MEDICAL REFORM GROUP OF ONTARIO

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WHAT DOES THE WEILER REPORT REALLY SAY, or MANY ARGUE ABOUT IT BUT FEW HAVE READ IT COVER TO COVER.

The Weiler Report contains the conclusions of Paul Weiler, Chairman of the Joint Committee on Physicians' Compensation for Professional Services, who was appointed jointly by the OMA and the Government. In January, after two months of negotiations with the OMA, the government declared an impasse and invoked the fact-finding procedure by which the Chairman provides a non-binding recommendation. At this point the OMA was asking for a 27% increase in the fee schedule over one year (12% for inflation and 15% as a beginning on their ultimate "catch-up" goal of 32%). The government, which declared that there was no case for any catch-up, was offering 10% for inflation.

Weiler's report explores four general areas:

I The general economic climate.
II The status of Ontario physicians' incomes with respect to those in other provinces, to past incomes, to the CPI, and to average industrial wages.
III The status of the OHIP fee schedule with respect to those in other provinces, to past fee schedules, to the CIP, and to average industrial wages.
IV The relationship between the fee schedule and physician incomes.

I will summarize the report's reasoning and conclusions in each of these areas.

I The general economic climate: This is a greatly misrepresented section of the report. Weiler does not conclude that physicians must forego what is equitable because it is not feasible. On the contrary, he specifically rejects the idea that physicians should be singled out by virtue of their high incomes, visibility, or dependence on government financing for any special "anti-inflation" wage controls not applied to society as a whole. (However, he also does not see physicians as one of the more underpriviledge groups in society!) He proposes to approach his task by attempting to review the past, to see whether any injustices exist which must be rectified and to try to anticipate inflation in order to protect the final fair income decided upon.

II Ontario Physician Incomes: There are numerous difficulties with calculating the desired figure, which is the average net income of full-time fee-for-service physicians. These difficulties are discussed in some detail, but the main problem is in deciding which physicians to count as full-time, with fee-for-service as their chief source of income. Weiler's decision is to count only physicians whose billings to OHIP/WCB exceed the 30th percentile. This cuts off GPs with net incomes below $26,000 and specialists with net incomes below $41,000. After this decision and several others on how to use the available data, Weiler concludes that the average full-time fee-for-service GP in Ontario will net $70,000 in 1981, and the specialist $101,000.
In comparing these figures to past physician incomes, other provinces, the CPI, other professional incomes, and average industrial wages, Weiler further concludes that:
1) Ontario physician incomes only appear to have fallen if they are compared to 1971, a peak year after a general climb from the 1951 low. There was a decline from 1971-78, with a recovery since then which has nearly restoring the previous peak in 1931
2) Ontario physician income is now the third highest in the country, after lows of 6th (for specialists) and 9th (for GPs) in 1977.

III The OHIP Fee Schedule: Weiller concedes that the OMA makes a "powerful argument" when it points to fee schedule erosion from 1971-81. This is true when comparisons are made with any of the standard indices or with fee schedules in other provinces. This erosion has been due to the 1971-75 period, when inflation began to accelerate, and to the 1975-78 Anti-Inflation Program controls.

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IV Relationship Between Fees and Income: In the current negotiations the government has insisted on focussing on physician income, while the OMA refuses to discuss income and insists on looking at fees alone. Weiler concludes that total income, though not the only relevant index, must be considered in deciding what is fair to doctors. After all, part of their case for increased fees is that their earning power is falling behind other economic indicators.

The report then considers the possible explanations for why Ontario physicians are doing so much better in total income than the OHIP fee schedule increases would seem to predict. Weiler rejects the several explanations put forward by the OMA as being either untrue, unsubstantiated, or insufficient to explain the entire gap between fee rises and income rises. In particular, he rejects the idea that doctors are working much longer hours than they did 10 years ago, or than physicians in other provinces are working. Undoubtedly physicians are performing more services per patient, an increase in the factor termed "utilization", but it is not clear whether this reflects "harder" work or more efficient work. Normally when production becomes more efficient, the unit price of the goods or services falls, lowering the cost to society while maintaining the income of the producer.

In the end, perhaps the most important conclusion Weiler reaches is that the relationship between the fee schedule and physicians' total incomes is not understood. What is really important from the physicians' point of view is what their total income is and what amount of time and energy must be expended to earn this. What is important from the government's point of view is what the total cost to it will be of providing physicians' services. What is important to citizens of this province is what quality of health care they receive for the amount of their tax dollars which go into the health care budget. The interests of these three parties must be reconciled, and to do this an inquiry with a broader mandate must be conducted.

CONCLUSION

Following all the economic and socio/political arguments through to their conclusions, these guidelines are arrived at:

1) There is no reason why either income or fees should necessarily be maintained at the 1971 peak level, rather than at any other arbitrary base level.

2) There is no reason why all fees should automatically rise according to the CPI, since prices for other goods and services do not necessarily do so.

3) The answer to the problem of price vs income must await a more extensive inquiry into the utilization phenomenon, whose understanding and control are essential if physicians are to be fairly rewarded for their work within a finite funding system.

The specific recommendations made are:

1) An 11% increase in the fee schedule should be given to protect against inflation in 1982. This would ideally be given in continuous increments over the year as inflation climbs, but computers cannot be continuously reprogrammed. As a compromise, Weiler proposes 7% on April 1, 1982, and another 4% (not compounded) on January 1, 1983.

2) Physicians deserve some "catch-up", but the exact amount cannot be specified in the absence of a better understanding of the utilization phenomenon. Weiler proposes giving 3.25% on January 1, 1983 (not compounded with the inflation increases).

3) A public inquiry into utilization - its explanation and possible means of controlling its increase - must be undertaken, with the possibility hinted at of linking future "catch-up" increases to utilization control.

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EDITORIAL NOTE BY THE REVIEWER: We should all give some thought to the dissatisfactions and injustices being publicly aired by physicians, especially the OMA. Some of these involve specific fees (e.g., the often mentioned "total obstetrical care" at $280.20 in the 1981 fee schedule), which are set internally by the OMA Economics Committee. The government only specifies the total increase in funding, not how it should be divided among various services. Other grievances involve conditions of training or work which are also within the power of the profession to influence, if not to rectify, without going through the Ministry of Health. The current clash between the OMA and the Ministry is a huge expenditure of money and energy with a detrimental effect on the public, and it does not have the potential to change some of the most fundamental inadequacies in the present health care system which affect both physicians and patients. THINK ABOUT IT. REALLY THINK ABOUT IT.

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For MRG

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