Rémunération Mixte and the New Pool

Henry Olders
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I am one of the individuals who has not signed up for rémunération mixte. I would like to tell you why.

My objection is not with rémunération mixte. Like most of you, my income will increase with this system. My objection is solely with the new pool system that is planned to accompany rémunération mixte in our department. I believe that this scheme promotes inequality and unfairness, and may have a negative impact on our patients. Let me explain.

In the existing pool system, if everyone billed at 100% of their contracted hours, then there would be no inequality between pool members in terms of their contributions to the pool or their share of pool expenses (see Appendix, table 1). Inequalities arise when some members bill more and others less than their contracted hours. In general, this has been dealt with by exhorting members who bill less to increase their billings, while those who consistently bill more can ask to increase their contracted hours. In any case, the inequalities have not been so glaring that individuals felt compelled to change the system.

With the proposed new pool system to be implemented along with rémunération mixte, the rules will change. Instead of all billings being pooled, only the "by the act" billings during the hours contracted to the hospital as "rémunération mixte" hours, will go into the pool. Since these acts can be billed at only 30% of the usual tariff (except for inpatient acts and consultations, which are billed at 45% and 60% respectively), the amount of money going into the pool will be considerably reduced. Moreover, doctors who see a lot of patients will be contributing the bulk of the pool funds, and thus the bulk of the pool expenses will be covered by these people.

It is my understanding that pool funds, after expenses, will be distributed according to the number of hours that individuals are contracted for. Since most people will be contracted for 35 hours per week, most people will receive an equal share of the pool.

However, it becomes entirely possible for someone to collect their share of the pool and submit no "by the act" billings whatsoever. A person doing this would receive the same amount of money from the pool as his or her peers, but would be making no contribution to either the pool funds or to pool expenses, including the departmental contribution (called the "Director's Fund"). Thus, there is absolutely no financial incentive to see patients and submit "by the act" billing.

The lack of incentive to see patients within the rémunération mixte hours will be potentially harmful to our patients, who are already likely to be affected negatively by rémunération mixte. I'll use myself as an example.

I am contracted to work 36 hours per week for the department, over 4 days. On the fifth day, I work at CLSC René-Cassin, and I work on my research (non-remunerated), and I do some work providing psychiatric expertise for lawyers. In the hospital, I work in four services, seeing lots of patients. Over the past several months, I have been generating income for the pool at about 130%.

With the new system, I will have to reduce my hours at the CLSC, because I will need to be at the hospital for at least several hours five days a week, instead of four. And I will be spending 7-hour days at the hospital, not 9 hours. So in essence, my hospital time will be less than it is now, and without the financial motivation to see patients and bill "by the act", it is likely that I will preferentially use my time in activities such as team meetings, rounds, journal clubs, teaching, CQI activities, etc. Of course, I could work on fewer services to reduce the number of team meetings and rounds that I attend. But who would be willing to cover those services?

Perhaps the most problematic aspect of the proposed pool system is that pool expenses (including the Director's Fund of $75,000) will bear no relationship to the number of hours a person is contracted to the department, nor to the amount of time a person is actually working for the department, nor to a person's billings with respect to the department, nor to a person's income from department work, nor to a person's total income. It will be based solely on how much "by the act" billing an individual does during rémunération mixte time. Table 2 in the Appendix shows how it would work for two physicians, based on actual numbers. Such a system promotes inequality and is inherently unfair.

I do not feel that I can participate in a pool system which has such a degree of inequality built in, and which may have a negative impact on our patients. Thus, I have not signed up for rémunération mixte, because I have been led to understand that signing up for rémunération mixte includes accepting the new pool scheme that accompanies it.

Please understand that I am not against rémunération mixte. I would see a significant hike in my income with rémunération mixte, as would many others. And I could have this increase with fewer hours worked. At my age, that sounds attractive. My objections are only to the pool scheme that has been proposed to accompany rémunération mixte, because it is unfair and because the hospital's patients may suffer.

There are several alternatives possible:

1. Continue with the present system;
2. Rémunération mixte, with no pool. Individuals could be "taxed" to cover pool expenses;
3. Rémunération mixte, with a pool for both rémunération mixte billings and for "by the act" billings during rémunération mixte hours;
4. Rémunération mixte, with a pool only for rémunération mixte billings.

I believe that this last alternative has the most going for it:

1. Everyone will enjoy a good income, including individuals who devote their time exclusively to teaching and/or administration, as they will still earn over $85 per hour;
2. Pool administration will be simplified: only rémunération mixte earnings go into the pool; all other billing or income is outside the pool;
3. Pool expenses will be fairly distributed, based on the number of hours contracted to the department;

4. Because seeing patients will increase hourly income by at least $20 per hour (even more for inpatient work or consultations), physicians will be motivated to see more patients, which will improve departmental productivity and benefit patients;
5. Furthermore, it will be attractive financially for individuals with private practices (remunerated by the Régie) to increase their hospital hours and to see these patients as hospital patients: per hour income would increase from $68 or more to at least $105 ($85 + 30% of $68);
6. Since the more stressful settings (inpatient and ER) will lead to higher levels of remuneration, more physicians will be attracted to work in these areas;
7. The advantages of a pool system (eg a constant cash flow in spite of holidays, vacations, or short illnesses; sharing of expenses and contributions to the department; collegiality) will be much greater with the larger sums of money which will be pooled (eg 778 hours per week x 45 weeks per year x $85 per hour = $2,975,850, versus $273,958 – see Appendix).

Given all these advantages, I would certainly opt in to rémunération mixte if the pool were to adopt this proposal, and it is possible that the other two pool members who have opted out would also change their minds. Pool cohesiveness is important! Don't contribute to divisiveness by supporting a system which promotes inequality!

Appendix

Basic Premises:

From the pool statistics as of November 1998:

Total pool hours per week:		778
Total "by the act" hours per week:		318
Overall Ratio:	318 / 778 = 0.41	
Highest ratio: Dr. A.:	"by the act" hours	18
	total hours	28
	ratio 18 / 28 = 0.64	
Lowest ratio: Dr. B.:	"by the act" hours	6
	total hours	37
	ratio 6 / 37 = 0.162	

From the 1998 Pool Financial Statement:

Pool distribution			$2,067,344
Expenses:	Pool Administration	75,528	
	Taxes	10,924	
	General Expenses	3,316	
	Director's Fund	75,000	
	Residents' Dinner	2,050	
	Total expenses		166,818
Pool Income			$2,234,165

If we assume that both Drs. A. & B. contributed at 100% of their contracted hours to the pool, then:

Table 1. Existing Pool System

	Dr. A.	Dr. B.
Contribution to Pool	28 / 778 x 2,234,165 = $80,406	37 / 778 x 2,234,165 = $106,252
Share of Expenses	28 / 778 x 166,818 = $6,003	37 / 778 x 166,818 = $7,933
Income from Pool	28 / 778 x 2,067,344 = $74,403	37 / 778 x 2,067,344 = $98,318
"Return on Investment"	74,403 / 80,406 = 92.5%	98,318 / 106,252 = 92.5%

Note that for each doctor, contribution to the pool, share of pool expenses, and income from the pool vary directly as the number of hours contracted to the department. Thus, the existing system treats everyone equally, as long as people bill at 100% of their contracted hours.

The Proposed New Pool System:

Only the "by the act" billings during the hours contracted to the hospital as "rémunération mixte" hours, will go into the pool.

The pool share will continue to be based on the number of hours that the individual is contracted for.

For the sake of simplicity, in this analysis I will use the same hours for total and "by the act" billing as above, even though for some individuals the hours will increase.

Thus, I will use 318 hours of "by the act" billing per week (the actual figure may be somewhat lower, since control visits will no longer be remunerated under rémunération mixte);

and a multiplication factor of 30% (given that the majority of acts will be remunerated at 30%; the actual figure should be somewhat higher, because inpatient acts will be remunerated at 45%, and consultations at 60%);

Also, using the totals from 1998:

Annual Pool Income: 1998 income x ("by the act" hours / total hours) x 30%

$2,234,165 x (318 / 778) x 30% =	$273,958
less: expenses	-166,818
Available for distribution	$107,140

Table 2. Proposed New Pool System

	Dr. A.	Dr. B.
Contribution to Pool	18 / 318 x 273,958 = $15,507	6 / 318 x 273,958 = $5,169
Share of Expenses	18 / 318 x 166,818 = $9,442	6 / 318 x 166,818 = $3,147
Income from Pool	28 / 778 x 107,440 = $3,866	37 / 778 x 107,440 = $5,109
"Return on Investment"	3,866 / 15,507 = 24.9%	5,109 / 5,169 = 98.8%
Remuneration per hour (for 45 weeks per year)	3,866 / (18 x 45) = $4.77	5,109 / (6 x 45) = $18.92

This analysis demonstrates that with the new pool system, Dr. A. would contribute 3 times as much to the pool and to pool expenses as Dr. B., because Dr. A. would be submitting bills for 3 times Dr. B.'s amount for patients seen by the act. However, Dr. A. would receive only 76% as much income from the pool as Dr. B., even though he is seeing more patients. Dr. A.'s "return on investment" and hourly remuneration would only be 25% of that of Dr. B.

If we consider each doctor's contribution to pool expenses in proportion to the hours contracted to the department, the inequality becomes even worse: Dr. A. will pay $7.49 per hour (based on 45 weeks worked per year) while Dr. B. will pay only 25% of that rate, ie $1.89 per hour.

Because of the low hourly remuneration and the excessive proportion that he pays to pool expenses, it is likely that Dr. A.'s motivation to see patients and submit billing for them will drop sharply under the new pool system.

Dr. A. and Dr. B. are not hypothetical cases; they are real. Most pool members operate with a ratio of "by the act" to total hours closer to 0.5, however; the overall pool ratio is 0.41. At this ratio, the remuneration per hour of "by the act" billing would be $7.51, while at a ratio of 0.5, remuneration would be $6.14 hourly. This is one-third what Dr. B. gets per hour; conversely, Dr. B. will be contributing to pool expenses only one-third as much on an hourly basis as the physician at a ratio of 0.5. The inequality remains striking.