MRG NEWSLETTER

MEDICAL REFORM GROUP OF ONTARIO P.O. Box 366, STATION "J" TORONTO, ONTARIO M4J 4Y8

VOLUME 6, NUMBER 1 FEBRUARY 1986

CPSO Officials at MRG Meeting

Two representatives of the Ontario College of Physicians and Surgeons, Dr. Peter Granger, the President of the College, and Dr. R.F. Beckett, the Director of Professional Review, will be attending an MRG meeting on Tuesday February 18 at the South Riverdale Community Health Centre, 126 Pape Ave., in Toronto, at 8 p.m. Members of both the Hamilton and Toronto chapters (as well as other members within commuting distance) are invited to attend this meeting, which will focus on the subject of Peer Review as well as other subjects.

This should be a highly interesting meeting, and members are urged to come to hear the presentations and participate in the discussion.

Media Coordinator's Report Jan.10, 1986

The introduction of the bill to ban extra-billing was anticipated and there was consultation about the MRG response with Philip Berger, Gord Guyatt, Fran Scott, and John Frank. Philip and I attended the special briefing session on Thursday, December 19 with Dr. Allan Dyer, the Deputy Minister of Health. I then wrote a press release and attended the minister's press conference. There was fairly successful "piggy-back" coverage over the next two days. Philip was on CITY-TV and I appeared on Global as well as the CBC and CTV national news. There was also coverage by most Toronto radio stations with special interviews on Ontario Morning (CBC morning program for the province outside of Toronto and Ottawa), CKO, and Radio Noon (Gord Guyatt) and CBC French Radio (Bob James). There was also coverage of our position in the Toronto Star, Globe and Mail, and the Sun.

The issue appeared to "die" on the Saturday but the Star's lead story on the Sunday was about the OMA threatening to strike. This generated more interest in the story and I phoned most of the Torono media on the Sunday generating coverage on CITY-TV, CBC, the Globe, Star, and the Sun. There were featured interviews on Global, CKFM, and a London open line program. Unfortunately, I have been misquoted in the Sun comparing the OMA to Hitler. The OMA council appears to know about this.

There continues to be considerable media interest in this story. I wrote an op-ed for the Star which appeared on January 8 and will be shortly taping an interview for CBC radio Ottawa. I have contacted and briefed Dr. Susan Stock who has agreed to coordinate media response in Ottawa.

It is expected the bill will be referred to the Standing Committee on Social Development after second reading which is expected within the next two weeks. There will likely be three days of hearings and I have contacted the clerk of the committee to say we wish to submit a brief at that time. The main issues with which we must address are the Nova Scotia model and "merit pay".

Michael Rachlis

MRG STEERING COMMITTEE MEETINGS

MRG members are welcome to attend Steering Committee meetings. Meetings are usually held the last Thursday of each month. If you are interested in attending, call Ulli Diemer at (416) 920-4513 or (416) 960-3903 for information about where the meeting will be. Meetings alternate between Hamilton and Toronto.

PRESS RELEASES

MRG PRESS RELEASE DECEMBER 19, 1985

The Medical Reform Group of Ontario is pleased that the Ontario Goverment has introduced legislation today to ban extra-billing. The group, which represents 150 Ontario physicians, has been concerned that extra-billing presented a financial barrier to health services for some Ontario residents.

The MRG is concerned about the growing practice of doctors to charge fees for telephone calls, referral letters, or other services not covered by the Ontario Health Insurance Plan and regrets there is no mention in the legislation of these potential deterrents to access. Dr. Michael Rachlis, a spokesman for the group noted that there was no negotiation process mentioned in the bill. He called upon the Ontario Medical Association and the Ministry of Health to develop a bargaining process which was fair to the profession and the public. He further appealed to the OMA to accept the will of the Ontario people to ban extra-billing so that, together with other health workers and the public they may address the other important issues which face the health care system.

MRG PRESS RELEASE JANUARY 18, 1986

MRG Decries Further OMA Protest And Urges Doctors to Negotiate End To Extra-Billing

The Medical Reform Group of Ontario, a group representing 150 doctors and medical students, today expressed its disappointment that the Ontario Medical Association had not decided to enter into meaningful negotiations with the Provincial government to end extra-billing. Dr. Michael Rachlis, a spokesman for the MRG, said that he viewed it as unfortunate that the OMA was going to continue to fight the legislation when public opinion polls have consistently shown that three-quarters of the Ontario population is opposed to extra-billing.

Dr. Rachlis was particularly concerned that some of the OMA's tactics might end up hurting patients. He noted that the OMA's call to doctors to send patients to emergency departments after-hours would inconvenience patients and staff. Rachlis also noted that the OMA statement asked doctors to break the law if the proposed legislation is passed.

""Instead of asking their members to break the law, the OMA leaders should be sitting down with the government to talk. By acting more responsibly now the OMA can have more influence on future changes to the health care system" said Dr. Rachlis.

DES

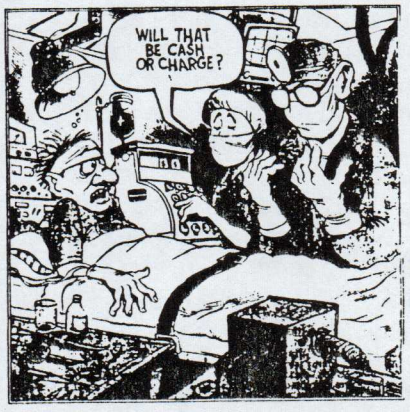
A small news item appeared in the September issue of the MRG newsletter which I would like to respond to. The heading was "New Registry will track DES Patients". While I was delighted to see the item, there were a few factual errors that I wanted to correct, and hope that you might print this correction in your next newsletter.

The piece states that DES is now "banned because of links to cancer and other health problems". The drug has only been banned for use in pregnancy. It is still available and on the market for treatment of breast and prostate cancer.

It was also stated that the Registry offered "the first concerted effort in Canada to find individuals with known or suspected exposure to the drug and alert them to medical problems linked to its use". DES Action/Canada with chapter groups across Canada have been working actively since 1983 to do just that. Problems associated with the drug have been brought to the attention of thousands of Canadians. The DES Registry is a response to the fact that more and more Canadians now know that they were exposed and need specific medical attention. We are working closely with the Registry toward a common goal.

Anne Rochon Ford

The myth that extra-billing is good for all



☐ Toronto physician Michael H. Rachlis is a spokesperson for the Medical Reform Group of Ontario.

This month we have seen the resurrection of many myths that extra-billing is a good thing for patients and the health care system. It is claimed that:

☐ It is the better doctors who extra-bill because the Ontario Health Insurance Plan fee schedule pays no bonus for experience or skill;

☐ These doctors spend more time with patients and no one has been denied access to care because of extra-billing; and

☐ Many of our best doctors will leave the province because they will lose their freedom to practise medicine as they see fit.

What is the truth?

There is no evidence that doctors who are opted out are more skilled than their colleagues. Few doctors are opted out in Northern or Eastern Ontario. Few general practitioners (4.6 per cent), pediatricians (2.4 per cent) and internists (3.9 per cent) are opted out. Opting-out is concentrated in certain specialties: anesthesia (58.3 per cent); psychiatry (27.6 per cent); obstetrics (33.8 per cent); surgical sub-specialties (31.1 per cent); and geographic locations, particularly Toronto and the Golden Horseshoe. To say that better doctors opt out is to claim there are few good doctors in Eastern Ontario or in general practice.

The Ontario Medical Association itself is largely responsible for the OHIP fee schedule not rewarding skill. The OHIP schedule was adopted directly from the OMA schedule in 1971 and set at 90 per cent of its value (on the estimate that prior to medicare, 10 per cent of doctors' fees went uncollected). The OMA list of fees, which has existed since 1922, has never had a special bonus for experience or expertise. Officials within the ministry of health have said they would be prepared to consider any system of merit pay as long as the total bill for doctors' services did not increase.

The evidence shows little difference in practice style between opted-in and opted-out doctors. Professors Alan Wolfson and Carolyn Tuohy of the University of Toronto conducted an exhaustive survey of opting-out, which was published by the Ontario Economic Council in 1980. They found no difference between opted-in and opted-out practices in patient loads, hours of work or waiting times for appointments. There is no good evidence that, on average, opted-out doctors spend more time with their patients.

There have indeed been patients who were hurt because of extra-billing. Some opted-out doctors are considerate in their billing practices but there are some who extra-bill everyone and expect the patient to ask for a reduction. A 1980 study by professors Chris Woodward and Greg Stoddart of McMaster University for the Hall review found serious problems with access to services because of extra-billing. Nearly 20 per cent of respondents said they had reduced their own visits to physicians and nearly 5 per cent said they had not sought care for a sick child.

There is little fear that doctors will flee Ontario if legislation is passed banning extra-billing. All provinces except Alberta and New Brunswick already have such legislation. The United States has more doctors per capita than Canada and all the desirable practice locations are taken. An average doctor could find work in Texas but only west of the Pecos, not in Dallas or Houston. It is also unlikely many highly skilled specialists will leave. They could have left Ontario years ago and made at least three times as much money in the U.S. They are no more likely to leave when the province bans extra-billing. The U.S. is rapidly becoming an unattractive place for those doctors who value their freedom of practice. In the United States, large corporations are taking over the practice of medicine and 30 per cent of physicians are employees. They are sometimes told how many lab tests to order and when their patients should leave hospital. In Ontario, opted-in doctors have freedom to practise with almost no government involvement.

Thus, it is clear that there is a need for legislation banning extra-billing and that neither doctors nor patients are likely to suffer from such a prohibition. Public opinion polls have consistently shown 70-80 per cent of Ontario residents oppose extra-billing and the Liberals and New Democrats garnered nearly two-thirds of the votes in the last provincial election with a ban on extra-billing prominent in their platforms. The Ontario Medical Association must realize that in a democratic society the interests of powerful minorities must be subordinated to the will of the majority. Physicians would do well to remember that they have been given a monopoly by government for the practice of medicine. They do not have to compete with nurses, physiotherapists or others. The public provides their patients with insurance so they never have to worry if their patients can afford suggested treatment. The public provides them with hospitals and skilled staff to assist them to care for their patients. The public also pays over 95 per cent of the costs of physicians' training, which is estimated at more than $100,000.

The rhetoric of the Ontario Medical Association and the Association of Independent Physicians damages their cause and reduces the credibility of all doctors.

As a group of physicians, we appeal to the OMA to realize that extra-billing will be ended and sit down and talk with the government. There is still much to negotiate in the legislation, including a fee bargaining process that would be fair to the profession and the public. With an end to extra-billing, the medical profession should begin talks with the government, consumers and other health care workers to deal with the other problems of the health care system. If the OMA wants a respected seat at that table they should act responsibly now.

Toronto Star

MRG CONTINUES BATTLE AGAINST EXTRA BILLING . . .

It was known for months that the new Liberal government would introduce a bill in 1985 to outlaw extra-billing. Philip Berger and Michael Rachlis kept in touch with Queen's Park and were prepared for first reading of the legislation which was given on December 19, 1985. Philip and Michael were briefed by Dr. Alan Dyer, the deputy minister of health and then consulted with Fran Scott before drafting the press release issued that day. Consultation had also been obtained with John Frank and Gord Guyatt the night before. There was a great deal of media interest in the story with an extra "blip" resulting from the Sunday Toronto Star's report that the OMA would consider withdrawal of service to support their side. Comments and interviews were given by MRG spokespersons to virtually all the major media in Ontario including CBC and CTV national news. Michael debated Dr. Earl Myers, president of the OMA, on CKO radio. Gord debated Dr. Carol Guzman, a board member of the OMA on CBC Radio Noon.

The media remained extremely interested in the item for the next four weeks as they led up the OMA council meeting scheduled for January 18, 1986. Michael and Philip kept in virtual constant touch with the Star and the Globe and Mail and Queen's Park. Susan Stock agreed to talk to the media in Ottawa and has done interviews for CBC radio and the Ottawa Citizen.

The OMA scheduled a press conference for late in the afternoon of January 18 and primarily on the advice of reporters who counselled that we needed an immediate response to meet their deadlines, we attempted to attend the OMA's press conference. At the beginning of the OMA conference, an OMA official asked all people who were not "senior members of the OMA" or members of the press to leave the room. Eventually we were asked to leave the antechamber. Most of the MRG members present (Philip, Michael, Doug Sider, Fran, Abe Hirsz, and Debby Copes) are also members of the OMA. We examined the OMA's press release and developed our response. Michael typed a press release (arrangements had been made for a typewriter and a photocopier) while the rest gave interviews. Although the following list is not complete it does attest to the success of the event from the MRG's point of view.

CBC national and local TV
CTV local (CFTO)
CITY-TV
CKVR (Barrie)
The Toronto Star
The Toronto Sun

Gord Guyatt appeared on Radio Noon presenting the MRG opinion in response to OMA Executive Secretary Edward Moran.

It is not clear at this time what action may result from the OMA's angry words. Our approach has been to urge the OMA to negotiate with the government because an end to extra-billing is the will of the majority of the Ontario population. A steering committee meeting on January 10 (just prior to a very successful pot-luck supper at John Frank's) decided not to articulate a specific policy on the merit pay issue. Rather it was concluded that we would point out that extra-billing had nothing to do with rewarding excellence and that the government was keen to negotiate merit pay with the OMA. The steering committee also decided not to specify a fee bargaining process but rather to urge the government and the OMA to develop a "fair" process. The MRG does have a resolution that supports doctors freedom to withdraw their services as long as "essential services" are maintained.

It had been the government's and the NDP's hope that the legislation would be passed by the end of January, but the Conservatives have been stalling the drug-pricing bill and with a break expected from mid-February to mid-March it is likely the bill will not get second reading until the end of March. Some sources at Queen's Park have suggested the Tories have stalled on the drug bill specifically to allow the OMA more time for their protest. A committee of the steering committee, composed of Philip, Fran, John, and Michael continue to plan the MRG response and will draft a brief to be presented to the Social Development Committee after second reading.

Michael Rachlis

End of extra-billing: what do MDs merit?

GLOBE & MAIL, DECEMBER 12, 1985

BY JUDY STEED
The Globe and Mail

RIGHT AFTER delivering a baby at the hospital next door, Dr. Robert Nadel strides into his private office to deliver a spirited defence of physicians' right to extra-bill — or as he prefers to put it, to opt out of the Ontario Health Insurance Plan and bill patients directly.

It is a right that will soon end. This week, Ontario Minister of Health Murray Elston will introduce legislation that brings the province into compliance with the Canada Health Act, outlawing extra-billing. This will leave Alberta, New Brunswick, Prince Edward Island and Newfoundland as the only jurisdictions outside the fold.

Wearing clogs and blue cotton pants and shirt, with a stethoscope dangling around his neck, Dr. Nadel's appearance discloses his profession, but not his income level. He earns in excess of $200,000 a year and belongs to an élite profession that is ranked No. 1 in earning power in Canada.

He is sensitive about it. "The public just sees the gross amount of money," he says. "What you don't see are the expenses, the time involved, the tax bracket and the expertise we bring to a very heavy responsibility." He delivers about 350 babies a year and resents that no matter how long he spends with a woman in labor — "whether I'm with her for hours or just catch the baby" — he gets the same fee from OHIP: $181.45.

Even the Medical Reform Group, which supports the ban on extra-billing, agrees that Dr. Nadel has a point. "There is legitimate concern that obstetricians, gynecologists and psychiatrists are not fairly compensated," says Dr. Philip Berger, a general practitioner and member of the Medical Reform Group. He notes, however, that the real problem lies within the profession. The Ontario Medical Association sets the fee schedules on which OHIP payments are based; therefore it is the OMA that is seen by many doctors as undervaluing certain services.

In his travels across the province, Mr. Elston has heard similar complaints. He has been told, for instance, that many general practitioners feel they don't get a fair share of wage settlements and that there's a need for a more equitable distribution of money. Mr. Elston has floated the notion of "merit pay" as a way to recognize superior skills, but so far has had no discussion on such matters with the OMA. Since the Liberal Government promised to ban extra-billing, the OMA has refused to negotiate.

To talk about how much money doctors make is not easy. The Canadian Medical Association, for one, no longer gives estimates, on the grounds that incomes vary too widely from one region and practice to another. In Ontario, from a health ministry budget of $8.9-billion, $2.2-billion goes for paying doctors' fees. And that doesn't tell the full story: a 1982 report on physicians' compensation said that Workers' Compensation Board medical bills added $1.3-billion to doctors' pockets as well as such lucrative pursuits as medical-legal reports and insurance examinations.

The most widely reported figures place the average net income of a general practitioner before taxes at $85,000, and of specialists at between $120,000 and $150,000 annually. Some earn more; some less. Those who earn much more tend to have opted out of OHIP, usually charging fees above OHIP rates. Yet the vast majority of doctors are content with OHIP: of 14,895 physicians in the province, only 1,813 (1,464 of them specialists) have opted out.

Medical associations across the country were not pleased when then health minister Monique Bégin introduced the Canada Health Act in 1984, requiring all physicians to accept provincial insurance payments as full fees. To enforce the act, Ottawa chose to withhold transfer payments in the amount roughly equivalent to what doctors extra-billed their patients. In Ontario, the amount withheld will reach about $50-million a year. If the province outlaws extra-billing by 1987, as it promises to do, that money will be refunded.

But in conjunction with a Richmond Hill physician and patient, the CMA has initiated a case before the Supreme Court of Ontario, proposing that the Canada Health Act is unconstitutional. Health care is supposed to come under provincial jurisdiction, says the CMA's Doug Geekie, and Ottawa has no right to lay down the law on matters under provincial control. He also charges that physicians have been "uniquely singled out for price controls."

Dr. Norton Lithwick, a Toronto orthopedic surgeon, agrees. Though he earns between $200,000 and $300,000 a year, he feels surgical procedures are drastically underpaid. He is outraged that OHIP's fee for a total hip replacement is $614.40; including one post-operative assessment, while veterinarians charge from $700 to $1,000 for the same operation on dogs. He bills $1,500 for a hip replacement and says "that's reasonable." But when the ban on extra-billing comes into effect, he will be forced to accept the OHIP rate. His response is that he will do less surgery and more medical-legal work which, he says, "really pays."

Dr. Lithwick's conviction that the public will receive poorer quality medical care as a result of the ban is shared by Dr. Nadel. An emphasis on minimizing costs will mean, he says, private practitioners banding together in clinics where patients will no longer be able to count on the commitment of a particular doctor. He also talks of a brain drain of the most talented physicians to the United States.

Dr. Berger calls such fears "empty threats." He says medical journals regularly report on physicians who left home for the greener fields of the United States 10 years ago who are now trickling back to Canada. Among the advantages of being a doctor in this country, he says, is that physicians are guaranteed payment of their bills, and "how many groups in society can count on that?" Indeed, he thinks that if the majority of opted-out doctors had behaved with more sensitivity to patients, extra-billing might never have become a hot issue.

Cont'd....

What do MD's Merit...

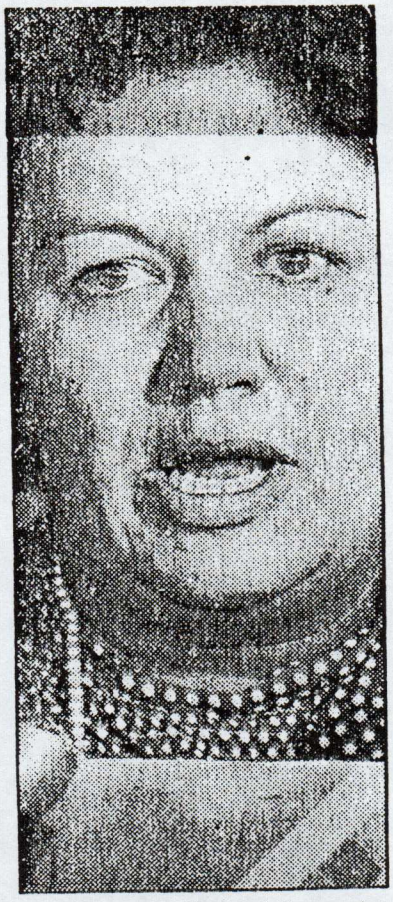
The problem, says Dr. Fred Freedman, a Toronto general practitoner, is that extra-billing created "a two-tier health-care system," especially downtown where the majority of gynecologists, anesthetists, psychiatrists and many surgeons have opted out. "Patients are afraid to complain about extra fees because they don't want second-class service," says Dr. Freedman. "People are embarrassed to admit they can't afford to pay extra." Stories are legion about women in labor being told, just seconds before an anesthetist administers an epidural, that "of course you know I'm opted out."

However, Dr. Nadel rejects the notion that most doctors ignore patients' economic circumstances. He does not extra-bill one-third of his patients. "If people can't afford to pay more than OHIP, there's no way I'd charge them extra," he says. Still, he believes he should have the right to do so. "Our training and expertise should command a premium."

He cites his own experience as typical of many of his peers: with a Grade 13 average above 80 per cent, he entered the University of Toronto in 1965 and earned a Bachelor of Science degree before going into medicine in 1969. His internship at Toronto General Hospital was followed by a four-year residency in his specialty, obstetrics and gynecology. In 1977, after 12 years of study and training, he went into practice. Eight years later, he figures he has delivered 2,500 babies and does 20 per cent of the obstetrics work at York-Finch Hospital. He is married, lives in Willowdale and his wife stays at home with their four children. His working days often run from 7 a.m. to 7 p.m. He sees patients in his office on Mondays, Tuesdays and Thursdays. On Wednesdays he operates and Fridays he does paper work.

Now he fears that, with Ontario due to line up under the umbrella of the Canada Health Act, "all self-employed physicians are threatened by the spectre of being told how to practice, how many patients we can see. . ."

Mr. Elston says that's not true. He is backed by Dr. Berger; who insists that "the practice of medicine is not being interfered with." Dr. Berger observes that when medicare was introduced, first in Saskatchewan in 1962, then under federal legislation in 1967, it was strongly opposed by medical associations. But studies have shown that physicians' incomes subsequently improved.



Begin introduced the act.

Extra-billing:MD claims won't wash

BY GORDON GUYATT

Dr. Guyatt is a specialist in internal medicine at St. Joseph's Hospital in Hamilton and is on the provincial steering committee of the Medical Reform Group.

THE ONTARIO Government's decision to eliminate extra-billing has generated outrage and resentment among some Ontario physicians. These doctors point out, quite correctly, that they will no longer have the freedom to decide independently how much to charge for their services.

Unfortunately, to bolster their arguments they have made a number of additional statements that, viewed from within the profession, are at best misleading and at worst false to the point of being ludicrous.

The first such statement is that the legislation will end the only available method of rewarding excellence in physicians. This raises the image of a small number of physicians in each area or specialty, chosen by their colleagues, who are allowed to extra-bill. The reality is very different.

The physician himself decides to opt out; he doesn't have to ask his colleagues' permission. Opting out is heavily concentrated in certain specialties: psychiatry, obstetrics and gynecology, orthopedics and anesthesiology, and in certain geographic areas.

It is not true, for example, that all the psychiatrists in Toronto (the majority of whom extra-bill) are superb physicians, while all the general practitioners and specialists in internal medicine (almost all of whom are opted-in) are a mediocre lot. Rather, the psychiatrists (including the junior and the less skilled) are responding to an economic milieu that allows them to get away with extra-billing.

What qualifications are required to opt out and extra-bill? Any doctor, however junior, however questionable his reputation among his colleagues, can extra-bill. The only requirement is a willingness to risk imposing a financial burden on one's patients. Top-quality physicians who believe in universal access to health care without financial disincentives will not extra-bill.

As it turns out, most of the very best Ontario physicians — those who are chosen to teach medical students and physicians in training, and who have international reputa-

Extra-billing:MD claims won't wash

tions — are members of medical faculties and full-time university employees. These physicians do not extra-bill.

It is clear that extra-billing is not a mechanism for rewarding excellence — but are there any such mechanisms? Few people realize that while the mean level of fee increases for the Ontario Health Insurance Plan schedule of benefits is negotiated between the Ontario Medical Association and the Ontario Government, it is the OMA alone that decides how these increases are divided among physicians.

It is fully within the OMA's power to allocate funds so that senior physicians are paid more for the same service. It is also possible for the OMA to establish mechanisms for identifying superior physicians and to then specify that these physicians will receive more per service or procedure than their colleagues.

In fact, the provincial Government has informally approached the OMA, encouraging it to consider such merit-rewarding policies. No doubt it would be extremely difficult to establish schemes of physician evaluation that all would consider fair and just. Nevertheless, it is clear that if the OMA is sincerely concerned about providing financial rewards for excellence, there is plenty of opportunity to do so within the constraints of the Government's legislation.

It isn't a method of rewarding excellence among doctors

The Ontario Government saw extra-billing as a threat to the underlying principle of our health-care system: to guarantee high-quality medical care to all citizens irrespective of their ability to pay. Doctors who oppose the legislation claim that the poor and needy are not extra-billed, that extra-billing does not present financial barriers to equal access.

Until recently, the Alberta Medical Association was making similar claims. In 1984, a researcher, using data from the Alberta Government, analyzed the incidence and amount, by age and income class, of extra-billing.

His data suggested that there were few differences between the degree of extra-billing applied to the poor versus the higher income earners, and he concluded as follows: "It is an unquestionable fact that the aged, welfare recipients and the lowest income groups in the province are forced to bear additional out-of-pocket charges in order to receive medical attention."

In 1985, the AMA, in its own study, found that 800 Alberta physicians had extra-billed patients who were on welfare. Even the president of the AMA, formerly a staunch advocate of extra-billing, felt that this finding cast serious doubt on the practice of extra-billing.

Data from the Ontario scene are also available. Two epidemiologists from McMaster University, Greg Stoddart and Chris Woodward, conducted a survey to determine how people in areas of the province with a high incidence of opting out reacted to extra-billing. Eighteen per cent of the poor reported the cost of seeing an opted-out physician had resulted in delay in seeking medical attention or resulted in their staying away from the doctor altogether, versus only 4 per cent of those who were not poor.

Dr. Stoddart and Dr. Woodward also found that even the low-income group in their study was routinely extra-billed. In addition to these studies are the personal experiences of primary-care physicians who work in poorer areas. These physicians know that their patients will avoid seeking a needed consultation because of the financial consequences and can cite numerous instances of poor patients being extra-billed.

Physicians most distressed with the new legislation cite their role as independent businessmen. If health care is simply another commodity like shoes or a haircut, they are right: it then follows that the physician should not be constrained any further than the shoe salesman or the barber.

However, if one views health care as an essential or special service, the situation changes.

First of all, it then enters the realm of public policy, and the Government assumes a responsibility for public access to the service. Viewed in this regard, health care becomes analagous to education, or to the services of the fire department, and physicians assume a responsibility quite different from that of the shoe salesman or the barber.

While it might be nice for them if school teachers could charge parents an extra fee per student in addition to their salary from the board of education, or if opted-out firemen could charge the householder a fee for every fire put out, such charges would be contrary to our view that education and fire control are essential public services.

There is no doubt that the new legislation to end extra-billing limits physicians' freedom to determine what their services are worth and to charge patients accordingly. This freedom must be traded off against our country's commitment to provide high-quality medical care without financial deterrents.

This is the issue, and it should not be obscured by misleading contentions that extra-billing provides a method for rewarding excellence in physicians, or that no one suffers as a result of extra-billing.

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However, if one views health care as an essential or special service, the situation changes.

First of all, it then enters the realm of public policy, and the Government assumes a responsibility for public access to the service. Viewed in this regard, health care becomes analagous to education, or to the services of the fire department, and physicians assume a responsibility quite different from that of the shoe salesman or the barber.

While it might be nice for them if school teachers could charge parents an extra fee per student in addition to their salary from the board of education, or if opted-out firemen could charge the householder a fee for every fire put out, such charges would be contrary to our view that education and fire control are essential public services.

There is no doubt that the new legislation to end extra-billing limits physicians' freedom to determine what their services are worth and to charge patients accordingly. This freedom must be traded off against our country's commitment to provide high-quality medical care without financial deterrents.

This is the issue, and it should not be obscured by misleading contentions that extra-billing provides a method for rewarding excellence in physicians, or that no one suffers as a result of extra-billing.

OHIP feud centres on freedom, fairness

GLOBE & MAIL
December 27, 1985

BY ROBERT MATAS
The Globe and Mail

To hear the two Toronto-area family doctors talk about extra-billing, the controversy over the Ontario Government's proposed ban is a battle between freedom and fairness.

Dr. Stanley Lofsky and Dr. Debbie Copes are general practitioners who graduated from the University of Toronto medical school and now operate within the Government-run health plan. Neither charges extra fees for services.

Although considerable public attention has been directed at doctors' incomes, both said money is not the issue. That, however, is the only point on which they agree.

Dr. Lofsky fiercely defends the doctors' right to have the option of setting their own fees without Government interference. He accuses the Government of persecuting doctors and predicts a substantial deterioration in health-care services once extra-billing is banned.

Dr. Copes is equally passionate in speaking about a patient's right to be provided with medical care without having to pay extra fees. A person who cannot afford to pay additional fees is not treated equally, she said.

"There are a few wonderful doctors, but most doctors are not like that," she said. "If I refer a patient to an obstetrician who is opted out and she cannot afford the fee, I'm told to send her to the hospital clinic."

Ontario has introduced legislation to prohibit doctors from charging more for their services than a fee schedule set through negotiations with the Ontario Medical Association. The bill is expected to receive final approval some time next year.

Health Ministry records show that 1,787 doctors — 11.8 per cent of the province's 15,029 practicing physicians — operate outside the Ontario Hospital Insurance Plan and bill their patients directly for their services. Doctors in OHIP receive payments for their services directly from the Government.

Only 6 per cent of the doctors, however, actually charge more than the OHIP fee schedule, says the Medical Reform Group, an association of doctors opposed to extra-billing.

Doctors who opt out are concentrated in certain specialties and in certain areas of the province. Only 4.5 per cent of the general practitioners — 344 doctors — operate outside OHIP, but 19.5 per cent of the specialists — 1,443 doctors — are outside the plan. About half of the opted-out specialists are anesthetists, obstetricians, gynecologists or ophthalmologists.

About 75 per cent of the opted-out doctors live in the province's major cities; 60 per cent are in Southern Ontario, between Oshawa and Mississauga, Health Ministry figures indicate.

Dr. Lofsky, 44, would not disclose what he earns as a family doctor. He indicated that his gross income is close to the provincial average of between $100,000 and $110,000 for a family physician.

His office is in the basement of his home, near Leslie Street and Sheppard Avenue in suburban North York. Office expenses claim about 40 per cent of his income. About $25,000 is spent annually for receptionists and $3,000 for an answering service and paging system.

On average, he works a 56-hour week. For 31 hours, he sees patients in his basement office, devoting about 10 minutes to each patient.

House calls, work in a nearby hospital, and emergency calls claim another 13 hours. He also spends six hours on medical charts and other paper work, and six hours on what he described as education: hospital rounds and the reading of medical material.

Dr. Copes, 37, who works in an office of "four doctors, two full-time secretaries and a copying machine," did not object to disclosing her income.

Her gross billings to OHIP for 1985 were $65,000. Office expenses were $1,800 a month and additional expenses, such as insurance, loan payments and membership fees, raised her annual overhead costs to about $30,000.

Dr. Copes sees patients in her office nine hours a day, four days a week. She estimates that each visit with a patient lasts from 15 to 20 minutes. She spends three or four hours on the weekend reviewing charts and doing paper work. Another three hours are spent on professional development and reading.

Dr. Lofsky set up his family practice in 1968 as an opted-in physician. He began to resent Government control over his work and opted out in 1979.

He did not want to restrict his practice to only those who could pay, but he wanted to spend more time treating his patients. Dr. Lofsky said he charged about 70 per cent of his patients more than the OHIP rates. "If doctors know their patients very well, they should be able to know their financial circumstances."

Nevertheless, he came back to OHIP two years later, after discovering that he could make more money under the Government-run plan than as an opted-out family doctor.

The problem was the method of payment, he said. OHIP reimburses the patient directly for medical fees charged by opted-out doctors, rather than sending the payment to the doctor. Several patients kept the OHIP cheques and did not pay their bills, Dr. Lofsky said.

Even though he returned to the OHIP plan, Dr. Lofsky still believes doctors should have the freedom to opt out. "It provides a safety valve for the system."

Dr. Lofsky also sees the ban on extra-billing as a watershed in Government-doctor relations. Once the Government controls doctors' fees, it could set a maximum limit on a doctor's income or decide what medical procedures a doctor should use, he said.

He predicts that a ban on extra-billing will not stop some doctors from charging more. The payments will be made under the table, with those who can afford it paying for a better level of health care.

He acknowledged that some people have problems with specialists who charge above the fee schedule. But, he says, the medical profession, rather than the Government, should make the changes to the health-care system.

To ensure that medical service will be provided regardless of financial circumstances, Dr. Lofsky suggested that everyone should carry an identification card that would allow a doctor to know who could not afford to pay additional fees.

"We do it with welfare, old-age benefits and other Government assistance. It does not stigmatize anyone but allows the proper thing to be done."

Dr. Copes said she is not against doctors being paid more. She believes she deserves higher pay for what she does.

Any increase, however, should be built into the fee scale set under OHIP, she said. A doctor should not have the option of deciding what to charge and how to extract it from his patients.

Dr. Copes, who graduated in 1978, said she does not believe the prediction that the health-care system will deteriorate once extra-billing is banned.

She also dismissed concerns about increased Government interference. Private insurers in the United States probably exert more influence over what procedures a U.S. doctor will or will not undertake than a government would, she said.

Privatization of health care seen as no solution to problem of cost

November 30, 1985

BY ANN SILVERSIDES
The Globe and Mail

Allowing the private sector to take over more of Canada's health care will not necessarily make the system more efficient or less costly, says a recent study commissioned by the federal Government.

The study says that the real problem with health care is the separation between the source of funds — the taxpayer — and control over spending, which lies with the physicians.

Control of health-care costs is high on the agenda of policy makers these days, notes the study entitled Privatization in the Canadian Health Care System: Assertions, Evidence, Ideology and Options.

Private health firms from the United States, touting their efficiency, have taken the opportunity to try to establish a presence in Canadian hospitals. For instance, the largest private hospital firm in the world, the Tennessee-based Hospital Corp. of America, recently received federal approval to engage in hospital management and construction in Canada.

But there is no good evidence to show that private management of hospitals is more efficient than public management, the study says.

And private philanthropic funding of hospital capital expenditures — such as expensive medical technology — often means higher operating costs, a tab that is picked up by the taxpayer, the study states.

The push to privatize health care is most often an attempt to promote new sources of capital in order to escape the financial pressure to change the existing style of health care. The net result is an increase, not a decrease, in health-care spending, the study by two McMaster University professors states.

That doctors should react to attempts to control health-care costs by raising a cry of underfunding is "hardly surprising" since such control "must ultimately manifest in slower growth of either the number of providers (which has not happened to date) or in their average incomes."

The increasing supply of physicians over the past few decades "has contributed to pressure for higher incomes, more hospital beds, and increased availability of technology," says the 96-page report, prepared for the Department of Health and Welfare.

Such pressure has not been effectively checked because a key problem in the current system is that it is open-ended, and there are no built-in incentives for efficient allocation of resources, professors Greg Stoddart and Roberta Labelle state.

Fee-for-service payment to doctors and cost-reimbursement to hospitals, through negotiated budgets, do not encourage efficiency, and there is no real incentive for doctors to make efficient use of hospitals, says the study, which was released last month.

The fundamental problem in the system is that while the public assumes the responsibility for paying for 75 per cent of health care expenditures, health care professionals — primarily doctors — have the authority to decide how the money is spent.

It is physicians "whose clinical decisions, practice styles, and views on the appropriate content (and context) of medicine determine production and utilization decisions throughout the health care system."

The separation the taxpayers — who pay for health care — and the professionals who have authority over that money, sets the stage for tension, if not collision, between doctors and governments.

"By claiming expertise over how much should be spent on health care as well as how that overall resource should be spent in order to maximize the effectiveness of the systems, health care professionals pose a direct challenge to the legitimacy of collective choice mechanisms."

The authors conclude that general debate over the merits of public and private health care "is not enlightening or productive" because it diverts attention from "careful analysis of system performance and the mechanisms that might improve it."

TORONTO SUN
January 19, 1986

Reformer rips OMA 'blunder'

By LINDA BARNARD
Staff Writer

The Ontario Medical Association's plan to opt out of OHIP en masse and extra-bill patients is a "disaster" and a "tactical blunder," says the Medical Reform Group of Ontario.

"I think they've made a grave mistake," said Dr. Doug Sider, spokesman for the group. "The end of extra-billing has nothing to do with (improving) health care."

The MRG represents about 150 Ontario doctors and medical students.

NDP Leader Bob Rae also blasted the OMA for its proposals, especially Health Care Accessibility Week.

The OMA said doctors could refuse to work after 5 p.m. or before 9 a.m., forcing patients to seek medical care in hospital emergency departments.

"That tactic is really unacceptable, given what doctors are saying about the burdens on emergency care now," Rae said.

Bill an 'act of terrorism' Stephenson charges

By Sandro Contenta Toronto Star

The Liberal government bill to ban extra-billing by doctors is a "blatant act of terrorism against the medical profession," former Treasurer Bette Stephenson has charged.

And Dr. Howard Eisenberg, chairman of an Ontario Medical Association group representing about 800 opted-out doctors, said last night the legislation is "tantamount to a declaration of war".

But Dr. Michael Rachlis of the Medical Reform Group said, "As a group that has been fighting for a ban on extra-billing for six years, we're pleased to see it has come in. It is important because with extra-billing people have been hurt, either because they think they will be charged and don't go to the doctor or because they are poor and do get extra-billed. There is also the matter of who is in charge of the system. We think it should be the public rather than the physicians."

In a fierce attack in the Legislature yesterday, Stephenson said the government "seems to be motivated more by sheer vindictiveness than it does by any real concern for health care" with its move to ban extra-billing.

Premier David Peters... he was pleased that ... who recently returned ... lature after an illness ... her flair for inte... guage."

Stephenson, w... self in the Le... independe... cian," ... ers ...

Doctor calls new law 'declaration of war'

Rachlis said the reform group is still concerned about some other charges to patients, such as an annual fee being charged by some physicians to cover uninsured services (such a advice by telephone or renewal of prescriptions.) He said the reform group also wants to see the Ontario Medical Association negotiate with government on implementation of the proposed legislation.

Eisenberg said he thinks the government has "seriously miscalculated" the medical profession if it assumes that only the 12 or 13 per cent of doctors who have opted out are upset with the bill.

He said the doctors are "having a number of meetings regarding sanctions" to protest the bill, but he was not at liberty to reveal the tactics being considered.

The long-awaited bill to ban extra billing permits doctors to bill their patients outside the Ontario Health Insurance Plan, but forces ... OHIP ...

more experience.

At present, he said, a doctor who is one day past internship is paid the same for a procedure as a doctor with 20 years experience and an international reputation.

Opting out and charging more, he suggested, is one way more senior doctors can earn pay beyond junior doctors.

The government's fee schedule with the OMA ends in two years and Progressive Conservative leader Larry Grossman said doctors — some of whom will lose up to 30 per cent of their income because of the ban — will undoubtedly demand a raise.

The bottom line, Grossman said, is that increases will hit everyone through tax increases rather than only the wealthy who use opted-out doctors.

Quick payment

The Ontario Nurses Association expressed concern that the legisla...

...Park might be ...on medical in...

...o delegations at ...g intend to pro... doctors in Ontario opt out of OHIP ...harging patients a ...bove that set out in ...

Min... to ... extra-billing

...who have opposed extra-billing for years.

"The ban is a decisive action against extra-billing e... which is welcomed by the people of Ontario," said Edith ... Thompson of the Ontario Health Coalition.

"We're pleased," said Dr. Michael Rachlis of the Med... ical Reform Group of Ontario, representing 150 doctors. ...nt-... The Ontario Medical Association will respond to the leg... eek-... islation today.

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...some ...urally, ...Khan ...me."

...spokes... ...of Inde... Ontario, ...ourage all ...opting out ...a token ...the OHIP ...

...(OHIP) fee schedules pay a physician the ... same amount whether he or she is one day out ... of residency or a 20-year veteran," Eisenberg ... said. "I can't think of any other profession that ... does that."

Eisenberg said he tried repeatedly to meet ... with Health Minister Murray Elston but was told ... the minister didn't have time.

● Hundreds may split: Page 22

...rates.

...ocal mee... ...ers recorded in 1982.

...on behind the increas... ...ation, he said, is that ...even more outraged ...cause the issue is a ...illing.

...realizing the ...lation poses to ... O'Keefe said. ...places where ...ling are fight... ...and the govern...

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...g civil diso... ...bedience aga... ...a bad law," Piper said.

Meanwhile, Dr. Michael Rachlis, spokesman for the Ontario Medical Reform Group, said he still hopes the association will begin negotiating with the provincial government.

Rachlis, who says his group supports the government's bill, said he doesn't believe the council members will support the resolution in favor of rotating strikes.

"There may be a lot of thunder, but not much rain," he said.

OMA — Page A2

BY ANN ...
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Group opposed

Dr. Charles Shaver, vice-president of the Ottawa Academy of Medicine, said the doctors have to fight back because "this legislation could result in the complete demoralization of our profession."

He said the rallying cry among the doctors in the province has been the harsh fines proposed by the legislation for physicians who extra-bill.

But at least one group of doctors — the 150 members of the Medical Reform Group of Ontario — is strongly opposed to the association's proposed action.

"It is unfortunate that the OMA is going to continue to fight the legislation when public opinion polls have consistently shown three-quarters of the Ontario population is opposed to extra-billing," said spokesman Dr. Michael Rachlis, who says his group supports the bill.

Manit... comm... "W... just a ... elimination of extra-billing ... matter went to the college of physicians and surgeons, which has not yet ruled on the question," Mr. McCaffrey said.

Neither Manitoba nor Nova Sco... tia experienced a loss of physicia... after passage of the legislation, ... in both provinces most doctors had been extra-billing chose t... back into the insurance scheme.

Under the Canada Health ... federal Government with... transfer payments, roughly equal to the amount extra-billed, from provinces where doctors make extra charges.

...me — their roots are here."

Willard said he doubted many doctors would move to Alberta, which still allows extra billing.

"I think we would lose 100 or maybe 200 doctors in total," Willard said.

"These are top-flight people here and, like them, I'm proud to be an Ontario doctor," he added.

Willard said he feels most for the Quebec doctors who came to Ontario when Quebec banned extra billing and then began cutting doctors' pay by as much as 25% if they practised in large cities rather than outlying areas.

"A lot of doctors came here from Quebec and now they have nowhere to go," Willard said.

He added he finds the term extra billing "inflammatory," because the additional amount charged is really the difference between OHIP rates and the higher Ontario Medical Association fee schedule.

But some doctors are welcoming the end to extra billing.

"Extra billing presents a financial impediment to patients," said Dr. Emily Berger, member of the Medical Reform Group. "But there are opted-out doctors who are sensitive to people who can't afford it. Not all doctors are greedy and some doctors opt out only on principle."

Berger said he's pleased with the ban, but stressed it should be accompanied by a fair system for physic...

...ian's failure to mention ... charges in the bill is regretta... the Medical Reform Group of ...ario said in a press release.

But Mr. Elston said he did not ... anticipate a widespread increase in ... the practice, and said that abuses of ... the right to charge for such services ... would be dealt with by Ontario's ... College of Physicians and Surgeons.

In Manitoba, some psychiatrists reacted to the ban on extra-billing of fees by charging patients a special, "standby" fee to cover expenses such as telephone consultations out of offices hours, said Gordon McCaffrey, executive ...

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...ch th... ...expected ...ernment, he sa... ...dical Association ...stablished a firm strategy to op... ...pose the legislation.

The issue will be taken to the ... OMA's council, representing 13,000," he said. ... members, early next year, he said. ...mber of conse... ...There are 14,895 doctors in Ontario, ...nity are now ... of whom 88 per cent do not extra-bill. ...ch and will ... their patients.

Dr. Michael Rachlis, a spokes... ...man for the 150-member Medical ... Reform Group, said the OMA's fac... ...ing a definite plan of action has the ... ...backing of its membership.

"If they had any serious plans for ... withdrawal of services, (it) would ... have been announced today. I don't ... think the OMA is prepared to go to ... the barricades over this issue," he ... said in an interview.

Dr. Myers told reporters that ...on behind the increas... Ontario's Liberal Government is ...ation, he said, is that ... engaged in an attack against profes... ...even more outraged ... signals. The proposed extra-billing ...cause the issue is a ... ban is akin to the move to deprive ...illing.

...lawyers of the Queen's Counsel des... ...realizing the ...ignation and ... legislation that ...lation poses to ... would require pharmacists to reveal ... O'Keefe said. ...the prices they pay for prescription ...places where ...drugs, he said. ...ling are fight... ...and the govern...

The provision in the legislation ... that allows doctors to "opt out" and ... charge patients directly above the ... ...rs are op... ...government ...ibits charges above the amount ... insured by the province's health ... care plan — is a meaningless, emp... ...ssion be... ...he gov... ...e next ... ...ty concession which "makes a tra...

ANTI-ABORTION BILL RULED INVALID

A Saskatchewan private member's bill that would have dramatically restricted access to abortion in the province has been declared invalid by the Saskatchewan Court of Appeal. The bill would have required that a woman obtain her husband's consent before obtaining an abortion, and would have obliged all women seeking abortions, and their husbands and parents when involved, to receive information detailing the probable age and characteristics of the fetus. The court ruled that the bill would conflict with the federal Criminal Code, the law which set the conditions under which abortions may be performed in Canada.

--Globe and Mail, Dec. 21, 1985

PHARMACY ADS CALLED MISLEADING

The Ontario Health Coalition has condemned the recent advertising campaigns launched by the Ontario Pharmacists' Association, and two local pharmacists' groups. "These associations are attempting to alarm the public, especially the elderly, by threatening them with loss of service," said Michele Harding, OHC Executive Director. She criticized one of the ads for presenting "a totally false picture of the draft legislation". "The only way...customers will experience longer waiting periods for prescriptions or less protection from drug interaction and drug potency is if the pharmacist makes a deliberate decision to withdraw services or their physician is not doing his or her job." Ms Harding said that it was high time that the health industry and health providers face the fact that times have changed and the public is no longer awed by professional mysticism. "We expect these interest groups to defend the perks they have had to date, but they must do so in a responsible manner by placing clear information before the public and engaging in reasoned and ethical discussion. They must also cease to threaten us if they want to maintain credibility as a self-governing profession."

--OHC press release

STRICTER ELECTROSHOCK CONTROLS RECOMMENDED

Electroshock therapy should continue to be used in Ontario but under stricter controls, says a report by a provincially appointed committee. The committee was struck two years ago by then-health minister Keith Norton amid charges that electroshock therapy is dangerous and an abuse of patients' rights. The report says that patients should be told in detail the risks and benefits of procedures such as shock therapy, and recommends that without consent by the competent patient or a proxy appointed by the patient, doctors not be permitted to administer shock therapy. Under present law, patients admitted involuntarily to psychiatric hospitals have no absolute right to refuse ECT or any other treatment. A review board has the right to override the wishes of an involuntary patient's nearest relative if the patient is considered incompetent. The committee says in its report that poor record-keeping by medical practitioners kept it from coming to a conclusion about whether doctors have in fact been abusing their patients with ECT.

The Ontario Coalition to Stop Electroshock criticized the report for "whitewashing" and "covering up" the dangers of ECT. "I deeply resent the minimizing of the fear and the brain damage by this Government-appointed committee" coalition spokesperson Don Weitz said. "Electricity going in the brain always destroys. There is no acknowledgement of that horror in the report."

--Globe and Mail, Dec. 28, Jan. 10

PATIENTS GET RIGHT TO QUESTION COMMITTAL

Patients being treated against their will in Ontario psychiatric hospitals now must be told why they have been committed and will have the right to challenge the reasons before an independent tribunal. As of January 1, any person committed to care in a psychiatric hospital must be informed of his or her legal rights by specially trained advisers or by local lawyers, according to Dr. Tyrone Turner, co-ordinator of the Psychiatric Patient Advocate Office.

--Globe and Mail, January 4, 1986