Geriatrician and General Internist Clinical Payments in Canada 2022–2023: Fee for Service and Alternative Payment Plan

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ABSTRACT

A Comprehensive Geriatric Assessment (CGA) completed by a geriatrician assessing an older person living with frailty and multiple comorbidities involves longer visit durations than standard General Internal Medicine (GIM) consultations, reflecting the need for detailed evaluation. Medical trainees have little formal education about how they will be remunerated as specialists or that there are different methods of clinical payments between provinces of Canada, including Fee for Service (FFS) and Alternative Payment Plans (APP). GIM is a reasonable comparator to Geriatric Medicine because, while not using CGA, GIM residents are also trained to assess medically complex patients who often have comorbidities. The goal of this paper was to provide transparency for medical trainees about differences in the proportion of FFS or APP and the average clinical payments made to geriatricians and general internists between the provinces of Canada. Using data from the Canadian Institute for Health Information (CIHI), we show mean, mean trimmed to $100,000 and median clinical payments to geriatricians across Canada. Average payments were generally lower in provinces with predominantly an APP as the main source of payments compared to provinces with a split model of APP and FFS where payments demonstrated larger variances. The clinical payments to general internists were higher than for geriatricians. In addition to increasing transparency in specialist payments, Provincial Medical Associations and Sections or Divisions of Geriatric Medicine, could use these data to advocate for comparable remuneration between geriatricians and general internists when renegotiating clinical payments funding agreements.

Key words: geriatric medicine, CIHI, health economics, physician compensation, remuneration, female

INTRODUCTION

Geriatricians trained in Canada complete three years of Internal Medicine, followed by two subspecialty years of Geriatric Medicine. The patient population for which geriatricians provide specialist consultation are older adults who typically have multiple comorbidities and are often, in addition, physically and/or mentally frail. Frailty can be measured using instruments such as the Clinical Frailty Scale.[1,2]

Comprehensive Geriatric Assessment (CGA) is the assessment by a geriatrician of a frail older person usually in collaboration with at least one other geriatric trained team member.[3] The assessment counselling and recommendations may be informed by awareness of the five M's: medication, multi-complexity, mobility, mind, and matters most.[4] The goals are to improve an older person's functioning for Instrumental Activities of Daily Living (IADL) cognition, mood, reducing the possibility of iatrogenic harm, and improving their quality of life. CGAs involve longer visits than standard General Internal Medicine (GIM) consultations. In addition to the medical domain, a CGA often covers the cognitive/mental, social, and environmental domains that may have a bearing on an older person's IADLs. It may require collateral history from more than one source. By prioritizing patient-centred outcomes and integrating medical and social domains, CGA represents a cornerstone of geriatric care that differs in scope, purpose, and philosophy from other clinical assessments.[5,6]

Medical students, residents, and subspecialty residents in any discipline have little formal education about how they will be remunerated as a specialist, or an understanding about differences that exist between provinces or specialties. Across the provinces of Canada, there are different methods of clinical payments to specialist physicians and surgeons including Fee for Service (FFS), Alternative Payment Plans

(APP), Alternative Relationship Plan (ARP), salary, and sessional payments. Annually, the Canadian Institute for Health Information (CIHI) publishes the clinical payments paid to physicians and surgeons by the type (FFS, APP) and amount of payments for all medical and surgical specialties in each province, except Quebec and Saskatchewan.[7]

All Internal Medicine specialties, except for Cardiology and Gastroenterology, are grouped together in the annual CIHI report. It is not transparent for trainees in Geriatric Medicine or GIM to know how clinical payments differ between provinces for their discipline in the current data aggregation. FFS, with time-based codes to account for additional time to do a CGA, and APPs are commonly used to remunerate geriatricians whether they are practising in an Academic Health Science Centre, hospital or in the community. GIM is a reasonable comparator for Geriatric Medicine because, while not using a CGA, GIM residents are also trained to assess medically complex patients who often have comorbidities.

To provide transparency for trainees, the Canadian Geriatrics Society (CGS) Human Resource (HR) committee posed the following two questions:

1. Are there differences in the proportion of FFS or APP clinical payments made to geriatricians and general internists between provinces?
2. Are there differences in mean and median clinical payments made to geriatricians and general internists between provinces?

METHODS

We made a formal request to CIHI for data specific to Geriatric Medicine and GIM, drawn from the National Physician Database—Payments Data, 2022-2023, being the most recent data set available.[7] In provinces with a small number of geriatricians, Nova Scotia (NS), Prince Edward Island (PEI), Newfoundland/Labrador (NL) and Manitoba (MB), data were pooled to preserve anonymity, and the median and variance data were suppressed.

Included data have both the mean and median for the entire data set, in addition to the mean trimmed at $100,000. The $100,000 trim provides the most accurate comparison. It excludes physicians working part-time and those who started or stopped working part way through the year and, therefore, reflects physicians working full-time. The CIHI annual payment data for all specialties does not differentiate between inpatient or outpatient clinical activity.

RESULTS

Physician demographics are in Table 1. There was a higher number of GIM physicians compared to Geriatric Medicine physicians. GIM was male-predominant, whereas Geriatric Medicine was female-predominant.

The proportional differences in payment methods to geriatricians and general internists are in Table 1. APP payments for geriatricians were more common in Alberta (AB), New Brunswick (NB), and NS/PEI/NL, compared to

TABLE 1.
Physician remuneration by province and specialty
comparing geriatric medicine and general internal medicine

		Total n	*Females*	*Males*	*n Trimmed at 100K* [a]	*% FFS*	*% APP*
BC							
	GERI MED	72	41	31	64	48.3	51.7
	GIM	488	216	272	397	81.7	18.3
AB							
	GERI MED	24	16	8	23	0.3	99.7
	GIM	524	208	316	434	91.2	8.8
MB							
	GERI MED	9	-	-	8	50.3	49.7
	GIM	292	87	166 (39 undefined)	208	61.8	38.2
ON							
	GERI MED	192	117	75	168	58.9	41.1
	GIM	2069	707	1,362	1,705	88.9	11.1
NB							
	GERI MED	14	8	6	12	3.1	96.9
	GIM	62	17	45	51	49.3	50.7
NS/PEI/NL							
	GERI MED	8	-	-	8	0.8	99.2
	GIM	302	100	201 (1 undefined)	255	48.3	51.7

[a]Where a threshold of $100,000 per annum is applied, physicians earning less than the threshold are removed from the calculations.

a split model of APP and FFS in British Columbia (BC), MB, and Ontario (ON). Payments to general internists were mainly FFS, except for NB and NS/PEI/NL which are relatively evenly split between APP and FFS, with MB at 61.8% FFS.

In Figure 1, the mean, mean trimmed to $100K and median clinical payments to geriatricians were lower in provinces with predominantly an APP as the main source of payments (AB, NB, NS/PEI/NL), compared to provinces with a split model of APP and FFS in which payments demonstrated larger variance, (BC, MB, ON).

The clinical payments to general internists were higher than the clinical payments to geriatricians.

DISCUSSION

This paper provides transparency with an objective report on the type and level of clinical payments to geriatricians and general internists. Overall, the data obtained show lower clinical payments to geriatricians compared to general internists. This is significant to the recruitment of trainees to Geriatric Medicine and the retention of geriatricians to focus on geriatric practice.[8] As trainees from any discipline graduate with more debt, future income potential may play a larger role in career selection.[8,9] Furthermore, given Canadian population demographics, attracting specialty trainees into Geriatric Medicine could be beneficial to the health-care system as a whole.[6]

A recent cross-sectional survey identified work–life balance, collegiality, and reasonable call as the key factors determining practice location of new Geriatric Medicine graduates. However, respondents indicated income was an important recruitment factor in open-ended questions.[10] As this survey was of Geriatric Medicine trainees, it did not capture "core" internal medicine residents (years 1-3) before career selection and, therefore, could not determine the importance of income for those considering a career in Geriatric Medicine or GIM.

An explanation for higher clinical payments to both geriatricians and general internists in provinces with a split clinical payment model of FFS and APP is the FFS component of clinical payments may be an incentive to see more patients. For the time taken, it is well-recognized that FFS applied in the acute care hospital generally remunerates at a higher level for both geriatricians and general internists. This is in stark contrast to the time taken to complete a CGA and the FFS

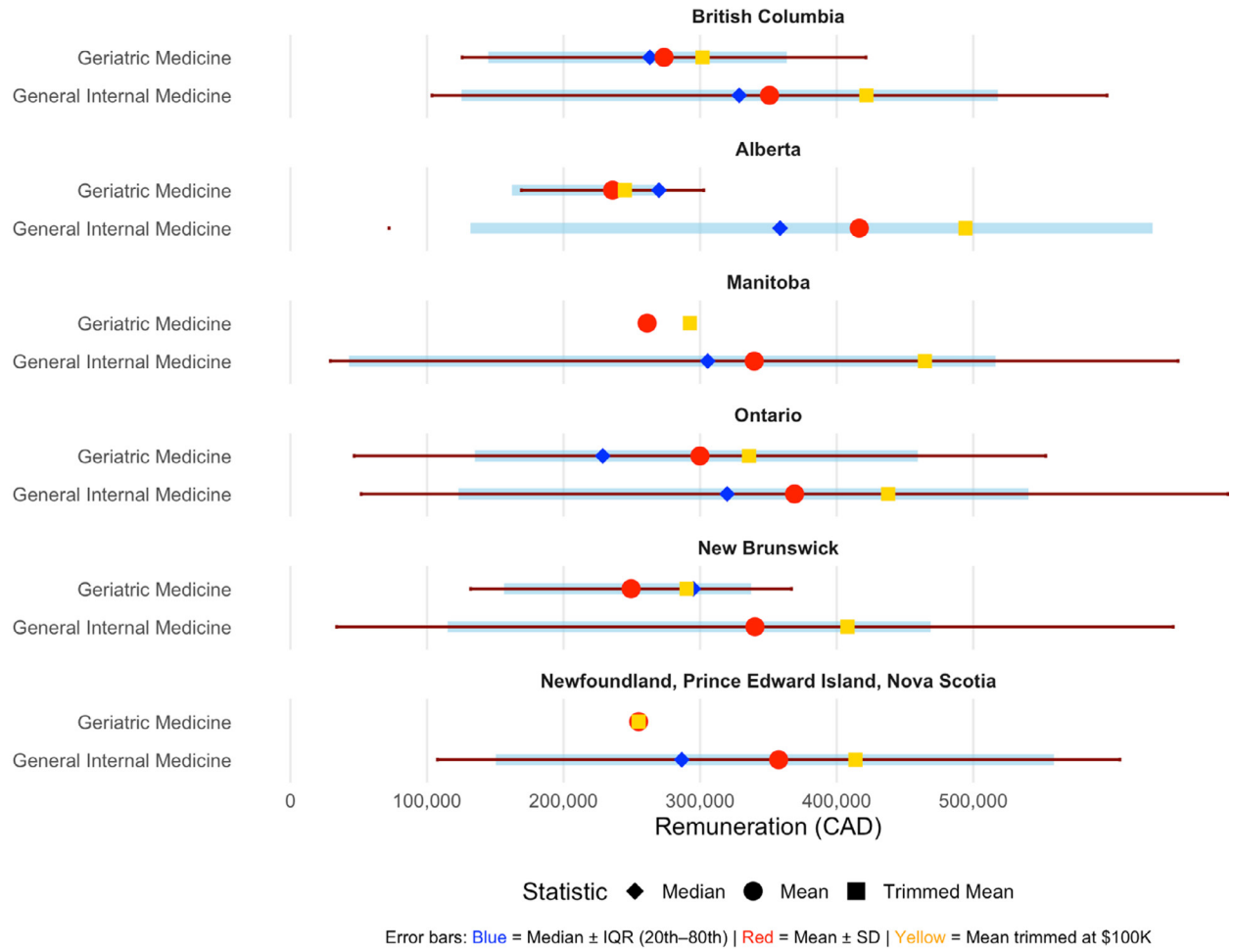

FIGURE 1. Geriatrician and general internists clinical payments in Canada: National Physician Database—Payments Data, 2022–2023

payment to assess a frail older patient in a geriatric outpatient clinic or on a home visit. Given the proven value of a CGA for the health-care system, this calls for the re-examination of the FFS dollar value for a CGA and the value of APPs for geriatricians.

The CIHI data do not show the mean number of patients seen per FTE, per year, for any specialty. However, this could be examined, in the future, by using provincial health-care databases. In Ontario, the Institute of Clinical Evaluative Sciences has data on FFS billing codes which could quantify mean/median numbers of patients seen by geriatricians and general internists.

This is the first report of its kind comparing the types of and the clinical payments to geriatricians and general internists in Canada. Annual CIHI reports group all Internal Medicine subspecialties together, and also report Gastroenterology and Cardiology separately.[7] Infographics for trainees in the Canadian Medical Association Geriatric Medicine Profile list remuneration data that are pooled from all Internal Medicine subspecialties.[11] Such aggregation does not provide an accurate representation of clinical payments for those considering a career in Geriatric Medicine. Furthermore, the reported income does not account for non-clinical payments or benefits, which may be part of APP or salaried positions, such as a pension plan, health-care benefits, or paid vacation time.

There are limitations to the data presented. The provinces of Quebec and Saskatchewan were excluded as data were not reported to CIHI. Because geriatricians are trained in GIM and Geriatric Medicine, they can bill FFS as a geriatrician or general internist. Geriatricians using >50% GIM fee codes were classified as general internists in the CIHI annual report. The CIHI 2022/2023 data reported eight geriatricians in NS/PEI/NL and 24 geriatricians in AB. These are lower than the CGS HR Committee's 2024 provincial count in progress of geriatricians, of 14 and 38 geriatricians, respectively. For MB, CIHI counted nine geriatricians and the CGS HR Committee's 2024 provincial count is four. We don't have an explanation for these differences. Finally, in each province the terms, restrictions, clinical billing codes, and the role of shadow billings are different and are not explicit in the CIHI annual tables.

CONCLUSION

This data can serve two purposes. First, it provides a level of transparency for trainees considering a career in Geriatric Medicine by showing how clinical payments differ between payment type and amounts between provinces. Secondly, given the lower clinical payments to geriatricians compared to general internists, this objective data may inform remuneration negotiations. Provincial Medical Associations and Sections or Divisions of Geriatric Medicine could use these data to advocate for comparable remuneration between geriatricians and general internists when renegotiating clinical payments funding agreements.

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CONFLICT OF INTEREST DISCLOSURES

We have read and understood the *Canadian Geriatrics Journal*'s policy on disclosing conflicts of interest and declare the following: MB has received Grants or Contracts from the CIHR Institute on Aging for the Canadian Collaboration on Neurodegeneration in Aging, NIH Alzheimer Disease Neuroimaging Initiative (ADNI1-4), Biogen, Alector, Eisai, Abbvie, Eli Lilly, Hoffman-La Roche, Medical Imaging Trials Network of Canada C6 Project – MITNEC – C6, the Speakers Bureau, Hoffman-La Roche, Biogen, Advisory Board, Eli Lilly and EISAI; JB has received Grants or Contracts from the CIHR Institute on Aging for the Canadian Collaboration on Neurodegeneration in Aging, Biogen, Alector, Eisai, Abbvie, Eli Lilly, Advisory Board - Eli Lilly and EISAI; JM, AM and KS have no conflicts of interest to declare.

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REFERENCES

1. Rockwood K, Song X, MacKnight C, Bergman H, Hogan DB, McDowell I, *et al*. A global clinical measure of fitness and frailty in elderly people. *CMAJ* [Internet]. 2005 Aug 30; 173(5):489–95.
2. Rockwood K, Andrew M, Mitnitski A. A comparison of two approaches to measuring frailty in elderly people. *J Gerontol Series A*. 2007 Jul 1;62(7):738–43.
3. Devons CA. Comprehensive geriatric assessment: making the most of the aging years. *Curr Opin Clin Nutrit Metabol Care*. 2002 Jan;5(1):19–24.
4. Tinetti M, Huang A, Molnar F. The Geriatrics 5M's: a new way of communicating what we do. *J Am Geriatr Soc*. 2017 Sep; 65(9):2115–15.
5. Stuck AE, Siu AL, Wieland GD, Rubenstein LZ, Adams J. Comprehensive geriatric assessment: a meta-analysis of controlled trials. *The Lancet*. 1993 Oct 23;342(8878):1032–36.
6. Ellis G, Gardner M, Tsiachristas A, Langhorne P, Burke O, Harwood RH, *et al*. Comprehensive geriatric assessment for older adults admitted to hospital. *Cochrane Database Syst Rev*. 2017 Sep 12;9(9):CD006211. DOI: 10.1002/14651858.CD006211.pub3. Accessed 01 December 2025.
7. Canadian Institute for Health Information. National Physician Database—Payments Data, 2022–2023. Ottawa, ON: CIHI; 2024.
8. Gagné R, Léger PT. Determinants of physicians' decisions to specialize. Health Econ. 2005 Jul;14(7):721–35. doi:10.1002/hec.970.

9. Galarneau D, Gibson L. Trends in student debt of postsecondary graduates in Canada: results from the National Graduates Survey, 2018. Ottawa, ON: Statistics Canada; 2020. Available from: https://www150.statcan.gc.ca/n1/pub/75-006-x/2020001/article/00005-eng
10. Mah J, Kanagalingam T, Best S, Elhayek S, Thain J, Morais J, *et al*. Determinants of first practice location among Canadian geriatric medicine trainees and recent graduates: finding of a cross-sectional survey in 2023. Can Geriatr J. 2024 Dec 2; 27(4):485–99.
11. Canadian Medical Association. Geriatric Medicine Profile updated December 2019 [Internet] (cited 2025 Aug 7). Available from: https://www.cma.ca/sites/default/files/2019-01/geriatric-e.pdf

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