Health Professional Compensation

Health professional salaries was a topic of discussion in the Conversation on Health. The model used to compensate physicians and the salaries of health professionals were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of Health Professional Salaries.

Models of Physician Remuneration

Many participants in the Conversation on Health feel that fee for service is not the most cost effective way to compensate physicians, since it does not create accountability for health outcomes. Many feel that fee for service acts as an incentive to over-service urban areas and patients with minor ailments while under-servicing rural areas and patients with complicated chronic conditions. Some suggest creating salaried positions as a means to address these issues. Offering salaried positions to physicians, they argue, would also facilitate creating integrated teams of health professionals while allowing doctors to find a more amenable work/life balance. Participants also examined blended compensation models including components of fee for service, salary and capitation, with the goal of achieving more holistic care and better alignment of remuneration with accountability for health outcomes.

Some participants suggest addressing accountability concerns through pay for performance models. Many international jurisdictions use performance incentives linked to health outcomes as one part of physician compensation. Others are cautious about pay for performance, suggesting that the model would have to be very well thought-out to limit unintended consequences and that the monitoring required would only be possible with a fully implemented electronic health record system.

*Fee for services is like the nail in the foot. It's holding us down. It's not in itself a problem except that it's preventing anything else from happening…*

- International Symposium, Vancouver
Health Professional Salaries

There is little agreement about the range of health professional compensation: participants see the amount health professionals are paid as both too high and too low. Many participants feel that general practitioners should be paid more in order to attract more medical students into family practice instead of specialty fields. They also suggest increasing pay incentives to draw more health professionals to rural areas of the province. Some participants think the disparity of pay between health professionals is too great, with doctors making too much compared to Registered Nurses, for example. Others are troubled that too many health professionals are being asked to work as casuals while their peers are working excessive over-time, which creates retention issues and staff burnout.

Many participants express concern about the wages for community care workers, long-term care aides and hospital support staff. They feel that their wages are no longer competitive enough to attract and retain staff and that the continuity and quality of care have suffered as a result.

Conclusion

British Columbians are looking for a model that compensates health professionals fairly for the difficult job they perform, ensures services are accessible around the province and provides more holistic care for patients. Most feel that the current fee for service model cannot achieve these goals and that the model of physician remuneration will have to change if the health care system is going to adequately address the needs of British Columbians. British Columbians’ opinions are divergent on the rate of pay for physicians and other health professionals, except in the need to increase incentives for family doctors and for health care professionals who work outside of urban centres.

*If you do not bring the… physician into this picture with clear incentives for appropriate care and disincentives for suboptimal care, we will not measurably alter the system.*

– Online Dialogue, Pender Island
Health Professional Compensation

This chapter contains the following topics:

Models of Health Professional Remuneration
Health Professional Salaries

Related Electronic Written Submissions

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Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Morale and Health Human Resources.

Models of Health Professional Remuneration

Comments and Concerns

Fee for Service
Doctors Working on a Salary

- Comments on the fee for service structure:
  - Fee for service is the wrong approach. A different kind of agreement where capitation and fee for service or some combination of the two methods has to be
shaped. The fee for service system mitigates against innovation in service delivery because the only way you can deliver a service is face to face with a doctor. That is really the biggest barrier.

- Fee for service billing is a disincentive for doctors to practice outside of the heavily populated urban centres.

- The current method of payment for physicians has a built in conflict of interest. The physicians are rewarded with fees per patient seen. The more often patients are seen, the easier the clinical condition; the higher volume of patients will be seen per day and the higher the physician income. Physician reimbursement should be modified with provisions for rewarding experience of the caregiver, excellence of care, better patient management process and outcome.

- Physicians are operating like lawyers; their only concern is to bill for as many hours as possible.

- The fee for service system prevents integration with professionals who are not on fee for service.

- It has been said that physicians could not be expected to be dedicated to their profession if they did not receive a fee for service. What about the Hippocratic Oath?

- I wonder if the most cost effective way to remunerate doctors is fee for service. I believe fee for service encourages doctors to take on too large a case load and results in overpayment for specialists who frequently have too low a case load.

- A fault of the system is that it provides free equipment, supplies and facilities to doctors who insist that they are self-employed. What other self-employed person enjoys this benefit?

- As a doctor who is paid on a fee for service basis, I would instead opt for sessional work. At least that way I am getting paid for my time rather than per patient. Having been in a medical clinic where volume was the key to financial success, and now in a clinic where the majority of my patients take a lot more time, I am ready to throw in the towel and go back to seeing colds and flues. I could make a lot more money than I do seeing 25-30 patients daily in six hours and making peanuts because I take time to explain things. It is frustrating to be making multiple calls, filling out forms and spending time because it makes people feel better while I am getting paid nothing for it.

- Fee for services is the nail in the foot. It is holding us down. It is not in itself a problem, except that it is preventing anything else from happening.
There is no accountability in a fee for service system. It is simply a rolling account that you can draw from indefinitely. No one has to justify their actions and decisions. It is the most bare bones form of accountability possible.

The fee for service structure does not lead to a holistic approach to patient care.

The fee for service payment is a protected envelope for physicians. There is nothing to stop them from over-doctoring. It is a perverse incentive.

The trouble is that fee for service is not satisfactory for physicians anymore because it only rewards low acuity behaviour and high volume care. The physicians were okay with that at first because they could still make money, but now they have cornered themselves. The acuity has gone up, and the pay by fee for service has not kept up with their workload. There was a readjustment at some point back to what the market would be for the service and not the visit anymore, but we are not funding a visit anymore. We are trying to fund a service, but the cost of the service is now bigger than what the visits were paying. We have to add in the accountability piece that was not there. It may actually cost us more money to move to this model, but if we can get better accountability and the outcomes that we were expecting in the service levels, it would be worth the cost.

It is a problem that doctors get paid the same amount for seeing a sixty five year old with complications from diabetes and chest pains as they do to see a five year old with the ear infection.

Doctors are working like they are on commission, pushing people through the system rather than providing quality care.

The fee for service remuneration model for doctors works against the needs of seniors.

Due to a daily patient cap on family practice, the only way for general practitioners to make a profit is to work overtime, or to avoid the overhead costs of family practice by working in a walk-in clinic.

There is no doctor educated in this province that has not had the subsidy of every tax paying British Columbian behind them. Yet, every physician that I have ever known has explicitly declared their right to fee for service, because of the privileged position they have now as a physician.

Faster diagnosis and treatment might result from doctors being paid for each patient they treat, and not by each patient's visit. This may also encourage doctors to take more of an interest in the patient's lifestyle so that fewer visits to his office would be needed.

There is no alignment between current remuneration methods and outcomes.
The pay structure can influence a doctor’s treatment approach.

Family doctors are becoming a thing of the past because we have allowed the fee schedule to be managed by the British Columbia Medical Association (BCMA) and the walk-in clinic doctors have a stronger voice in that organization than the family doctors.

**Comments on salaried physicians:**

- In Vancouver Coastal Health Authority we have hospitals that are staffed by salaried doctors and it is not the solution. The salaried doctors have the mentality that they are only there for eight hours and we should not expect them to be there beyond that. That is one of the reasons salary is not always the answer.

- If doctors were salaried, they would not be able to hire the other staff needed to run a clinic. Whatever the model of funding, it has to account for everybody on the health care team.

- Surgeons’ being paid based on a fee for service model is problematic. The more surgeries they do, the more money they make. We could get away from the issue of excessive and unneeded surgeries by placing surgeons at the acute care level on salaries.

- It is difficult to staff remote areas like the Sunshine Coast on a fee for service basis. Salaried positions are one way to address this issue.

**Ideas and Suggestions**

**Performance Incentives**

**Ideas about Salaried Physicians**

**Capitation Systems**

**Ideas about performance incentives:**

- My concern about providing performance incentives is that you can create skewed deliveries. You end up with a percentage of the population who get bounced from pillar to post because they are too expensive to treat. However, it does depend on how it is structured. Unintended results are a well-known side effect of any kind of pay for performance scheme, which is not to say that you should stay away from paying for performance. You need to balance the side effects with the positive elements.

- Physician salaries must be linked to appropriate patient outcomes.
- There are all kinds of professions where performance is not related to pay. What are doctors going to say when you hit them with this demand? Why are doctors being singled out?

- We should avoid pay for performance as it increases competition.

- Doctors should receive incentives for providing holistic care.

- Physician pay should be based on performance measured in patient outcomes. You must clearly define the targets and measure the results.

- When we are comparing the health business to any other type of business, ask yourself when do we reward shareholders or employees for poor performance? Do we continue to increase salaries? No. So why should we do so in the business of health? There is not an endless pot of money in the system to reward people and institutions for poor outcomes.

- The contract between family practitioners and the National Health Service (NHS) in the United Kingdom was changed two years ago so that a significant element of their pay is now related to doing surveillance of their patients. For the first time, money was to be properly spent on quality, prevention and early health rather than late disease.

- Instituting a pay for performance system requires costing procedures in greater detail than is required in a fee for service setting. That process will create some anomalies and introduce more paperwork. There is quite a lot of refinement required, especially in establishing how to pay for the whole service rather than for a procedure.

- Other countries are experimenting with pay-for-performance approaches to motivate improvement and hold physicians accountable for care. The Dutch and German systems blend capitation, fees for consultations, and payments for performance with an integrated, electronic disease management system.

- I am all in favour of people getting paid more money for doing better. That strikes me as an inherently good principle.

- If you had a fully implemented electronic health record, you would not need the capitation model because you could base fee schedule payments upon deviations from established standards. Health promotion and prevention would be paramount if you had that electronic records and knew exactly what was going on with your patient the minute you turn on your computer.

- **Ideas about salaried physicians:**

  - Salaried doctors are ideal in smaller communities as they treat patients in a more holistic fashion.
- We should put doctors on salary so they are not competing for budget dollars. We could include office expenses in the salary.

- Fee for service is the best model for paying doctors.

- If all physicians were paid salaries, we would have a much more accurate picture of the true cost of providing care to the population and physicians would not spend any of their time with patients who could be better attended to by a less costly provider.

- Salaried family practice clinics such as the University of British Columbia's Family Practice work very well.

- There is a whole cadre of young doctors who really hate fee for service. We are on the cusp of an opportunity to change how we pay physicians in a fundamental way. These young doctors are not prepared to work 85-hour workweeks. We have to take advantage of this opportunity.

- We need a remuneration system between fee-for-service and salary.

- Fee for service providers are more efficient than those on a salary.

- New Zealand, in a decade, has managed to get almost all of their doctors off of fee for service and they did it in an ingenious way. The money to pay doctors was given to the regional health authorities and they organized multi-professional primary healthcare clinics. The government then subsidized the user fee for any patient that went to one of these new clinics which made them very cost effective for patients.

- Doctors should be federal public servants and paid a salary.

- We should not put doctors on salary, except in unusual circumstances. Some will say that doctors on salary are less rushed and therefore provide better patient care. I challenge them to provide hard data that shows better objective health outcomes when doctors are on salary. Patients may feel as though they are getting better care, but I am not sure that is worth the added costs.

- A World Health Organization (WHO) study revealed that Canada has only 2.1 physicians per 1,000 patients, while Italy, which uses a salaried system, has 5.8 doctors per 1,000.

- In a salaried environment, family practice doctors could negotiate working conditions, giving them a life outside medicine. The current environment discourages potential family practice doctors.
• **Ideas about Capitation Systems:**
  
  - I would like to see a system where family doctors are paid by how many healthy patients they have on their lists, and less on how many sick people they treat.
  
  - We should explore the option of giving physicians the mandate to manage the care of a certain number of people for a fixed price instead of fee for service compensation. This may encourage earlier prevention and promotion of healthy lives instead of waiting to deliver episodic care when it is too late and much more expensive.
  
  - The doctors should be compensated like they are in China, where they are only paid when they keep the patient free from the disease.
  
  - In the clinics, where there is a blended pay structure, doctors are assigned a certain number of patients and they are measured against those patients’ outcomes. It works beautifully, but the problem is that it only works when the patients are in the community. Once they are transferred to the hospital, the doctor in the community clinic does not go to the hospital to look after them and there is a breakdown in continuity.
  
  - It is very important to have payment and incentive systems that align physician and system goals
  
  - We should change the pay structure for providers to encourage integrated care centres as a 24 hour alternative to emergency rooms.
  
  - A valued employee is a happy and more efficient employee, which ensures quality patient care.
  
  - Doctors should be paid by the time spent with each patient, not by the number of appointments.
  
  - It should not matter if it is a general practitioner or a specialist that provides a service: they should be paid the same rate for the same service.
  
  - Physicians should be paid sessionally or by a mix of sessional and fee for service.
  
  - Changing the way physicians work requires changing the physician pay structure.
  
  - In the Interior Health Authority, there are fee for service social workers, nutritionists and physicians, working on the same team and under the same model. It allowed for each service to be compensated appropriately and facilitated innovations like group appointments. However, the feeling seems to be that we do not want to create more fee for service professions, but if we were to use a blended system it would achieve the same results.
• The practice program is making a case for family doctors moving to giving their patients same-day access to their clinics. The short, simply treated patients would return to their family doctors instead of going to walk-in clinics, which means that doctors could earn 10 to 25 per cent more money.

• Funding the practice instead of the physician individually is a good way to bring more people into the primary care system.

• We should have options available so physicians can either work in a fee for service private practice or in a community health centre on salary.

• If we could pay family physicians differently in primary health care clinics, we would have more primary health care and more integration, with many types of professionals all working together.

• We have to change the billing situation so that doctors are no longer rewarded for the quick fix prescription.

• Doctors would be less inclined to bring back patients for unnecessary visits if they were paid according to how many patients they are treating rather than per visit.

• The South Community Birth Program got federal grant money to start up a multicultural, multidisciplinary program for prenatal care. They took the midwives’ and the physicians’ billing rates and put it all in a pot with an agreement about how they would pay everybody on the team. So, even though the funding mechanism looked at midwives and physicians quite differently and individuals who performed a service billed based on their own billing rate, there was a more rational system that pays them.

**Outstanding Questions**

• Are physicians accountable for the money they receive?
Health Professional Salaries

Comments and Concerns

Doctors
Nurses
Support Staff and Community Care Workers

- Comments on doctors salaries:
  - Doctors are not paid adequately for the services they provide.
  - I am appalled by the level of compensation that doctors have extorted from our politicians.
  - The health care system is in trouble because doctors and dentists charge too much for the services that they provide.
  - The difference in the roles between health professionals, such as doctors and nurses, does not justify the huge differences in the incomes.
  - The salary for general practitioners is not sufficient.
  - Family medicine is not chosen as a postgraduate program due to the significantly reduced lifetime income of family physicians in comparison to most specialty disciplines.
  - It is absurd that the compensation package for family doctors is so low that it forces them to schedule 15 minute interviews with patients.
  - A high salary for doctors just attracts those people looking to make as much money as possible. Greed should not be the driving principle in selecting who should become a doctor. The status of doctors in Canada is out of whack; they are not paid this way in much of the world. You would still have good people wanting to do this work at a much lower rate of pay.
  - The unintended consequence of paying doctors well is that they may choose not to maximize their income; they may choose to maximize their lifestyle instead.
  - The greatest cost to the health care system is the cost of our highly trained physicians. A general practitioner can bill in excess of $300,000 a year, and a cardiologist can bill in excess of $1,200,000 per year. How can they demand these figures? It is because the barrier to become a physician in North America is extremely high, which leads to fewer physicians, who are overworked and have very high salary expectations.
Family Practice is doomed to fail in this province due to doctors having to finance the facilities and costs of salaries out of the returns meted out by the government. Any normal business increases prices when costs increase.

Walk-in clinic doctors work nine to five, make three times the money other family doctors do and they never have to set foot in a hospital, have no hospital privileges, no emergency room experience and do not work on-call.

Doctors in Canada make an average of $202,000 a year. Alberta has the highest average salary of around $230,000.00 while Quebec has the lowest average annual salary of $165,000.00. This discrepancy creates interprovincial competition and pressure to increase these already high rates of pay.

Wages for physicians in British Columbia need to be competitive with Alberta which pays about 30 per cent more for the same services. As time goes on, it will be more and more difficult to compete.

Most doctors only remain in rural areas long enough to receive the incentives.

Current Medical Service Plan billing regulations dictate that physicians’ fees are reduced by 50 per cent if they see more than 50 patients a day, and are reduced to zero if that physician sees more than 65 physicians daily.

I would bet there are some feelings of inequity around pay between physicians and nurse practitioners. I think there are a lot of general practitioners who do not earn $85,000 a year and have to work a lot harder for what they do earn. The physician is paid for fee for service while the nurse is on a salary and if the nurse takes patients away from the physician, then there is a problem for the physician.

It is not right that physicians do not get paid for emergency room service.

Clinics do not stay open 24 hour a day because they are not paid to do so. Doctors are only paid by the number of patients they see and not enough patients come into clinics at two AM to make it worthwhile for the clinics to stay open.

Medical professionals working in a medical research role are paid much less than practicing doctors. However, researchers add much more than the practicing doctors.

Pediatrics is the lowest paying specialty. Children are not getting their share of the pot.

There is an inconsistent fee structure for surgeons. They get the same flat fee per procedure despite improvements in technology and surgical procedures, which have decreased pre- and post-operation care requirements.
More consideration needs to be given to alternate payment plans for physicians. As a physician, I see many inequities in the payment systems. A glaring example is the fee for cataract surgery. This used to be a difficult, time consuming operation. Now, thanks to improved technology, eye surgeons can do upwards of 10 to 14 procedures per day. This means a surgeon can earn upwards of $7400 per day, in addition to a mark-up the surgeon may charge on a foldable lens, which is not supplied by the hospital. This practice may create an inducement to schedule patients for this surgery. I think this is a great example of the benefit of paying physicians and surgeons on a time, rather than piecemeal basis.

The majority of doctors are paid on a fee for service basis. However, there are some on salary, contracts, sessional work or a combination of several different systems, depending on local or regional circumstances. As with many professions, there is a competitive national and international market for physician services. British Columbia is challenged by Alberta, where higher payments, particularly for specialist services, attract specialists who might otherwise have chosen to work in British Columbia. The resulting shortage of specialists affects service delivery here. Now that the federal and provincial first ministers have declared that the five national priorities for wait-time reduction are heart disease, cancer care, vision care, diagnostic imaging, and joint replacement, the Society of Specialist Physicians and Surgeons expect that the provincial competition for specialist services will intensify.

Naturopaths can be registered through the government, but they only get about $15 per patient. Every Naturopath I have seen has spent about an hour with me because their process involves the whole body, not just one part of it. What doctor can make a living being paid $15 an hour?

Comments on nurses salaries:

- The wage gap between Licensed Practical Nurses (LPN) and Registered Nurses (RN) is too large.

- How do you think I feel working beside a Registered Nurse (RN) who is getting twice the pay while doing the same job? I am dealing with patients’ lives. If I give the wrong dose or miss a medication a patient could suffer or even die. Tell me, is all that responsibility worth $22.00 an hour? I do not think so.

- New nurses are not offered full-time jobs and are mostly working in casual positions.

- We have thousands of nurses working incredible amounts of overtime at a huge cost to the system when additional full-time or part-time nursing positions could be added at regular pay rates. This would save money and reduce employee
burnout. However, current managers seem unwilling to add positions to their departments because it will affect their budget.

- Many nurses are still bitter about the wage rollback.

- I appreciate that nurses do a difficult job, but they are overpaid for what they do in comparison to the real world.

- A nurse working shift on a long statutory week end, can earn approximately the equivalent of working a full week of day shift at regular pay because of lucrative stat holiday pay, shift differential and weekend pay. If he/she should not finish work on time and puts in for overtime, the hourly rate increases phenomenally yet again.

- Nurses are often left to do the cleaning since hospitals started contracting out. The cleaners are not trained to infection control, and ten dollars an hour is not incentive to do a thorough job.

- A nurse receiving WorkSafe BC compensation can match or better her regular salary, as compensation has not been subject to income tax. I have seen this arrangement go on for months and months. It is an embarrassing scam that has not been addressed. Most nurses who have not been recipients of WCB do not realize this and those who discover the benefit are apparently not talking.

- We cannot encourage enough nurses to take leadership positions because of drop in wages they would experience.

- I am not happy about nursing students having to work for no pay during their training. Would you come to work for no pay? This practice really discourages potential nursing students from signing up. We should pay at least the minimum wage for the training hours.

- Comments on support staff and community care workers salaries:

  - Some facilities do not pay enough for health care workers to live comfortably.

  - Casual workers are not staying around as there are not enough hours available for them to earn a decent wage.

  - Staffing hospitals with casual labour is cheaper, but it causes retention issues. In many parts of the province, living on part-time hours with no guarantee of work is impossible.

  - There is too great a discrepancy in pay between managers and health care workers.

  - A friend of our grandson is earning $27 per hour for laundry work. At those wages, laundry work should be contracted out.
• The Health Employees Union (HEU) took a pay cut of 15 per cent, and then had their jobs privatized. The pay cut has forced many workers to hold down two jobs and work lots of overtime to make up the difference. Many HEU workers cannot make ends meet on the reduced wages.

• The Hospital Employees Union holiday pay is three to five times greater than basic pay.

• Hospital management receives bonuses while health care employees continue to receive poor wages.

• How do you hope to retain support staff when they are improperly classified and inappropriately paid? I am appalled that government would give themselves a 29 per cent pay increase when I still have not come back to my previous pay level since our mandated decrease a few years ago.

• The wage rates for maintenance staff are too low. Low wages result in higher turnover and more costs.

• The pay cuts to care aides who work with seniors was like a slap in the face.

• The wages paid to hospital cleaning staff, which at one time were higher than those paid for similar jobs in hospitality industry, are now worse than similar jobs outside of hospitals.

• Health care workers are one of the most likely professions to be exposed to violence and are protected by inexperienced contract security guards who are paid eight dollars an hour.

• Home care workers are trained as long-term care aides. They drive their own vehicles to remote homes, bathe, cook and care for frail elderly in the worst weather, and are paid less than their counterparts working in facilities with modern conveniences and co-workers on hand to assist if needed.

• There should be a relationship between the minimum wage and health administrators’ salaries.

• Public sector employees lead the country in wages, benefits and quality of working conditions.

• The rate of pharmacist remuneration in British Columbia is one of lowest in Canada.

• Pharmacists should be compensated for their medication management role within the primary health care model. Compensation should not be restricted to the professional pharmacy services associated with product distribution.

• Paramedics deserve a wage increase.

• I would like to see a significant increase in funding directed to midwifery.
Salaries alone make up over 50 per cent of the health care budget, but increased salaries and staffing rates have not resulted in better health care.

Retired medical professionals are paid too much money. They have taken a large payout, have a large pension and are paid well to come back to work. Essentially, they have three wages.

**Ideas and Suggestions**

**Physician Services**

**Pay Incentives for Family Physicians and Rural Health Care Workers**

**Support Staff and Community Care Workers**

**Doctors**

**Nurses**

- Ideas about physician services:
  - I think if a patient is willing to go to the trouble of getting a certificate of authenticity, and is willing to use secure e-mail, then doctors should consult via e-mail and should be able to bill for that service.
  - We should allow family physicians to bill at least one hour per year for a comprehensive general physical examination for each patient. Not only would that help attract doctors into family practice, but it would help develop a proper doctor-patient relationship and reduce unnecessary appointments and inaccurate diagnoses.
  - Health care providers should be motivated to encourage healthy lifestyle choices over use of drug treatments.
  - Doctors need to be financially motivated to have a healthier patient list that requires less acute care.
  - I would like to be paid for all the phone consultations I do directly with my sick, elderly patients. Phone guidance is very helpful when managing chronic disease, and patients appreciate not having to make a trip to the office.
  - Pay doctors fairly for visiting long-term care facilities.
  - Doctors should deal with all presenting health issues in one appointment.
  - We should change the billing rules to allow physicians and specialists to bill for longer appointments for people with multiple needs.
  - There should be more remuneration for doctors practicing prevention and health promotion. Patients will get more time, which they want, fewer referrals,
prescriptions and procedures, which they do not want, the wait times will decrease and doctors will be happier.

- Physicians should receive higher rates of pay for office visits that occur after 5pm.

- I have had glaucoma for 18 years. I visit my ophthalmologist every four months for a check-up. My doctor has scheduled me for a field vision test, photos of my optic nerve and then an appointment to discuss these with him. I have been told I cannot do this all on one day as he will not get paid. I have to make two appointments for the same thing and then he will get paid. I have to travel a considerable distance to see my doctor and this puts the added pressure of more expense to me. Where is the logic in this? Who is the brain surgeon that came up with this nonsense? This needs to be changed.

- Pay physicians a fair fee to spend time counseling patients on weight loss, smoking cessation, alcohol abuse, etc.

- Ideas about pay incentives for Family Physicians and rural health care workers:
  - Full service family physicians should be paid more than those who work in walk-in clinics.
  - The fee for service schedule should be subsidized to encourage more doctors to work in smaller rural hospitals.
  - Retaining doctors in rural area requires more salary incentives.
  - The provincial government needs to provide increased isolation pay and remote allowances for health professionals.
  - We could attract more family physicians into practice by assisting them with the start-up costs of a new family practice.
  - Wages should be supplemented for health care workers wanting to upgrade their credentials and pursue one of the careers experiencing a shortage.
  - Attract more medical students to general practice by paying general practitioners at a rate competitive with specialists. Retain general practitioners already in practice with a substantial increase in compensation and annual increases thereafter for the rising costs of running a medical practice.
  - We should treat family doctors as a specialty and pay them accordingly.
  - Specialists should not be paid more then general practitioners.
  - We have to match other provinces’ wages and recruitment incentives.
• The Ministry of Health’s 2006 agreement with the British Columbian Medical Association (BCMA) to increase the remuneration of family doctors is positive and welcome.

• **Ideas about wages for support staff and community care workers:**
  
  • Community health care workers should be paid to work for eight straight hours, but their work days are broken up and they end up being paid for a fraction of the time they dedicate to their job. They should also be subsidized for the money they spend on gas.
  
  • The government should not target health care workers’ wages to reduce expenses.
  
  • Restore the cleaning and food services positions to the public health care system using fairly paid, well-trained unionized staff.
  
  • The government should give back the 15 per cent that was taken away from health care workers.
  
  • Working in a care home is a very important job and the workers pay should reflect that importance.
  
  • Home care workers need better pay and the ability to perform a wider range of duties.
  
  • There must be more equity in remuneration for all health professionals engaged in primary health care and prevention.
  
  • We have to set wage rates that are competitive with the private sector or market-based wage rates.
  
  • Competitive wage rates are needed to retain trades people in this competitive economy.

• **Ideas about doctors salaries:**
  
  • We should set doctors’ pay at a multiple of the average provincial wage. Two times the average would be appropriate and fair.
  
  • Institute a pay structure that rewards productivity.
  
  • Many medical students, nurses and doctors go to the United States because they have the opportunity to make more money there. They should be paid what they are worth, so they will stay in Canada.
  
  • Opening a large number of new training seats and flooding the market with doctors would allow us to reduce doctors’ pay.
• We should limit doctors’ salaries to no more than what the Premier of the province gets per year.

• We should create differential wage scales based on types of practice. For example, there should be premium pay for specialists and less pay for less demanding, long-term care facility positions.

• All doctors should be made employees of the government.

• **Ideas about Nurses Salaries:**

  • The salaries of nurse practitioners should be above those of other nurses, but well below those of doctors. For most of patients, a visit to the nurse practitioner would suffice and could reduce the cost of health care.

  • Nurse practitioners who want to partly or wholly replace general practitioners should be placed on fee for service and not paid a salary.

  • The casual part-time mentality for nurses needs to stop in order to cut back on paying for benefits.

  • Open up the fee for service envelope to pay for nurse practitioners and other providers. This is the only way that the nurse practitioners’ role will flourish.

  • There needs to be incentives for students to go into nursing and to stay in British Columbia once educated. There should also be incentives to return to nursing for those who have left.

  • We need to appeal to health care professionals to limit their incomes. The salary of professionals is disproportionate to the wages of service workers. Reducing the wages of the lowest paid workers is not a sustainable way of saving health care dollars.

  • Unions have to be more flexible in offering competitive incentives and salary ranges.

  • There should not be any more market adjustments for health care workers wages.

  • Employees need to have a break from work and to be able to refresh and refuel. They should have more breaks over the half hour and more paid vacation that increases with seniority.

  • I think it is about high time the Paramedics were given a wage increase and a signed contract.

  • If there is a totally open and free market private system, then doctors and nurses will obviously choose to work in private care. There must be some harmony in pay rates between both systems to avoid draining the public system of all its staff.
• The government should not pay pensions. Employees should pay their portions out of their salary, and no benefits, such as extended medical, should be paid after the employee retires.
• A higher wage means better job satisfaction, which means higher productivity.
• All personnel in the health care system should have full-time positions with benefits.
• Health professionals’ salaries should be indexed quarterly according to the rate of inflation.
• We should cap all salaries so we would have more money to hire more health professionals.

**Outstanding Questions**

• How do we create incentives for health care professionals to be more effective and efficient in providing services?
• Why is it not possible for patients to book a double appointment with their physician to discuss multiple health issues?