into the medical workforce, we can expect numbers to continue to increase faster than the rate of population growth. If, on the other hand, there is greater focus on not just access, but on the appropriateness of care (a declared provincial priority) and an openness to a different division of labour, the justification for both current and forecasted numbers is open to challenge.

**Implications for Saskatchewan Physicians**

1. A larger physician workforce will create upward pressure on healthcare spending.

2. Whether the province needs more physicians depends on objectives, models of care, distribution, and prospects for reducing inappropriate care.

3. As the province intensifies efforts to increase the appropriateness of care and to adopt more interdisciplinary modes of primary care, it will be increasingly difficult to accommodate the anticipated influx of new physicians.

4. Unless general economic conditions improve substantially, the growth in the healthcare budget will likely be modest.

5. A different payment model could create room for more physicians working differently, emphasizing primary and secondary prevention and harvesting the rewards of implementing Choosing Wisely and related initiatives. Whatever payment models are eventually explored and developed should be aligned with the shared goals for the system and the profession.
B. Physician Payment Redesign: Incremental or Transformational?

The government and the SMA, based on recently concluded MCRC negotiations, are currently engaged in what has been termed a fee schedule modernization exercise. The project charter lists ambitious goals, including:

- Better health, better care, better value, better teams. (Saskatchewan’s version of the Triple Aim)
- Outlining a principled fee code review process that is responsive to changes in technology, accurately reflects standards of care, and supports modern service delivery.
- Ensuring the best possible distribution of public resources, with a focus on patient-centered care, appropriateness, fairness and equity among and between physician groups.
- Adding clarity and precision to billing and reporting services, allowing physicians to bill with confidence and support fair and effective audits.

Much depends on whether “modernization” means retaining the basic structure of the existing fee schedule, or whether it suggests the possibility of a fundamentally different system. If the current fee schedule is to be the foundation for the next collective agreement, the negotiations will mainly consist of individual fee code modifications, the elimination of obsolete codes, and the addition of new codes.

Attempts to align FFS with system performance goals have generally taken two approaches:

1. Attach performance bonuses to the achievement of specific care targets.
2. Provide additional payments for participation in designated quality improvement activities (e.g., chronic disease management) and/or practice redesign (e.g., hiring non-physicians to augment primary care).

Neither approach has had the desired effect despite (in some cases) large scale investments. In British Columbia, after close to a billion dollars in incentive payments to primary care physicians over a decade, researchers found that care had declined in both comprehensiveness and accessibility. A systematic review of Pay for Performance (P4P) experiments found few examples of major positive impact and a general inability to attribute any observed effects to P4P rather than other factors. In the UK, P4P did have short-term positive effects for two of three target conditions, but improvement levelled off and non-incentivized aspects of care worsened.
These experiences have sparked a debate about what motivates physician behaviours, and whether classical economic theories apply. The debate is not definitively settled, but healthcare is paying greater attention to the insights of behavioural economics. A recent study reviewed both the logic and the empirical results of P4P schemes and concluded that not only are purely financial incentives ineffective, they can also “crowd out” more altruistic motivations. In an interesting experiment, Green found that retrospective payment systems (FFS and P4P) encouraged over-service and lowered quality.

Re-engineering the Workforce: The Role of Payment Systems

Payment models are means to ends. They are effective when they reflect and align with shared perspectives on what is important and what constitutes value. The historical assumption was that all services delivered value. That is no longer tenable – there is simply too much evidence that more is not necessarily better. There is an epidemic of overdiagnosis. Drugs and technologies that are highly effective in some circumstances are often deployed “off label” to little effect. Quality experts estimate that as much as 30 percent of healthcare is either useless or harmful. In theory, eliminating waste is an ideal solution that frees up enormous resources. In practice, it has proven very difficult to reduce inappropriateness.

There may be broad consensus that the payment model needs to align with broader goals, but that does not guarantee that the transition will be easy, or that payment reform alone will accomplish Saskatchewan’s goals of better health, better care, better value and better teams. Working out the details of a transition is by no means simple and trouble-free. Unintended consequences are a risk in any transformation. Among the issues that need to be addressed are:

1. What does productivity mean if it does not mean volume? There has to be a persuasive alternative definition of productivity that works to the benefit of both patients and providers, and provides a valid and transparent basis for accountability. There also has to be a health information system that captures what is done and charts outcomes as a key element of continuous quality improvement.

2. The fee-for-service system (FFS) is based on the premise that more volume always equals better care. As the physician-led Choosing Wisely Canada initiative and research on low-value care have demonstrated, this premise is no longer persuasive. It is undeniably the case that where care is fully appropriate and useful, a FFS system is compatible with the goals of better care and lower per capita costs. But it also leads to major practice pattern variations that often result in major differences in resource consumption, e.g., different propensities to use expensive diagnostic procedures or higher surgical intervention rates. Payment reform
alone will not resolve these dilemmas. It is part of the solution but the persistence of major practice is a serious challenge to improving value for money.

3. No one disputes that effective, interdisciplinary team-based care is the pathway to providing better care for a population with increasingly complex needs. There is likewise consensus that the division of labour among healthcare occupations is far from optimal. Ideally all occupations would work to their maximum capacities, and expand capabilities throughout a career based on continuous learning. Current payment systems, regulations, standards defined by individual professions, and in some cases legislated practices can create barriers to workforce flexibility. Some of these constraints protect the public; others merely entrench existing interests and practices.

Table 2 below describes how physicians are paid in ten American healthcare systems renowned for their excellence. The dominant mode is a combination of salary and some modest performance-based additional compensation. It cannot be said that the compensation method caused the performance; the doctors have self-selected to be part of these systems and others may not find the environment to their liking. But it is striking that American medicine is moving rapidly away from FFS across the board. Sylvia Burwell, the US Secretary for Health and Human Services, has stated, “Our goal is to have 85 percent of all Medicare fee-for-service payments tied to quality or value by 2016, and 90 percent by 2018... [and] to have 30 percent of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50 percent of payments by the end of 2018.”

The American examples show how pockets of excellence can thrive even in a system that is elsewhere the worst combination of quality and cost in the world. By contrast, the NHS is ranked first on most of the indicators in the 2014 Commonwealth Fund report (see Figure 2 above). While that system is by no means perfect, it is distinguished by three main features: a) physicians who are more fully integrated into the system and who play leading executive roles in system design; b) a strong commitment to evidence-based practice supported by a robust health information system; and c) major investment over the past two decades to strengthen and expand a patient-centered, team-based primary care system. Notably, the system is the second least expensive of the 11 countries, with per capita expenditures 25 percent lower than Canada’s.
Table 2. Physician Compensation Models in High-Performing Health Systems

<table>
<thead>
<tr>
<th>Health system</th>
<th>Number of physicians</th>
<th>Salaried</th>
<th>Percentage of physician compensation linked to performance</th>
<th>Performance domains</th>
<th>Performance measured at group or individual physician level</th>
<th>Is individual physician performance data viewable by colleagues?</th>
<th>Process for metric development</th>
</tr>
</thead>
</table>
| Atrius Health                  | ~1000                | Yes, prod adjusted | Up to 42% in primary care only                            | 1) Quality  
2) Patient experience  
3) Population management  
4) External activities  
5) Admin duties | Both                                                      | Yes                                                                          | Middle managers select metrics                                   |
| Cleveland Clinic               | ~3200                | Yes, prod indep. | None                                                      | 1) Patient care  
2) Education  
3) Research  
4) Expanding access | Mostly individual                                                                  | Yes; plan to start public disclosure of physician quality                      | Each department selects metrics                                 |
| Geisinger Health System        | ~1100                | Yes, prod adjusted | 20%                                                      | 1) Quality  
2) Patient experience  
3) Expanding access | Both                                                                  | Yes; staff and publicly in general sense “star rating 1–3”                      | Service lines select metrics                                  |
| Group Health Cooperative       | ~1000                | Yes, prod adjusted | 5–10%                                                     | Primary care:  
1) Service  
2) Quality  
3) Utilization,  
4) Panel size | Both                                                                  | Service lines select metrics                                  | Both service lines and management select metrics               |
| Intermountain Medical Group    | ~1100                | No (75% fee-for-service) | 25%                                                      | 1) Quality  
2) Service  
3) Cost  
4) Downstream utilization patterns | Both                                                                  | Yes; patient satisfaction viewable by general public                          | Both service lines and management select metrics               |
| Iora Health                    | ~20                  | Yes, prod indep. | None                                                      | 1) Patient experience  
2) Health outcomes  
3) Teamwork  
4) Downstream utilization patterns | Both                                                                  | Yes                                                                          | Both service lines and management select metrics               |
| Kaiser Permanente (Southern California) | ~6000 | Yes, prod indep. | 5–10%                                                     | 1) Quality  
2) Service  
3) Health outcomes  
4) Teamwork  
5) Downstream utilization patterns | Both                                                                  | Physicians see personal rank, but not names                                | Departments and management select metrics                      |
| Mayo Clinic                    | ~3800                | Yes, prod indep. | None                                                      | 1) Patient experience  
2) Efficiency  
3) Effectiveness  
4) Mortality  
5) Safety  
6) Service  
7) Quality  
8) Teamwork  
9) Utilization  
10) Panel size | Both                                                                  | Departments and management select metrics                                  | Departments and management select metrics                      |
| One Medical Group              | ~150                 | Yes, prod indep. | 5–10%                                                     | 1) Quality  
2) Service  
3) Teamwork  
4) Downstream utilization patterns | Both                                                                  | Yes                                                                          | Service lines and management select metrics                     |
| Partners Healthcare (MGPO)     | ~2000                | Yes, prod adjusted | 20%                                                      | 1) Quality  
2) Safety  
3) Academic  
4) Productivity  
5) Efficiency  
6) Effectiveness  
7) Mortality  
8) Teamwork  
9) Utilization  
10) Panel size | Both                                                                  | Sometimes, but often blinded                                                | Departments and management select metrics                      |
tem efficiency. One reason for this is that there are different perspectives on getting good value for money among patients, practitioners, and managers. What is waste to some is reassurance or extra precaution to others. Responsibility for eliminating waste (e.g., reducing readmission rates or hospital admissions related to chronic conditions that ideally are best managed in the community) is diffused. Every additional cost generated by an unnecessary test or a doubtful procedure consumes scarce resources. These phenomena have been known for decades. Understanding the factors that lead to poor value for money is essential to developing strategies for improvement.

One of the unique features of North American medicine is the fragmentation of clinical practice. Since the beginning of medicare, physicians – especially those working in the community – have worked mostly independent of other parts of the health system (e.g., hospitals, long term care homes, etc.). Moreover, the information system does not inform providers about how their practices compare to those of their peers and the consequences for both patient well-being and resource use. If physicians do not get useful feedback on their practice patterns, they have no concrete basis on which to make changes.

A third element of the problem is that physicians are not organized into peer groups that support each other in efforts to improve quality and efficiency. One of the hallmarks of high-performing health systems is the standardization of care where the evidence for clinical pathways is strong. As Dr. Brent James, Chief Quality Officer with Intermountain Healthcare, shared with Representative Assembly delegates a few years ago, there is little chance that unwarranted practice variations will narrow unless there are opportunities to bring doctors together in a learning environment to address issues of variation and appropriateness.

Closer to home, community-based physicians remain largely outside the orbit of health regions. The regional board and administration have a duty to manage their budgets and allocate resources to achieve the maximum health benefits for the populations they serve. Clinicians have not traditionally been expected to share this broader stewardship perspective; their obligations have, understandably, been focused on their individual patients. This creates a structural tension in the system between those focused on advocating for individual patients irrespective of the financial impact and those obligated to be prudent resource stewards for the population served.

The issue for the future is not so much how much physicians are paid, but whether they can be paid well and fairly while at the same time promoting better use of the system’s total resources. If physician supply continues to grow as rapidly as in recent years, short of a return to economic boom, it will be extremely difficult if not impossible for the prov-
ince to afford both paying doctors at current levels and the extra costs to the system incurred by greater diagnostic and therapeutic activity. There is a potentially huge dividend to harvest through concerted efforts to root out the non-value-added costs associated with Choosing Wisely Canada and other quality improvement initiatives. The likelihood that there will be more money to add to the physician compensation envelope is tied to prospects for achieving savings elsewhere.

**Working in Teams and the Division of Labour**

There is one further challenge and opportunity for medicine: the optimization of the division of labour. Within the physician community, a more comprehensive and robust primary care system should, when all else is equal, result in fewer referrals to specialists. Currently a complex case is a financial challenge for a family doctor whose income is largely dependent on the number of patients seen. The incentive is either to limit the number of complex patients in a practice or to refer quickly to a specialist. Similarly, in a high-functioning primary care team, much of the work would be done by nurse practitioners, psychologists, pharmacists, and others. That creates the capacity for much larger physician panels and potentially – but not inevitably – a need for fewer physicians.

Hence the overall configuration of the system and the models of care have major implications for health human resource requirements, total costs, and physician incomes. The SMA should be central to discussions on what tomorrow’s health system should look like, and the role of physicians in that system. The shift from volume-based to value-based compensation requires a definition of value. We have the opportunity to advance our perspectives on resource stewardship and the practice styles that ensure physicians have rewarding work that uses all of their knowledge and skills and sustains fair and reasonable compensation.

**Where Do We Stand and Where Do We Begin?**

A number of concurrent trends and realities have converged to create an unprecedented opportunity to rethink how medicine is conceived, practiced, and paid. While we have no crystal ball to foretell the future, it is improbable that we or anyone else can successfully argue that the solution to the system’s performance problems is to do more of the same. That hypothesis was generously tested over a long period of major funding growth and was definitively rejected after the disappointing results. Even partial victories, such as reduced wait times for surgery, are proving provisional. No system has gone from mediocre to excellent without fundamental redesign.

The immediate questions for the SMA are:
1. What role do we want to play in system redesign, and what principles should underlie it? Are we prepared to embrace Saskatchewan’s objectives of better health, better care, better value and better teams and align our roles accordingly?

2. Are we prepared to play an active, leadership role in addressing appropriateness of care and in resource stewardship more generally?

3. Do we want to play a leadership role in developing physician payment alternatives that are aligned with the broader health system goals? Should we signal to government that we are prepared to engage in principle-based, open discussions?
References:


