Features

Chroniques

Nancy Robb is a freelance writer living in Halifax.

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Interest in physician-buyout packages grows as more doctors contemplate retirement

Nancy Robb

In brief

PROVINCIAL GOVERNMENTS ARE TURNING TO VOLUNTARY RETIREMENT PROGRAMS, buyouts and phase-outs to help manage physician supply. Demographic data show that in 1996 nearly 27% of Canada's active physicians were aged 55 or older and that the average age of retiring physicians was 68. Although 1 goal of such programs is to give willing older physicians the financial ability to retire, provinces also hope to do away with some billing numbers.

En bref

LES GOUVERNEMENTS PROVINCIAUX ADOPTENT GRADUELLEMENT LES PROGRAMMES de retraite volontaire, les rachats et les retraits progressifs afin d'aider à gérer l'offre de médecins. Les données démographiques indiquent qu'en 1996, presque 27 % des médecins actifs du Canada avaient 55 ans ou plus et que les médecins prennent leur retraite à 68 ans en moyenne. Si de tels programmes visent notamment à donner aux médecins plus âgés qui y sont disposés la capacité financière de prendre leur retraite, les provinces espèrent aussi éliminer des numéros de facturation.

For Dr. Arthur Shears of Halifax, age 65 seemed too young to retire. The specialist in physical and rehabilitation medicine had built the Nova Scotia Rehabilitation Centre from the ground up and had been its director since it opened in 1977. He had also started the School of Physiotherapy at Dalhousie University and was its head for 12 years. Even so, when he turned 65 in 1989 he felt he "still had too many interesting things to do."

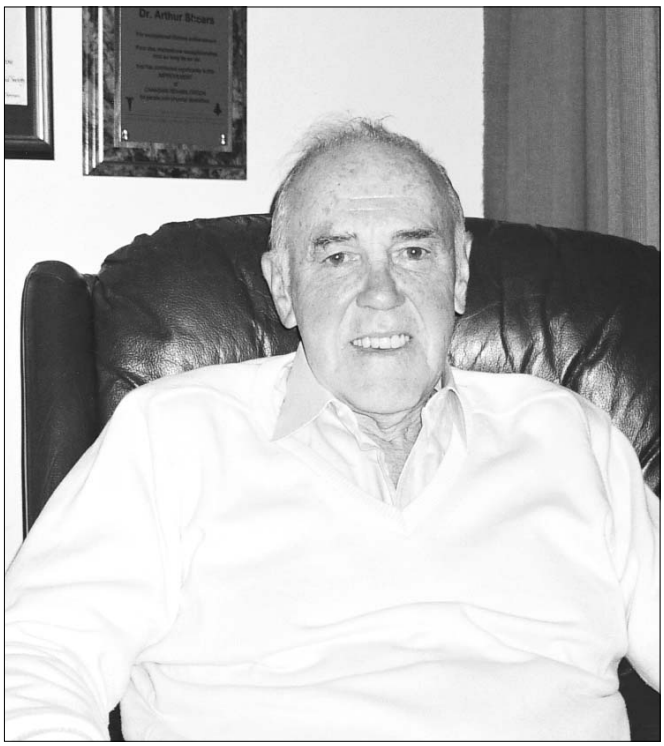
His outlook soon changed. In 1991, after experiencing bouts of spinal stenosis and angina, Shears stepped down as head of the rehabilitation centre, stopped teaching and reduced his practice commitments. He set his sights on retiring altogether at age 71.

"I didn't want to be nailed to doing it every day anymore," he says. "I had a 7-day-a-week responsibility for sick and injured people for 48 years. I just felt that while it was interesting . . . there were other things I should do not only for my benefit but also because it might be better for my patients."

His timing was right. In 1995, the year he turned 71, Nova Scotia introduced a retirement incentive for physicians aged 71 or older. Shears took advantage and sold his billing number back to the province.

Although he says the incentive isn't really enough to entice doctors to retire, it does cover the cost of closing down a practice. "It was no bed of roses," he says candidly, "but it was going to coincide with my own planning."

And it is a sign of the times. More provinces are turning to voluntary retirement programs to help manage physician supply. After Nova Scotia launched its incentive package in the spring of 1995, Quebec medical federations followed with generous end-of-career allowance programs. In New Brunswick the government has set up physician "buy-out" and "phase-out" plans and Executive Director Marilyn Lowther says the Prince Edward Island Medical Society is eyeing a policy to facilitate "the orderly recruitment and exit" of physicians. Ontario, too, plans to study the possibility of retirement incentives.



Dr. Arthur Shears: "I just felt there were other things I should do"

But physician resources is only 1 side of the coin. Some medical societies are also discussing pension funds simply to enable members to retire when they wish. Since British Columbia took a brief stab at a pension fund a few years ago, Ontario, Alberta, and Quebec doctors have all expressed interest.

Our greying MDs

According to the CMA's demographic data, 10.7% of "active" physicians in 1996 were 65 or older, while 15.9% ranged in age from 55 to 64.

Calgary internist Dr. Mamoru Watanabe, chair of the CMA's Physician Resources Committee, says doctors retire about 40 years after getting their degree. "Those retiring at this point are predominantly specialists," he says. "But within the specialties . . . laboratory medicine and general surgery are relatively older than other groups."

Statistics on retirement trends are sparse, but CMA data show that the mean age of the 2000 physicians who retired in 1995 and 1996 was about 68. "National studies have shown that [male] physicians retire at a much later age than the rest of the male workforce," says family physician Eric Wasylenko, cochair of the Alberta Physician Resources Planning Group. "They did historically retire much later."

"I had 1 doctor describe [medicine] as a priesthood," says John Klaas. "It's a lifetime kind of thing."

Klaas is assistant vice-president of training and financial services at MD Management, the CMA subsidiary that handles financial planning for about 36 000 doctors. He says the growing number of medical students and residents who seek MD Management's advice is a sign of shifting attitudes.

Another indication is that younger physicians are attending MD Management's retirement workshops. "We'd plan them for people 55 and over," says Klaas, "and I'd be surprised because we'd find people in their 30s attending as well. Quite clearly, these people know that someday they'll need that type of information. However, because the seminars provide very detailed coverage of current retirement rules, they may not be as helpful to them as some of our other seminars directed more at getting the right savings in place between now and retirement."

Dr. Cynthia Forbes, a family physician from Bedford, NS, who heads the Medical Society of Nova Scotia, says younger doctors look forward to retiring at an earlier age. The trend reflects Canadians' growing emphasis on lifestyle and the increasing number of women in medicine, who try "to maintain more of a balance" between family and practice commitments.

However, declining income, rising overhead costs and the shorter working life of doctors all threaten their financial ability to retire. "In most discussions about physician remuneration, [retirement] comes up as a major issue," notes Forbes, who hopes to be able to retire by age 60.

She says the emergence of physician-retirement plans comes as little surprise. "The idea of a retirement package is consistent with other people paid with government funds," she says.

Retirement packages

Forbes says assisting older physicians who "wish to retire if given the financial ability to do so" was one impetus behind Nova Scotia's retirement package. Another was to create openings for younger doctors.

The billing-number buyout, part of the most recent contract between the province and its doctors, offered 60% of the average annual gross income in the 2 preceding fiscal years to physicians who were 71 or older by Sept. 1, 1995. The same offer applies to doctors who turn 71 between that date and Aug. 31, 1999.

In all cases, physicians must have been in active practice in Nova Scotia for at least 10 years and must relinquish their billing number within a set time of accepting the buyout, which is paid in annual instalments. Of 60 physicians eligible to date, 38 have taken the incentive.

Although medical residents disagree (see sidebar), Dr. Jacques Provost says the end-of-career allowance plan for Quebec's 7500 specialists was introduced to help ease the burden of cutbacks on new doctors by facilitating the exit of older physicians.

"Like everywhere . . . there are [more limits] on entry to medicine," says Provost, director of professional affairs for the Fédération des médecins spécialistes du Québec. "I think that everybody knows that our medical [future] is in the hands of the younger physicians and our creativity is there."

Provost says the allowance program has 3 parts: a general application for doctors who turn 65, an exceptional application for doctors aged 60-64 who have lost positions due to hospital closures, and a transitional application, which expired last August, for doctors 65 or older when the program was introduced in October 1995.

It's an attractive plan. Under the general and exceptional applications, specialists will receive over 5 years a maximum of $300 000, or 200% of their average annual income in the 3 years preceding their application. Doctors who fell into the transitional category received proportionally less for each year they were over 65.

By fall 1996, 370 of about 850 eligible specialists had accepted the buyout. Provost says the average age of recipients was about 67; the federation expects about 450 doctors to have accepted it by the time it expires in March 1998. Provost says the program will likely meet that target and be extended.

Today, he explains, about 300 specialists enter the medicine in Quebec each year while 200 leave the system. With the allowance program and further reductions in the number of positions for medical students, projections show that the specialist surplus will begin to drop by the turn of the century.

For the program to have a real impact, he says, it should be kept in place until 2002. "In Quebec, we have a fixed envelope of money and we must include all those new [specialists], so I think if we want to [achieve a] balance we must help those who will go."

But the decision to take the buyout doesn't come easily. As in Nova Scotia, Quebec doctors who take the package may not bill the provincial health insurance plan even though they may keep their licence and work in the private sector or perform uninsured services.

"Most I have spoken with . . . were hesitating at first," says Provost, who noted that 53 doctors rejected their contract at the final hour. "It's not easy for anybody after 30 years or 40 years to say, 'Well, the next morning I'm retired.' "

Quebec GPs also seem to be suffering adjustment pains. "Many, many doctors are anxious about the plan and many of them are still calling after they get their allowance," says Dr. Hugues Bergeron, director of professional affairs for the Fédération des médecins omnipraticiens du Québec. "They don't know what to do. They were not prepared mentally."

The GP plan applies, with some exceptions, to doctors who are 55 or over and make at least $80 000 a year. GPs who opt for the allowance receive up to $288 000 over 4 years, depending on their average annual income in the previous 5 years.

Dr. Cynthia Forbes: "Some physicians have retired and lost all equity in their practice"

But there are penalties. Doctors who continue to practise and bill the province after taking the allowance have to repay twice the amount they've received. It doesn't seem to be a deterrent. "It's working," Bergeron says. "We had enough doctors who took the buyout. We thought about 300 would take it."

The federation was almost on target. In 1996, the program's first year, 285 out of 800 eligible GPs opted for the allowance. Bergeron says most were about age 70. However, he expects only about 50 of 650 eligible doctors will apply for the allowance this year, most of whom will be over age 60. In 1997, the program applies to physicians aged 55-64, and in 1998, its third and final year, to doctors aged 55-63.

"Many doctors still want to work or they are not [well off] enough to retire," Bergeron says. "Many told us that they have no more income if they stop working. They have no retirement plan."

Intended result not always achieved

While buyout programs are intended to address physician oversupply, they also take undersupply into consideration. Nova Scotia and Quebec plans specify that recipients in underserviced areas may continue to practise without penalty until they are replaced. Not that it's been enforced much — in Quebec at least, the majority of retirees have come from overserviced areas like Montreal.

But numbers can be deceiving, says Dr. Tony Wade, a family physician from Bathurst, NB, who heads the NB Medical Society. "Statistics are very nice to look at. You

Quebec residents say province's retirement agreement took from young to pay old

Dr. Denis Soulières, president of the Fédération de médecins résidents du Québec (FMRQ), says residents "still feel betrayed" by an agreement reached between the province and its 7500 specialists in October 1995.

At the time, Soulières says, the Quebec government capped the budget on doctors' fees. To live within those means, he says, the Fédération de médecins spécialistes du Québec (FMSQ) agreed to introduce a retirement program for older doctors and expand graduated fees for new physicians.

"All that is good is for old doctors and all that is bad is for young doctors," says Soulières, now in his sixth year of a pediatric hematology residency at l'Université de Montréal.

He calls the FMSQ's program "a big end-of-practice bonus for doctors who would have taken their retirement anyway." (Specialists who turn 65 and take the buyout receive up to $300 000 over 5 years.)

Dr. Denis Soulières: "residents feel betrayed"

He says new specialists who set up shop in large urban areas used to make 70% of the fee schedule for their first 3 years of practice. Now, he says, those in urban and "intermediate" regions are paid 70% of the fee schedule in their first 2 years and 80% in their third and fourth years.

He says new doctors in outlying regions get 85% in their first 2 years and 95% in the third. The only way residents can bypass some or all of that fee schedule is by leaving the province to train in a subspecialty.

Soulières says residents favoured the approach of the Fédération de médecins omnipraticiens du Québec (FMOQ), which opted for a buyout program for doctors 55 and over instead of reduced fees for new physicians.

"In our view it was a real plan that could save money, which was the objective of the fixed envelope," he says. "We had an actuarial evaluation done that estimated the savings [would be] sufficient to make sure all new doctors could enter practice at full pay."

Soulières says about 200 doctors retire in Quebec each year. Under the FMOQ's allowance program, about 80 to 100 general practitioners decided to take the buyout prior to the time they would have normally retired. "There's the saving," he explains. On the other hand, the specialist-allowance program "was a big bomb. All those who decided to take it were over 65, so there were no real savings."

Dr. Jacques Provost disagrees. Provost, director of professional affairs for the FMSQ, says the program is saving money and not off the backs of residents. He says actuarial studies showed that Quebec medical specialists generally stay in practice for 5 years after they hit age 65, earning on average about $750 000. Since the allowance program pays recipients up to $300 000, that represents a saving of about $450 000 per doctor.

"We are [funding] the plan with this and not with money from the young," says Provost, who adds that the average age of program recipients as of last fall was 67. "If there were no end-of-career allowances, I think young specialists would have a hard time [getting] a job."

But that's of little comfort to Soulières, who thinks the FMSQ is being short-sighted. As the FMRQ outlined in a proposal, he says, residents believe the medical profession "should move toward the instalment of a real retirement plan with earnings taken at the source" and contributions from government.

He says the medical profession needs to make sure it is constantly renewed with young blood. "It's not only that we want a place now," he says. "We think that when we are 60 or 65 we should not be practising medicine the same as we do now. . . . We want to make sure that there will be ways for us to be able to take our retirement."

But so far, the FMRQ's suggestions have fallen on deaf ears. "The health minister is much more interested in discussing quick measures with the [FMSQ] than in discussing real measures with us," Soulières says.

That may soon change. Soulières says the FMRQ, which went on strike for 10 days over the FMSQ agreement, plans to "battle the whole agreement" before the Quebec Human Rights Commission.

can look at a large province and say, 'This is what is needed.' But it totally breaks down when you look at micro numbers . . . because you may do a tremendous disservice to the community. The 65-year-old may still be a tremendous asset to the community and getting another [doctor] is not going to be the same."

Wade says the government has recently introduced buyout and phase-out plans to help keep physician numbers within designated targets. But the medical society does not recognize them as retirement packages, even though the province has "incorrectly" called them that.

Wade says the plans simply don't offer enough money: only a few doctors have accepted a buyout, and only 6 have participated in the phase-out program. "I don't think the government has [the] money to be serious," he says, noting the medical society hasn't pursued a retirement package for this reason.

Dr. Jacques Provost: many doctors hesitant about retiring

Wade says it may look cheaper to buy out physicians in areas of oversupply, but statistics often don't indicate "that there are physicians who do not see the same number of patients, patients are not interested in seeing certain physicians or that certain physicians seem to be better than others."

Cindy Forbes says Nova Scotia is feeling the pinch. When the province introduced its package, it also restricted billing numbers in Halifax-Dartmouth. The buyout "doesn't override billing-number restrictions," says Forbes. "If you retire there, you are not replaced. This is very much an issue for the medical society."

Forbes says the purpose of the billing-number restriction, like restrictions and fee disincentives in other parts of the country, was to encourage practices in underserviced areas. But "that hasn't been the result," she says. "There are different communities in metro [Halifax], and it's becoming more evident that not all are overserviced."

She adds that family physicians under 71 who want to retire but are ineligible for the buyout aren't able to leave practice because they can't find doctors to take their patients or can't sell their practice (see page 756). "Some physicians have retired and lost all equity in their practice," Forbes says. "They've just had to leave practice basically."

"Detailed, well-developed plans that end up micromanaging the system often result in problems," agrees Alberta's Eric Wasylenko. He says he's "not in a position to be critical" of other provinces' approaches, but in Alberta, one thing is certain: "Our focus is going to be on nonprescriptive and incentive-based mechanisms to help distribute the cohort of physicians we have in a better way. We are not going to be micromanaging the system and we won't be forcing people out. We're trying to enhance the professional opportunities for choices in location, lifestyle and activities."

He says the Alberta Medical Association recently rejected the notion of a mandatory retirement age. It's also not entertaining billing-number restrictions or buyouts. "We don't believe we have evidence to suggest there are too many physicians," he says, "so we can be much less focused on aggressive exit-management policies."

Wasylenko says many Alberta doctors would like to see, among other things, a retirement-assistance plan, preferably with government contributions. "Pension plans are appropriate ways to help manage the practice life of a physician," he says. "That's not necessarily to entice them to retire . . . but to say they need the opportunity to retire at an appropriate age."

Tapping into expertise

Wasylenko believes retirement planning is a function of organized medicine, but medical associations have failed to help doctors manage the economic, technical and emotional aspects of retirement.

"I don't think we've addressed the emotional part of that at all well," he says. "People need to have dignified and respected ways to decrease their clinical activity. There's this huge wealth of knowledge and experience in these very competent individuals that we need to tap."

Mamoru Watanabe agrees, and says measures such as buyout packages mirror those in other sectors faced with downsizing. But the medical profession should consider alternatives. "Given that the projected oversupply [in Canada] is not huge — it's 10% — you could easily rearrange activities and encourage more doctors to go into research or administration," he says. "There are ways of using the expertise available."

In Nova Scotia, Cindy Forbes says the medical society is beginning to tap that expertise by "providing more opportunities for retired members to participate in the society." Among other things, the society is eyeing benefits for senior and retired physicians, and is relying on them to perform various functions.

"We have a growing interest in our retired members," she says. "It's wonderful."