MEDICAL REFORM GROUP OF ONTARIO

POLITICAL LETTER

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The recently appointed Minister of Health for the Province of Ontario, Larry Grossman, has decided that the Ministry's exposure to the diverse groups with interests and ideas conserning the health care delivery system in Ontrio has been insufficient. To correct this problem, the Minister has been meeting with a number of such groups over the past few months. Dr. John Frank represented the MRG as part of a delegation from the Ontario Health Coalition which met with Mr. Grossman in April, 1982. Recently, the MRG itself was invited for a conversation with the Minister. This report summarizes the impressions of the MRG members who participated in this meeting.

When we accepted the Ministry's offer to meet with Mr. Grossman we had a number of goals in mind. We hoped to make the Minister aware that the positions and policies advocated by the Ontario Medical Association did not represent the opinions of all Ontario physicians. We wished to outline our most pressing concerns, and present perspectives and specific options which might be new to the Minister. In addition, we were happy with the opportunit to gain a sense of the direction in which the Ontario government was moving with respect to the present serious problems facing the health care delivery system in this province.

The aim of the Steering Committee in choosing participants for the meeting was to select physicians who were both very familiar with MRG positions through participation in the drafting of our policies, and who represented a cross-section of the membership. The delegation included primary care physicians involved in fee-for-service (Bob James), capitation (Barbara Lent) and community health centre (Debby Copes) practices, an academic involved in primary care (John Frank), and a specialist involved in research at an academic institution (Gordon Guyatt); and, Howard Cash attended in his capacity as Executive Secretary of MRG. An attempt was also made at geographical balance: two members were from the Hamilton chapter, two from Toronto, and one from London.

What follows is a summary of the points raised, some of the Minister's specific replies, and our impressions of the general tenor of his comments.

UNIVERSALITY AND REASONABLE ACCESS: OPTING OUT --- The MRG delegation reiterated our long-standing opposition to opting out and the threat to access it entails. We cited examples of the oft occurring difficulty of arranging referrals to opted-in specialists in certain areas. Patient embarrassment and humiliation at having to ask to be exempted from extra billing, and the likelihood of neglecting needed medical attention as a result, were stressed. We argued that the only way to really solve the problem is by eliminating opting out, or reducing it to negligible proportions through institution of the Quebec option. We acknowledged that such a solution may be politically difficult but we argued that at minimum an effective system on monitoring and controlling opting out must be instituted. We suggested establishing a maximum patient to opted-in physician ratio for primary care and major specialties, with a mechanism for correction should the agreed upon ratio be exceeded.

Mr. Grossman was quick to concede that opting out was a major problem, that patient access to appropriate care from opted-in physicians was being compromised, and that the present mechanisms for dealing with the problem (such as the OMA "hot line") were ineffective. Nevertheless, he ruled out the abolition of opting out as an alternative. The Minister felt that the idea of establishing a maximum patient to opted-in physician ratio had merit. Another option was to require opted-out doctors to provide care for any patient, irrespective of his/her willingness to pay above the OHIP Schedule of Benefits. The Minister took the position that whatever soluation is adopted, the responsibility for enforcement should rest with the OMA. We were left with the impression that the Ministry would insist on enforcement of access to opted in physicians

PREMIUMS --- Our group cited the fact that 15% of patients seen at Ottawa's Centretown Clinic, and at Toronto's South Riverdale Community Health Centre, are not covered by OHIP. The Minister and his staff were aware of these figures, and found them disturbing (especially since, as they stated, if more than 5% of the provincial population is not covered, this contravenes "the law of the land"). We cited examples of how lack of coverage led to

deferral of necessary care, and reminded the Minister that those most likely to suffer, the working poor, are also those who bear the greatest burden of illness in our society.

Once again, while acknowledging the problem, Mr. Grossman asserted that ending the premium system, the only real solution as far as we are concerned, was not an option. He alluded to the recent meeting between provincial health ministers and the federal Minister of Health & Welfare, Monique Begin. Apparently, Madame Begin has nothing against premiums as long as access to health care is not affected by whether one pays them. Mr. Grossman suggested that such a change in the approach to health care premiums is the direction of the future. How the government would enforce payment of the premiums if there is no penalty in terms of access to health care as a result of failure to pay remains a mystery.

OTHER TRENDS TOWARD USER FEES --- We expressed concern about the increased leeway that has been given the hospitals to charge higher fees for private and semi-private beds. This may lead to decreased access to OHIP rate beds, and allows for the possibility of elective admission procedures which discriminate on the basis of the ability to pay the higher rates for private and semi-private beds.

We cited two specific examples of how the hospitals are adopting the business-like approach advocated by the government to the detriment of patients. In some hospitals, rooming-in of new mothers with their babies is allowed only in private rooms, which, of course, means paying the private room rate. As well as being generally more desirable, there is some evidence that the sort of increased early contact consequent on situations such as rooming-in may improve the quality of long term mother/child bonding. A second example involved the decision of a large medical centre in Hamilton, which discreti leads us to leave unnamed, to charge patients receiving antineoplactic chemotherapy for their drugs. This is done by giving the patient the prescription which he/she fills outside the hospital, returning to have the drug administered by intravenous infusion.

In general, Mr. Grossman expressed his endorsement of user fees when they act as a way of playing Robin Hood; that is, as long as essential services are protected user fees constitute a form of progressive taxation. However, he did strongly assert that the Ministry would take great care to insure that the hsopitals did not abuse their new options. The ratio of general to increased rate beds would be monitored, and access would not become dependent on ability to pay. The Minister seemed especially concerned about the two specific examples we cited, and took careful note with the assurance that he would do something to remedy the situation.

THE DOCTOR-CENTRED FEE FOR SERVICE SYSTEM: The MRG delegation described a number of problems with the present organization of medical care in the province. The fee for service system, with physicians operating essentially as private businessmen, is difficult to control both in terms of expenditures and cost effectiveness of services. The doctor is always the entry point for the patient into the system, which is often inappropriate or inefficient. The present system actively discourages coordinated, multidisciplinary care. Alternative approaches, such as community health centres in which physicians are reimbursed on the basis of hours worked rather than number of patients seen, are needed. While largely concurring with our description of the present system as inefficient and archaic, the Minister presented himself as largely helpless to institute measures that would alter the situation in the near future. Organized medicine was portrayed as resistant to innovations. Without its cooperation, there was little that Mr. Grossman felt he could do in terms of reorganizing the system. However, encouragement of the slow, voluntary development of alternative models does seem to be a possibility.

THE OHIP BUREAUCRACY, AND THE FEE SCHEDULE: The present system of physician reimbursement is clumsy, inefficient, and, at times appears deliberately to make life difficult for the physician. The situation here was contrasted with Quebec, where each patient has a unique number, and a trivial mistake in filling out a card does not lead to the claim being rejected. There are major problems with the fee schedule. It is procedure oriented, discourages preventive care, and leads to an excessively large discrepancy in income between specialist and family practitioner. In addition, it requires "creative billing" from the conscientious primary care physician, which essentially amounts to the need to perjure oneself to run a high quality practice.

The Minister was sympathetic to these complaints, but he sighed about the mysterious and frightening ways of the computer. In terms of the fee structure, he seems to be considering an intriguing change.

To date, the government has gone lock-step with the OMA fee schedule in terms of physician reimbursement. That is, despite the discrepancy in absolute fees between OHIP and OMA fee schedules, each item in the OHIP schedule is a fixed percentage of what the OMA suggests physicians charge. Therefore it is the OMA who up to now has determined the relative charges for physician services. At the risk of incurring the wrath of organized medicine, the government is thinking of abandoning the lock-step approach, and itself deciding how future increases in reimbursement should be distributed. However, it is far from sure that this change will actually be instituted.

OUR GENERAL IMPRESSIONS: We found the Minister to be well-informed, intelligent, and genuinely concerned about the problems facing the health care system. His willingness to acknowledge, unhesitatingly, the major deficiencies in the present system, such as the problems in access that result from opting out and health care premiums, was gratifying. He made careful note of specific small problems that we had experienced, and seemed anxious to remedy them.

On the other hand, it was clear that he felt unable to institute major changes that would deal effectively with the scope of the present problems. Opting out and premiums are, for the time being, here to stay --- the best we can hope for is a plan to minimize their ill effects. The blossoming of community health centres is not just around the corner.

Mr. Grossman consistently blamed the resistance of the OMA for his inability to institute major changes. We feel that it is not acceptable for the Minister of Health to plead helplessness in dealing with the system, nor to use the OMA as a scapegoat for problems that need to be dealt with.

While a great deal of productive discussion did occur, there were certain specific statements that, due to pressure of time, we were unable to question adequately. It would be interesting to know the details of how hospitals will be monitored with respect to extra patient charges, or how the payment of premiums will be enforced if their link to access to health care is cut.

Despite these problems, it was very clear that the Minister listened carefully to our comments and responded in a fashion that reflected the serious consideration he was giving to our suggestions.

We feel that the goals we set for the meeting were successfully accomplished. Most important, the Minister agreed that it would be appropriate to meet again in a few months to continue our discussions. Suggestions from the membership as to issues that should be directly addressed in future meetings with government officials would be much appreciated.

In addition, it would probably be desirable that the delegation not be the same for each meeting. Thus, the Steering Committee would appreciate hearing from anyone who is interested in attending future sessions.

Sincerely,

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Barb Lent

GG/ghc/bc

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