Ontario Hospital Association

BACKGROUNDER

July 2019

HOSPITAL PHYSICIAN COMPENSATION AND EMPLOYMENT MECHANISMS

Purpose

Understanding physician compensation and employment mechanisms is vitally important. The recent introduction of integrated care delivery systems (commonly known as “Ontario Health Teams”) requires a nuanced understanding of how current physician remuneration models can be integrated into future health care delivery models. This backgrounder provides a general overview of these compensation mechanisms across Ontario.

Overview of Key Findings

The dominant model of compensation for hospital-based physicians, the fee-for-service (FFS) model, has its legislative basis in the *Health Insurance Act.* This Act provides the parameters around how physician services are to be charged under the Ontario Health Insurance Plan (OHIP). It also provides a legislative “carve out” for alternative funding / payment arrangements (commonly referred to as AFAs or APAs) that depart from the FFS model – these arrangements are contractually rooted, often with numerous parties involved.

The Ontario Medical Association (OMA) plays a pivotal role in the physician compensation process, as the body representing physicians in Ontario. Its unique role in negotiations with the government is not specifically rooted in legislation; rather, it is the result of policy decisions and mutual acknowledgment between the OMA and the Ministry of Health (MOH).

The binding arbitration framework agreed to by the OMA and the MOH in 2017 resulted in an arbitration decision that was issued by a three-member arbitration board in early 2019. This represented an end of Phase 1 of negotiations for a new Physician Services Agreement, and Phase 2 is expected to determine allocation of payment-rate increases. The new four-year Physician Services Agreement runs from April 1, 2017 to March 30, 2021.

The *Public Hospitals Act* also has a significant role in the legislative context around physician employment and compensation. It sets out detailed rules around granting, renewal, termination and restriction of privileges, and provides a rigorous dispute-resolution framework for privileging-related issues.

There are important lessons to be learned from reviewing non-FFS compensation mechanisms in Ontario. Salaried models, contract models, alternative funding and payment arrangements, and primary care physician compensation models all offer insights into remuneration strategies that support changing patient population and physician health force needs.

Background and Context

The nature of hospital-physician relationships is evolving, as physicians' changing expectations around engagement, work-life balance and overall job satisfaction drive the need to reconsider traditional mechanisms of compensation and employment. Furthermore, the *Connecting Care Act, 2019* (CCA)[1] and the creation of Ontario Health Teams (OHTs) may have a role in determining how hospital-physician relationships may evolve in a period of health system transformation.

As integrated care models, OHTs require that all providers and organizations come together and demonstrate clinical and fiscal accountability while delivering a full and coordinated continuum of care. Strong physician participation and leadership (both primary and specialist) plays an essential role in this model.

At the same time, hospitals are also facing ongoing pressures to improve outcomes, quality of care and patient satisfaction – issues which are invariably connected to workplace culture and staff morale. As such, there is a need to examine physician compensation and employment mechanisms in the context of these emerging trends.

Physicians, Privileges and the Schedule of Benefits

There are several compensation mechanisms which govern the working relationship between physicians and hospitals in Ontario. These mechanisms, which are described in more detail below, include the following:

- Fee for Service;
- Alternative Funding Arrangements / Alternative Payment Agreements;
- Enhanced Fee for Service;
- Capitation Models;
- Complement-Based Base Remuneration (plus Bonuses & Incentives) Models; and
- Blended Salary and Salaried Models.

[1] *Connecting Care Act, 2019*, S.O. 2019, c. 5, Sched. 1

Statutory Framework: *The Public Hospitals Act*

The *Public Hospitals Act* (PHA)[2] governs the hospital-physician relationship. It requires the hospital's medical advisory committee (a committee of the hospital board) to consider and make recommendations regarding the appointment and privileges of physicians. As such, any physician seeking to provide services in a hospital must follow the processes outlined in the PHA. The PHA also sets out detailed rules around granting, renewal, termination and restriction of privileges.[3]

Despite varying mechanisms for compensation, physicians delivering services in hospitals do so primarily through a privileges-based model. This model grants physicians the right to perform specific acts or services within the hospital and recognizes the independent nature of physicians. It assumes that physicians have "privileges" to use hospital clinical space and resources, in return for providing care to patients.

Physicians have both procedural and substantive rights under the PHA in relation to appointment, suspension, revocation or other changes to privileges, including: a meeting before the medical advisory committee; a hospital board hearing; an automatic right to appeal any board decision to the Health Professions Appeal and Review Board (HPARB); and an automatic right to appeal any HPARB decision to the Superior Court of Justice.[4]

The privileges model provides physicians with significant control over their relationship with the hospital; it also supports their status as "independent contractors" rather than as employees of the hospital. This model can be viewed as a corollary of the fact that most physicians independently bill OHIP for remuneration (on an FFS basis), rather than being paid a salary by hospitals.[5]

Fee for Service

Most physicians working in Ontario hospitals are not compensated directly by the hospital itself; rather they bill the Ontario Health Insurance Plan (OHIP), based on a set fee for every service they provide to patients, as determined by the Schedule of Benefits (Schedule) under the *Health Insurance Act* (HIA). This is known as a "fee for service" (FFS) model of compensation. The legislative basis is provided in section 15(1) HIA, which states:

---

[2] *Public Hospitals Act*, R.S.O. 1990, c. P.40 (PHA)
[3] PHA, sections 35-37
[4] PHA, sections 37-43.
[5] *For more information, please see the Professional Staff Credentialing Toolkit, Ontario Hospital Association, 2011.* *https://www.oha.com/Professional%20Issues1/OHA%20Professional%20Staff%20Credentialing%20Toolkit%20(2012).pdf*

> *A physician shall submit all of his or her accounts for the performance of insured services rendered to an insured person directly to the Plan in accordance with and subject to the requirements of this Act and the regulations, unless an agreement under subsection 2(2) provides otherwise*.[6]

The Schedule lists services insured by OHIP and includes the general preamble (which impacts all physicians), consultations and visits sections (which applies to all specialties) and specific system and/or specialty sections (including specialty preambles). Physicians are prohibited from charging patients for services that are otherwise insured under OHIP and cannot charge patients more than the amount payable under OHIP (this is known as "extra-billing" and is contrary to the *Commitment to the Future of Medicare Act* or CFMA).[7]

Fees set in the Schedule are negotiated between the MOH and the OMA, as the body representing physicians across Ontario. This relationship largely based in policy, rather than being a legislative requirement. Physicians are required to pay membership dues to the OMA under the *Ontario Medical Association Dues Act, 1991*;[8] however, this Act does not explicitly require the OMA to negotiate the Schedule of Benefits on behalf of physicians.

The CFMA also points towards a permissive regime that supports the relationship between the OMA and the MOH, as set out in section 12:[9]

> *The Minister of Health and Long-Term Care may enter into agreements with the associations mentioned in subsection (2), as representatives of physicians, dentists and optometrists, to provide for methods of negotiating and determining the amounts payable under the Plan in respect of the rendering of insured services to insured persons.*
>
> *(2) The associations representing physicians, dentists and optometrists are,*
> *(a) the Ontario Medical Association, in respect of physicians.*

Additionally, negotiated (i.e. voluntary) agreements support a permissive relationship between the OMA and the Ministry. For example, the 2012 Physician Services Agreement provides that "the OMA and the MOHLTC [as it was then known] entered

---

[6] Subsection 2(2) of the HIA allows the Minister of Health to enter into arrangements for the remuneration of physicians and others on a basis other than fee-for-service. See page 6 for further discussion.

[7] *Commitment to the Future of Medicare Act*, 2004, S.O. 2004, c. 5. See also: Ministry of Health and Long-Term Care, "Protecting Access to Public Health Care" (2016) available at: http://www.health.gov.on.ca/en/public/programs/ohip/cfma.aspx.

[8] *Ontario Medical Association Dues Act*, 1991, S.O. 1991, c. 51, section 2

[9] *Supra* note 7

into a Memorandum of Agreement that recognizes the OMA as the exclusive representative of physicians practicing in Ontario."[10]

The flexible structure around physician compensation is further supported by the HIA. Section 2(2)(a) of the HIA provides that the Minister of Health and Long-Term Care may "enter into arrangements for the payment of remuneration to physicians, practitioners and health facilities rendering insured services to insured persons on a basis other than fee for service."[11]

As noted above, various legislative authorities and policy rationales support payments through non-FFS mechanisms, including, without limitation, AFAs[12], blended capitation models, enhanced FFS, complement-based remuneration (including bonuses and special incentives) and salaried models.

The following discussion highlights that when considering the legislative authority under section 2(2)(a) of the HIA with respect to alternatives to FFS, it is important to understand the relationship between the MOH, the OMA, physicians and other parties that may be involved. There are often detailed contractual provisions and governance issues that must be examined. However, the legislative authority does not suggest that the HIA restricts physicians to remuneration through the FFS model; rather, there is room to explore other mechanisms for physician remuneration, depending on both hospital and patient needs.

Alternative Funding Arrangements (AFAs) / Alternative Payment Agreements (APAs)

The terms "AFA" or "APA" are often used interchangeably. AFAs and APAs are contractual agreements between the MOH, a group of physicians, and in most cases, the OMA.[13] They may also include other organizations such as hospitals and universities. AFAs for specialists are also subject to the provisions of the Physician Services Agreement between the MOH and the OMA. Most of these funding agreements are blended models that combine a base rate and FFS or shadow billings (further detailed below), with possible additional incentive/premium payments.[14]

Typically, either the OMA or a specialist group that is interested in receiving compensation on a non-FFS basis approaches the MOH, requesting that an AFA be

[10] 2013 Physician Services Agreement between the Ontario Medical Association and the Minister of Health and Long-Term Care http://www.health.gov.on.ca/en/pro/programs/phys_services/docs/phys_services_agreemnt_en.pdf.
[11] *Health Insurance Act*, section 2(2).
[12] Also called Alternative Funding Plans (AFPs).
[13] The role of the OMA in alternative funding arrangements is not detailed in the public domain. However, there is relevant literature and funding templates available through the members-only section of the OMA website.
[14] HealthForce Ontario, *Compensation, Incentives, and Benefits* (September 2015).

established. Through this process, standardized contracts have been developed for most AFAs, including those involving emergency departments, academic health sciences centers, and northern specialists.

The AFA contracts have general provisions detailing the amount of funding specialists will receive; the service levels that specialists must provide; recruitment and retention mechanisms for new specialists; and information that specialists must report to the MOH. As well, the contracts usually include objectives such as improving patient access and patient satisfaction; supporting the clinical training needs of medical students, physicians, and other health-care providers; and advancing innovation in medicine.[15]

It is notable that AFAs are sometimes driven by payment equity considerations. AFAs are often established where, for example, patient volume in a region is too low to provide a full-time specialist with a FFS income level similar to what he or she would earn in other parts of the province.

Some physician remuneration within this category is based on a mixed (blended) model. The model of remuneration may include FFS, salary and other earnings, based on specialty or particular incentives. The specific benefits and obligations of this arrangement may be negotiated between numerous parties, for example, as between a physician, a participating teaching hospital and a medical faculty and/or research facility.[16] These types of contractual arrangements are often presented as an AFP or AFA. Shadow billing (an approach that generates a premium that represents a percentage of the full value of a FFS claim) may also form part of an AFP or AFA.

An academic hospital AFP is a contract between academic physicians, teaching hospitals, universities, the OMA and the MOH. It sets out non-FFS funding for a range of services, and aligns the interests of the parties by merging multiple funding sources for the remuneration of involved medical staff for clinical service, education, research and associated administration. In exchange for the merger of funding sources, the parties of an AFP agree to meet a comprehensive set of deliverables in clinical service, education, research and associated administration.[17]

[15] Office of the Auditor General of Ontario, Annual Report (2011), *Chapter 3: Funding Alternatives for Specialist Physicians*, p 176, available at: http://www.auditor.on.ca/en/content/annualreports/arreports/en11/307en11.pdf.

[16] Canadian Medical Association, "Practice Management Module 8: Physician Remuneration Options" (2012) available at: https://www.cma.ca/Assets/assets-library/document/en/practice-management-and-wellness/module-8-physician-remuneration-options-e.pdf.

[17] Ontario Health Insurance Program, Resource Manual for Physicians (2018) available at: http://www.health.gov.on.ca/english/providers/pub/ohip/physmanual/pm_sec_6/6-7.html.

An example of an academic AFP is the one signed between the Physician Clinical Teachers Association (PCTA) and the Northern Ontario School of Medicine (NOSM), working with the OMA and the MOH.[18] In 2009, these parties signed an AFP agreement that provides for $7.1 million of annual funding. The agreement provides funding that recognizes the unique contributions of clinical physicians for academic activities at NOSM; increases the capacity of academic physicians to provide clinical services and academic activities in an integrated manner; and ensures that the funding reaches participating physicians in an open and transparent manner.

A governing body, the Northern Ontario Academic Medicine Association (NOAMA), was established to manage, distribute, and administer the AFP funding on behalf of the MOH and the members in accordance with the contractual terms of the AFP agreement.

NOSM has a distributed medical education model, as its two campuses (Sudbury and Thunder Bay) are more than 1000 km apart. As such, rather than centralizing all AFP activity through the NOAMA, the NOSM AFP is implemented through Local Education Groups (LEGs). LEGs are self-organized groups of NOSM clinical faculty who are responsible for providing selected medical education services at the undergraduate and/or postgraduate level. LEGs also support other academic activities such as professional development, research and clinical innovation.[19]

AFAs may also be used as a remuneration strategy to support areas within the hospital that have difficulties in maintaining adequate physician staffing and 24/7 coverage [i.e. Emergency Departments (ED)]. There are two types of ED AFA models: the workload model for larger hospitals, where base funding is determined by annual patient volume and acuity; and the 24-hour model for smaller hospitals, which provides tiered base funding determined by annual patient volume.[20]

While ED AFAs have been widely adopted, a study conducted by the Institute for Clinical Evaluative Sciences concluded that the ED AFAs have not led to substantial changes in the overall physician workforce. [21] Trends toward increased physician numbers were seen in small and teaching hospitals, which may represent an AFA-related stabilization of the ED physician workforce in the short-term for these hospital

[18] Northern Ontario Academic Medicine Association, “About Us” (2018) available at: http://www.noama.ca/about-us.
[19] Northern Ontario Academic Medicine Association, “Local Education Groups” (2018) available at: http://www.noama.ca/legs.
[20] Health Force Ontario, “Compensation, Incentives and Benefits – Transition into Practice Services” (2015) available at: http://www.healthforceontario.ca/UserFiles/file/PracticeOntario/TiPS/TiPS-CIB-EN.pdf
[21] Schull M, Vermeulen M. *Ontario’s alternate funding arrangements for emergency departments: the impact on the emergency physician workforce*. Can J Emerg. Med. 2005; 7 (2): 100-106

types. The AFA program appears to be least appealing to physicians in community hospitals.[22]

Blended Salary and Salaried Models

In other scenarios, either blended or full salaried models may be adopted. A blended salary model exists where the majority of physician income is derived from salary. In certain contexts (e.g. primary care), a physician may be a salaried member of a Community or Mixed Governance Family Health Team. The salary would be based on the number of enrolled patients, plus benefits and/or bonuses.

A full salaried model will exist where all physician income derives from a salary, plus any applicable pension or benefit entitlements. For clarity, a physician who works on salary receives regular payment from their employer, which is set out pursuant to the terms and conditions of their employment contract.

At one hospital, approximately one third of psychiatrists have opted for a salary arrangement (employment agreement) with the hospital. The other two thirds have opted to receive compensation as an independent contractor or through a professional corporation. However, all psychiatrists working at the hospital receive the same dollar value of compensation annually (the global budget for physician services is determined in negotiations with the government through the Physician Services Agreement).

None of the psychiatrists bill OHIP, however, the hospital can still shadow bill the government on their behalf. Those who are on a salaried/employment model also receive benefits (including pension, health insurance, fees and dues coverage and parental leave) – the value of which is deducted from the annual compensation amount.

Physician privileging at the hospital is tied to the employment agreement or contract. Privileges are contingent on continued employment or a continued contractual arrangement with the hospital. The process for ending privileges is largely uncontested, given that it is tied to the end of a contract or employment agreement. As a matter of practice, the privileges dispute resolution process under the PHA is not typically engaged.

[22] *Ibid*

Physicians Working Outside of Hospitals - Enhanced Fee for Service and Capitation Models

While this backgrounder is focused on compensation of hospital-based physicians, other practice arrangements highlight different compensation mechanisms for physicians working outside hospitals. For example, primary care in Ontario has evolved from a predominantly FFS system to one based on group practice, centred on patient enrolment and comprehensive care.

Enhanced FFS models fall within this category. Enhanced FFS models exist where physicians are compensated primarily based on FFS but are also eligible for bonuses and premiums for enrolled patients (for example, to incentivize after-hours primary care). Additionally, physicians may receive monthly comprehensive care capitation payments for all enrolled patients.

Capitation based models exist where physicians receive the majority of their income through capitation fees based on the number of enrolled patients for care during regular hours and after-hours. Capitation is based on a defined basket of services provided to enrolled patients based on age/sex of each patient, while FFS is paid for other services. In the primary care sector, bonuses, premiums and special payments may also be paid for services such as chronic disease management, preventative care, pre-natal care and home visits for enrolled patients, and for hospital visits, obstetrical care and palliative care for all patients.

Complement-Based Base Remuneration (plus Bonuses and Incentives)

Complement-based base remuneration exists where physicians receive the majority of their income through base rate payments. A base-rate payment for a full-time equivalent “complement” is given for a specific community / geographic area in addition to overhead payments, locum coverage, premiums and other bonuses, as applicable. The Rural-Northern Physician Group Agreement (RNPGA) is one example of this model.

Conclusion

The complexity and variation in physician compensation and employment mechanisms is illustrated above. Understanding these relationships is the first step in more broadly considering how these arrangements can be best and most appropriately integrated into Ontario Health Teams.

For more information, please contact Alice Betancourt at abetancourt@oha.com.