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E-BRIEF

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HEALTHCARE POLICY

Doctors without Hospitals: What to do about Specialists Who Can't Find Work

by
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- Canada faces a healthcare paradox: we have growing ranks of recently graduated specialist physicians without work at the same time as we have long wait times for specialist services.
- The authors examine why separate budgets for hospitals and specialists is contributing to this problem.
- Their proposed solution involves breaking down the two-silo approach to paying doctors and funding hospitals. The results could benefit both specialists looking for work and hospital performance.

Canadian healthcare is facing a new challenge: recently graduated specialist physicians who struggle to find work (Fréchette et al. 2013), even as Canadians report long wait times for their services. If policymakers do not shift course, the problem could worsen, resulting in a significant underutilization of resources, and even outmigration of Canadian-trained specialists.

In this E-Brief, we examine one reason for this paradox: the inefficient allocation of resources that arises from paying doctors and hospitals out of different funding envelopes. Hospitals rely on fixed, lump-sum payments to cover their operating costs. Specialists are paid on a fee-for-service basis by provincial insurance plans, not by the hospitals where they work. This creates two "silos" with conflicting incentives. Provincial insurance plans fix the prices for specialist services according to fee schedules, encouraging them to take on as much work as they can manage.

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However, the fixed budgets given to hospitals restrict the resources available to doctors who need operating room time and nursing staff.

If hospitals instead were given responsibility for paying for specialists' services – and the authority to negotiate with specialists directly about both their pay and access to the hospitals' facilities – available specialists could be better matched with hospital capacity, and the value for money in our health system would improve. This would lead to a new model for bargaining with specialists that would give more attention to local factors, and would require a sensible transition plan.

The Growing Supply of Specialist Doctors

A decade ago, when wait times began to dominate health policy debates, the prospect of specialists not being able to find work would have seemed unlikely. At the time, policymakers emphasized increasing medical school enrolment. The result is that the number of specialist doctors has ballooned by 36 percent since 1999, more than double the growth of Canada's population (Figure 1).

In the past few years, concern has risen over the fact that a growing number of these newly minted specialists are under- or unemployed.[1] To estimate the size and scope of the phenomenon, the Royal College of Physicians and Surgeons of Canada surveyed newly certified specialists in 2011 and 2012 (Fréchette et al. 2013). The Royal College reported that a remarkably high number of recent medical graduates – 16 percent, on average – were not able to find work within three months of graduation, with many others taking up positions for which they were overqualified.[2] The results are especially troubling for those specialists who are dependent on hospital resources for their work, with 34 percent of them, on average, reporting not finding work after graduation (Figure 2).

A lack of employment canot simply be explained by an over-supply of specialists[3] – there is strong and growing demand for specialists and there has been no broad-based reduction in wait times (CIHI 2013, WTA 2014, Barua and Esmail 2013).[4, 5]

1 Although physicians are generally self-employed, specialists who require hospital facilities to practice cannot earn an income unless they can get access to such facilities. If this is the case, they are effectively unemployed.

2 The Royal College surveys were conducted for both 2011 and 2012 cohorts of specialists following their examinations, with response rates of about 30 percent from the population of about 3,400.

3 Based on the advice of health economists, Canada has gone from a recommendation to restrict the number of doctors to curb cost growth, to a later recommendation to increase them, and now risks going back to decreasing them again (Bliss 2010). Policymakers should continue to be skeptical of these shifting mandates.

4 The wait times for some procedures have fallen (so-called "priority procedures," in particular), and in some provinces more than others, but overall they have remained flat. Although there is not a universally accepted time series on wait times in Canada, work by the Canadian Institute for Health Information (CIHI 2013), the Fraser Institute (Barua and Esmail 2013), and data from the provinces examined by the Wait Times Alliance (WTA 2014) all corroborate this lack of broad-based improvement. In fact, for many procedures there are no established guidelines for acceptable wait times, making it hard to benchmark data even when available.

5 The lack of a clear relationship between specialist physicians per capita and waiting times has been observed in many countries (Siciliani et al. 2013), especially when the demand for procedures is rising and sometimes outstripping supply.

Figure 1: Specialists Growing Faster than Population as Wait Times Persist, 1999 to 2013

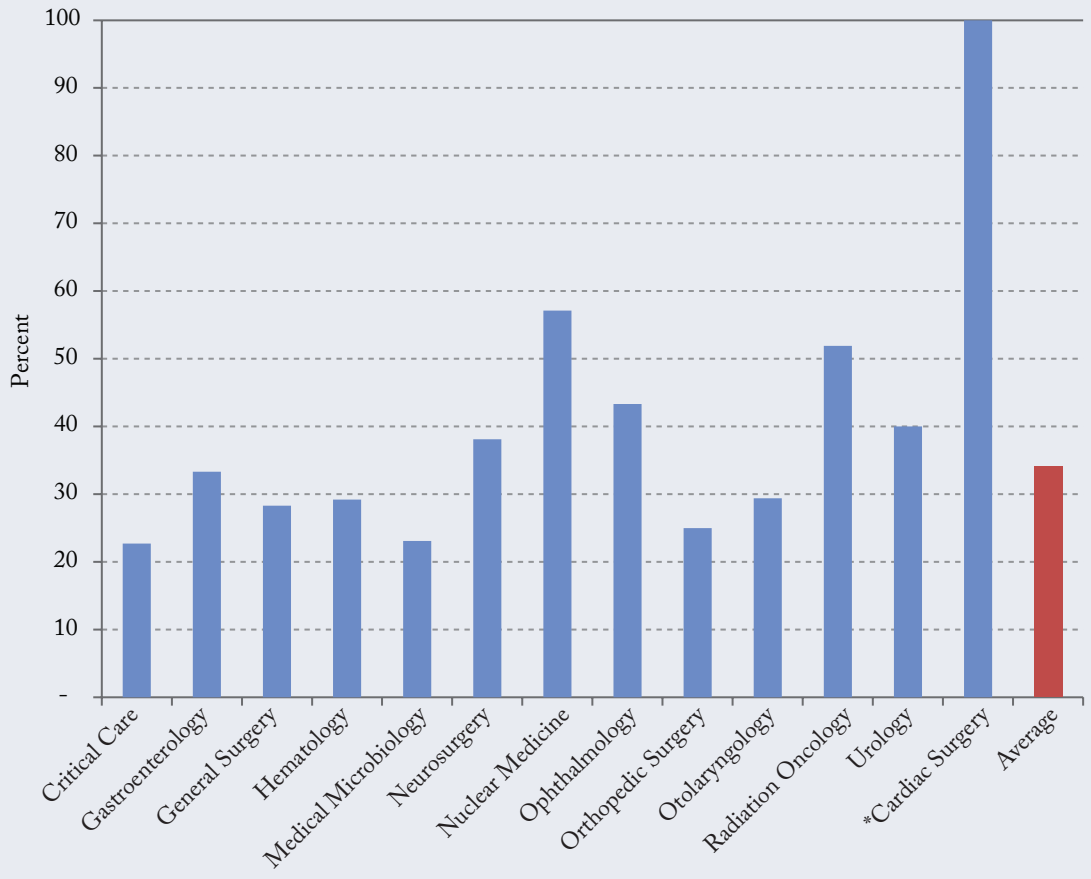
Sources: CIHI (2014), Statistics Canada.

Why Are Recently Graduated Specialists Struggling to Find Work?

Drawing on interviews with healthcare planners, the Royal College suggests a number of potential reasons to explain unemployment among specialists, including later-than-expected retirement of current doctors and inappropriate career planning, among others. They also highlight that hospital resources are a major bottleneck in the provision of services. Specialists care and hospital resources are complementary and used in tandem: to perform a procedure, many specialists require operating room time, nurses, and beds, so coordination between hospitals and specialists is paramount. In recent years, this coordination has not been working well: the report notes that specialists are now "competing with each other for fewer hospital resources" (Fréchette et. al. 2013, 31).

One cause of this poor coordination is the funding scheme. Provincial payments for Canadian hospitals and specialists come through different channels and follow different rules. Most specialists are self-employed, and paid by provincial insurance plans on a fee-for-service basis according to a schedule negotiated between provincial medical associations and ministries of health. From the specialist's perspective, each additional procedure means additional income.

Figure 2: High-Number of Hospital-based Specialists Unable to Find Work Shortly after Graduation, 2011 and 2012



Note: The sample size for cardiac surgeons is low, with only five of a possible sixteen graduates responding to the survey.

Source: Fréchette et al. (2013).

In contrast, funding arrangements between health ministries and hospitals create different incentives. Most hospitals are allotted annual lump-sum (global) budgets to cover their operating costs.[6] Hospitals' revenue does not increase with the number of procedures their doctors perform, but they are responsible for the cost of the complementary hospital resources the doctors need, such as operating room time and nursing staff.

6 Ontario is one province that is implementing policies to move away from a purely global budget model to one that mixes global payments with funding by the type and number of patient treatments. These payment principles are commonly known as activity-based funding, or funding associated with diagnosis related groups (Sutherland et. al. 2012).

The result is an inefficient allocation of resources and labour slack among specialists, and other health professionals, despite implicitly high demand for their services (Blomqvist and Busby 2013). Under the current models that governments use to pay hospitals and doctors, efficient resource coordination has become difficult to achieve.

What to Do?

Hospitals may currently be limited in their ability to make operating room time available to junior specialists owing to costs associated with supplying the required additional hospital staff. One way to read the Royal College's analysis is that older specialists have well-established access to hospital resources, and that it can be difficult for junior specialists to challenge this incumbency.

Hospital resources essential to performing specialist procedures will not be used efficiently so long as hospitals and doctors are paid via separate provincial envelopes. We propose that the funding rules should be changed by bundling the payment streams for hospitals and hospital-based specialists, and making the hospitals responsible for contracting with specialists to provide needed services.

A complementary reform would be to partially finance hospitals according to the volume and outcomes of services provided. Just as fee-for-service payments encourage specialists to increase their volume of procedures, hospitals may react positively to a move away from a strict global budget. Paying hospitals per procedure is a form of activity-based funding, which is not presently common across Canada (Blomqvist and Busby 2013).

In order for this approach to work, the hospitals' managers would have to be given the authority to allocate access to operating rooms and other facilities to those specialists who offered their services on the terms that were most favourable to the hospitals. That is, incumbency would not necessarily give an automatic advantage to more senior doctors. Specialists could be paid a share of what the hospitals were paid per procedure, by salary, or some combination of the two.[7]

Clearly, allowing the terms for paying specialists to be established through bargaining between doctors and local hospitals would imply a major change relative to the current approach. Presently, fees are determined through bilateral negotiations between provincial governments and the medical associations, and access to hospital facilities is governed by a combination of medical staff and hospital managers. Transitioning towards this new model of negotiations could begin by setting a range around current fee schedules – say, a floor and a ceiling – in which hospitals could contract with doctors. Over time, hospitals may set up their own bargaining units to negotiate fees, or hire more salaried physicians.

Were hospitals responsible for paying specialists, they might be able to negotiate lower fees in local markets where many specialists are competing for hospital facilities. The same holds for fees during the hours that specialists consider most desirable, with higher rates during off-hours such as evenings and on weekends. Hospitals might be able to use any net savings to pay for additional nursing hours or other inputs not otherwise affordable.

7 An alternative would be to give doctors the budget required to purchase hospital services. This differs from the way we traditionally have organized health services, but from an economic perspective the two approaches are similar. Both solutions would encourage one party to make better decisions by incorporating the costs faced by the other.

The results of giving hospitals the authority to negotiate terms with specialist doctors would be uneven within provinces and across specialties. The prices for some specialists' services may rise, but prices should fall in areas where many recent graduates are looking for work. Indirect benefits of such a reform might include clearer signals to medical students regarding what, and where, specialties are in demand. Further, hospitals may be inclined to specialize by performing more of the procedures that they do most cost-efficiently and with the best patient outcomes.

Concerns with our Proposal

The approach we propose is intended to overcome the problems that stem from the current model of siloed payments for hospitals and specialists, within which neither party has an incentive to pay attention to the costs and effective use of the other's services. Legitimate concerns about our proposal include a fear that specialists would be reluctant to give up the bargaining power they have under the present system of centralized fee negotiations, and the transactions costs that would arise in a model of decentralized local fee or salary negotiations. While we are not sure exactly what the final bargaining processes would look like, the current models in many provinces have a number of flaws (Grant and Hurley 2013). On balance, we believe that our recommendations have potential benefits that outweigh the costs, and with safeguards in place – such as using an upper and lower range for negotiated fees based on current fee schedules, for example – the risks of introducing a new bargaining approach can be mitigated in the short run.

Conclusions

Although the supply of specialists has been growing fast, the inability of our health system to better deploy the growing number of specialists has resulted in many recently graduated specialists struggling to find work and taking up positions for which they are overqualified. If this issue goes unaddressed, the problem may worsen, and more trained specialists may migrate elsewhere.

Policymakers should avoid concluding that Canada is graduating too many doctors. The availability of more specialist doctors may be an opportunity to get better value for money in provincial health systems, and to better match skilled specialists with the unmet needs of patients. To do so, we need more flexibility in how we determine prices and budgets in negotiations between governments and providers. Giving hospitals the budgets and authority to contract for specialist physician services could be a first step toward a more flexible approach, and would encourage a more efficient use of public funds.

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