OMA Section on General Surgery

c/o Ontario Association of General Surgeons
P.O. Box 192, Station Main, Peterborough ON K9J 6Y8
Phone: 705-745-5621
Fax: 705-745-0478

May 28, 2017

Attn. OMA Negotiations Committee
Ontario Medical Association
150 Bloor St. West, Suite 900
Toronto, ON M5S 3C1
Email: negotiations@oma.org

Re: Section on General Surgery Negotiation Priorities

General Surgery submission to Negotiating Team May 2017

The General Surgery section executive met on May 27th to discuss priorities regarding negotiations. We have **2 sets of priorities**. The first and arguably more important priorities are **long term objectives** that we realize will not be quick fixes but are important strategic moves by the OMA for long term stability. They will require a more complex agreement with the government but significant progress could be made within a 4-year agreement. The second is a pragmatic list of fiscal issues felt to be rapidly achievable (**short term objectives**), if this round of negotiations are similar to previous rounds of negotiations.

Long Term Goals

1. Relativity and fee schedule modernization: **50%**

While declining income levels are a significant concern, our section is even more frustrated by the blatant inequalities within the medical profession, with both significant undervaluation as well as overvaluation of some work. Working side by side with other physicians that make far more money for far less work is a constant and daily source of irritation. We want to emphasize that while we seek relativity, we do **not** see CANDI as a reasonable solution and feel that CANDI itself poses significant risks to our profession. We fundamentally and completely disagree with the underlying premise of CANDI that all physicians' work is of equal value. It is an absurd position that defies common sense, is not used in any other jurisdiction in the world, and will only foster further inequities within the profession. Fee schedule relativity issues already foster unhelpful practice patterns, as physicians avoid poorly remunerated procedures and gravitate towards those that are better remunerated. CANDI will magnify that as physicians avoid hard work and lean towards easy work. Such practice patterns are detrimental to the overall functioning of physicians and to the health of Ontarians. We readily acknowledge within our own General Surgery fee schedule that some work is far more difficult, intense and risky and that such work should be compensated at a higher rate than simpler endeavors.

We also think that strategically in the long term, the CANDI model itself poses many threats to our profession. If we really believe that all physicians' work is of equal value and then delegate some of that work to nurse practitioners, then logic would say that nurse practitioners should be paid the same as all doctors or the converse. Tasks that can be delegated to allied health professionals should be paid at a lower rate. If we don't do this ourselves, then any rational government will try to maximize the use of allied health professionals to reduce cost, taking away a significant amount

of physicians' work. Basically, CANDI will price physicians out of market for delegable procedures. There are significant risks with this, and in an era when many physicians are underemployed, it does not seem a prudent move.

A true relative value fee schedule needs to be created that values complexity, intensity, risk, and training time. It also needs to account for the impact of technology, which has simplified many tasks but has made others more challenging. This would be a win-win-win situation. It is in the interests of physicians, for the aforementioned reasons. To the extent that it would eliminate "cream skimming" practices, over delivery of well-paid services and under-delivery of underpaid interventions, it is in the interests of both patients and government. It should be relatively easy to convince government that a true relative value fee schedule is in their best interest.

The last tPSA mandated "modernization of the fee schedule", and we strongly concur with this but feel that the principles to do this should be an integral part of the negotiated agreement. We have grave concerns that the OMA governance structure renders it incapable of making the hard decisions that are necessary to enable significant relativity reform. We, therefore, want the principles of relative value to be incorporated into the terms for modernization of the fee schedule and become an integral part of the negotiated agreement. This indirectly gets the government to do the dirty work of short term major relativity corrections and would be good for the overall health of the OMA and should be a strategic goal of the negotiating committee.

Introduction of relativity cannot be incremental, based on bringing the lower end up over time by redistribution of new money but needs to be substantial based on both significant downward and upward valuation of fee codes to create a fair system within 2 or 3 years. You cannot modernize a fee schedule without bringing some codes down.

We would acknowledge that fee schedule modernization is considered a major threat by high billing specialties. It was a significant but usually unstated reason for the opposition to the last tPSA and may not proceed as we wish it to. As a fallback, we would reiterate our desire to have the ability to independently modernize the general surgery fee schedule to reflect modern surgical practice patterns. This can be accomplished in a revenue neutral fashion within the framework of an overall envelope assigned to General Surgery. We should have the discretion to both raise and lower fee codes, rewrite fee code descriptors and introduce new codes. We would require significant help from OMA Economics Dept. to model the changes to achieve a revenue neutral position for the specialty. We feel that all sections should undertake a similar exercise.

2. Accountability: 30%

We have major concerns that the OMA has not stepped up to the plate with regards to accountability issues. The void they allowed to exist is the reason for Bill 41. We are annoyed about irregular billing practices with no policing, as well as perceived abuse within the non-fee-for-service sector. Prescribing kickbacks for very expensive drugs and indirect lab referral incentives persist with no perceived attention from the OMA. We do not want a heavy handed, blunt, government-imposed system designed by those unfamiliar with the nuances of billing practices. We would strongly lobby for the OMA to negotiate to play a leading and active role in creating a system that creates accountability and deliverables for both the fee-for-service and the non-fee-for-service sectors. Those with fee-for-service incomes well above median specialty income should be regularly audited. In a similar vein, the HOCC system is widely viewed to be unfair and widely abused. Some people work hard for their HOCC dollars, while many do almost nothing. Its initial premise to compensate short leash specialties is very sound, but its expansion to include almost every specialty is not. Many HOCC contracts were established 15 years ago when circumstances were very different. We would recommend that funding be preserved at current levels, but that a detailed review take place over the next year with plans to create and introduce a replacement (HOCC2) during the term of the agreement.

3. Unemployment and Underemployment: 20%

Teaching hospitals have evolved to the point that they cannot provide care without a cohort of residents that far exceeds the number required for replacement or population growth. It is unethical to train residents with no prospect of a long term appropriate job. The only viable long term solution is to create a system that replaces some residents in

short leash specialties in teaching hospitals with hospitalists and/or physician assistants. We would seek negotiation to "right size" physician human resources and for funding to be allocated for replacement of some resident spots with hospitalists/PAs. We also think that most communities with physicians who bill well above average incomes would be better served if their resources were shared by an increased number of physicians billing more average incomes. Measures such as graduated fee reductions at the top end of billing profiles would encourage such redistribution and potentially allow hiring of new graduates.

Short Term Goals

Our executive was concerned that our focus on long term goals, while important, may mask the fact that we also have concerns about income levels, especially the impact of unilateral actions. We prioritized short term goals as follows:

1. **Reversal of universal claw backs (but not the targeted cuts): 40%**
   While we felt that some of the targeted cuts were appropriate, the universal claw backs need to be immediately reversed.

2. **Cost of living increases annually going forward and retroactively to 2013: 30%**
   This is a simple basic principle of fairness, and every other public sector group gets at least inflationary increases - so should we. It should be an integral part of the agreement.

3. **Unbundling of peri-operative visit codes and allowing post-operative MRP codes**: **30%**
   Although this issue overlaps with fee schedule modernization, we are also treating it separately in order to emphasize it. We have long felt that bundling the surgical fee with 2 weeks of post-op care and 2 days of pre-op care is grossly unfair and is an historical anachronism dating back to when patients were admitted days in advance for bowel preps, shaving, etc. Many procedures that are now 4- hour stays used to stay for a week. Only sick people are in hospital now and their daily care is time consuming, a significant burden on a 24-hour basis, and needs to be fairly compensated. We perceive the inability to bill for post-op care or bill MRP codes in the post-operative setting to be grossly unfair and strongly in need of rectification.

Non-Fiscal Issues:

Resource tracking: Surgeons cannot practice without hospital resources. The contraction of hospital resources has forced many productivity gains over the years as we do more with less. However, most of the fat has been taken out of the system and productivity improvements have plateaued. New resources are clearly needed to deal with a growing and aging population. Many hospitals reduce OR time to balance budgets, which directly impacts both patients and surgeons. We strongly feel that accountability works both ways, and just as we are advocating for accountability for physicians, the hospitals likewise need to be held accountable. The OMA should negotiate that total provincial elective OR time and endoscopy resources be tracked and reported at the LHIN and hospital levels on a monthly basis. It should also be reported by specialty. Availability and usage of non-elective ORs should also be tracked. This should not be an expensive exercise, as every hospital will almost certainly be tracking this type of data already. This data should be publicly accessible with no more than a 2-month delay. There would be an expectation that OR resources would expand as the population grows and ages.

Transparency: Historically, the OMA Department of Economics has produced a document called Physicians Characteristics, which has allowed section leadership to compare average incomes and activity between sections. This document does not include data about the non-fee-for-service payments at the section level, which now represent a huge proportion of some section incomes. This deficiency effectively means that reasonable comparisons can no longer be drawn. This needs to be corrected.

Total cost of allied health professionals: Although this is not a direct negotiation item, we feel that physicians in Ontario would be well served if the OMA in conjunction with a respected consultant group undertook a detailed assessment of the true cost of health care when delivered by nurse practitioners or midwives. We suspect that when adjusted for pension, benefits, malpractice coverage costs and when adjusted for productivity and availability (on call) that they may well be a much more expensive option. For example, the total midwifery budget is $130 Million per year, which corresponds to a cost of about $10,000 per delivery - many times more than the cost when delivered by physicians. Having this type of data available might well make future negotiations easier.

Re: Partial Salary question…

We have been asked to address the issue of whether there is support for a partial salary model. The majority of the executive had significant reticence about this. A lot of our concerns about accountability relate to perceived low productivity and work avoidance of those on salary or capitated payment models. While there are examples of successful salaried systems, we feel that the majority of such systems have been a failure and require significant and expensive oversight. The Ontario system does not (and should not) have an expensive administrative infrastructure such as is present in the US where salaried models are more prevalent. We feel that the ability to work at a pace that suits your desired lifestyle is important but such choices should impact income in a direct fashion. Our concerns are not an absolute rejection, and although there was little enthusiasm, some felt that it could be further explored.

Respectfully submitted,

Chris Vinden, Chair
Section on General Surgery

CV/lq