NATIONAL POST

Steven Lewis and Terrence Sullivan: How doctors are bankrupting health care

National Post
Fri May 31 2013
Section: Comment
Byline: Steven Lewis and Terrence Sullivan

The Canada Health Act specifies that physicians are entitled to “reasonable compensation,” and the current agreements are the accumulation of four decades of incremental negotiations, compromises and accommodations. All are based on the assumption that a doctor’s “activity” and “productivity” are identical. They are not. Increased medical activity increases costs in the system — but only some increased activity is productive. Some is useless, and some is harmful.

The only way to permanently de-escalate health care spending is to do less with less. Collective agreements with physicians encourage them to practice more medicine, at greater cost. The only way to contain health care spending is to change the deals we make with doctors.

Collective agreements between governments and provincial medical associations are complex and varied, but they share a few key elements. The dominant payment mode remains fee-for-service. Most physicians are independent contractors to the government and operate as cottage industry entrepreneurs with often only fleeting attachments to their place of work and its corporate objectives. Those with office-based community practices are neither formally part of, nor meaningfully accountable, to health regions or their equivalents. Surgeons do have to compete for operating room time, but their practice patterns remain highly autonomous.

In the main, physicians have huge discretion over how they practice, and the claims they make on system resources. Moreover, with a few notable exceptions, they can set up practice wherever they want, regardless of whether the community is under- or over-supplied with doctors. The entirely predictable result is huge variation in how physicians work and the resources they consume.

The collective agreement neither requires nor prohibits excellent practice, but often poor practice is more lucrative. Conscientious and engaged family doctors who spend time dealing with the challenges of complex geriatric cases earn lower incomes for doing so. Others who refer every difficult case to specialists, see 60 patients a day and prescribe drugs indiscriminately make a lot more money. One physician may order three times as many tests for her patients as her colleagues; neither is likely to know that this is the case and there are no consequences for doing so.

“Perverse incentives privilege piecemeal problem-solving over holistic care”

The paymaster — government — may or may not be aware of these variations, but rarely, if at all, will anything be done to address them. The one constant under fee-for-service is that each activity generates income for someone, and each activity avoided reduces income for someone. Moreover, there are neither rewards for prudent system resource consumption nor penalties for profligate use.

The perverse incentives that privilege piecemeal problem-solving over holistic care, prescriptions over conversations and procedural specialists over generalists must be erased. So, too must the mechanisms that get in the way of an efficient division of labour between doctors and other providers. A new agreement must prize integration above fragmentation and balanced entitlements with contractual obligations to deliver and be accountable for high quality, appropriate care. Every collective agreement renewal that buys temporary peace by pretending that the price and volume of procedures operate independently is a dagger pointed squarely at the heart of cost containment. Governments and doctors unwilling to depart from the historical path doom the system to a sorry combination of poor performance and eternally rising costs.

“Physician polls reveal that most doctors, and especially younger and female doctors, are ready for change”

Ah, but how do we get there, given the deeply entrenched nature of current structures and the conservative nature of both governments and medical leadership? We propose the equivalent of a two-state solution. Let the primarily older physicians finish out their careers under the general provisions of existing agreements. Invite the others to a separate table to create a new deal that redefines their roles, relationships, clinical accountabilities to the organizations and regions in which they practice, and payment models.

It is one thing to grant late-career doctors the right not to change; it is going too far to allow them to continue to hold their colleagues, governments and the citizenry hostage to the obsolete constructs of the ancien regime. Physician polls reveal that most doctors, and especially younger and female doctors, are ready for change. It is time governments insisted on giving expression to their desires, and for their change-averse colleagues to get out of their way.

This is an excerpt from the June issue of Policy Options. Steven Lewis and Terrence Sullivan are the authors of a newly-released IRPP Insight report titled How to Bend the Cost Curve in Health Care available at irpp.org.