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Mythbusters

A series of essays giving the research evidence behind Canadian healthcare debates

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Myth: Doctors do it for money

Discussions about health services and how to improve them often focus on the importance of gaining the support of the people delivering healthcare, such as nurses and other health professionals — and of course, doctors.

Debates over matters such as primary healthcare reform, multidisciplinary care, and the supply and distribution of health professionals often hinge on the support of those professionals. When it comes to doctors, it's commonly assumed that they are guided primarily by financial considerations when they decide where, when, and how to practice. Therefore, so the theory goes, doctors won't co-operate or change their behaviour unless they believe there is a financial incentive for them to do so.

The evidence casts significant doubt on this assumption. Doctors are not purely "economic creatures," and while money is important to them, it is only one of many factors that influences their behaviour.

When and how to work

A popular opinion is that fee-for-service payment, a prominent feature of Canada's healthcare system, provides an incentive for doctors to provide care — and by extension, to "slack off" and work less if they aren't paid for each service they provide. Canadian studies, however, have demonstrated the opposite.

In the 1980s, a group of primary care physicians working in Ontario's health service organizations switched to capitation payment, meaning they received block funding to care for enrolled patients. Compared with colleagues who were still paid by fees for services, the doctors paid by capitation had the same hospital use rates — both by number of patients and number of days — despite incentives in the capitation formula to use the hospital less.[i] In other words, concerns other than finances were motivating these doctors when determining what care their patients should receive.

Surgeons at Kingston, Ontario's teaching hospital started receiving annual negotiated payments instead of fee-for-service payments in 1994. In tracking their practice patterns for four non-urgent procedures, researchers found the surgeons' behaviour changed over time, but no more so than their colleagues' at Ontario's other academic health science centres, who remained on fee-for-service payment.[ii] Of course, healthcare in Ontario went through a number of changes in the 1990s, including fee caps, hospital mergers, and bed closures. These factors appear to have had a larger effect than capitation payment.[ii]

One area where capitation does seem to have an effect is in the number of patients primary care doctors take care of. Research has found that fee-for-service doctors generally have more patients than those on salary.[iii] However, as many doctors — especially young ones — are looking for smaller practices and better work-life balance, it's unclear how much of a factor the financial incentive was in relation to other variables.

Where to set up shop?

Just as discussions about *how* doctors work often centre around ensuring incomes are not affected, programs to affect *where* doctors work almost singularly focus on how to provide financial incentives to influence behaviour.

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Attracting doctors to rural and remote areas is a perennial challenge in healthcare systems, particularly when it comes to attracting family doctors, according to vacancy lists. In Ontario, Canada's most populous province, 129 rural and remote communities have vacancies for 593 general practitioners, as of summer 2003.[iv] British Columbia's rural communities are recruiting 62 GPs, Alberta is looking for 56, Saskatchewan wants 27, Nova Scotia is after 19, and Manitoba is seeking 11.[v-ix]

Every province has an incentive program to attract doctors to rural and remote areas.[x] Typically, these plans provide signing bonuses or guaranteed-income contracts, and they encourage medical students to select rural practice through a combination of financial and academic incentives.[xi, xii]

However, these financial incentives shouldn't be the whole answer, given what doctors say on surveys, both Canadian and international. They rate family and community factors well above economic ones; as an example, forgiveness of student loans ranked 22nd out of 23, 20th out of 24, and 24th out of 26 significant factors in three studies,[xiii-xv] and signing bonuses ranked 21st out of 24.[xiii] Moreover, evaluations of Quebec's incentive program found that financial incentives alone won't work; they have to go hand-in-hand with modern facilities and high-quality infrastructure.[xvi, xvii]

Broader lifestyle concerns appear to be more important. The availability of work for their spouses, education opportunities for their children, and recreation opportunities for the whole family are all things that doctors and their families consider more important than financial incentives.[xiii, xv, xviii] This is a big part of the reason that 37 percent of doctors in one 10-year Australian study left their rural practices, including 24 percent of the doctors who had originally intended to stay in rural practice.[xix] Family and lifestyle concerns were also a major motivation for the 62 percent of doctors who left rural practices in Quebec's Outaouais region between 1985 and 1990, despite the fact that 76 percent of rural doctors receive financial incentives in that province.[xvii]

Conclusion

Much of the discussion around quality of care and improving the healthcare system centres on how to work with doctors and how to bring them on board. In trying to do this, we shouldn't lose sight of the fact that doctors are not motivated solely by money.

Mythbusters *are prepared by Knowledge Transfer staff at the Canadian Health Services Research Foundation and published only after review by researcher experts on the topic.*
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References

i. Hutchison, B et al. 1996. "Do physician-payment mechanisms affect hospital utilization? A study of health service organizations in Ontario." Canadian Medical Association Journal; 154(5): 653-661.

ii. Stanton, S, and Shortt, SED. 2003. "The influence of payment method on patterns of physician practice: experience at a Canadian academic health centre." Research in Healthcare Financial Management; 8(1): 43-58.

iii. Hutchinson, JM, and Foley, RN. 1999. "Method of physician remuneration and rates of antibiotic prescription." Canadian Medical Association Journal; 160(7): 1013-1017.

iv. Ontario Ministry of Health and Long-Term Care. 2003. "July/August/September 2003 list of areas designated as underserviced for general/family practitioners." www.health.gov.on.ca/english/providers/program/uap/listof_areas/gp_ladau.pdf.

v. Alberta Rural Physician Action Plan. 2003. "Practice opportunities listing — 16 June 2003." http://rpap.ab.ca/pdf/Pracopp.pdf.

vi. Nova Scotia Department of Health. 2003. "Family practice opportunities." www.gov.ns.ca/heal/physicians/positions.htm.

vii. Health Match B.C. 2003. "Physician vacancies." www.healthmatchbc.org/HMBC_view_vacancy_dr.asp?region_id=&specialty=31&pageid=659&submit2=Search+Now.

viii. Manitoba Health. 2003. "Healthy opportunities, caring careers." http://web3.gov.mb.ca/healthcareers/main.jsp?portal=1.

ix. Saskatchewan Physician Recruitment Project. 2003. "SPRP practice opportunities." www.mdopportunity.org/cgi-bin/search.cgi?specialtyID=8.

x. Barer, ML et al. 1999. "Toward improved access to medical services for relatively underserved populations: Canadian approaches, foreign lessons." Centre for Health Services and Policy Research, University of British Columbia.

xi. Ontario Ministry of Health and Long-Term Care. 2001. "Underserviced Area Program." www.health.gov.on.ca/english/providers/program/uap/uap_mn.html.

xii. Alberta Health and Wellness. 2003. "Alberta Rural Physician Action Plan." www.rpap.ab.ca/index.htm.

xiii. Costa, AJ et al. 1996. "To stay or not to stay: factors influencing family practice residents' choice of initial practice location." Family Medicine; 28(3): 214-219.

xiv. Szafran, O et al. 2001. "Location of family medicine graduates' practices: what factors influence Albertans' choices?" Canadian Family Physician; 47: 2279-2285.

xv. Cooper, JK et al. 1975. "Rural or urban practice: factors influencing the location decision of primary care physicians." Inquiry; 12(1): 18-25.

xvi. Contandriopoulos, AP et al. 1995. "Évaluation des mesures incitatives visant l'amélioration de la répartition géographique des médecins au Québec." Ministere de la Santé et des Services sociaux.

xvii. Beaudoin, R, and Charette, A. 1990. "Évaluation des effets des mesures incitatives sure le recrutement et la rétention des effectifs médicaux dans l'Outaouais." Conseil régional de la santé et des services sociaux de l'Outaouais.

xviii. Scammon, DL et al. 1994. "Understanding physicians' decisions to practice in rural areas as a basis for developing recruitment and retention strategies." Journal of Ambulatory Care Marketing; 5(2): 85-100.

xix. Kamien, M. 1998. "Staying in or leaving rural practice: 1996 outcomes of rural doctors' 1986 intentions." Medical Journal of Australia; 169: 318-321.