Restricting billing numbers
Position statement

Statement
Doctors Nova Scotia does not support restricting billing numbers as an effective physician recruitment and retention strategy.

Background
Restricting billing numbers in order to influence physician supply has been used across Canada in various jurisdictions, including Nova Scotia. Currently New Brunswick is perhaps the jurisdiction with the tightest control of physician billing numbers; an excerpt from the New Brunswick Medical Society web site advises that:

The New Brunswick government has managed the number of medical practitioners in the province by limiting the issuance of new Medicare billing numbers. A physician must obtain a Medicare billing number in order to get paid for providing publicly-funded services. New Brunswick is the only province in Canada to impose these kinds of limits on physician resources.

The New Brunswick Medical Society supports eliminating the cap on the issuance of Medicare billing numbers.

Nova Scotia successfully negotiated the removal of controlled billing numbers through the 1997 Physician Master Agreement negotiations. Restricted billing numbers was seen by physicians as a 'heavy handed' means of controlling physician supply, for what are essentially independent practitioners. The removal of the restriction was widely supported by members of the association.

Assessment
While an argument could be made that tight control of billing numbers can effect changes to physician supply, by restricting where physicians are able to practice, there are several arguments that would perhaps suggest that this is not the most effective means of ensuring, as much as is possible, a balance between demand for physicians, and supply of physicians.

- **Economic realities**

  Foundational to the fee for service system is that a physician must be able to generate enough income to sustain a practice. The immutable laws of supply and demand would suggest that markets ultimately will correct themselves; that is, if a physician opens a fee for service practice in an area with insufficient volume, ultimately that physician could not sustain his/her practice.

- **There is essentially a 'cap' in place already**

  Alternative payment plans (APP's) exist in order to help ensure sufficient physician supply in areas where there is insufficient capacity to generate a sustainable revenue stream through a fee for service payment model. This could be as a result of smaller populations, or required practice patterns, and Nova Scotia already has the highest non fee for service ratio of physicians in the country. (This would reflect AFP physicians as well). The province therefore has already moved to a model where it seeks to influence practice in specific areas by limiting or restricting APP contracts.

- **Capping is potentially seen as regressive rather than progressive**

  Perhaps one of the greatest challenges to implementing restrictions on billing numbers is that many physicians view this as 'controlling', and therefore regressive. Physicians are for the most part independent contractors and as such limitations on where they can practice are seen to be an infringement on rights to earn a living; B.C. for example tried to implement restricted billing numbers and on 2 occasions courts overturned the decision. When one overlays the generally accepted maxim that you can 'catch more flies with honey than you can with vinegar', restricting billing numbers seems to be counter- productive in the longer term. Creating a climate where physicians want to practice, rather than having to practice, would it seem to be in the best interests of all.

Alternative recruitment and retention strategies

Again there is probably little doubt that restricted billing numbers could have some impact on physician supply in the short term, however their longer term impact remains questionable, certainly at least when evaluated against potential systemic 'costs' as identified above.

Perhaps a more practical, and tenable, approach is to reinforce recruitment and retention. This could be done through a variety of means including:

- Retention and/or Recruitment payments through the Physician Services Master Agreement.

- A vibrant and robust locum program (since many of the areas that would benefit from restricted billing numbers would by definition have lower physician resources).

- A focused effort on distributed medical education. There is significant evidence that physicians who learn in communities are more predisposed to ultimately practice there. The Dalhousie Faculty of Medicine has an initiative underway to provide more student learning in a community environment for both the undergraduate and post graduate level, and this should be encouraged and supported.

- A vibrant and robust practice profile. Many physicians for example, want to be able to practice full scale as much as is possible. Working with GP's therefore, to identify practice scopes that would provide interesting and challenging, but at the same time rewarding, clinical care would almost certainly be more effective in the long term that restricting billing numbers.

- Provide for reasonable work/life balances. Again because many of the areas of NS that would perhaps benefit from restricting billing numbers would have lower physician populations, as identified above, it is imperative that in addition to a vibrant locum program physicians be able to balance the care needed by the community, with a personal life balance. In a 2012 Doctors Nova Scotia membership survey, 92% of physicians who responded identified work/life balance as important in being able to attract and retain physicians. Nova Scotia, because of its geography, is perhaps better positioned than others to begin to achieve this. For example call schedules could be looked at across communities and in fact across regions. Investments in CME could be provided at a community/regional level, and physicians, DHA's and the Department of Health and Wellness could establish working groups to look at effective ways to support community physicians. In the association's membership survey, 66% of students and residents identified their ideal practice type as a "group practice with physicians and other health practitioners."

- Perhaps the biggest argument in support of alternatives to restricted billing numbers is simply the ‘cost/benefit’. It remains to be seen how effective, at least in the long term, restricting billing numbers can be, but we know for certain that physicians view restricting billing numbers in a very negative way. Given the potential marginal return, along with the existence of other perhaps more palatable (and effective) options, the risk of alienating or disenfranchising the physician community relative to the benefit derived would we believe suggest that this be very, very carefully considered before any decision is made.