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The Medical Fee (Fee for Service) Negotiation Processes of Several Canadian Provinces (- to 1978)

A Review

by

ALBERT JOHN KELLY

Submitted in Partial Fulfillment of
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Abstract

The method whereby fees are set for medical services is of significant relevance to the operation and overall total cost of a health care delivery system. Until the advent of medical insurance, the setting of fees was traditionally a matter for the profession. Although many of the early medical insurance organisations were physician sponsored, the profession began to lose its autonomy as these insurance bodies became involved in the process. With the introduction of medicare the setting of fees became a joint government and profession matter with fees, for medical benefit purposes, being set by negotiation. It may be argued that by 1978 the Government had assumed responsibility for medical fee setting in many Provinces.

The purpose of this paper is to review the conduct of fee negotiations in five Provinces - Alberta (in depth), British Columbia, Saskatchewan, Ontario and Quebec - up until 1978.

In the first chapter the purpose is further defined and explained, while in the second the method to be followed is developed. The third chapter is devoted to a review of the literature relevant to physician behaviour in relation to fees and income. As an introduction to the chapters dealing with the individual Provinces the fourth chapter develops a set of possible objectives for the profession and the government in the fee negotiation process; this reference set is provided to allow the reader to access the conduct of negotiations in each Province.

The individual provinces are dealt with one by one in Chapters V to IX. In the final chapter the conduct of fee negotiations is discussed.

Acknowledgements

This project would not have been possible without the assistance of many people in Government, the Medical Profession, and Academia. My deepest thanks go out to all those people and organisations, many of whom are listed in Attachment 1 which gives the itinerary for the project.

As a stranger in Canada during the conduct of the study, I would like to express my gratitude to those many Canadians who in many ways, both small and large, went out of their way to make my family and I welcome and at home during our stay. In particular I would express my thanks for the hospitality shown during travels through the various Provinces.

A special thanks goes to Mrs Leitia Codey and the ladies in the Australian Department of Health Automatic typing pool for typing draft and re-draft of this paper without complaint.

Finally, I would like to thank Dr C. Lay, Dr R. Sutherland, and my wife for their patience and perserverance during the writing of this paper.

The views and opinions expressed in this paper are soley those of the author, and should not be taken to represent Australian Department of Health policy in any sense.

A.J.K.

Table of Contents

CHAPTER I

INTRODUCTION

Purpose and Definition of Project

The purpose of this paper may be defined as 'to review the fee negotiation processes of five of the Provincial medical insurance systems of Canada up until 1978'. However, to fully appreciate the purpose, further explanation and definition of the terms used in the above definition is required.

The Canadian medical insurance system is based predominantly on the Fee-for-Service physician payment mechanism. This mechanism is one of three basic methods used in the Western World, the other two being Capitation and Salary, and involves the physician being paid separately for each individual medical service he renders. A schedule of fees for specifically defined services is the cornerstone of this system, and the fee specified in such a schedule for a particular defined service is referred to here-in as the 'schedule fee'. The Fee-for-Service method is in some ways analogous to the piece rate method of remuneration commonly used in some factory situations.

For the purpose of this paper 'Medical Fee Negotiations' is defined as the process through which the individual schedule fees and the fee schedule itself are negotiated between representatives of the medical profession and a health insurance program.

The 'processes' through which fee schedules and individual fees are arrived at may vary from the quite simple to the extremely complicated. The information or data used by the respective parties to the negotiations is an important component of the 'processes'. Similarly, the monitoring techniques and payment mechanisms of the Plan are part of the 'processes'. Without labouring the point by giving an exhaustive list of such components of 'processes', as it is apparent that there are many possible contenders for the list, it is preferable to define 'processes' as the general method of arriving at an agreed fee schedule by the two parties, including inputs at all levels to the decision making processes of each party.

The final word requiring further definition and explanation is 'review'. This is probably the most important word in the definition of the purpose of this paper as it denotes what is actually to be done. In the literal sense it is defined by the Concise Oxford English Dictionary, in this context, as "Retrospect, survey of the past; general survey or re-consideration of subject or thing". This definition is precisely what is intended for this paper.

The intention is to generally present a survey of the significant events, in each Province, related to fee negotiations; describing fully in at least one Province (not necessarily the same) those aspects common to all the Provinces and briefly touching them in others; outlining the general history of negotiations for each Province, and giving full attention in the discussion of a particular Province to aspects unique or more pertinent to that Province.

The above will only partially satisfy the definition of 'review'. To achieve the 'reconsideration' aspect of the definition, the actual conduct of the negotiations will be considered against a framework of possible objectives for fee negotiations.

The Provinces to be considered in this paper are Alberta, British Columbia, Saskatchewan, Ontario and Quebec. For each Province the principal source of data for the paper was an interview with at least one senior officer of the Provincial Medical Association and of the Provincial Medical Plan. In the case of Sashatchewan, the Provincial Plan data is based on a particularly protracted interview (two full days) with the Director in charge of fee negotiations and substantial information subsequently forwarded to me by that officer.

Similarly, in the case of Alberta I was fortunate to be permitted access to Plan files and I spent a period of one month with the Plan obtaining data, in addition to the interviews specified above.

Approach

The general approach followed in this paper is to first establish and describe the research method (Chapter II); then present the literature review (Chapter III); at that point the framework of possible objectives for fee negotiations is developed, including discussion of the importance of fee negotiations to the discipline of Health Administration (Chapter IV); in Chapters V to IX each of the five Provinces is considered individually; finally, in Chapter X a summary of observations is presented, including some discussion of the extent to which possible objectives as identified in Chapter IV are actually pursued and achieved.

CHAPTER II

THE RESEARCH METHOD

At a very early stage in the planning of this research it was established that there is little published literature available concerning either the development of the fee negotiation processes of the several Canadian health insurance programs or the current mode of negotiation. It was noted, however, that some reference mainly of a factual nature was made from time to time in the Medical Journals concerning the progress of negotiations. Given this and the nature of the research project, which does not involve the testing of an hypothesis, the choice of research method was severely limited.

Indeed the research project could be regarded as a basic input into the process of formulation of a reasonable hypothesis concerning fee negotiations. The research project as formulated basically consists of establishing a range of relevant factors and of the collection and collation of material not generally available, and which to a significant extent is held in the memory of participants to fee negotiations. The research was also conceptualised as involving two phases, the first covering in general terms all those provinces to be studied; the second a selected province, Alberta, in more detail.

The literature review, as discussed in the following chapter, was in general conducted prior to the formulation of the research design; however, a significant amount of the review was conducted subsequent to the first phase of the research but prior to the second phase of

data collection in Alberta. The literature review had an important impact on the initial design and subsequent refining as it revealed that physician income, and hence cost to the community, is not directly dependent on fees. Thus, in conducting the research the question of how relevant fee negotiations are to income and level of servicing had to be considered.

The General Phase

Given the above, the basic alternatives for the conduct of the general phase study were:

(i) to circularise by mail a questionnaire designed to obtain the necessary information;

(ii) to interview persons holding positions relevant to the conduct of fee negotiations.

The first alternative was rejected in the early planning or conceptual stages of the project for some very basic reasons which clearly indicated that the questionnaire method was by the nature of the project quite inappropriate.

As previously put forward such negotiations are conducted by persons, therefore for a questionnaire to be effective one would have to ensure that it reached the right people. If this could be achieved, there would be further problems in that such people are usually quite senior and would in all probability be unlikely to react favourably to a questionnaire which would require detailed and sometimes quite long answers.

The design of the questionnaire was also seen to be a problem if, as anticipated, the experience of the

parties involved had been different from Province to Province. In this circumstance a questionnaire being essentially a fixed document would not respond appropriately. As a complementary point to this it was realised, from personal contact with persons occupying similar positions in Australia, that persons occupying positions responsible for the conduct of fee negotiations are generally deeply involved and only too anxious to expand on their particular problems and the history of negotiation. This was felt to be particularly so where the interviewer was in a position to convey a similar appreciation of the Australian experience. For the above reasons it was considered that a questionnaire approach would be inappropriate.

This conclusion, however, does not imply that the personal interview technique was seen as a completely satisfactory alternative. The interview was seen to have one major drawback, that of a particular predisposition to possible errors of minor fact as a result of reliance on the memory of the interviewer, which would not occur as readily in the questionnaire technique. The interview by its very nature would give rise to errors through a variety of sources. Briefly these were seen as:

(i) lapses of memory on the part of the interviewee;

(ii) misunderstandings, either in interpretation of questions or answers;

(iii) errors in note taking.

It was also apparent that there would be errors of bias; however, such errors would be common to either the questionnaire or interview technique, and perhaps more obvious during interview.

It was recognised that the three sources of error could be minimised by making use of any available time during the interview schedule to check source documents, factual reports and commentary in medical journals of the time and make accurate notes.

Having decided on the appropriate technique there were now two problems to be resolved:

(i) Organising appropriate introductions to the relevant officials of the Provincial Health Plans and Medical Associations - plus, the subsequent task of arranging appointments;

(ii) the design of an interview guide.

Organisation of Interview

Contact with the hierarchy of the Canadian Provincial Plans was made in the first instance through Dr Armstrong, Director-General Health Insurance, Health and Welfare, Canada, whom I had previously met in Australia. He had been informed of my arrival and purpose in Canada by Dr Scotton, Chairman of the Australian Health Insurance Commission. Dr Armstrong kindly undertook to write to all the Health Plans seeking their cooperation. The process of organising an itinerary was then simply one of logistics, following receipt of letters from all Plans agreeing to my interviewing appropriate personnel during a pre-specified period.

Similar contact with the Provincial Medical Associations was initially made through Dr Wilson, President of the C.M.A., whom I had had the good fortune to meet socially soon after my arrival in Canada.

Attachment 1 is a detailed itinerary.

The Interview Guide

An interview is in essence a personalised questionnaire, it is a formal occasion which if it is to achieve the type of objective of this research project must be structured to the maximum extent possible commensurate with appropriate courtesy towards the persons being interviewed and the informality necessary to allow that person the latitude to expand on any points of particular interest to him. For this reason it was necessary to construct an interview guide.

The content of the guide was based on a combination of two basic inputs.

(i) The literature review, which highlighted areas of relevance to the outcome of fee negotiations.

(ii) The researcher's personal knowledge, gained during participation in Australian fee negotiations.

The construction of the guide, which in final form took the shape of a two page "aide-memoire" presented some significant problems. Fee negotiations cover a particularly wide range of inputs and outputs. Inputs vary from historical considerations to the most sophisticated data collection and processing systems. Outputs vary from fee schedules to doctors incomes, and in particular instances to doctors strikes.

For information to be adequately obtained it was seen as desirable to design a guide which would lead from generalities to specifics. That is, the questions towards the beginning of the list should be general enough to allow the subject of the interview to fully expound on the

question, with questions becoming gradually more specific so that towards the end they would in effect be a check list of items of particular interest.

In practice the concept of moving from generality to specific point was modified to a format of major headings with a sub-list of specific points related to that major heading to be covered at some stage during the actual interview. Attachment 2 is an example of the interview guide as actually used, in Quebec in this instance. As presented in the attachment it is a personalised document with quite cryptic points. The concept of the interview guide is presented below in a rearranged format which better expresses the approach taken in the interviews, and which is expressed in an annotated form to explain, where necessary, the object of the points in the guide.

MAJOR HEADINGS

Fee Negotiations

History from the Government's (Medical Association's) View

- to generally set the scene and pick up historical reasons for variations between Provinces.

Form of Negotiation

- to ascertain how formal the negotiations are; what agreements exist, reasons for this type of negotiation.

Structure of Argument

- the structure of argument of each side; economic factors; social factors; historical; comparison with other professions etc.

Use of Statistics

- how important has the increasing availability of statistics been; is there a two way flow of statistics; does each side readily accept the statistics of the other; is there co-operation in the production of statistics; could it have been possible to effectively negotiate without statistics?

Basis of Negotiations

- is the basis of negotiation fee levels, or income; what is basis for determining an appropriate income - are such matters considered?

Physician Supply

- attitude to hypothesis that to a large extent physicians are able to generate their own income.

Relatives Between Specialties

- does either party have a particular policy, what is basis for determining appropriate? relativities? life time earnings? training etc?

Discipline

- how is overservicing controlled, what are powers of review committee, disciplinary action, etc?

MINOR HEADINGS

Specific Points to Check (If Not Covered In Discussion Above)

- Was there medical opposition to co-operation?
- How effective were early statistics?
- Did either party make use of actuaries or similar resources?
- Was account taken of Overseas, or other provincial experience?
- Base periods - was there any problem regarding the definition of base periods (a common problem in wage and fee negotiations in Australia)?
- Effects of A.I.B. on fee negotiations.
- Who really determines the increases?
- Role of the Provincial Medical Association.
- Physician identification - unique? - any problems?
- Role of Federal Government - Statistics?; Policy?
- Taxation statistics, what others?; particular specialties?
- Mechanisms used for re-location of physicians, is there a deliberate government policy?
- Any particular problems e.g. pathology?

- The Future.

- Mistakes, what would be done differently?

The Alberta Phase

Experience gained in the fee negotiation processes of Australia, together with a brief survey of journals such as the Canadian Medical Association Journal indicated that neither the interview nor questionnaire approach could be expected to produce much more than an overview of the fee negotiation processes of the Canadian Fee Negotiation processes. Therefore, to supplement the interviews, it was realised that access to actual governmental files would be required to obtain a detailed knowledge of the processes of the provincial fee negotiations.

To obtain detailed information in respect of each province, would be a massive task involving many months of painstaking research, clearly beyond the scope of this project. However, the project would not be complete without a detailed appreciation of the processes of at least one province. Therefore, it was decided to sound out the attitude of each Provincial Government to allowing me to spend a period of four to six weeks in its Plan office obtaining data. This permission was sought during the interviews of the first phase and in the case of the Provinces of Alberta, Saskatchewan, Ontario and Quebec permission was readily forthcoming. The British Columbia Plan was willing but somewhat hesitant, I suspect due to the sensitivity of relationship between the Government and the Association.

For a variety of reasons I chose Alberta as the Province to look at more closely. Briefly, Ontario was

dismissed because of the relative infrequence of fee negotiations; Quebec for the same reason plus my very restricted knowledge of French; and Saskatchewan because of its complicated and long history in this area, which is not typical of Canada as a whole. Alberta on the other hand had a history of frequent fee negotiations and had appeared during the first phase to be one of the more interesting Provinces in terms of fee reviews.

In the Alberta phase, the actual research involved the reading and taking of notes from Plan files regarding the process of several negotiations. Naturally, the discussion contained below is restricted to those matters not considered confidential by the Alberta Plan. In reading the discussion various points may appear to be "brushed over", in many cases the information was not made available; in the remaining cases I am respecting the requirement of confidentiality. It should be noted that this latter information, while confidential in terms of this paper, was given to me in my capacity as an officer of the Australian Department of Health, for use in that capacity only. In general terms the requirement of confidentially imposed on me was one of degree; the confidential material referred to relates to the internal process of policy development within the Plan and the actual proceedings during negotiations.

CHAPTER III

LITERATURE REVIEW

The subject of provincial fee negotiations is briefly alluded to, generally in passing, in several articles. In these cases the author generally notes that the negotiations exist and passes comment as to whether they are appropriate or achieve the desired object. However, the topic of the conduct and worth of fee negotiations is not to be found as a study in its own right.

The actual topic of the negotiations is of course found regularly reported in newspapers and journals such as the Canadian Medical Association Journal (CMAJ). Indeed the CMAJ has over the years regularly reported the basic facts of most negotiations. This reporting has generally been limited to a brief statement of the results of the negotiations, in some cases a resume of the political manoeuvering within the profession, and where there is particular difficulty with the government, a statement of the problems.

In addition to this normal process of reporting, there are many very short political commentary articles regarding the need for increasing, defending or countering perceived threats to physician incomes and rights. Further, over the years three articles of particular interest to fee negotiations appeared.

These three articles were "Medical dollars and data: collection and recollection" by Milan Korcok published in April 1975,[1] "The need to establish cost-of-practice data" by Milan Korcok published in

October 1977"[2] and "CMA calls conference to review state of art of negotiating fee schedules" by D.A. Geekie published in November 1977[3].

All three articles were primarily of an educative nature, acquainting the physician reader with background and data concerning the process of fee negotiations. In his article "Medical dollars and data: Collection and recollection" Korcok discusses issues such as the evolution of fee schedules and the insurance system; the systems of, and importance of, data collection; the methods used to allocate negotiated fee increases; and the problems of income disparity between the sections of the profession.

In the second article Korcok discussed in the context of wage and price control the importance of accurately measuring the movements in costs of practice if fee negotiations are to achieve the desired result of maintaining the relative position of physicians income in a time of rapid inflation.

In his article on the fee negotiation art Geekie gives a brief run down on the situation in the majority of provinces. The article is primarily a report of a meeting of representatives of the 10 provincial Medical associations who met in Toronto on September 25, 1977 to "exchange information on negotiations on behalf of their members with provincial medicare commissions". A major topic covered at the meeting being how "divisions could help each other should any one province find itself in a confrontation situation".

All three articles, being of an educative and reporting nature, provide together with the more general references in the CMAJ and other journals, a store of information and data against which to check the background

and detailed information obtained during interview. Indeed this source was also used to fill gaps either not covered in the interviews or only briefly covered in passing. The articles are not analysed here because of their factual nature; however, the use of the articles as source and checking material is appropriately noted in the later text.

The objectives of the literature review were not simply limited to provide a store of source and background material. Three other objectives are also apparent, namely to establish the basis for: -

(i) the construction of the interview guide;

(ii) the construction of the 'framework' of possible objectives of fee negotiations; and

(iii) critical analysis of the fee negotiations.

Although these objectives may be conceived of as being separate and distinct there is a significant overlap in the literature over the three topics. The essential difference in the review directed towards each is essentially of depth and purpose. The review was not conducted in its entirety before the interviews; the review as conducted prior to the interviews was directed principally to the first and second objectives, with the review conducted after the interviews being directed exclusively to the third; other than to direct research into the documentary literature to cover any points subsequently found to be absent or obscure in the interview notes.

Therefore, the literature review needed to provide the questions to be asked to understand the negotiation process, and the factors relevant to the objectives of the process being achieved. Given that a principle object of the negotiations at least appeared to that of cost control, it was important to establish the factors effecting the total cost of medical services. As is further explained in Chapter IV these are seen to be: -

(a) Specialty of physician

(b) Location of physician

(c) Socio/Economic Status of patient population

(d) Number of hours worked for period before marginal utility of income per unit time equals that of the marginal utility of leisure per unit time (i.e. physicians objectives)

(e) Physician comfort

(f) Physician density

(g) patient generated contacts

(h) fee level of individual items

(i) structure of fee schedule.

Historical, the interest in the factors determining utilisation of medical services appears to have been triggered by the outcome of several studies in the 1960's conducted by Roemer which demonstrated an association between the supply of hospital beds and surgical rates.[4,5,6] These studies indicated that an

increase in hospital bed density without a change in physician density, tended to result in a change of physician practice patterns to utilise all available beds.

In an interesting, if emotive, article published in the CMAJ in 1967, Dr J.A. McMillian[7] demonstrated an effective insight into the factors affecting the utilisation of medical services. Although his investigation of the factors was not put forward in terms directly equivalent to current theory, a reading of the article reveals many glimmers of current theory. His categories, re-expressed (with his term in brackets) are:

(i) Doctor Density ('Availability')

(ii) Specialty ('Nature of Services'); he observes that saturation point had nearly been reached in obstetrical services

(iii) Patient Demand (part of 'the level of Education of Doctor and Public')

(iv) Technological changes ('New Knowledge')

(v) Socio/Economic Status and distribution of Patient Population ('Age and Geography')

(vi) Cost of Service ('Patterns of Practice')

(vii) Physician Generated Demand ('Patterns of Practice' and 'the level of Education of Doctor and the Public')

(viii) Physician Comfort ('Patterns of Practice').

The remainder of Dr McMillan's article is devoted to a warning regarding the results of the impending imposition of government controlled, rather than doctor sponsored, medical insurance programs.

In 1963 the method of re-imbursing physicians in Baltimore, for services rendered to the indigent population, was changed from the capitation method to the fee-for-service method. The results of two studies[8,9], based on data related to that changeover, indicated that a significant increase in utilisation and physician income per visit occurred as a consequence of the change. This result demonstrated not only capitation to be probably cheaper than fee-for-service, but also that patient per annum visit rates increased significantly. Given that there was no significant change in the patient situation, the studies suggest that doctors could possibly generate services.

Several studies have compared the utilisation rates of various surgical procedures under differing types of remuneration methods. Two of interest were those conducted by Bunker[10] and Vayda,[11] which compared surgical rates in the United States and Great Britain in 1967 and 1963 respectively. Factors which emerge from these studies as having a possible impact on the utilisation of services (and thus costs) are surgeon density, payment method, differing surgical philosophy and the differing geographic distribution of doctors and patients.

Other studies have identified marked differences in the rates of utilisation of services within the same geo/political unit. For instance, Roos, Roos and Henteleff[12] were unable to explain regional differences in tonsillectomies and adenoidectomies in the various regions of Maintoba by variations in morbidity or the standards of selections for the operations. There were

indications that age (of the surgeon), place of training, and qualifications had some bearing on the rate. Further, the distribution of physicians did not present itself as a satisfactory explanation. Vayda[13] et al in the analysis of surgical rates and elective procedures in Canada suggest that surgeon density determines the number of elective procedures and the number of acute care beds is a determining factor in the amount of non-elective surgery.

In general terms the above discussion supports a simple contention that Physician density, patient demand, location and 'physician comfort' are factors to be considered in any analysis of the utilisation rates of medical services. The term 'physician comfort' is used above to denote the propensity of a physician to practice in a mode acceptable to his peers, and the inertia he experiences when other factors exert an influence to change his practice mode. Data indicating this later phenomenum is present in the above studies, and indeed the concept has been developed to some extent by Wolfson and Evans although the name 'physician comfort' is not theirs; it is used herein as an appropriate term for the concept.[14]

The relevance of socio/economic status of the patient population is not as readily gauged. The intuitive reasoning being that the poor or indigent are likely to be sicker, but for a host of socio/economic reasons are more unlikely to make initial patient contacts. Similarly, the wealthy are less likely to be deterred from making an initial contact and are less likely to be as sick, but more likely to elevate the importance of minor ailments to the status of requiring medical intervention.

In a study based on data collected over one year, in each case, pre and post the introduction of medicare into Quebec, Enterline et al[15] examined the effect of

the introduction of Medicare on the distribution of physicians' services among income and age groups, and its effects on certain measures of availability and satisfaction. Enterline reported statistically significant changes at the 5% significance level in: -

(1) the ratio of home and office visits;

(2) the distribution of physician services by income range of the patient;

(3) distribution of physician services by age of patient;

(4) the waiting period for an appointment (it increased significantly); and

(5) a decline in the percentage of persons putting off medical care.

Overall, the result of the introduction of medicare was seen to be an increased utilisation of services by lower income groups, and a decrease in the patient perceived quality of the service.

Probably the most comprehensive analysis of the effects of socio-economic status in a full or near full insurance environment have been conducted by Beck.[16] Although his results have elements of conflict in them, Beck is clear in his interpretation that the main effect of the introduction of a patient moiety (or co-insurance payment) was to redistribute care towards higher income groups at the expense of the poor and the elderly. Further, he asserts that there is no evidence to support any hypothesis that the introduction of a co-payment charge resulted in a lower proportion of unnecessary or less meaningful services.

Beck's work showed an overall reduction in utilisation as a consequence of the introduction of the co-payment. However, he is of the view that his approach ignores the possible effects of physician manipulated demand. Several important aspects of his work need to be isolated to fully appreciate its significance. These are: -

(1) The distribution of utilisation by user class within income groups suggests that while most families remain at low or zero benefits levels in any one year, average expenditure rises. This has been interpreted as implying that "wanton overconsumption" does not follow from "free" care.

(2) Co-payment reduced overall utilisation by an average 7%, up to a maximum 24% for some groups.

(3) For some groups utilisation remained relatively constant but expenditure actually rose.

Wolfson and Evans[17] have interpreted Beck's work as suggesting "the utilisation impact of co-payment through the demand side thus appears to have been partially offset by physicians providing more services to less price sensitive groups, and changing billing patterns to claim for more expensive services". These two observations, particularly the latter, are of particular importance to the determination of physician incomes.

Anne Skitovsky and M.S. Nedla,[18] have also investigated the effect of co-insurance on the provision of, and use of, physician and other services in a comprehensive medical care plan operating in Stanford University. They report that the introduction of a 2.5%

moiety resulted in a dramatic utilisation and cost reduction (24%). Again, the impact was greatest in the lowest socio-economic groups.

Therefore, it appears that socio-economic status, and age of patients are relevant factors in the determination of physician income. It would also appear that a more subtle variation on physician generated demand, namely legitimate manipulation of the fee schedule to reclassify services in more expensive categories is a possible factor.

Having established the above it is now relevant to consider the mechanisms and interactions of the factors in determining utilisation of physician services. Although it is rare to find a health economist today who would dare to assert that conventional demand and supply theory was capable of satisfactorily explaining behaviour in the Medical Marketplace, it is not uncommon, in my personal experience, to encounter conventional economists responsible for planning and advising on health care issues who hold that the medical market place is no different to any other.

There are in essence two schools of thought amongst health economists regarding demand and supply of medical services. These groups are characterised by the Canadian Health Economist Dr R.G. Evans (see above discussion and Bibliography) and by Dr M.S. Feldstein.[19,20]

The Feldstein school holds that a permanent excess demand for physician services prevails in the general community and that physicians have the discretionary power to vary both the price and quantity of services. It is asserted by this school that price tends to rise with the patients' increased ability to pay and

concurrently relative quality falls. In essence this group adopts the more classical economic approach and contends that insurance and public subsidisation are the major influences on demand.

The Evans school rejects the classical economic concepts of demand and supply in the provision of medical services and asserts that doctors manipulate demand to persue target incomes. A simple statement of this school's position might be "utilisation and cost performance in the health care industry are to a large extent the result of provider behaviour and their modification must be sought through the objectives of the provider and the incentives and constraints which bear upon him".

An example of the research which supports the Evans school is the Ph.D dissertation of G.L. Stoddart who develops the concept that consumer demand as normally understood by economists can only be meaningfully applied to the patient initiated stage of an illness episode. He divides patient treatment which he defines as the 'utilisation process' into two components; the patient-initiated stage (i.e. the first patient/physician contact) and the physician generated stage, which is composed of the treatment regimen which the physician dictates in response to the illness.

Stoddart is of the opinion that consumer demand as normally understood by Economists is limited in the delivery of health services, to the patient initiated stage of the utilisation process. He contends that previous attempts to measure and model demand are incorrect in that they do not account for the physician generated component, volume of services consumed is seen by him as a function of both the patient's request and physician behaviour in response to requests.

To overcome this problem he develops a measure of demand related to episodes of medical service. This measure is then tested on utilisation patterns of families attending a Vancouver family practice unit. His results strongly support the contention that to explain variations in medical service utilisation it is necessary to include variables which take account of physician generated services.

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1. Korcok, M., "Medical Dollars and Data: collection, recollection". Canadian Medical Association Journal, 4 parts; Part 1, "the evolution of fee schedules"; Vol 112, (8 March, 1975) pp 623-625; Part 2, "medicare benefits staticians", Vol 112, (22 March, 1975), pp 770-777; Part 3, "sharing the increase", Vol 112, (5 April, 1975), pp 899-903; Part 4, "fee schedules and income disparities", Vol 112, (19 April, 1975), pp 995-996

2. Korcok, M., "The need to establish cost of practice data". Canadian Medical Association Journal, Vol 117, (22 October, 1977) pp 966-972, and (5 November, 1977) pp 1090-1092

3. Geekie, D.A., "CMA calls conference to review state of the art of negotiating fee schedules", Canadian Medical Association Journal, Vol 117, (19 November, 1977), pp 1197-1200

4. Roemer, M.I., "Hospital Utilisation and the Supply of Physicians", Journal of the American Medical Association, Vol 178, No 10, (9 December 1961), pp 989-93

5. Roemer, M.I., "Bed Supply and Hospital Utilisation: a national experiment" Hospitals, No 35 (1 November 1961), pp 36-42

6. Roemer, M.I., "On Paying the Doctor and the Implication of Different Methods", Journal of Health and Human Behaviour, No 3, Spring 1972, pp 4-14

7. McMillan, J.A., "Factors Influencing Utilisation of Medical Care", Canadian Medical Association Journal, Vol 97, (December 16, 1967), pp 1513-1517

8. Rodman, A.C., "Comparison of Baltimore's Utilisation Rates under Two Physician-Payment Systems", Public Health Reports, Vol 80, No 6, (June 1965), pp 476-80

9. Alexander, C.A., "The Effects of Change in Method of Paying Physicians: The Baltimore Experience", American Journal of Public Health, Vol 57, No 8, August 1967, pp 1278-80

10. Bunker, J.P., "Surgical Manpower: A comparison of Operations and Surgeons in the United States and in England and Wales", The New England Journal of Medicine, Vol 282, No 3, (15 January, 1970), pp 135-44

11. Vayda, E., "A Comparison of Surgical Rates in Canada and in England and Wales", The New England Journal of Medicine, Vol 289, No 23, (6 December, 1973), pp 1224-29

12. Roos, N.P. and L.L. and Henteleff, P.D., "Elective Srugical Rates - Do High Rates mean Lower Standards", The New England Journal of Medicine, Vol 297, No 7, (18 August, 1977), pp 360-65

13. Vayda, E. et al: "Surgical Rates in the Canadian Provinces, 1968-1972". Canadian Journal of Surgery, Vol 19, (May, 1976), pp 235-242

14. Wolfson, and Evans, R.G. "Moving the Target to hit the Bullet" unpublished manuscript dated January, 1978

15. Enterline, P.E. et al, op. cit.

16. Beck, R.G., "The Effects of Copayment on the Poor". Journal of Human Resources, Vol 9, (Winter, 1974) pp 129-42

17. Evans, R.G. et al, "Moving the Target . . ." op. cit.

18. Skitovsky, A.A. and Nelda, M.S. "Effect of Co-insurance on Use of Physician Services" Social Security Bulletin Vol 35, No 6, (June, 1972), pp 3-19

19. Feldstein, M.S. "The Rising Price of Physician Services". The Review of Economics and Statistics, Vol 52, No 2, (May 1970), pp 121-33

20. Feldstein, M.S. "Hospital Cost Inflation: A Study of Nonprofit Price Dynamics". The American Economic Review, Vol 61, No 5, (December, 1971), pp 853-72

21. Stoddart, G.L. An Episodic Approach to the Demand for Health Care, Unpublished Ph.DL. Thesis, University of British Columbia, July 1975

CHAPTER IV

A REFERENCE SET - POSSIBLE OBJECTIVES OF FEE NEGOTIATIONS

The brief discussion below is presented as a 'framework' for the later consideration of the objectives and effects of the fee negotiation processes of the five Provinces studied. The 'framework' is derived from personal experience and expectations (or bias), the literature review, the interview guide, and the actual conduct of the study. This 'framework', which is not intended to be exhaustive but rather a guide, is used in Chapter X as such for the final analysis of the fee negotiation process as defined and required by the definition of 'Review' in Chapter I.

In the development of a set of possible objectives three questions appear relevant and perhaps obvious, namely: -

(i) Why do Governments participate in Fee Negotiations?;

(ii) Why do the Medical Associations participate?;

(iii) What is the relevance of fee negotiations to the delivery of health care?

As might be expected, the answers to these questions overlap to a significant degree and consideration of the first gives rise to a large part of the answers to the latter two.

WHY DO GOVERNMENTS PARTICIPATE IN FEE NEGOTIATIONS

The answer to the first question may be considered in terms of four broad objectives which are discussed in detail below. For reference, the broad objectives, which are discussed in this order, are: -

- The Orderly Provision of an Essential Service
- Cost Containment
- Social and Political Considerations
- Health Care Delivery Planning

The Orderly Provision of an Essential Service

The provision of necessary medical care, as defined in the particular society, is one of the basic needs of man. In a highly developed society such as Canada it is of significant interest to the Government that medical services be provided in an orderly manner. The extent of government regulation of the provision and access to medical care varies from society to society, in Canada as in most Western Countries that regulation is basically indirect. That is, regulation is by way of licencing of who may practice and the enforcement of laws designed to ensure that physicians practice adequately and within ethical limitations.

If a Government restricts its regulation to licencing and general laws in relation to ethical practice, the provision of medical services is, in essence, a free market situation, provided the licencing restriction is primarily based on academic or technical qualifications. In these circumstances and providing that the cost of medical services in certain situations could be regarded as calamitous by certain segments of the population, it is possible and indeed probable, dependant

on the culture and attitude of the citizens, that various schemes designed to remove the threat of calamitous medical bills would evolve utilising the insurance concept, say variations of prepaid insurance, group plans (e.g. Blue Cross) and various forms of sessional schemes funded by local authorities or citizen groups. Indeed, it was through the development of these types of systems that the current health/medical insurance programs in many Western Countries, including Canada, evolved.

In a free market situation it is apparent that the rich would have better access to medical care than the poor.[22] It would not be unreasonable to assume that for the majority of the population access would be directly related to wealth. It would also be reasonable to assume that a large number of physicians would adopt a form of price setting, price discrimination, which would maximise income.

Unfortunately, as many studies show,[23,24] real medical need is more likely to be inversely proportional to wealth. That is, the poorer one is the more likely he is to be sick.

In order to correct this situation, the Canadian Federal Government sought to guarantee equal access to medical services for all citizens by building on the insurance system which had naturally evolved in many areas of Canada.[25] It introduced, by proxy, a system of universal insurance under which the Canadian Provincial Governments have elected to fix fees for all individual medical services provided by physicians to members of government subsidised plans. The plan in return for premiums pays all medical bills at agreed rates. Some provinces have merely sought to set a guaranteed fee to the physician, effectively a minimum, over and above which additional payment is a matter between physician and patient.

As a system of stable or agreed fees is crucial to the effective operation of an insurance system, the government is almost by definition, in a free society, required to partake in fee negotiations with the medical profession if the orderly system of medical services is to be maintained.

Cost Containment

In the process of ensuring this orderly provision of medical services the Canadian Government has created several other problems for itself. Not the least of these problems is that of cost containment.[26] In fact, a major policy objective of any Government underwriting a universal health insurance program, which is based on the fee for service mechanism, is that of cost containment; the reasons behind such a policy are many, and they vary from the moral, a duty to spend public monies wisely, to the pragmatic, the competing demands of all sectors of the economy for limited resources.

It is perhaps obvious that Governments are interested in fee negotiations as a cost control mechanism. However, it is important to the study of fee negotiation processes to understand the suitability and limitations of fee negotiations as a cost containment mechanism.

Under a free market situation the income of physicians is dependent on a number of factors[27,28,29]. If one assumes a modified type of supply and demand, as developed by Stoddart, is applicable in the free market for physician services, then those factors may be conveniently grouped under three general headings as follows: -

Patient Demand

(a) Patient Generated Contacts

Supply

(b) Specialty of Physician

(c) Location of Physicians Practice

(d) Number of Physicians in specialty group and total number of physicians (physician density)

Doctor Induced Demand

(e) Socio/Economic Status of patient population

(f) Number of hours worked per period by the physician before his marginal utility of income per hour equals that of leisure

(g) Peer norms of pattern of practice and acceptance of changing or different servicing patterns (physician comfort)

In this situation the fee levels are an intermediary stage in determining income, as the physician can practice price discrimination. However, under the universal insurance situation (Canadian model) fee discrimination is not generally possible. The factors controlling physician income then become (a) to (g) above, albeit with a different significance in most cases, plus the following factors which can be groupted as 'fee schedule' factors: -

Fee Schedule

(h) fee level of individual items

(i) structure of the fee schedule.

It is significant from the Government viewpoint, in cost control, that it has little control over any of the above factors except fees. However, it could also be anticipated that the fee negotiation mechanism would be used to gain some control over (d), (g) and (i).

The above discussion basically concerns the income of individual physicians. Further evidence of the reasons for government interest in fee negotiations may be obtained from consideration of the following equation.

Total Cost = Average Fee per service x Number of Services =

Average Earnings per physician x Number of Physicians

If the total cost of services is to be controlled, this equality reveals two sets of variables which may be the subject of negotiation and control. Therefore, in the examination of the fee negotiation processes of the various Provinces attention should be devoted to the direction taken by the various governments in their efforts to control total cost.

Social and Political Considerations

Having moved to correct one social and political problem by guaranteeing a form of equal access to all, the Government creates some further problems for itself in the same arenas. Some may argue that this is not just restricted to medicine, rather that as a general rule governmental interference in a free market situation to correct one problem throws the whole system out of balance and this creates further (unforeseen?) problems.

An example of the further problems created in the health insurance system is that of physician income. Although there may be criticism from both the social and political viewpoints of high physician incomes in the free market situation, it may to a large extent be muted and lost through a large variety of mechanisms, such as the acceptance of the capitalist system of rewards, the earnings of other professionals and merit etc. (note the differences between Canada and the U.S.A.).

However, once universal insurance is introduced physicians may be regarded as being to all intents and purposes on the public payroll. As such their high incomes draw political and social criticisms from the more socialist sections of society, who question the relative worth of physicians in comparison to other sections of society. This criticism may be quite widely based in the community and most likely directed at both physicians and the Government.

Therefore, regardless of the political persuasion of the Government, fee negotiations are a useful mechanism for legitimising physician incomes. Physicians are seen to be subject to the same constraints of bargaining when seeking income increases as are other sections of society. Again, this mechanism may be observed in the consideration of individual fee negotiations, the bargaining process will be particularly evident in the discussions of the fee negotiation processes of Alberta and British Colombia.

Health Care Delivery Planning

In the Canadian Health Care System physicians are but a part, albeit a major part, of the total system. However, as in all human systems the roles of the various elements are changing with time, as Governments more and

more consider the cost effectiveness of various forms of health care delivery and modes of operation and make policy commitments in line with these considerations.

Given that resources in the health sector are limited, this planning may or should take into account such factors as manpower, high cost technology and delivery modes. Fee negotiations may be used in the pursuit of policy objectives such as:

(a) diversion of resources from physicians to substitute personnel;

(b) limitation of high cost technology to major centres such as hospitals - by setting fees for the private doctor owner/user at an uneconomic level

(c) encouragement of physicians to enter various specialties.

Although fee negotiations are in many ways peripheral to the overall thrust of health care planning, they can be a critical element in efforts to exercise control over the provision of health service.

WHY DO THE MEDICAL ASSOCIATIONS PARTICIPATE

Although the details vary from Province to Province it can be argued that the medical association participate in fee negotiations simply because they have to if fee increases are to be obtained. Briefly, this is because the Government gains much from the formal process and has often arranged that the fee levels set by negotiation are the maximum chargeable, if the physician is to remain a participating physician. In some Provinces 'Extra Billing' by a physician is more or less allowed and

the significance of this is dealth with in the discussion of Saskatchewan.

Having established the basic reason, it is important to further state that the medical associations are not unwilling participants. The course of Canadian history has shown that in the final analysis physicians are a very powerful force in society and that when sufficiently provoked they are prepared to use weapons such as strike action to obtain objectives. In general, the associations participate on a pragmatic basis, and it is apparent that several very real objectives are pursued.

The first advantage is that participation adds a very important extra dimension to the provincial medical association. The importance and mode of negotiation requires a build up of expertise within the association executive and secretariat. The association becomes more the focus of political activity within the profession, and given the additional resources and expertise, is better able to mobilise and represent the opinions of the profession in other peripheral areas affecting health care delivery.

Secondly, participation in negotiations forces the association, and through it the profession, to come to grips with itself and its objectives. An example is the realisation of, and belated activity to correct, the disparities between the incomes of various specialist sections of the profession. It is common for the provincial Governments to leave the allocation of total increases between the sections to the medical association. Such a policy, of course, has quite significant ramifications for the profession. Through such activities the profession itself is to a degree made more extravert.

Finally, fee negotiations are useful to the profession for their value in legitimising and rationalising the economic advantages of members. Just as the bargaining process is advantageous to the Government in moderating criticism, the process is of advantage to the profession; it is seen by both the public at large and by its members as being required to justify income increases on an essentially similar basis to the majority of the community.

Relevance to Health Administration

In the light of the above discussion, it is apparent that the study of fee negotiations is of particular relevance to the field of health administration. Fee negotiations are important to the field of health administration almost by definition because of their importance to the people, the Government and the medical profession as discussed above. However, the importance may be further developed in at least two more ways.

Fee negotiations are an important element of the institutional mechanisms which have evolved for the resolution of conflict between society, represented by the Government, and the medical profession. Just as a study of labour relations is relevant to health administration for its inherent value in obtaining an understanding of the processes at work in resolving conflict between management and staff, say in a major hospital, the study of fee negotiations gives an understanding of the process involved in the resolution of similar problems between management (the Government) and staff (the highly independent medical profession) in the health insurance arena.

The study of fee negotiations is also important as it gives the student an insight into the problems of change, and the resistance to change put up by the vested interests. The negotiations in British Columbia are of particular relevance in this regard. Policy planners in the health care delivery system need to appreciate the nature and strength of these forces if they are to minimise conflict and harness those forces in the evolution of improved systems.

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22. Enterline, P.E. et al, "The Distribution of Medical Services Before and After "free" Medical Care - The Quebec Conference" New England Journal of Medicine, Vol 289, No 22, (November 29, 1973)

23. Morris, J.N. "Social Inequalities Undiminished" The Lancet, Vol 1, No 8107, (January, 1979)

24. Newacheck, P.W. et al, "Income and Illness", Medical Care Vol 18, No 12, (December, 1980)

25. Andreopoulous S., "The Health of Canadians" in S. Andreopoulous, ed. National Health Insurance: Can We Learn from Canada? New York: John Wiley, 1975 pp 1-2, 6

26. Andreopoulous S., "The Health of Canadians" . . . p3

27. Enterline, P.E. et al. "The Distribution . . ."

28. Evans R.G., "Beyond the Medical Market Place: Expenditure, Utilisation and Pricing of Insured Health in Canada" in S. Andreopoulous, ed. National Health Insurance: Can we Learn from Canada? New York: John Wiley, 1975

29. Evans R.G. et al. "Moving the Target to Hit the Bullet: Generation of Utilisation by Physicians in Canada" unpublished draft, January 1978

CHAPTER V

ALBERTA

SECTION 1 - INTRODUCTION

Background

Up until the introduction of medicare on 1 July 1969 the principal medical insurance carrier in Alberta was Medical Services (Alberta) Incorporated (MSI) which commenced operations in 1948. This plan was a physician sponsored plan, controlled by the profession through majority representation on the Board of Directors.[30]

In 1963 the Alberta Government began a program aimed at encouraging universal coverage through commercial carriers.[31] The Alberta Medical Plan came into force through an amendment to the Insurance Services Act which allowed the Minister of Health to

> "enter into agreements with Medical Services (Alberta) Incorporated or any insurance corporation whose basic program of prepaid medical services or medical services insurance has been approved by the Government and the College of Physicians and Surgeons of the Province of Alberta to make available prepaid medical services or medical services insurance with comprehensive benefits to those eligible residents who desire it and need assistance to purchase the contracts provided by that corporation and to provide a specified dollar subsidy in respect of those residents who need assistance on the condition that the cost of the prepayment premium or insurance to these residents is reduced by the amount of the subsidy".[32]

In pursuing this objective, the Government adopted the approach that companies selling insurance had to meet criteria of a certain standard of benefits, continuity of contracts for persons who become chronically ill, and approved premium levels.[33]

In 1967 the Alberta Health Plan commenced operations replaning the Alberta Medical Plan; this plan was established by the Government to participate in the provision of health insurance in addition to the private insurers. The intention was for the Alberta Health Plan to provide coverage for all subsidised resigtrations in addition to non group coverage open to all Albertons.

At the time of the introduction of the Provincial Plan on 1 July, 1969 a coverage of some 80 to 85% of the population had been achieved.

Fee Negotiations - An Outline

Between 1969 and 1973, negotiations between the Alberta Medical Association and the Government were of a relatively informal nature. MSI up until 1969 agreeing with the A.M.A. upon appropriate fees in a rather loose way, it really being a matter of judgement as to what the traffic would bear. In view of the experience of some physician sponsored plans of having to pro-rate payments and the predominance of physicians on the Board of MSI, it would have been highly unlikely for there to have been any major disagreement.

Several fee increases were agreed on during the period 1 July 1962 to 1 July 1969 and they were as below:[34]

	%
March 1964	2.1
July 1965	4.0
October 1966	5.3
July 1967	8.5
July 1968	4.9
July 1969	6.3

The July 1969 increase was adopted by the provincial medical association, but was not included by the Alberta Health Care Insurance Commission in its list of fees until one year later.

Subsequent fee increases to 1 July 1978 were as follows:[35]

	%
July 1970	6.3
November 1972	.8
October 1973	4.0
October 1974	4.0
March 1975	7.2
January 1976	9.0
January 1977	7.0

The informality of the pre-medicare fee negotiations was continued in the negotiations of the early 1970's. As mentioned above the Alberta Medical Association list of fees was increased by 6.3% on 1 July 1969 at the inception of Medicare. The Provincial Plan, however, paid only 93% of that Schedule. The principal reason advanced for the payment of this percentage was to compensate for the automatic increase accruing to physicians by the elimination of bad debts as a result of the guaranteed payment effect of medicare.

However, as the Alberta Plan only allows physicians to charge more than the schedule fee when the patient is notified in advance there was a substantial adherence on the part of the physician to the A.M.A. list. In july 1970 the Plan schedule was raised to match the A.M.A. schedule and additional billing was to all intents and purposes eliminated, for the time being.

In 1971 there were negotiations resulting in some minor changes to the benefit schedule. Again, in 1972 a small increase accompanied by a reduction in fees for some specialist sections was negotiated.

It was the 1972 series of negotiations which proved something of a watershed in the development of the negotiation process. The A.M.A. and the Government were by this time getting comprehensive and up to date statistics from the operations of the Commission. Arising out of this statistical information, both the Government and the A.M.A. had expressed concern as to the size of the income differentials between the various specialty groups.[36]

As a consequence of the 1972 negotiations, fees for four specialty sections were reduced. In particular the fees for pathology services were reduced. However, the resulting furour and internal disention was such that the A.M.A. is very unlikely to ever propose or accept the actual reduction in fees of a particular specialty section again.[37]

Since that time the A.M.A. has actively been engaged in a process of reduction of the disparities between the various Sections. This program has involved the selective allocation of new money to give more to the lower groups.

In 1973 the negotiations became more formal and both sides put forward negotiating teams. The outcome of this particular series of negotiations was a 4% increase to operate from October 1973 together with a further 4% to operate from October 1974. However, in March 1975 due to the unexpected increase in the inflation rate, the A.M.A. came back to the plan seeking an interim adjustment of a 26.7% increase to carry the profession through until December 31 of 1975. At the final meeting between the negotiating Committee of the Alberta Medical Association and the Alberta Government representatives, which was held on Tuesday 14 January 1975, the Government put forward a 6.5% increase as the maximum it would allow. It was accepted by the A.M.A. (these negotiations are discussed in detail later).

In June 1975, a further series of negotiations began between the A.M.A. and the Government at which the A.M.A. at first sought a 39% increase. At this stage, the Government was offering 6%. The negotiations broke down in early October and were resumed later that month and settled in early November, with a 9% increase. The reason for this settlement was not a sudden change of heart by either the Government or the A.M.A. but rather the introduction of the Anti-Inflation Board Legislation control in the country.

On October 13, 1975 the Prime Minister of Canada Pierre Elliott Trudeau, announced that the Anti-Inflation Board Legislation would be introduced into Canada to be effective from October 14, 1975. On that day, the Government tabled a policy statement in the House of Commons which described the program of controls to be established. Part of that Policy Statement dealt with the way in which incomes could be increased during periods of

controls. Various approaches could be used, however, the overriding consideration was that net income could not increase by more than $2 400 per year. The relevant part of the policy statement is as follows:

> "Increases in fees for professional services such as the services of doctors, lawyers and accountants, should be governed by the same general principles as apply to other prices and incomes. Subsequently, such fees should be increased only by the amounts required to cover the increased costs of providing the services and to improve the net income of a self-employed professional person by the same amount as would be available to the salaried professional person. Thus a $2 400 maximum increase would apply in the determination of the professional fees. Professionals would, of course, have the right to increase their incomes by more than $2 400 if that increase reflected increases in workload. The basic fee schedule must not be increased in a way which will allow the average professional working the same amount as in the base year to increase his income by more than the guidelines permit".[38]

Having settled the issue of net income in an effective manner, the resulting negotiations were able to be concluded swiftly and the increase of 9% came into effect on January 1976.

Operating on the same guidelines a further increase of 7% was negotiated in 1976 to be operative from 1 January 1977.

Clearly, the introduction of Wage and Price control had to have a profound effect on the tactics and strategy adopted by both parties, as well as on the actual mode of negotiations. The negotiations resulting in the 1975 interim increase were the last completed before the imposition of wage and price control, and the negotiations leading to the 1 January 1977 increase were the first wholly conducted under wage and price control. As such it is instructive to consider each of these two sets of negotiations in some detail.

The conduct of these two series of negotiations is described below, that description is followed by an analysis of the positions of both parties. This chapter is then concluded by a discussion of A.M.A. and Government policies and attitudes in respect of the other topics covered by the interview guide.

SECTION 2 - THE FORMAT OF ALBERTA NEGOTIATIONS

(1) 1974 NEGOTIATIONS FOR 1975 INCREASE; LAST COMPLETE NEGOTIATIONS PRIOR TO WAGE AND PRICE CONTROL[9]

Consequences and Implications of the 1973 Negotiations

The 1973 round of negotiations was finalised in August 1973 when a memorandum of agreement was signed by representatives of the Government and the Board of Directors of the Alberta Medical Association. This agreement, in essence, raised the Schedule of Benefits by 4 percent, effective from 1 October 1973. The agreement also specified that the Schedule of Benefits would increase by another 4% effective October 1, 1974. The second adjustment was to remain in effect for 15 months until the termination of the agreement on December 31, 1975.

The A.M.A. decided to use the October 1, 1973 increase to continue the policy adopted in 1973 of selectively reducing disparities amongst specialties. Preference was given to General Practitioners and specialists in internal medicine, paediatrics, general surgery and neurosurgery, however, unlike 1972, there were no reductions in fees. This policy was not followed in the allocation of the October 1974 increase which was implemented as a 4% across the board increase.

At the 1974 Annual General Meeting of the A.M.A., which was held in Calgary in October, widespread concern was expressed about the content of the agreement, particularly the second phase 4% rise for October 1974. Criticism was levelled at the Negotiating Committee which had made the agreement. This agreement was thought by the annual meeting to be a poor one. As a result of this general criticism a new Negotiating Committee was elected with a mandate to seek a further increase.

Perhaps the most important consequence of this meeting was that a resolution was passed requiring the consent of members of the A.M.A. before future agreements with the Government could be ratified. The consent of the members was to be obtained by means of a simple majority of those members voting in a province wide referendum. The question to be put to referendum would be acceptance or non-acceptance of any agreement reached between the Negotiating Committee and the Government.

1974 Negotiations

Following the Annual General Meeting of the A.M.A. on 1 October 1974, the A.M.A. approached the Government on October 3 expressing its concern that because of the hostile attitude of a majority of the Association towards previous agreement and the level of fees, standards of care were in jeopardy. The A.M.A. further stated that the present agreement was below that of all other Provinces and that the average payments to Alberta physicians had fallen not only in relative terms to other Provinces but in absolute terms since the agreement was signed.

The Government's response was sympathetic to the predicament of physicians, who it believed had been caught by the spiralling cost of living which had occurred after the agreement had been settled. It agreed that there was justification for some adjustment and sought meetings with the A.M.A. to discuss adjustments to the existing agreement.

The first meeting was held with the A.M.A. on 10 November 1974. The A.M.A. adopted the position that it was prepared to meet regularly with the Government until settlement was reached. It asked for a 26.7% increase in

the Schedule of Benefits to be effective June 1, 1975. This increase was sought to return the average payment to Alberta physicians, after overhead costs were deducted, to the level of June 1973. The general position of the A.M.A. as presented at that meeting can be summarised under three headings:

(i) the spiralling increases in overhead costs and the consumer price index had substantially erroded the purchasing power of physicians;

(ii) the relative position of Alberta physicians in comparison to other Provinces had dropped; and

(iii) a token adjustment would not be satisfactory - if negotiations broke down the A.M.A. was prepared to take other measures to regain the relative position of their members vis a vis other provinces.

The starting point of the Government negotiating team can be summarised as follows:

(i) the 1973 agreement was made in 1973 circumstances;

(ii) the Government was sympathetic with Alberta physicians with respect to spiralling inflation;

(iii) the Government did not want to reopen the agreement but preferred an interim adjustment;

(iv) although the 26.7% increase was out of the question, the Government did not have a set position as to the degree of an acceptable interim adjustment and sought information from the A.M.A. on which to base any increase.

The meeting concluded by agreeing to meet again after the A.M.A. had supplied the information to support its request.

A further meeting was held two weeks later on 25 November 1974 at which a position paper prepared by the A.M.A. was discussed. This paper had been previously circulated to members of the Government Negotiating Committee.

The position paper listed three objectives of the A.M.A.:

(i) to return the average physician in Alberta in 1975 to the same level of puchasing power as the June 30, 1969 level, plus gain an equitable share of productivity increases;

(ii) to restore net professional income of Alberta physicians in comparison to that of physicians in other provinces;

(iii) to restore the standing in terms of net professional income of Alberta physicians as compared to other income earners.

It also included various kinds of data in support of the above three objectives. An analysis of the type and structure of the data is covered in a later part.

The A.M.A. representatives spoke to the position paper and made the following specific points:

(1) the A.M.A. sought agreement that the 1973 agreement was based on the assumption that the 1973 financial position of Alberta physicians was going to be maintained;

(2) in determining the level of remuneration to physicians the Government should give consideration to the social welfare contribution of physicians;

(3) if Cabinet would not agree to (1) then the A.M.A. wished to present its case directly to Cabinet.

The Government's position was that the determination of appropriate remuneration for physicians was a complex question. The Government had a duty to the community at large and must take a reasonable and responsible position. The government representatives presented data of their own to refute or counter A.M.A. data.

The following general points were made by the government representatives.

(1) The Government did not want to open the present agreement for a new negotiation at this time but was prepared to give consideration to an adjustment in the second year of the present agreement to reflect the anticipated spiralling cost of living in the calendar year 1975.

(2) It was incorrect to assume that the Government had agreed in the present agreement to maintain the economic position of the physicians at the 1973 level.

(3) If it was agreed to make adjustments to the Schedule of Benefits, this would be on a percentage basis only. The percentage could vary

between the sections to reduce disparities but that individual items would not be subject to separate adjustments.

(4) It was decided to make the interim adjustment effective January 1, 1975. But if the adjustment could not be implemented by January 1, a method would be worked out to compensate for the later introduction of the adjustment.

(5) The Government representatives would pass the request by the A.M.A. to the priorities committee that the A.M.A. would like to present its case directly.

Between the second meeting and the third meeting the Government negotiating committee analysed the A.M.A. data and other data, and prepared a submission for the priorities committee of Cabinet to consider. The priorities committee made a decision that the Government would offer an interim increase of 6.5% effective 1 February 1975. This was equivalent to a 6.0% increase effective 1 January 1975.

At the third and last meeting, the Government representatives explained the offer of the Government. In effect it was made clear that the offer was final. The negotiating Committee made it quite clear that they were dissatisfied with the offer.

The A.M.A. Board of Directors later advised members to accept the offer and on February 10, 1975, the A.M.A. notified the government representatives that the ensuing referendum had been in favour of accepting the interim adjustment.

(2) 1976 NEGOTIATIONS FOR 1 JANUARY 1977 INCREASE; UNDER WAGE AND PRICE CONTROL

The Negotiating Committee of the A.M.A. and representatives of the Alberta Health Care Insurance Commission (A.H.C.I.C.) met on six occasions between 20 September and 28 October 1976, to discuss and obtain agreement on a fee schedule to operate from 1 January 1977.

Unlike the 1975 negotiations, the A.M.A. had completed its position paper prior to the first meeting. This position paper expressed the serious concern held by the Association concerning several major legislative changes affecting the professional freedom and income of physicians. Specifically, it expressed concern regarding three Federal Bills: namely; C-73 the 3 year AIB Bill introduced in October 1973; Bill C-2 passed in December 1975 which could prevent the publication of a Medical Association Schedule of Fees; and, in June 1976 Bill C-68 which placed ceilings on Federal Contributions to the Provinces under the Medical Care Act.

The A.M.A., however, accepted its responsibility to "assist in the battle against inflation" and, while reserving its position, in the event of the A.I.B. controls being suspended, took the view that the negotiations should only be directed to obtaining the maximum possible and due to the profession under the terms of the A.I.B. package.

The thrust of the A.M.A.'s argument was that since the introduction of Medicare into Alberta, costs of Medicare had not increased disproportionately, and physicians had suffered a substantial decrease in average real net income, both in absolute and relative terms. The point was also made that the A.M.A. would be very reluctant to recommend an increase of less than 9.6% to members.

The Health Care Commission responded to the A.M.A.'s 9.6% by offering an increase of 5.76%. Both parties had arrived at these figures using a similar method but different data as discussed below. Taking into account all the data which had been provided by the Commission, as well as other data it had obtained the A.M.A. responded to the Government offer by revising its position from seeking 9.6% to a lower target of 7.67%.

On October 28, 1976 the Commission tabled an offer of 6.9835%, which was subsequently rounded off to 7.0%. The following day the negotiating committee reported to the Board of Directors and recommended acceptance of the offer. The Board agreed to put the proposal to a referendum and recommended that it be accepted. The result of the referendum was an 85% vote (of those voting) in favour of acceptance.

SECTION 3 - THRUST OF ARGUMENT AND DATA PUT FORWARD IN 1974 AND 1976 NEGOTIATIONS

1974 Negotiations

The arguments put forward by the A.M.A. in the 1974 negotiations were naturally designed to support the A.M.A.'s principle objective of returning the average physician in Alberta in 1975 to the same level of purchasing power as of June 30, 1973, plus gaining an equitable share of productivity increases.

The A.M.A. produced a series of tables and data designed to show:

(1) Alberta physicians had slipped, in terms of average net professional income, from the highest earning province for 1970 to fourth in 1972;

(2) The average net professional income of Alberta physicians had slipped by 1972 to be below the national average;

(3) The percentage increases in Average Weekly Wages and salaries (Industrial Composite) had been much larger in Alberta than both percentage increases in Average Gross A.H.C.I.C. payments, and percentage increases in Net A.H.C.I.C. payments, since 1972;

(4) In terms of multiples of per capita G.N.P., the Average net professional earnings of all Canadian employees had remained relatively constant since 1972, whereas Average A.H.C.I.C. Payments to Alberta Physicians had declined;

(5) Whereas other highly skilled income earners had had increases of around 25% since 1972, Average Net A.H.C.I.C. payments had decreased by 6.4%;

(6) Chief Executives and other senior management personnel in Canada were receiving higher basic salaries as of 1 January 1974 (plus fringe benefits) than the average net A.H.C.I.C. payments to Alberta Physicians;

(7) Whereas the Schedule of Benefits had increased by 4.0%, the CPI for Edmonton and Calgary had increased by 17.76% during the period June 1972 to June 1974. It was further expected that the CPI increase for June 1974 to December 1975 would be another 12.0% whereas the schedule of Benefits would only increase by 4.0%;

(8) The health and personal care component of the Consumer Price Index, with a weight of 5%, was contributing a smaller percentage (3.6% in 1973, 4.38% for first 8 months of 1974) of the actual inflation rate. Health care was, therefore, in effect keeping down the rate of CPI increase at the expense of real income of the medical profession;

(9) The medical profession is entitled to a share of productivity increases as it contributes to real productivity gains through enhancing the well being of productive members of society. As the long run average real per capita increase in Gross Domestic Product in Alberta was approximately 3.96% it was considered appropriate for physicians to share this increase;

(10) In a period where average gross A.H.C.I.C. payments had remained relatively constant, and had in fact decreased by 2.1% from June 30, 1971 to June 30, 1974, overhead had risen substantially resulting in a decreasing net professional income;

(11) The medical profession had not enjoyed a disproportionate increase in income compared to movements in A.W.E. with the introduction of medicare. The relative gain was as low as 0.7%;

(12) From June 30, 1972 to June 30, 1974 average overhead of all Alberta Physicians had increased from 37.5% of average gross income to approximately 44%. Further, it was estimated that without an interim increase the overhead would increase to approximately 50.0% of average gross income in the calendar year 1975;

(13) Average net A.H.C.I.C. payments declined 2.41% in the year ended June 30, 1973 to the year ended June 30, 1974. It was also estimated that a further decline of 4.17% would occur in the following year.

The A.M.A. used the above data and argument to seek a 25.67% increase. The method of calculation of the 25.69% was based on data available from the Department of Health and Welfare. Assuming that 40% of average payment to be overhead, then average net payment to Alberta physicians was $25 999 for the benefit year 1972-73. It was calculated that to maintain this level of purchasing power and to obtain the average compounded productivity increase, the average payment after overhead would need to be $37 233 in the calendar year 1975. As overhead in 1975

would be $24 270, the average payment would be $61 503. Without the interim adjustment, average payment would increase to only $48 932. Hence an interim adjustment of $12 571 or 25.69% would be required.

The Government response to this line of argument was to prepare a set of tables which were presented to the A.M.A. The Government representatives pointed out that the determination of remuneration to physicians was a complex question. The Government must take a reasonable and responsible position. The question must be looked at, not only in the short term, but also in the long term. The Government tables made the following points:

- The average compound annual rate of increase in net income for self-employed professionals showed that between 1962 and 1972, physicians' net incomes had risen at a faster rate than those of engineers, lawyers, dentists and accountants.

- Historical trends of net professional income of physicians compared to other self-employed professionals showed an exceedingly high net professional income for physicians.

- In terms of average benefit schedules of provinces, Alberta ranked second only to Ontario as of October 1974. In reply to the declining relative standing of Alberta physicians pointed out by the A.M.A., the Government representatives suggested that physicians in Quebec and other Atlantic provinces earned more because they performed more services. The Alberta position was not due to the lower remuneration in the province.

Based on a consideration of the A.M.A. position and government data, the Government's final offer was arrived at by taking account of the following considerations:

(1) Taxation Statistics showed that for the period 1966-1972 the average net income of physicians had been the highest among self-employed professionals. Their incomes had been increasing faster than incomes of any other professional group and wage earners. It was acknowledged that since 1972 there had been some breaking off compared to other groups, mainly because of increasing overheads. However, in considering an interim increase it would be appropriate to give some consideration to the traditional advantageous position of physicians;

(2) In terms of comparing the relative position of Alberta physicians against those in other Provinces it would be appropriate to exclude the Atlantic Provinces and Quebec for reasons of different historical backgrounds. On this basis, Alberta physicians had maintained second position over the four years up to 1972;

(3) Some increase was justified to compensate for increases in overhead costs and the movement in CPI. It was felt that the A.M.A. had grossly overestimated these factors. It was calculated that, excluding the productivity factor, that an additional 12-15% would be required to maintain 1973 purchasing power in 1975, and 7-9% to maintain 1974 purchasing power.

(4) Negotiations in other provinces were seen as relevant in themselves and as a basis for assessing (1) to (3) above. An analysis of these indicated that general increases of 11-17% had been granted or were expected over the period of the current Alberta agreement. Therefore, as the Alberta agreement was around 9% in effective terms a moderate increase of 4-6% would be in order.

It was on this basis that the Government representatives made the final offer of 6.0%, effective 1 January, 1975.

1976 Negotiations

As referred to above, on this occasion the parties arrived at different figures using a similar method. The A.M.A. had arrived at a figure of 9.6%, whereas the Government had arrived at 5.76%.

After the initial meeting, the A.M.A. revised its estimate to 7.67%, and the following discussion is based on the arguments supporting the 7.67% figure.

The A.M.A. case was presented in terms of two components. The first component being an increase to compensate for overhead and the second an increase in average net income.

Before agreement could be made on either of the above it was necessary to establish a basis for both the average overhead costs and the average gross A.H.C.I.C. payments. The A.M.A. accepted the Commission's estimate of average gross A.H.C.I.C. payments, based on date of service payments, of $63 076 in 1976 as the base figure for gross income.

In arriving at its base for the Overhead component the A.M.A. identified five major components of overhead, and provided information regarding the proportion of total overhead represented by each component. This information was based on a physician's income survey conducted by Price Waterhouse and Company which covered the years 1972 to 1975.

The components identified and associated data were as follows:

(a) Medical Supplies: of several figures available concerning expected average price increases supplied by major medical supplies firms, the association selected the lowest, being 7.1%.

(b) Employed Physicians: although there was some dispute concerning the allowance of this cost under A.I.B. regulations, the A.M.A. submitted that it was allowable, and argued for an increase in this component equal to the increase in negotiated benefits. It assumed 9.0% in 1976 and 7.6% in 1977.

(c) Occupancy Expenses: the A.M.A. accepted an A.H.C.I.C. estimate of 13.2% in 1976 and 13.2% in 1977.

(d) Staff Expenses: the A.M.A. put forward data to show that average staff salaries in major clinics across Alberta had increased by 15.4% in 1976, and would increase by a further 11.7% in 1977.

(e) Other Expenses: both parties agreed to relate increases in other expenses to the CPI. It was suggested by the A.M.A. that fair estimates of these increases would be 8.0% in 1976 and 7.0% in 1977.

The actual overhead component was also ascertained by the A.M.A. from the results of the Price Waterhouse survey. This survey showed that in 1975 the average overhead was 42.2%, which when related to average gross A.H.C.I.C. payments for 1975 of $54 191 gave a figure of $22 869. The A.M.A. submitted that it would be appropriate to use the 1975 percentage as a base for projecting 1976 and 1977 overhead.

The second factor involved in the calculation of an appropriate increase was the increase in net income. The A.I.B. regulations allowed an increase of $2 400 in net average income, including that derived through increased prices in non-Medicare services. The negotiating committee of the A.M.A. provided documents which showed that these services represented as low as 6.6%. In order to reach a compromise with the stated Government case the A.M.A. was prepared to consider 10%.

The relative weights of each of the overhead factors, being Medical Supplies 0.097, Employed Physicians 0.089, Occupancy Expenses 0.226, Staff Expenses 0.398 and Other 0.19, were then applied in combination with the estimated percentage increase in each of the overhead factors and the base overhead cost to give $2 676 for overhead. Further, by adding $2.160 (.9 x 2400) a total of $4 836 was arrived at. This represented a 7.67% increase.

The A.H.C.I.C. representatives tabled data to support its original offer of 5.76%, to be effective January 1, 1976.

In respect of the components of overhead expenses a summary of the Government's position, and criticism made by the A.M.A. is below:

(a) Medical Supplies: - The A.H.C.I.C. tabled a 'Local Suppliers Price List of Medical Supplies' which indicated that for the products listed, there was a 3.8% increase from 1975 to July 1977 and assumed that a similar price increase would apply in 1976 and 1977.

- The A.M.A. rejoined that the increase so calculated was not weighted on the basis of actual usage. Further, it noted that the time span could refer to a half year only and, in addition, the use of such historical data could be distorted due to price freezes by manufacturers awaiting clarification of A.I.B. regulations. It stood by an increase of 8 to 10% as realistic estimate based on information from suppliers.

(b) Employed Physician Expense: The Government representatives put forward figures of 8% in 1976 and 6% in 1977 as against A.M.A. original estimates of 10.0% and 8% (subsequently revised to 9.0% and 7.6% respectively). The A.M.A. asked for justification.

(c) Occupancy Expenses: The A.M.A. brought forward further data which supported its previous assumption of 19.9% in 1976 and 20.0% in 1977 as overly conservative.

(d) Staff Expenses: The Commission tabled data showing an expected increase of 8% in 1976 and 6% in 1977. No documentation was supplied. The A.M.A. responded to the effect that the Commission had not allowed for any catch up. The survey of clinics had conclusively proved that catch-up increases were being granted. It submitted that to ignore the reality of these catch up increases would be frivolous.

(e) Other Expenses: The Commission had estimated CPI increase at 6% based on the 6.2% increase from August 1975 to August 1976. The A.M.A. responded by noting that the Conference Board of Canada had good reason for its forecasts of 8.0% in 1976 and 8.5% in 1977 and suggested that the considered opinion of the recognised agency should be used.

The Commission representatives preferred not to accept the average overhead percentages reported in the survey of physician income and expenses conducted by the A.M.A. through Price Waterhouse and Company. Rather than accept these overhead percentages reported in the survey the Commission used as a base an overhead percentage of 39.82%, as reported by Health and Welfare Canada for 1973. The A.M.A. was not prepared to accept the Commission position and challenged it on several grounds.

(i) The Anti-Inflation Board had questioned the Commission's approach.

(ii) The Health and Welfare figure was based on sample data, and Health and Welfare had reported difficulty in dealing with clinics, of which there were a relatively high number.

(iii) The Commission was being inconsistent by accepting the relative weights, and not the other data.

(iv) The average overhead percentage figures were based on a constant group of 674 physicians over 5 years.

On 28 October, the President of the A.M.A., Dr G.R. Zetter and the Alberta Minister for Hospitals and Medical Care, Gordon T. Miniely met and the Minister offered a 7% increase effective from January 1, 1977. The following day the Minister wrote confirming the offer, offering to re-open negotiations immediately the A.I.B. measures terminated or by 1 September, 1977 (whichever the earlier, and noting that the offer was to apply to fees for the 1977 calendar year. This offer was as discussed earlier accepted by the A.M.A.

SECTION 4 - FEATURES OF THE ALBERTA SYSTEM; DISCUSSION AND OBSERVATIONS

From the previous discussion it can be seen that the actual form of fee negotiations in Alberta has evolved to a State where two teams, one representing the A.M.A. and the other the Health Care Commission (and hence the Government), conduct face to face negotiations. These negotiations may extend over a protracted period and involve many meetings. As with many forms of negotiation, the length of the period of negotiation and the number of meetings is dependant on several factors. Not the least of these is the constant fact that neither team has a free hand, both are continually aware of the critical examination and inevitable criticism any agreement will attract.

The A.M.A. negotiators are fully aware that any agreement reached must be ratified by the members of the Association through the medium of a referendum. As discussed in the context of the 1975 negotiations above, this provision arose out of the substantial rank and file dissatisfaction with the agreement negotiated in 1973.

Similarly, the Government negotiators are perhaps even more restricted in their flexibility to maneouver. In general, the Commission team though the Minister has to obtain Cabinet approval to depart in any way from predetermined guidelines. Although all negotiations were conducted in terms of percentage increases, the actual monetary amounts involved at the various percentage increases would have been of interest to Cabinet, and would have been reflected in the negotiating position of the Government team.

A point was made in the preceeding chapter under 'Social and Political Consideration' of the legitimising process of negotiations, in that context the limitations placed on both teams are of significance to both parties. Indeed the obtaining of maximum benefit appears to require participation in protracted negotiations. Generally, a significant amount of publicity surrounds the fee negotiations, and it is this publicity which helps to legitimise the increase. For example, from the CMA Journal, December 1975, Vol. 113 page 1982

> 'Accepting Prime Minister Trudeau's wage and price guidelines, the Alberta Medical Association has agreed to an increase in medicare benefits of 9%, effective January 1 . . . Earlier, Alberta's physicians had proposed to bill patients directly at 35 to 40% above the current fee schedule . . . The increase, accepted last month by the AMA in bargaining with the Alberta Health Care Insurance Commission, also falls within the 11% which the Alberta government has set as a ceiling for increases in spending of all government agencies . . . Dr Robert Clark, AMA Executive Director . . . indicated that (meetings) indicated doctors would ratify the increase - even though the negotiating Committee had not gained either a greater increase or concessions. "We're law abiding citizens", he said, "we will live within the guidelines" . . . In September the AMA annual meeting rejected an offer from the province of an 8% increase and had been adamantly in favour of threatening withdrawal from medicare. At that time the associations bargaining team had said there was need for a formal bargaining system and formal recognition of the AMA as the bargaining agent as a top priority in the negotiations.'

The text of the above article, while more comprehensive than normal, is typical of the general

publicity surrounding the outcome of negotiations, and is indicative of the type of pre-agreement publicity. The article in fact legitimises the increase, it shows that both parties had had to compromise. The Government had obviously been forced to increase from its opening position and the AMA had had to accept a lower figure than it had origially sought. More importantly, it illustrated that the Government had held the line by not acceeding to outrageous demands and had achieved a result consistent with its overall objectives, which were applicable to all other "public" employees. Similarly, the AMA had not only saved face by achieving a reasonable increase but had also achieved the impression of grudging acceptance. In this way the AMA continued to foster the support of its rank and file.

The actual process of negotiation is now quite formal; and may become even more formalised as time passes, as the Association and the Government move towards routine schedule fee determination periods. As a corollary to the formalisation which had already taken place by 1978, the actual conduct of negotiations has become more sophisticated, both in technique and in the level of data support required.

With this formalisation of procedures, the need for hard data has become greater. In the Alberta system it is not possible to follow the procedure of Quebec where soft data, in various key areas, allowed room for compromise and 'horse trading'. It is perhaps something of a paradox that the movement to 'hard data' should in many ways make the actual process of negotiation more adversarial in nature.

The technique of negotiation now extends to the period prior to the actual commencement of negotiation. At interview, Dr Robert Clarke, AMA Executive Director,

explained that the AMA viewed public relations as being very important. While stressing that the AMA considered itself to have a general role in educating the public on a wide variety of issues, he did intimate that the AMA would in future be emphasising in its future public relations exercises the rationale and background to fee increases. At its annual meeting in Edmonton in 1978 the AMA unveiled a new public relations campaign, aimed at influencing government and popular thinking on health issues.[38]

While the AMA expressed many misgivings about its departure from its historical attitude to publicity which was a necessary consequence of its formal move into the public relations exercise, it was not nearly as reticent in moving to obtain hard data for its negotiations with the Government. Another consequence of the 1973 annual meeting, at which the decision to require a referendum to ratify negotiated fee increases was made, was the establishment of a program to obtain up-to-date income data, to parallel and provide more detailed analyses than that available through the Alberta Health Insurance Commission.

The data was to be more detailed in that it would provide a detailed break-up of the components of a doctor's practice. Before considering the history of this particular episode it is important to appreciate the implications of income/cost data.

When using hard data for fee negotiations there is a tendency to formalise the procedure for fee-setting. For instance the following formula could be adopted:

Fee Increase = (Price Index for Expenses x proportion expenses are of total income)

+ (Earning Index x proportion personal income is of total income)

Naturally, if one becomes even more sophisticated it is possible to split expenses into several components, each with its associated index, and personal income into several components, again each with its associated index.

In effect it can be seen in the above discussion of the negotiations for the 1 January, 1977 increase that the Alberta negotiations did in fact, at least under the AIB regulations adopt a form of this index. Indeed the expertise applied to calculation of the expense component is particularly important to the successful outcome of negotiations.

Until 1973 the AMA had had to rely on the material regularly published by the Department of National Health and Welfare to obtain cost of practice data. The AHCIC was in a similar position but better position, having only limited availability of data from the comprehensive data system then being developed through its own computer system. The unfortunate part concerning the NH & W data was, and still is, that it is obtained from an analysis of taxation returns; not that this in itself is prone to error, rather that by the very nature of this data base the data is three to four years old before it is fully collected, collated and published.

The disastrous, from the AMA viewpoint, negotiations of 1973 taught the physicians of Alberta a very salutory lesson; Inflation. A small fee increase negotiated during a period of relatively slowly moving inflation could be rapidly turned into a large effective net income decrease should the inflation rate suddenly increase. Thus, a two year agreement, or longer, can be quite disasterous under such circumstances.

A further complication of using old cost component data, in a time of low fee increases and high inflation is that the cost component is understated, perhaps quite significantly. Therefore, to obtain justice the AMA commissioned Price Waterhouse and Co, Chartered Accountants, to undertake a survey to elicite up-to-date data on fee income and expense.

Price Waterhouse elected to use a mail questionnaire, designed to conform with data supplied on taxation returns to Revenue Canada. This procedure eliminated, in Price Waterhouse's view, the problems of defining professional income, and by mailing the questionnaires at a time to coincide with the filing of tax returns facilitated a good response to the survey..

The first questionnaire sought information for the 1971 through 1974 taxation years; the purpose of the past data being two-fold: firstly, to obtain a comparison with the three/four year old NH & W figures; and secondly, to provide a solid base of well established physicians over a significant period, thus eliminating any error sources introduced by setting up or winding down practices.

This data was received with some suspicion by the Alberta Health Insurance Plan negotiations and in the 1974 negotiations was the subject of much critical evaluation by the Commission. In the final analysis the veracity of the survey has been generally accepted, with the A.M.A., through Price Waterhouse, updating the survey.

With regard to the general availability of statistics, the government regularly provided the A.M.A. with the information sought, when available, to assist it in the preparation of the A.M.A. case and to aid in the selective allocation of increases as between the various sections.

Indeed, the original impetus to the A.M.A. program of selectively allocating the increase to the various sections arose from the early statistics provided by the Plan in 1970 and 1971 which showed substantial income differentials between the various sections. This selective allocation is a feature of the Alberta process, and Alberta is the Province (of those studied) where adherence to such a policy has been the most consistent. The government has actively encouraged the A.M.A. in this activity, to the extent of imposing such a policy as one of the conditions of its offers (e.g. 1974 negotiations). However, while it has encouraged the A.M.A. it has left the actual implementation and extent to the A.M.A.

In 1972 the A.M.A. began its policy of selective allocation so as to achieve a readjustment of relative incomes and actually reduced the fees of four groups. However, the resultant internal discertion was such that, in the words of Dr Clark, the A.M.A. would 'never again actually reduce incomes'. Rather, the subsequent general policy has been to compensate each section for increase in overhead costs and then to selectively allocate portion of the remainder of the total increase to the various sections. Naturally, in following this policy the A.M.A. has had regard to the mathematical necessity of having the overhead cost increase for each section on the known overhead figure of the particular section, thus giving a different overhead dollar increase for each section.[39]

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30. This discussion is based on: The Report of the Royal Commission on Health Services, 1964, Vol. 1, Pages 383-422 and Malcolm G. Taylor, Health Insurance in Canada, pp35-38. Oxford 1956

31. Ibid, page 395

32. Ibid, page 395, quoted from Alberta Medical Plan, Bill 31, Amendment to the Treatment Services Act, 5th Session, 14th Legislature, Alberta, 11, Elizabeth II, Edmonton, Owen's Printer, 1963

33. Leclair, M., "The Canadian Health Care System" in S. Andropoulous, ed. National Health Insurance: Can We Learn From Canada? New York: John Wiley, 1975 pp11-93, see p16

34. Health and Welfare Canada, "Price Changes - Physicians' Services" mimeograph, August 1977

35. Ibid

36. From interview with both A.M.A. and A.H.I.C. officials, reference in Korcok, M., "Medical dollars and data . . ." p773

37. Interview A.M.A.

38. Imach, A. "Public Relations Campaign Unveiled at Alberta Medical Association Annual Meeting", Canadian Medical Association Journal, Vol 119, (21 October, 1978) p939

39. A discussion of the general method of allocation of increases may be found in Milan Korcok's article "Medical Dollars and Data: collection, recollection". Part III, Canadian Medical Association Journal, Vol 112, (5 April, 1975) p902

CHAPTER VI

BRITISH COLUMBIA

Introduction

The recognition of the need for some form of public participation in the design and administration of a medical care program in British Columbia may be traced back as far as 1919 when a Royal Commission was appointed to investigate health insurance. No action was taken on the report of this Commission, obstensibly on the basis of confusion as to whether the Provincial or Federal Government was the responsible authority.

A renewed campaign led to the appointment of a second Royal Commission which submitted its report in 1932. This report recommended a system of insurance; which was to be compulsory for all employed persons earning under $2 400 and voluntary for those earning in excess of this amount. Benefits were to be quite extensive and included "medical services, drugs and appliances, hospitalization and a dental benefit". Legislation was drafted and passed but owing to the controversy surrounding the bill and the strong opposition it evoked it was not put into effect.

However, during the interim period between passing the legislation and its abandonment (1 February 1937) a Health Insurance Commission was appointed and negotiations were undertaken with the British Columbia Medical Association (B.C.M.A.), presumably concerning physician representation and reimbursement.

Apart from the above early experience the B.C.M.A. has been involved in fee negotiations of one sort or another since 1941. Initially, the B.C.M.A. dealt with an organisation called Medical Services Associated (B.C.), (or the B.C.M.S.A.), which was set up under the Societies Act in April 1940 to offer group insurance to employees and their families. Under this arrangement the employers paid appropriate premiums and physicians received 75% of the agreed fee for service charge as full payment from the insurance company. After the war this 75% payment was increased to 90%.

Unfortunately, the Societies Act was not designed to regulate societies of this form, many of which appeared and some of which were of very dubious reputation and financial basis. After some prompting from the B.C.M.A. a Royal Commission was appointed to investigate these activities and eventually in 1947 the terms of the act were tightened. By the early 1950's some 12 non profit organisations and private insurance companies were offering group insurance.

After several attempts to extend voluntary health insurance to individuals had failed primarily as a result of high premiums and risk factors the Government introduced a system of compulsory insurance in 1965, supported by universal premiums.[40]

Fee Negotiations - An Outline

The schedule fee increases which have applied in British Columbia since 1962 are as listed below:[41]

	%
January 1964	3.7
January 1967	9.9
January 1969	6.8

May 1972	6.5
May 1973	6.7
April 1974	7.8
June 1974	1.0
January 1975	3.1
April 1975	12.0
April 1976	8.2
1977	5.6

Up until 1965 the B.C.M.A. had had annual meetings principally with the B.C.M.S.A. to set fees. It is of interest to note that the B.C.M.S.A. was governed by a board of eight directors; two of whom were representatives of the medical association, and three each representing the employers and employees respectively..

In 1965 the B.C. government established the B.C. Medical Plan which extended the availability of medical insurance to all, with subsidies to low income persons. This plan was administered through three organisations - the B.C.M.S.A., the B.C. Medical Plan, and C.U. and C. Health Services Society, which merely processed and paid claims on behalf of the B.C. Medical Plan. With the advent of this plan the first series of negotiations between the B.C.M.A. and the B.C. Government took place as to appropriate fee levels.

The principal result of these negotiations was the signing in June 1965 of an agreement, between the Government and the Profession, on the operation of medicare. This agreement is discussed further below, but one of its major features was it's acceptance of the then current schedule of fees as the basis for medicare payments. The agreement also further specified that fees were to be adjusted, on a two yearly basis, in accordance with the average of movements in Average Weekly Earnings and the Consumer Price Index up to a maximum of

6% annually. Any further increases were to be negotiated separately should the average index movement exceed the 6% cut-off. The agreement was to operate until December 31, 1970.

This arrangement ran until 1970 without any serious problem and was extended to bring in the Federal requirements pertaining to the introduction of the federally sponsored health insurance arrangement of 1968.

However, towards the end of the period of the agreement the relationship between the government and the profession began to "sour", as did the relationships within the organisation of the B.C.M.A. The "souring" can be traced to the publication of an editorial in the New Westminister "Courier", to coincide with a meeting of the B.C.M.A. in Harrison, in 1969, saying that doctors were earning too much money under the British Columbia medical scheme.[42] The editorial particularly upset the physicians at the meeting and a motion was passed denouncing the erosion of physician's privacy and freedom. Subsequent press pressure on the Government aimed at ascertaining its intensions in the face of this open defiance led Premier W.A.C. Bennett to announce that the incomes of physicians would be published under the Public Finance Information Act which required that the payment of more than $500 of Government money must be listed with the name of the recipient.

Towards the end of the agreement's life the Government, in 1969, offered to re-sign the original agreement for a further five years but the B.C.M.A. refused to accept the offer, on the grounds that the economic indicator formula was insufficient.

However, in 1970 the Government introduced a voluntary wage and price control program and during the negotiations of 1970 between the two parties, the Government applied pressure on the association to co-operate and set an example. Further, during those negotiations the Government was also adamant that the high earners should be brought down and the resultant saving re-distributed between the specialties.

The result of these negotiations was that, following a referendum of members of the B.C.M.A., which approved by a four to one margin, the original agreement was re-signed and a one year moratorium on overall schedule fee increases accepted. This moratorium in effect set the two year fee increase cycle, of the original agreement, back one year from 1 January 1971 (two years after the previous increase) to 1 January 1972.

During the negotiations leading to the agreement and the acceptance of the moratorium it was agreed that the B.C.M.A. would look to the schedule with a view to a re-allocation of income as between the various sections of the profession. The schedule was reviewed by the B.C.M.A. and in August 1971 it proposed some schedule changes which would result in an estimated $1.8 million per year reduction, with the fee reductions being primarily in the field of ophthalmology. The majority of the resultant savings being re-allocated to general practice and other low earning sections of the profession.

Towards the end of 1971 the B.C. Government of Premier W.A.C. Bennett offered an annual 10% increase in total gross payments for the duration of the government's period in office. This offer was intended to include population increase, increased utilisation, additional doctors, new fees, new diagnostic techniques, new

treatment procedures and any increase in fees.[43] The Board of the BCMA rejected the system as providing "a most uncertain amount, if any" for any increase in fees.[44]. Subsequently, the membership of the BCMA voted overwhelmingly to reject the Government's offer by a margin of 25 to 1.[45]

The BCMA proceeded to publish its new list of fees for 1 January 1972, which included the above reductions, however, it also included a general percentage increase which resulted in an overall weighted increase of approximately 8.2% in fees. The BCMA advised its members to bill according to the new schedule. The Government on the other hand refused to accept the new schedule and continued to pay on the basis of the 1969 schedule. By this time the Government was heading towards an election, and both the Government and the BCMA were anxious to reach an agreement. The Government for the normal political reasons, and the BCMA to ensure that the progress made was not obliterated by a change of Government.

Following a series of offers and counter offers the negotiators settled on a 6.5% increase in the average physician's earnings. This, however, was dependent upon the association further revising the fee schedule to even out even further the disparities between high and low income sections.[46] Consequently, a special six man subcommittee of the BCMA board was set up to again review the schedule. The revision resulted in the reduction of fee levels for some 300 items, affecting some 800 specialists directly by a reduction in income. Overall, the revision resulted in an estimated $3 000 000 reduction in the provinces 1972 medicare bill over the original estimate based on the 1 January, 1972 BCMA fee schedule, and was estimated to reduce the overall average income increase to 6.5% as agreed. However, the average

payments for the high earning sections were substantially reduced; by an estimated $5 000 p.a. per radiologist, $6 740 p.a. per urologist, $3 900 p.a. per neurosurgeon. and so on.[47]

After some further delay the B.C. Government accepted the revised schedule, as did the BCMA board and membership; the latter by only a 2 to 1 majority.[48] Indeed as discussed below this agreement set the scene for some bitter in-fighting within the profession.

In 1973 the negotiations concluded with a 6.7% increase in the fee schedule, effective from 1 April 1973 and a new agreement. These negotiations were the first undertaken with the new N.D.P. Government of Premier Barrett and the negotiations were concluded "quickly, cleanly and in a seemingly friendly spirit".[49] The estimated $10m increase in the fee schedule was negotiated in three parts; $5 million to cover increases in overhead costs, $500 000 for the relief of medical disparities, and $4.5 million for increases in income to cover inflationary advances.[50]

The new agreement incorporated several innovations over the previous document:[51]

(1) The commission agreed on the level of payments based on fees established as of April 1, 1973, plus any further revisions which were mutually agreeable;

(2) Agreement on the use of a standard account card and the right to opt out;

(3) The association had the sole right and responsibility of altering individual items of the schedule within the total medical claims cost where that cost was agreed upon by both parties;

(4) The association had the right and responsibility to examine and investigate abnormal payments to a physician and to refer to the commission the action that the association deemed proper and to expect prompt consideration by the commission;

(5) Agreement by the commission to provide the association with necessary statistical data to further their negotiations for revisions;

(6) The commission agreed to make an annual payment of $1 800 000 as long as the agreement was in effect for support of continuing educational programs for eligible physicians participating and receiving payment from the provincial plan;

(7) The Commission and the profession also agreed to the concept of disability insurance plans for eligible physicians whose services are paid for by the Medical Services Commission under the plan.

Point 3 above may be viewed as being particularly important as it conferred on the BCMA the sole responsibility for the allocation of funds set aside for the elimination of disparities between the various sections. It was noted above that as a result of government pressure the BCMA had, in the allocation of the 1972 increase, adopted a role Peter to pay Paul approach in the pursuit of rectifying income disparities, and indeed actually reduced the income of various groups, with the result of an intensification of internal faction fighting within the BCMA itself.

Following the 1972 troubles, the BCMA in its negotiations for the remainder of the pre AIB period followed a deliberate policy of first negotiating an across the board increase to be applied equally to all sections, and then an amount for the elimination of disparities. Thus as part of the 1973, 1974 and 1975 negotiations specific sums of $0.5m (1973), $1.5m (1974) and $1m (1975) were negotiated for the elimination of disparities.

The actual negotiations in those years followed the provisions of the written agreement and were conducted in a generally amiable fashion, as would have been expected given the attitude of the NDP government of the time, which on taking office had offered a 10% per annum increase in total payments for the duration of its period in office.

However, in 1976 the N.D.P. lost power and the Bennett Government was returned. An outside firm of auditors, Clarkson, Gordon, was commissioned to examine the Province's financial position, and it concluded that the Province was some $540 million in the red. Given this and the introduction of the A.I.B. rules the 1976 negotiations resulted in a 5.16% increase, where the B.C.M.A. had entered the negotiations with a starting position of 39%.

Similarly, in the 1977-78 negotiations the B.C. Government asked the doctors to set an example, particularly in respect of their net incomes and offered only 2% to cover increases in overheads, with no increase in the net income component. After the negotiations had dragged on for nearly three months, culminating in a meeting between the Premier and the President of the B.C.M.A., the Government increased its offer to 5.112%

(retroactive to April); this offer was essentially composed of a 2% increase to cover overheads and a $1 400 net income increase. This offer when put to a referendum of the membership was rejected. After further meetings, including one with the Premier, the Government increased its offer to 5.6%, ostensively in view of the increases in overheads. The membership subsequently accepted this offer at a referendum.[52]

Internal Dissention Within The B.C.M.A.

A feature of the B.C. negotiation process has been the existence of the so called "reform" group within the B.C.M.A. since the mid 1960's. This group has been led, or at least characterised by Dr Euan Horniman. The existence of this group has led over the years to some extremely bitter faction fighting within the B.C.M.A., which has been more intense than anywhere else in Canada. The internal manoeuvering for position and power has had significant effects on the conduct of fee negotiations.

The basic position taken by the "reform" group was that the "establishment", the other faction, was itself a small minority of the BCMA and had been too free with the rights of the 3000 plus physicians of the province. It also asserted that the establishment had been functioning in secret to the detriment of the Association as a whole.[53]

The movement began in 1966, when during the 1966 annual meeting of the B.C.M.A., in Trail, Dr Horniman, who had been dissatisfied with the size of the fee increase negotiated, started his campaign to return physician's "financial destiny to their own hands". At that meeting he advocated the introduction of a referendum to ratify any agreements between the provincial authorities and the association which affected remuneration or terms of service.[54]

An interesting and relevant feature of the B.C.M.A. organisation which has helped the "reform group" is that the Board is not bound by resolutions of the general assembly. In the other Provinces and the C.M.A. itself the general procedure is for the local districts and specialty groups to elect members to attend annual meetings (i.e. General Council or Assembly) as delegates, and although any member has the right to speak only delegates have the right to vote. The General Council or Assembly is the ultimate authority for association policy and the board is expected to follow, in general terms, policy determined by the General Assembly. In B.C. the system is different in two respects; firstly, every member can attend and vote at the annual general meeting; and, secondly, the Board of Directors is the final authority.[55]

This difference in the organisation is significant in that it permits the evolution of the equivalent of a multi-party system at general assembly and the 'stacking' of meetings. Under the general Canadian system the opportunity to mobilise opinion is more restricted to the district or sectional level and is thus more diffuse.

Dr Horniman was not successful in getting his referendum motion passed until the annual meeting in Victoria in October, 1971. This meeting was also a particularly stormy one, not in respect of the referendum motion, but in respect of two other motions which the reform group attempted to force - that annual meetings be held in Vancouver only, and that the Board become subordinate to the general assembly (without a delegate system). These two motions were both well defeated and substantial personal abuse directed at Dr Horniman.[56]

However, by the time of the next annual meeting in Penticton, in 1972, circumstances had changed significantly and the meeting was in effect partially "stacked" with a significant proportion of extremely disgruntled specialists.[57] It will be recalled that in 1971 the B.C.M.A. reduced the fee levels of approximately 300 items, resulting in a $3m reduction in the amount which would have gone to the high earning specialist sections. Thus, while the profession received a 6.5% overall average income increase (at the same work volume) the higher earning specialties suffered income reductions of some $5 000 to $7 000 p.a.

In the months leading up to the 1972 general assembly, the reform group used the forum of the "B.C.M.A. News" to generally castigate the establishment for its handling of fees negotiations over the previous few years; in particular the acceptance of the 1970 fee moratorium, for even entertaining the idea of reducing the incomes of high earners, and most particularly the haste and confusion concerning the 1972 fee schedule increase. The "B.C.M.A. News", in effect a newspaper controlled by members of the reform group (as against the more 'respectable' "B.C.M.A. Journal" controlled by the establishment), vigorously attacked the establishment and the running of the B.C.M.A. in general. The B.C.M.A. executive at one stage suspended the 'news' for a period of two months.

Leading up to the general assembly the reform group used the 'news' to promote its own candidates for various positions. In a break with tradition the B.C.M.A. nominating committee released the names and qualifications of the men intended for nomination at the general assembly. The 'news' published the curriculum vitae for the establishment nominees and ran the equivalent of political advertising, (e.g. sharp platform points) for its own nominees.

Members of the association descended in droves (a record 700 members) upon Penticton, by charter plane, private plane and other special transport. At the Assembly the reform group, aided by the disgruntled specialists, succeeded in having its candidates elected as President-Elect and Chairman of the Assembly. Dr Horniman only just failed in his bid for the honorary secretary-treasurer position. Further, they were successful in framing a motion setting up a formal negotiating committee, to be of three persons elected by the general assembly. The Committee could not include presidents or past presidents. In the event, one reformer was elected, with Dr Horniman as an alternate. Moves were made at the meeting to censure the previous executive and the president in particular; however, these were soundly beaten. By the end of meeting the reform movement could claim 13 reformers or sympathisers as members of the 38 man board of directors.[58]

In 1975 the faction fighting within the B.C.M.A. again surfaced with the firing by the B.C.M.A. board of Dr Horniman from his position as chairman of the negotiating committee dealing with the Workers Compensation Board. Dr Horniman had in fact been practising what he preached, he had been taking a hard line during negotiations and had been keeping association members fully informed through a newsheet, "the Negotiation News". The WCB negotiations had traditionally been easily conducted with good settlements.
Dr Horniman's stand apparently led to an impasse which was resolved at a closed meeting between executives of the BCMA and the WCB at the 1975 Kamloops general meeting. Despite a vote of confidence in Dr Horniman at that meeting, the board subsequently dismissed Dr Horniman. The reason given by the Board for the dismissal was that Dr Horniman had failed to follow a direction in respect of material to be included in the "negotiation news".

At a subsequent special general assembly meeting in Vancouver in October, the reform group again attempted to bring the board of directors under the control of the general assembly. The vote was roughly 50-50, but a majority were against the motion - which would have required a two thirds majority to pass. The effect and importance of the in fighting within the BCMA can be gauged from the record attendance of over one thousand doctors at the meeting.[59]

Mode of Negotiations

The formal negotiations between the BCMA and the BCMSC had evolved by 1976 to the stage where two teams of three meet at the negotiating table.

The BCMSC team is a permanent trio which negotiates on a regular basis with all associations representing workers in the health (clinical) arena. In its negotiation positions the team naturally follows the general policy set by the government, and on some occasions has more room to manoeuver than on others. In this regard the teams situation is no different to that of the Alberta experience and it is not necessary (or possible) to further explore this process.

The actual procedures followed by the BCMA in the development and presentation of its position during fee negotiations are to a large extent a consequence of the experiences discussed in the previous sections concerning sectional disparities and faction fighting. As also discussed above, the three members of the BCMA team are elected by the membership at the association's annual general meeting.

In effect, the negotiators are limited by the policy directions of the Board of Directors, which has the ultimate authority as to general policy. The derivation of this general policy is, however, a complicated process clouded by internal political considerations, as well as financial projections and calculations. Apart from the actual board of Directors there are many bodies that become involved in the determination of policy; the Economics Committee and its Secretariat, the intersectional council, and the individual sectional committees.

In broad terms the fee negotiations of 1973, 74, 75 and 76 could be regarded as having been approached in three segments; the overall increase, money for correction of interactional disparities, and other matters of concern which would be described as "fringe benefits". The general process of arriving at a negotiation stance follows a sequence of the type described below.

The secretariat of the Economics Committee determines from the relevant indices and "hard" statistical data the percentage increase to be sought. The Board of Directors then determines the general policy to be followed and the actual amount to be sought. In this process the Board also is advised as to an appropriate amount to be sought for disparity correction and possible objectives in the fringe benefit arena. Having determined a general policy the Economics Committee takes the policy and determines guidelines on how to handle and distribute the proposed disparity factor and the overall increase taking account of differing cost ratios and utilisation patterns. In this it is advised by the intersectional council. At the intersectional council representatives of the twenty or so sections meet and argue their case for a share of the disparity factor, and

indeed how much the overall factor should be. The results of this conference then feed up to the Board, which either modifies its approach, overrules, or seeks further counsel. In all a substantial amount of 'toing' and 'froing' can occur before a stance is arrived at.

The above process in reality has two basic components, the political and the 'hard' facts. The general political background to the negotiations has been dealt with; the overall result being that within the above process care is taken to ensure that the errors of 1972 are not repeated. The BCMA would be quite unlikely to ever reduce the incomes of any section ever again, although it is generally accepted within the profession that corrections are necessary.

The Statistical Data Base

When considering the 1973 agreement above some seven innovations were noted. Of these innovations, the fifth is of considerable interest in that it guarantees the BCMA access to all necessary statistical data to further negotiations for fee revisions.

Article 2(f) of the 1974 version of the agreement between the BCMA and the BCMSC actually states

> "the Commission agrees that all statistical data on physicians' claims, costs and services under the plan will be provided to the association".[60]

Therefore, in its dealings with the BCMSC the BCMA has complete access to all Commission statistical tabulations. The tabulations produced by the Commission are quite complete and very detailed (perhaps the most detailed of all five provinces considered), having a

multitude of analyses regarding payment to the different sections, by income range, location and various other key factors. However, as was noted in looking at the Alberta negotiations, and as in other Provinces, there is a significant failing in the Commission data: it deals with gross payments and not net income figures. As discussed previously National Health and Welfare, Canada, produce expenses data based on Taxation figures but unfortunately this is at least three years old. In times of moderate or high inflation projections of expenses based on this data and normal indicators such as the Consumer Price Index can be very much in error, and quite open to dispute.

Following the Alberta example, the BCMA engaged Touche, Ross and Company to prepare a report covering the incomes and expenses of the profession in B.C. for the years 1972, 1973 and 1974. In 1976 the B.C.M.A. had Touche, Ross extend the study to include 1975 and determine the extent in changes in incomes and expenditure in that year.

An important feature of the study is that Touche, Ross and Co, was specifically asked to neither analyse the information nor any conclusion from it.

Without the facility afforded in Alberta of examining actual files it was not possible to examine the use of the Touche, Ross information. However, at interview the BCMSC officials did not appear to be very impressed with the data.

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40. This discussion is based on: The Report of the Royal Commission on Health Services, 1964, Vol. 1, Pages 383-422 and Malcolm G. Taylor, Health Insurance in Canada, pp35-38. Oxford 1956

41. Health and Welfare Canada, "Price Changes - Physician's Services" mimeograph, August, 1977

42. Chazottes, M., "Dr Peter Banks: Profile of a future President accustomed to the hot seat", CMAJ, Vol 107, (23 September, 1972) pp577-579. This article gives some details of the incidents leading to the 'souring' of relations within the BCMA, and between the Government and the BCMA

43. Partly confirmed in Korcok, M., "Next month's annual meeting of BCMA in Vancouver likely to be turbulent" CMAJ, Vol 108, (April 7, 1973), pp915-922, see p920

44. News Article "Massive B.C. 'no' vote answers government offer", CMAJ, Vol 106, (January 22, 1972) see p195

45. Korcok, M.; "Next month's . . ." see p920

46. IBID, p920

47. IBID, p920. The article broadly covers and confirms the points raised here

48. IBID, p921

49. IBID, p915

50. CMAJ news article, CMAJ, Vol 108, (April 7, 1973), p922

51. As reported by Le Clair, M. in "The Canadian Health Care System" in S. Andreopoulous, ed. National Health Insurance: Can We Learn From Canada? New York: John Wiley, 1975. pp11-93, see pp60-61

52. Padmore, T.C., "BCMA meeting gloomy over low government offer", CMAJ, Vol 117, (9 July, 1977) pp86-88

53. Kocok, M., "Next month's . . ." see p916

54. IBID

55. IBID, see p920

56. IBID, see p916

57. IBID, see p921

58. The above discussion is drawn in part from Korcok, M., "Next month's . . ."

59. The above discussion is drawn in part from a news article in the CMAJ, Vol 112, (7 June, 1975), p1339

60. Agreement between B.C.M.A. and the M.S.C. dated April, 1974 - photocopy of original document

CHAPTER VII

SASKATCHEWAN

Background

The point was made in the Research Design (Chapter II) that Saskatchewan's experience cannot be regarded as typical of the other Canadian Provinces. Saskatchewan was the first province to introduce, in July 1962, a form of state sponsored medical insurance. This of course led to the infamous "Doctor's Strike" about which much has been written and will probably continue to be written.

While the "doctor's strike" was a landmark in the development of medical insurance in Canada, its relevance to this study is direct but limited. Therefore, it is not proposed to examine the "doctor's strike" in any detail but rather to draw on those salient features affecting the course of fee negotiation development. It is assumed that the reader is familiar with the history of the strike.

It is important to appreciate that the medical profession did not oppose medical insurance; indeed, it saw the insurance principle as the best guarantee of adequate medical care for the average family. The profession, however, saw certain factors which it considered to be highly dangerous in a government-controlled and administered medical insurance system. Briefly, these were generally:[61]

(a) an increase in costs, in conjunction with a lowering of standards;

(b) an unnecessary imposition on a majority of citizens to benefit a minority, which benefit could be achieved in better ways;

(c) overuse of the system, and extra overcrowding of hospitals, by patients with trivial complaints;

(d) the potential for medical care to be relegated to a political issue, having to compete other government services for funds;

(e) a clause (41g) in the proposed act which suggested that the Medical Care Insurance Commission (MCIC) would have authority to exert control over the professional judgement of physicians; and

(f) the absence of a provision for physicians to deal directly with patients on fees.

The latter two points were those particularly remembered at interview by Dr Baergen, President of the S.M.A. as being crucial to the S.M.A. opposition, and it was primarily in respect of these issues that negotiations took place during the lead up to the Saskatoon Agreement.

The Saskatoon agreement was naturally a compromise. The legislation and the MCIC remained; however, both were subjected to change. Extensive amendments, including the deletion of S41(g) were made to the Act to remove the perceived threat to professional freedom. Three representatives of the Medical Profession were added as members of the MCIC. Four methods of remuneration were introduced, being the facility to bill privately, and three variations on billing the Commission (in two cases via the patients). In respect of billing both sides really achieved their objective, but at a cost;

the doctors maintained a fiction of being able to receive payment from sources other than the Government; the Government retained the monopolistic role of sole source of medical funds except in the one instance where the doctor and the patient had their private arrangement. This latter arrangement in effect eventually becoming all but a dead letter, except in circumstances where the patient wished to keep records of the medical service being processed through the MCIC system; for who, already paying for compulsory medical insurance, would want to pay twice.[62]

Of importance to this particular study was a feature contained in the original draft Saskatoon Agreement, which recommended a method of mediation and arbitration in determining the remuneration of doctors. However, as Dr Baergen put it there was a total 'lack of faith' on the SMA part regarding Government motives, and consequently the SMA wanted nothing in the Act to do with fee negotiations. However Section 37 of the Act was retained which specified that if there was no agreement between the two bodies on remuneration, then regulations could be promulgated concerning mediation.

Fee Negotiations - An Outline

In the period since the introduction of Medicare in Saskatchewan in 1962, the fee increases as negotiated have been[63]

	%	
November 1967	15.3	
August 1968	17.8	
August 1970	8.0	
August 1972	6.8	
September 1974	10.0	(implemented on 1 Nov)

January 1975	5.2 (implemented as 7.8% from 1 May 1975)
January 1976	8.9 (implemented as 7.4% on March 1 - discounted for the actual 7.8% increase in fees the previous year rather than the notional 5.2%.)
January 1977	6.7
January 1978	6.49

In addition to the above, utilisation fees were introduced April 1968 and abolished in August 1971.

The schedule as adopted by the MCIC in 1962 for payment of benefits purposes was that as set by the College of Physicians and Surgeons. For the 10 years until 1972 the schedule used for benefits purposes remained that of the College; however, in 1972 the Commission published its own payment schedule. The original 1962 schedule had recently been updated at the time of the introduction of medicare, and under the medicare arrangements at that time the Commission paid benefits at 85% of the schedule fee. This payment level sufficed until November 1967 when benefits were increased to 100% for most visit services thus giving an effective overall 15.3% increase in actual fees.

In August 1968 the SMA fee schedule was increased by nearly 30%; however, the government restricted the benefit payment increase to 17.8% by reverting back to an 85% benefit level for all services and by introducing assessment rules, through promulgation of regulations under the Saskatchewan Medical Care Insurance Act, which restricted the payment of benefits in certain circumstances. A further increase of 8.0% was negotiated in August 1970.

In 1972, following a long period of negotiations, complicated by a change in the Government, an increase of the order of 6.8% in the MCIC payment schedule was negotiated, with the new schedule to apply for two years from 1 August 1972 to 1 August 1974. The result was considered "satisfactory" by the SMA and was within a quarter percentage point of the increase originally sought by the SMA.[64]

The bulk of the increase was allocated to family physicians, who it was estimated would receive about $2.0m out of the total $2.4m estimated cost of the change. Some sections did not receive any increase, and surgical fees were in some instances lowered. Dr Baergen recalled that the objective of the SMA was to try to get procedural fees into line with those across Canada. A further reason for the emphasis on family physician increases was SMA concern over the high turnover of general practitioners in the province - nearly 25% of long established general practitioners. It was felt that the low fees in this area compared to the rest of Canada was at least partially responsible; the increases in the G.P. area were estimated to bring the Saskatchewan schedule (G.P. items) to within 5% of the national average.[65]

A further consequence of these negotiations was the advent of the Commission's own schedule, with payments to be made at 100% of the Commission's schedule. The difference in the two schedules at that stage being approximately 20% (i.e. the SMA's schedule 20% higher than the MCIC's).

Also during the negotiations it was agreed that periodic meetings should take place between the SMA and the MCIC as a means of keeping payments for medical care under constant review and as a means of resolving unforeseen imbalances, as a result of utilisation changes, in the payments made to the various sections; but keeping

within the overall $2.35m calculated on 1972 total utilisation. This was the last two year agreement, with the subsequent agreements being for one year periods.

With the 1972 agreement due to run until 1 August 1974, negotiations began in December 1973 to reach a new settlement to operate from 1 August.[66] Initially, the SMA sought a 1 year 12.5% increase, and the Government offered 6.8%. By the end of 1974 negotiations had broken down, with the SMA seeking a 29% increase and the Government offering 12.5% plus a lump sum $750 000 to reduce physicians' income disparities. During the period leading up to the breakdown at least 10 formal offers and counter-offers were made. Prior to the breakdown the Government granted a 10% interim increase on the 1972 schedule to operate from 1 September 1974.

In addition to the fee increase the SMA was also seeking Government agreement to several other matters; namely recognition of the SMA as the sole bargaining agent for its members, changes to the payment schedule and assessing rules by agreement only, formal grievance procedures for breaches of the agreement, a termination date for the agreement and procedures for amending it, and a provision for the SMA to opt out of the agreement if new legislation was introduced to alter the payment schedule. In return the SMA was offering a guarantee that its members would not withdraw services during the term of the agreement.

The Government while generally prepared to accept these requests (other than the fee increase) was seeking variation and if possible elimination of the mode 3 billing arrangement. Mode 3 is the method whereby the doctor submits his bill to the patient directly, noting on the account certain details; the patient then has the right to submit the itemised bill to the Commission to

receive the benefit. This particular billing mode was perceived by the Government as a potential threat. Given the low volume (5%) of such billing it was seen as having the potential in a confrontation situation to cause the MCIC severe embarassment consequent on the MCIC's inability to process large numbers of these claims should the SMA adopt mode 3 as part of a confrontation campaign. The S.M.A., of course, from the other viewpoint saw mode 3 as valuable weapon, both as a threat and in actual use, in any confrontation. The S.M.A. viewpoint was simply that mode 3 was "non-negotiable" in the words of the then SMA President Dr M.A. Gormley and necessary "to maintain its (SMA) independence and freedom of choice of remuneration".

At the SMA annual general meeting in late October 1974, impatience and frustration resulting from the lack of progress in the negotiations led to the passing of a motion that the SMA negotiating team should withdraw if an impasse was reached, and for the economics committee to produce "an equitable fee schedule" and for the board to take "whatever other action is deemed necessary". Finally in December the impasse was reached and negotiations broke down.

In an attempt to resolve the situation a mediator acceptable to both sides was appointed. The mediator, Mr S. McDowell (a Saskatchewan Teacher's Federation Executive) eventually arrived at a solution acceptable to both parties, roughly in the middle of the two positions. However, the reaching of the resolution was by no means straight forward, and involved the negotiation of two packages before final acceptance.

The first package negotiated near the new year allowed for

(a) a 16 1/2% increase in fees over the 1972 shcedule for 1975 and a further 5 1/2% for 1976. The first increase to be based on 1973 utilisation and the second 1974 utilisation;

(b) Acceptance of the SMA as the negotiating agent for the profession;

(c) Recognition of the SMA peer review committee;

(d) Guidelines for the renegotiation of the 2 year agreement;

(e) A limitation on mode 3, under which physicians would only be allowed to bill at or below the schedule fee.

This package was acceptable to the Government and the SMA negotiating Committee. It was recommended by the Board of Directors and approved at referendum by a 3 to 2 majority. However, at a special meeting of the SMA on January 19 a secret ballot of delegates rejected the proposal by 270 to 31. In Saskatchewan as in the other Provinces, other than B.C., the General Meeting (comprised of voting delegates) is supreme (- see B.C. discussion).

The meeting generally accepted the 16 1/2% increase for 1975 but was wary of the 5 1/2% for 1976 in view of the rampant inflation of the time. Point (e) was violently opposed. Two other decisions were taken directing the board to seek a 1 year, calendar year 1975, agreement and to proceed immediately to draw up a new SMA schedule to arrive at a twenty five percent across the board increase.

In the following two weeks Mr McDowell negotiated a further agreement between the two sides. This agreement was accepted at a subsequent special meeting of the SMA on February 2. The final agreement was for the 1975 calendar year only, and the benefit increase was reduced from 16.5% to 15.75% in return for the SMA retaining billing mode 3 as then operational. As the package was a straight payment increase the other matters (referred to above) were lost.

During the two week period between the two special meetings, the SMA issued a new fee schedule which was designed to achieve a 25% increase for all segments of the profession. In view of the now substantial difference between the SMA schedule and the MCIC schedule several physicians announced that they would opt out of the plan and bill at the SMA rate using mode 3, thus getting the MCIC benefit and a substantial patient contribution.

As in other Western Provinces the increase as finally passed on was not across the board. The Economics Committee of the SMA in a session at which all sections were represented worked out an agreed equitable distribution, ranging from 7.9% for pathology to 25.55% for dermatology. As the increase was to apply from 1 January, with a 10% increase being implemented 1 November 1974 (retroactive to 1 September 1974) and the remainder not able to be implemented till 1 May adjustments were made to give an overall 15.75% increase for the '75 calendar year with the result that on 1 May the schedule of benefits actually increased by 7.8% (instead of the 5.2% necessary to increase the 1 November 1974 schedule to 15.7% higher than the 1972 schedule).

Although the negotiations for the 1976 fee increases commenced in September 1975 it was not until February 1976 that an increase was agreed to. These negotiations were interrupted by the introduction of wage and price control (A.I.B.) in October 1975. After much negotiation regarding the levels of income and cost components, the fee increases were eventually arrived at in accordance with the A.I.B. guidelines. The benefit increase negotiated was 8.4%, and in order to introduce it from March 1, the 1975 schedule was increased by 7.4% to take account of the inflated 75 schedule (see previous paragraph). In allocating the increase the SMA economics committee followed its established practice and allocated greater amounts to those sections in greater need in order to even out disparities, in this case anaesthetics, radiology and obstetricians received larger incomes. The average net increase averaging out at $2 400.

With the introduction of the AIB the negotiations for the 1977 fees proceeded on schedule and followed established procedures under the AIB. An increase of 6.7% on 1976 payments was negotiated with the schedule being adjusted accordingly from 1 January, 1977. During the negotiations it was agreed that 90% of physician income comes from medicare and hence $2 160 rather than $2 400 was allowed as income increase. Once again discriminatory application of the increase was applied to even out disparities.

In 1977 an increase of 6.49% was negotiated in the MCIC schedule to be implemented on 1 January, 1978 on the same basis as in the previous year and the same policies were applied in allocating the increase.

Saskatchewan - Discussion

As of 1977 the fee negotiation process in Saskatchewan had evolved to the stage of being fairly well "cut and dried". Negotiations for the following year's fee hike commence in August or September and are completed in time to implement the increase on 1 January. The negotiations are conducted by two teams, the use of an arbitrator in 1974 being an abberation. The SMA negotiating team is comprised of the Executive Director and his assistant and three or four representatives (1 G.P. and 2 or 3 Specialists) of the SMA Economics Committee. On the other side the Government is equally well represented by a Provincial Negotiator (from the Health Department) and the Executive, Medical and Economics Directors of the MCIC.

Negotiations are directed towards agreement as to a total overall sum of money. This sum is then converted to a percentage based on the utilisation pattern of the previous year (e.g. the negotiations for 1 January, 1977 increase, conducted in 1976 used 1975 utilisation data). Once the overall fee increase has been agreed to the SMA decides, through its Economics Committee on how the increase is to be allocated amongst the sections, in overall terms. The detailed adjustment of items is carried out by the MCIC. The process of allocation takes at most three weeks from the time of agreement as to the total increase. The MCIC also appears to have conquered the tricky problem of printing and distributing the new fee schedule by making use of advanced computer type setting arrangements, with the schedule book itself being printed within 4 to 6 weeks from the time the detailed adjustments to the individual items are completed.

Unlike the Medical Associations in its two Western neighbours, Alberta and B.C., the SMA has not resorted to the use of actuaries to determine the income/cost structure of the profession and its various sections. Indeed it was partially a result of this lack of data that the negotiations leading to the 1975 schedule were so protracted and difficult.

Given the lack of actuarial surveys the process used in Saskatchewan to arrive at an agreed basis to adjust the cost component in fees in the circumstances of the AIB controls varied significantly from the other two Western Provinces.

Starting in 1975 the Economics Section of the MCIC set about building up from scratch estimates of the cost of running various types of practice Using utilisation data and government doctors, the quantities and types of back up personnel, office space, utilities and general supplies were calculated and then priced using known data or by writing to the appropriate supply companies for prices. On the assumption that there was no reason for the Government to support or subsidise bad management a theoretical cost distribution was arrived at which gave an average overhead cost estimate of $17 500 for the 1975 calendar year. The SMA claimed in negotiations that an appropriate figure was $24 000, this being based on the NH & W published data updated using economic indicators. After some negotiation a figure of $21 000 was agreed upon. For subsequent years this figure was updated by the application of the CPI movement.

At interview there was a surprising agreement between the MCIC and the SMA as to the effect of the AIB controls. Dr Baergen expressed his opinion that while the AIB was not necessarily the best way of controlling inflation, the situation in 1976 was that something had to

be done. The SMA had received substantial fee rises in the previous two years and expectations were generally high. Similar views were held by the MCIC.

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61. Mac Taggert, K., "The First Decade (V)" CMAJ, Vol 107, (August 19, 1972), pp337-346

62. The information in this paragraph obtained from Mac Taggert, K. "The First Decade (VII)", CMAJ, Vol 107, (September 23, 1972), pp564-572, see p569

63. Health and Welfare, Canada "Price Changes - Physicians' Services", August 1977, mimeograph

64. Economics news article in CMAJ, Vol 107, (July 22, 1972), p165

65. Ibid, the article quotes Dr Baergen and confirms my notes of interview with Dr Baergen

66. The subsequent discussion of these negotiations is based on:

    (a) my notes of interview with Dr Baergen and Mr Thompson of the MCIC

    (b) Geekie D.A. "Saskatchewan Confrontation" CMAJ, Vol 112, (January 25, 1975) Special News Report

    (c) Geekie D.A. "Saskatchewan MD's, government reach 1-year peace on the prairie worth $6 1/2 million". CMAJ, Vol 112, (February 22, 1975), pp499-500

CHAPTER VIII

QUEBEC

Introduction

When one observes the workings of Canadian Society, it is often apparent that Quebec is the different province, be it its language, its legal system, its people or its political system. This general observation also holds true in respect of its health system, and with regard to the study being undertaken here the differences in the health system are particularly relevant.

The most obvious difference is in the organisation of the medical profession. In the other provinces the affairs of the medical profession are conducted by two bodies, the local provincial division of the CMA which is generally concerned with those matters normally associated in other professions or trades with those of a union; and the provincial College of Physicians and Surgeons which is responsible for licencing, discipline and standards. In Quebec both of these bodies exist, but the QMA (the provincial division of the CMA) is restricted to only those 'union' activities not involving medical economic matters. Activities such as preparing and negotiating medical fee schedules are left to two professional syndicates. The two syndicates are the Federation of General Practitioners of Quebec, generally known as the FMOQ from its french initials, and the Federation of Medical Specialists of Quebec (the FMSQ).[67]

The origins of this separation lie in the Professional Syndicates Act which was introduced in 1925 to permit professionals to syndicate themselves in a

manner similar to unions but without some of the stringent regulations of the Labour Code. The two current syndicates were established in the 1960's for the specific purpose of fee specification and negotiation of medical fees, and to safeguard the social and moral interests of the profession.[68]

The FMSQ[69]

The first medical syndicates were established in Quebec in the 1940's by radiologists, who were essentially hospital based and remunerated on a negotiated fee for service system. At that time each individual radiologist negotiated directly with his hospital as to the terms and conditions of his contract. Radiologists generally considered their employment conditions, particularly the financial aspects, to be somewhat parlous when compared to other sections of the medical profession and consequently they formed a syndicate. The objective of the syndication was to correct their employment conditions through the strength of collective bargaining. From the time of its formation the syndicate was generally successful and working conditions as well as remuneration, improved markedly and steadily from then on.

In 1961 the Radiologists entered the first of their confrontations with the government and went on strike for a period of several weeks. The issue which generated the strike was one of method of remuneration. With the introduction of Hospital Insurance the government had attempted to place radiologists on salaries. The radiologists immediately refused and counter offered with a schedule fee system based on relative value units for the various procedures. On the government refusing to accept this counter-offer the radiologists went on strike. Eventually, the government gave way and the

radiologists' system was accepted with two alterations, a reduced unit fee (1/2) for units in excess of 100 000 units and a limit on seniority. Seniority being a determining factor in the actual monetary value of a relative value unit.

The result of this agreement was the effective imposition of an income ceiling and the increased hospitalisation of patients when radiological services were needed. The latter effect being a typical result of the introduction of Hospital Insurance without the complimentary medical insurance, hence services for hospitalised patients were insured, and Services rendered to outpatients or in private offices were not covered by the Hospital Plan. The former point being of relevance to the eventual evolution of the fee for service system in Quebec as discussed below.

Without any prior consultation with either the diagnosticians or hospital authorities, the Quebec Government on 1 July 1967 extended coverage under the Hospital Plan to include all diagnostic services in hospital outpatient departments. The radiologists objected to the new arrangements on three basic grounds, the first was that they feared they would be overwhelmed by the additional workload that would be generated; the second was that the government had not extended the insurance to cover services provided in private offices, and that this would effectively destroy their private practices. The third was the level and method of remuneration proposed. After some generalised negotiations conducted by the FMSQ, which had been formed by that time, on behalf of the radiologists, anaesthetists and pathologists the radiologists again in effect went on strike by resigning, with doctors from some hospitals leaving in August and not resuming in some cases until November.

During the intervening period the Department of Health made proposals which were again indicative of the different Province. The Department offered to extend coverage to private clinics, but sought quite extensive controls to the extent of placing the onus of proof as to whether or not a radiological service was necessary on the radiologist, involving in some instances a physical examination of the patient by the radiologist to determine whether a service was necessary or not. Other features of the offer involved

- the Department of Health assuming responsibility for assessing the quality of work with the power to revoke the radiologist's licence;

- the Department of Health deciding who could have private offices;

- a general condition that if a radiologist had a private practice he would be required to have a hospital appointment;

- a radiologist with a solo private practice would be required to have an outside consultant review his work and determine its quality.

The radiologists were, of course, quite unprepared to accept such controls and in the final settlement it was agreed that the Medical Assistance Act would be extended to cover private clinics, with the result that social welfare recipients could get services free in a private clinic. This really was a compromise on both sides, where radiologists retained their rights of private practice with a minimum of control, and the Government only conceeding a coverage to a limited portion of the private practice population.

The Government had also determined to reserve unto itself the structure of the fee schedule. The position of the radiologists was that while they were quite prepared to negotiate overall cost, the structure of the fee schedule was professional responsibility and would be determined by the profession.

In the area of fees, the final agreement resulted in a fee schedule under which the seniority system was abolished and a fee for service schedule with the fees for each item or service determined by the monetary value of the relative value units involved, the monetary value of a relative value unit was struck at the previous average. In the end neither side could claim a victory. It was a compromise dictated by political necessities of other contemporary industrial problems but it did set the scene for the future negotiations of medicare.

During the years from the original establishment of the Radiological syndicate, other specialists practising within hospitals had been forming their own syndicates and in May 1965 the FMSQ was formed by the amalgamation of 11 groups, and by the time it was formally recognised in December 1975, a total of 21 groups had joined. Following the radiologists 1967 strike all bargaining on behalf of specialists has been conducted by the FSMQ.

The FMOQ[70]

The first general practitioners to take advantage of the Professional Syndicates Act and form unions were those of the Quebec City, the St Francois district and Chaudiere region who formed syndicates as early as 1956 to counter problems being encountered in the allocation of hospital admitting priveleges. The general practitioners felt that they were being discriminated against in favour

of the specialists, with the result that they did not have the privileges needed to meet the needs of their patients and to which they were entitled.

The concept of syndicates picked up momentum in the late 1950s, and in 1963 the FMOQ was established, with a charter uniting the 16 regional syndicates and covering the entire province. It is interesting to note that one of the early initiatives of the FMOQ was to establish a program aimed at improving the image and numbers of GPs. Quebec in the late 60s was unique amongst the Provinces having a preponderance of Specialists who outnumbered GPs by two to one, as against the general one to one ratio of the other Provinces.

Fee Negotiations - The 1970 Series - Establishing Schedules

Quebec's experience in the actual processes and progress of fee negotiations again differs from that of the other Provinces. Since the introduction of medicare in 1970 there have been only two completed series of negotiations (up until December, 1978). The first negotiations in 1970 established a fee schedule of a type similar to that of the other Provinces, and the second series of negotiations commencing in 1974 and culminating in September 1976, set the course for a future of medicine unique in Canada.

In June 1970[71] the Quebec Government introduced the Quebec Health Insurance Act, which outlined the manner in which the government intended to pay for all necessary medical services rendered by participating doctors. Doctors were to be given three basic options, accept direct payment for services by the government at the negotiated benefit level, accept payment by the patient who would in turn or first be reimbursed at 75% of the

benefit level, or opt out completely. The doctor opting in would not be allowed to extra bill at all. There was also a limitation placed on the option to opt out, in the words of the bill that opting out is allowed on condition that "Not more than 3% of the professionals subject to the application of an agreement have withdrawn" and further "the board cannot grant such claims (from the patient for 75% of the benefit) if too many professionals withdraw in a specialty or region as determined by the government in accordance with the regulations; in this case only the cost of services rendered by the professionals in the specialty or region contemplated will cease to be paid".[72]

The bill did not however provide the basis for the payment for services. Instead it provided through clauses 18 to 20 for this to be established by regulation and to take the form of an agreement between the two syndicates and the government. Further the bill in clause 19 indicated that any agreement signed would remain in force until such time as the government was prepared to accept a new agreement, even if the previous one had theoretically expired.[73]

Each of the two syndicates proceeded to commence negotiations with the government, amid suggestions and comment that the split in the profession (the FMOQ and the FMSQ) was allowing the government to divide and conquer. The FMSQ taking the stance, through Dr Raymond Robillard, President of the FMSQ that the policy of the FMOQ was to entertain division and to gain all the benefits that it could from exploiting the division. Dr Robillard felt that this was a short sighted way of looking at the issue and while the GPs might gain immediate benefits, they would lose in the long term.

Indeed this apparent division reflected a basic difference in the attitude of the GPs and the specialists. The GPs in general terms being fairly willing to co-operate with the Government in its implementation of the Castonguay principles, whereas the specialists were committed to the maintenance of the status quo.

While both the GPs and the Specialists objected to various aspects of the Act the FMOQ felt that a suitable compromise could be achieved within the terms of the legislation, whereas the FMSQ believed the Act should be changed. The negotiations undertaken by both syndicates were generally conducted in secret. The negotiations between the government and the FMOQ progressed slowly but satisfactorily and both parties reached an agreement in principle in September, 1970, although the FMOQ still objected to the inadequacy of the proposed schedule of benefits. Negotiations had been hampered by a lack of reliable data concerning the incidence of services rendered by medical practitioners. The GPs engaged consultants who studied income tax data, and made estimates derived from the experience of other Provinces and countries (particularly Sweden). At interview Dr Boileau (Editor of Le Medicin du Quebec) noted with some satisfaction that as it eventuated the FMOQ's actuary had been much closer to the mark than the government which had overestimated to the extent of $10m-$15m. The final agreement gave general practitioners the same fee schedule as specialists (much to the chargin of the specialists) which was based on the Ontario schedule with fees roughly 15% lower than the Ontario fees. Other features of the final agreement were the prohibition of individual contracts, and the establishment of 100% benefit for patients who had been billed by participating doctors.

While the negotiations between the FMSQ and the Government were also conducted in secret they were sporadic and quite unproductive. The FMSQ saw that there were few but significant differences between itself and the government. Principal among these were the right of the profession to control all aspects of licencing, ethics and discipline (or in other words the concept of professional self discipline), and quality control which it saw as being threatened by the very composition of the act, which would hand several traditional responsibilities of the College to the proposed Health Insurance Commission or committees comprised of commission and syndicate representatives. A further difference was the FMSQ wanted the individual physician to be able to opt out without loss to the patient. A third difference was the schedule of benefits proposed by the government.

On the 27 August 1970 the FMSQ convened a huge convention in Montreal to discuss and consider the implications of Medical Insurance and the Government's proposals. This convention was attended by over 4000 persons, including some 1600 specialists, and other doctors, government observers and the general public. At a subsequent special assembly meeting a vote was taken which by an overwhelming, almost unanimous, majority gave the FMSQ authority to use all necessary means, including in the final resort a strike, to defend the professional freedom of the doctor and achieve the FMSQs general objectives of overcoming those aspects of the government's proposals which were abhorant.[74]

A further complicating factor was that on 3 September, the Quebec Government released a further report of the Costangway Commission which advocated major revisions in the health care system, including a denunciation of the fee for service system in favour of a modified salary system.

With the virtual breakdown of negotiations the FSMQ ordered the withdrawal of services by its members in 38 hospitals. On October 8 planned emergency services which had been organised for some time, at least prior to September, were put into effect by the specialists and the specialists in general went "on holiday".[75]

However, the full effect of the strike was not felt by either party, due to circumstances beyond the control of either party. The October crisis had just begun and the federal government called in the army, the FMSQ immediately offered to return on condition that the government agree to negotiate meaningfully once the political situation had returned to normal. The Quebec Government was however determined to ascert its authority and enacted bill 41 which ordered the specialists to return to work and prohibited them from speaking out on the matter. However, the specialists by establishing their headquarters in Ottawa, on the Quebec border, circumvented the second facit by evading Quebec jurisdiction and said they would defy the order to return to work.

When Mr Laporte was assassinated, the FMSQ decided to return to work. The strike had lasted 10 days and bill 41 was eventually repealed. The government, possibly feeling somewhat guilty over its behaviour, finally made a relatively generous settlement which was finally signed on December 16. The federation was awarded 85% of its proposed schedule of benefits and it obtained a commitment from the government that the control of professional activity would remain with the College of Physicians and that the Quebec Medical Insurance Board would not interfere in the practice of medicine. According to the FMSQ actuarial consultants the schedule proposed by the FMSQ was generally compatible with that of

the Ontario schedule and hence the 85% offer was well received in view of the governments original offer of approximately 65%.

Fee Negotiations

Whereas from a financial viewpoint, the 1970 series of negotiations had principally involved the negotiation of a fee schedule the 1974/76 series revolved around the negotiation of incomes. These negotiations were also used by the government to further the eventual introduction of Claude Castonguay's community health centre concept.

The 1970 contracts were due to run from 15 January 1971 for a period of two years but negotiations were not commenced until 1974 and they dragged on for two years until the signing of separate agreements on 2 September 1976 in the case of the FMOQ and 4 November 1976 for the FMSQ.[76]

As mentioned previously of the two syndicates the FMOQ was by far the more sympathetic toward the government's plan for the introduction of a public system of distribution of medical and paramedical services based on community health centres and as it was organised on a regional basis it set about evolving a plan in 1973 to co-ordinate all general practice care services with the eventual aim of integrating the public service offered by the government with private practices to provide continuous health services.

The FMOQ was definitely in favour of health insurance but baulked at the concept of becoming salaried personnel of its government. However, at interview, the view was expressed by Dr Broileau, that no mode of

remuneration is more virtuous than any other one, but it is important that the mode corresponds to the type of practice. Further, the FMOQ was not prepared to accept any form of salary where there was no guarantee of autonomy but would accept an honarium provided that autonomy was maintained. Thus the settlement reached with the government by the FMOQ reflected this approach.

The agreement between the government and the FMOQ had the following major features:

- increases of 15%, 6%, and 15% in mean gross incomes for the 1st, 2nd and 3rd years respectively.

- individual and collective controls on GPs of the following nature:

  (a) a revision downward of the fee schedule if mean gross incomes exceeded the forecast levels by relative small amounts;

  (b) if a physician billed an excess of $23 000 ($24 000 and $25 000 in subsequent years) in a quarter his further billings for that quarter would be paid at 25%.

- the setting up of a committee of four persons, two appointed by the Minister and two by the FMOQ to study the problem of the geographic distribution of medical personnel and report.

- the setting up of a second committee to implement the recommendations of the first.

- a provision that GPs who fail to follow the recommendations would not be eligible for payment from Quebec medicare.

The base for the income increase was the average income for physicians in 1974 and although an income increase of 15% was negotiated, actual fees were increased by more than 15%, as it was anticipated that the controls would reduce the overall increase in income back to 15%

The AIB did not challenge the negotiated increases as the new agreement had been so long in coming and as evidenced in the discussion of other provinces practice costs had soared. In Quebec, based on a survey of 2000 GPs the FMOQ predicted that costs would increase by $5 500 from $13 925 to $19 679 between 1974 and 1978. As the actual increase in income projected for 1977/78 was only $8 689 ($57 909 in 1974 to $66 598 under the agreement) the GPs would indeed be lucky to cover increased costs.

The agreement between the FMSQ and the government differed from the one negotiated by the FMOQ. The differences while not particularly significant in themselves reflected the more cautious approach of the FMSQ in its dealings with the government. This agreement, effective from 1 January, 1977 provided for a 17.5% increase in the mean gross incomes of specialists over 1974 levels, with a subsequent increase of 7% to run from June 1, 1978 until September, 1979.

The major features of this agreement were: -

- an increase in mean gross incomes from $65 271 p.a. (1974 level), to $76 693 p.a. in the first stage, and to $81 261 p.a. in the second stage

- a retroactive lump sum payment of $3 000 to specialists working on a fee for service basis
- collective controls on mean gross income
- a redistribution of income between specialties
- a combined committee to study geographic distribution of specialist services
- $1m to encourage specialists, through settlement bonus or higher fees, to service areas of definite need
- a 20% fee differential between office and hospital services to account for the higher practice costs of private office services.

An important feature of this list is one of omission, the list does not include a control on the incomes of individual specialists in the manner of the G.P. agreement. Further, the collective controls agreed on were not as restrictive as those of the G.P. settlement. While provision was made for the automatic downward adjustment of fees if the mean gross income was exceeding the agreed limits, the cushions provided were significantly higher (3% in phase 1 and 1 1/2% in phase 2) and adjustments would be made to take account of any transfer of services from hospital to private office; the supplementary cost of office services to be deducted before the calculation of mean gross incomes.

The absence of individual controls arose out of an undertaking by the profession to maintain self discipline. Each section association would monitor and supervise its own members, so that a member whose

pattern of practice is outside the norm without good reason would have various of his services paid at 25% of the normal rate on the recommendation of the association.

67. Le Clair, M., "The Canadian Health Care System" in S. Andreopoulous, ed. National Health Insurance: Can We Learn From Canada? New York: John Wiley, 1975 pp11-93

68. De Grandpre, L., "Quebec federations battle to raise incomes for physicians" CMAJ, Vol 109, (August 18, 1973) pp324-327

69. IBID, much of the history discussed in this section is drawn from this article, as well as interviews with FMSQ officers

70. IBID, again much of the history of the FMOQ is drawn from this article as a supplement to interviews with FMOQ officers

71. IBID, see p109

72. As quoted in a news article of the CMAJ, Vol 103, (August 1, 1970), p318

73. IBID

74. De Grandpre, L., "Quebec Federations . . ." see p326

75. IBID

76. This discussion is based on a combination of interviews with officials of both the FMSQ, FMOQ, the Regie and the following article; Lalonde, C., "Quebec G.P.s and Specialists agree with government on new terms of remuneration" CMAJ, Vol 116, (March 5, 1977) p530, p562.

CHAPTER IX

ONTARIO

Introduction

Although Ontario was one of the last Provinces to join the Federal Government sponsored medicare program, it was the location of the first medical care insurance scheme in Canada. In 1935 Dr J.A. Hannah received a $5 000 grant from the Ontario Medical Association (OMA), which was matched by a similar grant from the Ontario Civil Service Association to set up the Toronto based plan, Associated Medical Services. A further plan sponsored by the Windsor Medical Society was established in January 1939, and in 1947 Physician Services Incorporated was established.

Ironically, unlike the Western Provinces, government interest in the provision of hospital and medical insurance was non existent; although in 1935 the Province introduced a scheme to provide basic ambulatory care by private physicians to those citizens who were recipients of public welfare.

As with the majority of physician sponsored plans these plans were controlled, and to an extent underwritten by the medical profession. In the case of Physician Services Incorporated not all members of the board of directors were physicians; of the twelve member board three non medical members were present to introduce business expertise in the running of the plan.[77]

Fee Increases

Prior to the introduction of medicare in 1969 the Plans paid a predetermined percentage of the OMA's fee schedule. P.S.I. for instance, paid 90% of the OMA Schedule. The OMA schedule itself started from an amalgamation of the schedules of the various individual sections, and by about 1955 it had become a total and relatively organised document controlled by a central tariff committee. The various sections of the OMA made representations presumably on a biennial basis to the central tariff committee for adjustments to the schedule. Certainly, since the early 1960s fee adjustments were made on a two yearly basis.

Fee increases from 1965 were as follows:[78]

April 1965	4.5%
April 1967	11.3%
April 1969	9.0%

Following the introduction of medicare in October 1969, the fee increases have been on an annual basis, except for a three year hiatus in the early 1970s associated with the Pickering Report discussed below. The fee increases were as follows:

May 1971	4.5%
May 1974	7.75%
May 1975	4.0%
May 1976	8.1%
May 1977	6.5%
May 1978	8.0%

The Pickering Report[79]

The Pickering Report arose out of a study commissioned by the OMA to review the role and position of the medical profession in Ontario. One of the four specific points in the terms of reference was:

> "To examine and report upon . . .
> (4) the method by which any modification in the physicians' fee schedule, indicated by this study may best be effected."[80]

The study was instituted by the OMA out of a perceived need to define the role of the medical profession in an essentially new era where the Government's role in the delivery of medical services had been completely reversed, from that of a basically disinterested observer to that of prime underwriter. Indeed the O.M.A. saw the study as sufficiently important to invest in excess of $200 000 in it. The actual study took less than a year to complete and Mr Pickering reported in April, 1973.

The following quotation from the report which urges the establishment of a joint committee is relevant.

> "More importantly, experience suggests that modification of traditional and long-established practices can be accomplished most effectively if the proposed change is reasonably susceptible of acceptance by those most immediately involved and, further, that the change does not introduce too many new elements which may prevent the new process from working effectively. Evolutionary change is better than drastic sudden change. The opportunity for success would appear greater if changes to the

existing system of modifying the Fee Schedule were confined to those which are essential to satisfy the public interest.

Exclusion of the universities and hospitals from participating directly in the process would not deprive them of having an effective voice in the matter. Through their existing channels of communication with both the government and the O.M.A., these organizations should have adequate outlets for their important points of view.

> IT IS WITH THESE CONSIDERATIONS IN MIND THAT I AM RECOMMENDING THAT THE O.M.A. EXPLORE WITH THE GOVERNMENT OF ONTARIO THE ESTABLISHMENT OF A JOINT COMMITTEE ON DOCTORS' COMPENSATION

The Committee comprising three representatives each of the Association and Government would be responsible for reviewing and revising the fee schedule. It would not function spasmodically but in a continuing process with both short-term and long-term objectives, as enlarged upon later."[81]

In October 1973 it was announced by Premier William Davis that the Provincial Government and the OMA had agreed to establish a joint Committee on physicians compensation. Features of the agreement were:[82]

(1) the first increase under the new system would occur on May 1, 1974.

(2) subsequent adjustment would be made at least once every two years.

(3) the Committee would have wide latitude in determining the overall fee increase, and could if relevant consider specific items in the schedule if necessary.

(4) the responsibility for overall organisation and allocation of fee increases between items (within the overall total increase) rested with the OMA.

(5) Membership of the committee followed the Pickering recommendation; 3 OMA representatives, 3 government representatives and an independent chairman.

(6) Terms of reference were established for the consideration of fee increases. These included the traditional factors such as comparative movements in other professions etc, and economic indicators etc. In addition specific mention was made of the following important factors

(i) Regional requirements
(ii) Utilisation of services
(iii) The effect of physician incomes in the health economy.

1971 Negotiations - May 1971 Fee Increase

As might be deduced from the establishment of the Pickering study, the OMA in the early 1970s was particularly conscious of the change in circumstances of the profession. Partially as a consequence of this and other factors, such as the lack of adequate data concerning the effects of the introduction of medicare on physician incomes the OMA opted for a 'responsible response' to Dr Young's Prices and Income Commission to

restrict the increase in fees to 4.5%. Although, the government participation in those negotiations is not known to me I understand that the increase was well accepted.

1973/74 Fee Negotiations - 1 May 1974 Increase

In the years following the 1 May 1971 increase the OMA Committee on Economics and Medical Practice continued to review the schedule. At its January 1972 meeting Council decided that the usual biennial revision of the schedule should be continued. Consequently, after engaging the services of a consulting economist the Committee reported to Council in May 1972 that a new schedule be introduced in May 1973 but only to permit the introduction of new items. The Committee noted that utilisation had increased, and that it would be well argued that a good proportion of this resulted from increased productivity. It had entertained the idea that the benefits of increased productivity should be split equally between the profession and the community when next fees were increased (i.e. there would need to be a negative correction for the productivity increase).

Although it recommended no increase the Committee did suggest that a case supporting an increase of from 0 to 7.5% as of 1 May 1972 could have been made.

Early the following year 1973 the Committee again reported, this time in the context of a proposed adjustment to the fee schedule in May 1974, that in the light of data then available that no justification could be found for an increase; however, it noted that the data available, namely:

(1) Sectional income data provided from taxation returns by DNH & W

(2) Four months of OHIP data

(3) Income Survey data - which was based on a low response

was sketchy, at best, and insufficient. It therefore suggested that a decision be deferred until the availability of more up to date and complete OHIP data later in the year. In the event the OMA eventually started out in the 1973/74 negotiations seeking a 36 3/4% increase.

The 1973/74 negotiations[83] were the first conducted through the medium of the "OMA/Government Joint Committee on Physicians' Compensation for Professional Services". For the time of its appointment on October 2, 1973 the Committee met some 23 times before agreement was reached. Indeed, even after 22 meetings and on the day of the OMA council convening (25 February 1974) agreement had not been reached.

By the conclusion of the 22nd meeting the Ontario Ministry of Health had made a final offer of a 12% increase in its fee schedule as of 1 May 1974. The government position was a 10% increase in two stages, either 5% on 1 May 1974 and 5% on 1 May 1975 or 7% on 1 May 1974 and 3% on 1 May 1975.

After some heated debate at the meeting of the OMA council on 25 February, the OMA representatives attended an emergency meeting of the joint Committee early on the morning of the 26th; by mid afternoon an agreement had been reached for consideration by the provincial

government and the OMA council. Even so there was substantial opposition to its acceptance within the OMA council, although the compromise was accepted by the OMA.

The compromise agreement provided for an increase of 7.75% effective as of May 1, 1974 and an additional 4% as of May 1, 1975. Overall an increase calculated to have been equivalent to a 10% increase as of May 1975. The OMA then applied the increase in the following fashion:

(1) first, an increase of 8% in the cost component for all Sections

(2) second, an allocation of the balance to the sections in accordance with a predetermined formula (discussed below) designed to decrease net income differentials between the sections.

Negotiations for May 1, 1975 Fee Increase

During the years immediately following the May 1, 1974 increase inflation of quite significant proportions took hold in Canada, and as in the other Province, Alberta, where a two stage, two year agreement had been negotiated in 1973, the Medical Profession began to feel the impact of rising costs on net incomes. In late 1974, the OMA formally sought through the joint Committee a revision of the agreement in the light of the inflationary situation. Although it looked as though the government might yield, it finally came out against any increase.

In response the OMA decided to honour its agreement. The actual OMA resolution is enlightening:

> "That this OMA council representing a responsible and honourable profession reaffirms the position of the OMA council of February 1974 in that they will honour the agreement between the OMA and the Government recognising that this agreement does not take into consideration the marked inflationary trends of the economy with its serious economic effects on our members and associates."[84]

However, not all of the resolutions passed were as benign. The council also passed a resolution calling for the 1 May 1976 schedule to reflect the effects of inflation, regardless of any negotiated schedule of benefits. This indeed reflected the attitude of the Saskatchewan Association which moved to produce its own schedule at around this time as discussed above. OMA President M. Mador was reported emphatically stating that the fee schedule was the property of the profession and in future would not be subject to discussions with, or approval by the Provincial Government.[85]

Negotiations for the 1 May 1976; 1 May 1977 and 1 May 1978 Fee Increases

Contrary to the experience in British Columbia, and to a lesser extent Alberta and Saskatchewan, the negotiations conducted under AIB controls proceeded in a routine manner. The government representatives on the Joint Committee did not oppose on any occasion the flow on of the full net income increase of $2 400 allowed as a maximum under AIB guidelines. As a consequence, once agreement had been reached on an appropriate measure of the cost component for the profession the negotiations proceeded smoothly.

However, activity within the profession during these years was not as routine. The relatively conservative stance taken by the OMA over the years 1971 through 1975, when to a large extent the financial consequences of small or no increases in fees for the profession had been cushioned by the introduction of medicare, had led to a situation where the majority of Ontario physicians were feeling a real decrease in income of substantial proportions.

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77. This discussion is based on: The Report of the Royal Commission on Health Services, 1964, Vol. 1, Pages 383-422 and Malcolm G. Taylor, Health Insurance in Canada, pp35-38. Oxford 1956

78. Health and Welfare Canada, "Price Changes - Physicians' Services" mimeograph, August 1977

79. Pickering, E.A. "Report of the Special Study regarding the Medical Profession in Ontario" April 9, 1973

80. IBID, see p 5

81. IBID, see pp 106-107

82. Korcok, M. "Ontario government and OMA establish joint committee on physicians' compensation". CMAJ Vol 109 (October 20, 1973), pp 780

83. The discussion of the 1973/74 negotiations draws on D.A. Geebie, "OMA and Ontario government agree on dollars" CMAJ Vol 110, (March 16, 1974), pp 110; as well as on data and interviews given by OMA officials

84. As quoted in Geekie D.A. "Ontario, Alberta medical associations gain compromice with provincial governments", CMAJ, Vol 112, (February 22, 1975), p 502

85. IBID

CHAPTER X

CONCLUDING REMARKS

The intention and purpose of this 'review' of medical fee negotiations was defined in some detail in Chapter 1. The preceeding chapters dealing with the negotiations in each of the five provinces have satisfied a large part of the task required by the definition of the word 'review', through the provision of a survey, and where appropriate discussion, of the significant events in each Province concerning fee negotiations. To complete the defined task, the reconsideration aspect of the definition of review is dealt with in this chapter.

As the research project has not involved the testing of any hypothesis, the very nature of the project dictates that the content of this chapter is primarily one of opinion. The preceeding chapters have dealt mainly with either historical fact or the opinion of others, whether based on quantitative research or not. The opinions put forward here are presented as the author's reasoned interpretation of the facts, events and impression obtained during the course of the data collection and collation process. Naturally, other interpretations could be made by other persons. Unfortunately, it is not possible within the limitations of this project to test any of these opinions; although, it is hoped that subsequent history and perhaps more specific research might achieve this in some instances.

A brief generalised history of the development of fee schedules up until the introduction of Medicare in the Provinces considered in this project is useful as an illustration of the fundamental change which occurred in the fee determination process during that period, and as a basis for the subsequent discussion.

During the late 1950's and early 1960's fee schedules as such were relatively new documents which evolved in a variety of ways, generally from local association or Section recommended fee lists, or from the writing down of fees commonly charged in a particular region or Section. The Provinical Medical Association gradually collated these local and Sectional fee lists into a fairly comprehensive schedule.

These fee schedules were of little legal or formal significance and were determined by the Medical Association or Section in a way which one could call 'loose', 'gentlemanly' or 'leisurely'. These fee schedules were primarily produced as a guide to members of the Profession or Section and did not have even the status of being recommended fees. It would also be fair to add that the schedule had an inbuilt allowance to cater for the "rob Peter to pay Paul" principle, and that individual practitioners in using the fee quide adjusted fees to take account of their own circumstances, such as a relatively high or low bad debt rate. Overall, it is most likely correct that the fees determined in respect of each Section were set so as to provide a reasonable income in the circumstances of the Section.

With the advent of medical insurance organisations, generally in the 1960's, these fee guides began to take on a more formal and legal status. The fee guides became in essence fee schedules, which were the basis for determining benefits to be paid in respect of particular types of service. As the financial viability of a medical insurance organisation, wholly funded by contributors or members of the organisation, is primarily dependent on the relationship between income, derived through contributions, and expenses, incurred through payment of benefits, the construction and level of fee schedules was of paramount concern to these organisations.

As noted in the discussion of the individual Provinces, the profession and the organisations began to consult, as against formally negotiate, as to appropriate fee schedules. In this respect it is relevant that such organisations were controlled by physicians. A major consideration in such 'consultations' would have been the relationship between contribution rates and membership levels; such consultations and the consideration of this relationship would have undoubtedly involved an appreciation of how much the 'traffic would bear'. This aspect is particularly important as it represents both the final step in the process of actually establishing fee schedules and the first step in the profession's ultimate loss of control over the actual fee schedule and physicians' fees.

With the introduction of Medicare the fee schedules assumed an even stronger legal status, with the schedule fee to all intents and purposes generally becoming a maximum. As an offset to this, the schedule fee, or a set large percentage of it, became a guaranteed fee and payment. The advent of Medicare also removed the relationship between contribution rates and membership level by fixing the level of membership at the total population (theoretically at least).

If one views the situation prior to the introduction of Medicare as being essentially a variation on the free market, the introduction of Medicare may be regarded as the virtual elimination of that free market, particularly in respect of the concepts of supply and demand as conventionally understood, in the delivery of medical services. While obvious, it should also be noted that this is also true concerning the actual medical insurance industry.

However, despite the elimination of the free market the introduction of Medicare established the existing fee relativities, which to a large extent represented free market levels, as part of the Medicare fee schedules.

Consideration of the Four Broad Objectives

For convenience the four broad objectives, which are fully explained in Chapter IV, are restated here; they are: -

- The orderly provision of an essential service
- Cost Containment
- Social and Political Considerations
- Health Care Planning

It is not intended to discuss in specific terms any of these broad objectives, rather the discussion is structured to allow the reader to draw his own conclusions regarding these objectives in the light of Chapter IV. As indicated in Chapter IV, discussion of particular aspects of the four broad objectives also occurs where appropriate in the text of the chapters dealing with the individual Provinces.

A reading of the preceeding Chapters concerning the individual Provinces brings forward several major points which are particularly relevant to these objectives and not discussed earlier. These in turn may be summarised as: -

- The effect of the AIB Regulations
- The movement from the negotiation of fees to the negotiation of Income, even prior to the AIB regulations

- Conflict within the medical profession, and between the profession and the Government
- The underlying similarity in the history of fee negotiations in all Provinces other than Quebec
- Fee and Income relativities between the various specialties

The first point listed above, is for good reason 'the effect of the AIB Regulations'. As explained in the text of the Alberta Chapter, the AIB regulations became effective from 14 October 1975. The introduction of these regulations came about at a critical time in the evolution of the fee negotiation process, particularly in the Western Provinces: In Alberta, the AMA had sought a 39% increase and negotiations had broken down; in British Columbia, the BCMA had also sought a 39% increase; and in Saskatchewan, a similar order increase was being sought by the SMA.

The introduction of the AIB regulations interrupted at least two evolutionary processes: The first, the gradual movement from the negotiation of fees to the negotiation of Income; and the second, the development of quite distinct negotiation processes in each of the Provinces.

A feature of the development of negotiations in the Western Provinces prior to the introduction of the AIB controls, was the increasing prominance of the word 'income' in the fee negotiations, to the extent where one could argue that in actual fact fee negotiations had become income negotiations. In British Columbia the negotiations could possible have been more aptly called total cost negotiations.

It is important to understand why this process was taking place. As part of the discussion, in Chapter IV, of Cost Containment as a possible objective in fee negotiations reference was made to a series of factors which determine the income of physicians; of these, it was suggested that four could be manipulated by Government in the context of fee negotiations to influence physician income. These four are: -

- Fee levels of individual items
- The structure of the fee schedule
- Peer norms of patterns of practice and acceptance of changing or different servicing patterns (physician comfort)
- Number of physicians in the specialty group and the total number of physicians (physician density)

The point was also made in that discussion that Cost Containment essentially revolved around the following equation.

Total Cost = Average Fee per Service x Number of Services = Average Earnings per Physician x Number of Physicians

Observation of the working of all five Provinces suggests that while the Governments in these Provinces appreciated the significance of total cost escalation, efforts to achieve cost containment concentrated, prior to AIB controls, on the more obvious methods of manipulation available in respect of the first two factors rather than the more subtle methods necessary to achieve cost containment if the latter two factors are addressed.

It was noted in Chapter IV that the first two variables could be classified under the heading of 'fee schedule' variables, and that indeed these variables came

about as a consequence of the introduction of Medicare, whereas the latter two are only apparent when physician incomes are considered in the context of a modified free market for physician services, such as that developed by Stoddart. Given the relatively recent development of theory along the Stoddart lines (Stoddart thesis - 1975), it is not surprising that Governments had generally failed by the time of introduction of AIB controls (October, 1975) to specifically address these variables in the Cost Containment context.

The movement from fee negotiations to income or cost negotiations most probably arose out of the realisation of the limitations of fee negotiations, using only the 'fee schedule variables', as a cost containment mechanism.

Initially, it is necessary to consider the two variables separately. In the early negotiations in all Provinces other than Quebec, the Government appears to have either assumed a general percentage increase in fees would be translated into an equal percentage increase in total cost, or chose to ignore the real situation.

It is important to appreciate that changes in technology and attitudes, inter alia, are of critical importance in the eventual cost result of an across the board percentage fee increase. Even if the total number of services remains constant a utilisation transfer from a low cost item to a higer cost item will result in a larger overall percentage cost increase than the percentage fee increase negotiated. Additionally, an increase in overall utilisation may have a profound effect in increasing total cost above that anticipated.

The ability of the Profession to translate a percentage fee hike into an even higher percentage total cost hike had become apparent in all Provinces, by the time of the introduction of AIB control, and each of the Provinces, with the exception of Ontario, had attempted to counter this by considering to some degree total cost or individual incomes as part of the negotiation process.

Of the Provinces, British Columbia and Quebec had moved the furthest in this direction. In the case of British Columbia the reason is probably the combination of several factors: -

- The relatively long experience of the Government in fee negotiations (1967 onwards)
- The economic conditions in the Province as illustrated by the 1970 voluntary wage and price control program
- The early availability of comprehensive statistical data concerning physician incomes

On the other hand, the reason in the case of Quebec is probably primarily one of basic philosophy in respect of the provision of medical services as exemplified in the the Castonguay proposals.

The movement from fee negotiations to income (or total amount) negotiations, prior to the introduction of the AIB controls, may be seen also as a logical consequence of failure to directly address the physician comfort factor. It was noted above and in Chapter IV that this physician comfort factor is inherent to the concept of the modified free market for physician services as developed by Stoddart. If the work of Stoddart and Evans is accepted then it appears that the Provinical Governments are missing out on the possible exploitation of a significant cost control mechanism.

The methods of application of a cost control mechanism, which relies on the physician comfort variable, could vary from the very subtle to the quite obvious. It is a feature of the Canadian system that the profession has maintained either control or primary influence in review bodies and methods directed towards control of what might be called overservicing. An example of a more subtle mechanism to use the physician comfort variable would be for the Plan to increase its control of the definition of overservicing to the point where through a gradual process, standards of servicing in particular circumstances are developed and tightened. This process would be aimed at reducing the ability of the individual physician to determine the treatment regimen in respect of the medical condition presented at first patient contact (without lowering standards of care).

Indeed, if one accepts the concept that a physician will practice in such a way as to achieve a desired income and that this is possible over a wide range of physician/population ratios, as appears to be widely accepted (1978) by both Medical Association Executives and Provinical Plans then the acquisition of the power to determine or strongly influence acceptable treatment regimens, even without tightening currently accepted levels of servicing, could prove a very necessary and powerful weapon in Cost Containment and Health Care Planning.

An example of a less subtle method would be the introduction of an inbuilt disincentive built into the fee schedule or payment mechanism to discriminate against physicians whose servicing pattern deviates on average from predetermined acceptable limits based on parameters such as average cost per patient seen over a period. This would naturally be based on peer group comparisons and

would be technically easier to implement than the method described above and was within the 1978 capabilities of all five Provinical Plans. In this context the limits imposed in Quebec on the earnings of General Practitioners might be regarded as a crude prototype of possible methods.

Of the four factors referred to above and in Chapter IV, which determine the income of physicians, the final one to be considered here is 'Physician Density' - the numbr of physicians in a specialty group and the total number of physicians. As with the 'Physician comfort' factor, 'physician density' is a factor which arises out of the modified free market concept; however, there appears to have been a general consensus in Canada for some time that a continually decreasing physician/population ratio was not necessarily a good thing.

It is of interest that this consensus may have arised independently out of appreciation of the equation referred to above and in Chapter IV, namely: -

Total Cost = Average Fee per Service x Number of Services = Average Earnings per Physician x Number of Physicians

and the estimation of an unsatisfied 'need' for medical services, rather than through acceptance of the modified free market concepts.

Barring resort to restrictive participating physician schemes, the control of physician numbers is a long term task and by 1978 a general country wide policy of restricting physician numbers had been arrived at; principally through Federal controls on the immigration of doctors.

The efforts put into income disparity corrections could possibly be regarded as being of consequence in this context and this particular point is covered in the discussion below on disparity corrections.

If the general consensus referred to earlier amongst Government and Medical Association officials that physicians can generate desired incomes over a wide range of physician/population ratios is correct then the Cost Containment objective can be viewed in terms of part of the above equation, specifically: -

Total Cost = Average Fee per Physician x Number of Physicians

or Total Cost = Constant x Number of Physicians

Thus either Physician numbers have to be curtailed and/or efforts directed through the fee negotiation process, inter alia, to the negation of the constant. This negation as discussed above can be achieved in a variety of ways, an example of which is the manipulation of the 'physician comfort' factor as discussed.

Consideration of the complete equation in the light of the above discussion also gives the reason for the earlier statement that "the movement from fee negotiations to income (or total amount negotiations, prior to the introduction of AIB controls, may be see also as a logical consequence of failure to directly address the physician comfort factor".

The negotiation of incomes or total amounts is only of limited value if measures are not included to enforce these limits. The only Province in which such limits applied by the time of AIB controls being effective

in terms of fee negotiations was Quebec. If the incomes or total amounts are based on a previous year's utilisation then the facility still exists for the profession to vary utilisation patterns in such a way as to increase individual incomes and total cost. This process is probably self limiting and eventually further manipulation would not be possible; the problem however is just how far can the profession manipulate the fee schedule and servicing patterns?

The above discussion has been directed towards the consideration of one of the two evolutionary processes which were identified above as being interrupted by the introduction of AIB controls. The second process was "the development of quite distinct negotiation processes in each of the Provinces".

The words 'quite distinct' are not meant to imply that the processes in each Province were evolving into completely different systems. Rather, it is meant to convey that in each Province a particular flavour and approach, a variation on the same theme, was in the course of development. While the introduction of the AIB controls did not halt such development, it certainly gave all the Provinces, other than Quebec, a push in the same direction.

The AIB controls were quite stiffling in terms of fee negotiations, even if they were highly effective in curling fee increases as might be argued. They essentially reduced each fee negotiation to a fairly mechanical exercise whereby an increase to cover costs was negotiated along with a $2 400 personal income component rise. The only spice was the vain effort of the BC Government to not allow the $2 400 personal income

component and some argument in each Province concerning the basis and method of determining the cost of practice component.

A brief resume of the differences between the provinces, the reasons for those differences and some speculation regarding the underlying direction of the evolutionary process within each of the Provinces certainly falls within the defined task of this chapter. However, before that it is also relevant that the basic similarities be examined.

Despite the differences listed below, the basic process followed in each Province is essentially the same. The negotiations are used to determine as and end result the fees in a Medical benefits Schedule; the two sides meet at a conference table, usually several times during the progress of a claim; there is ready access for the Medical Association to virtually all Plan data relevant to the negotiations; the profession at large either has or apparently will have a final say over whether a proposed agreement is acceptable. The list can be extended almost indefinitely.

The list could also at first sight appear trite; after all is there any other way of negotiating? Indeed there are other ways, the basic commonality here is the Canadian approach to most salary and wage negotiations. The basic Australian approach is different, it relies to a much larger extent on an Arbitrator. Indeed in virtually all labour relations exercises in Australia the issue is referred to binding Arbitration if agreement is not readily reached between the two parties; further, even if agreement is reached between the two parties other organisations can seek to have the matter referred to Arbitration during which that third organisation may enter

the argument. An example would be where an agreement sets a precedent which a Government might wish to prevent for overall economic policy reasons. In the Australian context the Arbitration is part of the Court system, with judges specialising in industrial matters.

Given that the Australian system is different it is also quite likely that there are many possible ways of conducting labour negotiations. The point here of course is that all Provinces have essentially translated the familiar Canadian Industrial relations process into the medical fees arena. In Australia the familiar process has also been translated into the medical fees area and an Arbitrator is appointed every year or so; he receives submissions from all interested parties (e.g. the State and Federal Governments, the Australian medical Association, Academics and other individuals) and makes a decision which is binding as regards the Medical Benefits Schedule.

It was important to make the above point concerning the underlying similarity in the processes of each Province so that the significances of the differences exhibited in the Provinces prior to AIB controls can be better appreciated. As a broad generalisation it would appear that prior to AIB controls the evolution of fee negotiations in each of the three Western Provinces was proceeding along similar lines, with the Quebec process evolving in a completely different direction, and the Ontario process perhaps flirting with the Arbitrator concept.

As may been seen from the discussion in Chapters V - VII, the negotiations in the Western Provinces exhibited the following common features: -

- Quite militant medical associations
- Substantial fee demands by the Medical Associations
- Quite resolute governmental resistance to medical association fee claims
- A tendency for the negotiations to concentrate on overall amounts or incomes

However, despite these common features the three Provinces also exhibited substantial differences; notably: -

- The existence of a written agreement between the Profession and the Government in British Columbia, this was also an objective of the Saskatchewan Medical Association
- The incorporation of a remuneration package, i.e. benefits other than fee for service, in the British Columbia settlements
- The use of Actuaries by the Alberta Medical Association to produce independent figures and argument for negotiation purposes. This procedure was later emulated by the BCMA to a lesser extent
- The use of an independent Arbitrator in Saskatchewan to resolve a fee negotiation deadlock
- The emergence of a sizeable militant minority within the BCMA
- The quite open and deliberate policy of maintaining independent Medical Association fee schedules in British Columbia and Saskatchewan

Whereas the Western Provinces seemed to conduct their pre AIB regulations with a certain zest, particularly on the part of the Medical Associations, the

approach to fee negotiations in Ontario was much more circumspect. Several points relevant to this issue emerge from the Ontario discussion in Chapter IX, these are: -

- The uncertainty of the medical association
- The Pickering report itself
- The hard but low key approach of the Government
- The simmering discontent on the part of many rank and file General Practitioners

With the introduction of Medicare into Ontario, the Profession appears to have been caught in a dilema between its perception of how such an honourable and professional profession should conduct its affairs and the very real example of the actual negotiation process in the Western Provinces. The Commissioning of the Pickering Report was, as discussed in Chapter IX, an attempt to define the role of the medical profession, including fee setting procedures, in the new era of Government funding.

The solution arising out of the Pickering Report for a joint Committee on physicians compensation, made very little change to the established Canadian negotiation process but it did establish two changes; first, a continuing liaison; and second, an independent but powerless Chairman. Although perhaps a very tentative step towards some form of Arbitration it really only had the effect of formalising the procedure of the Western Provinces.

By the time of the introduction of the AIB controls the Ontario situation was set to figuratively explode. The internal politics of the OMA virtually demanded a substantial fee increase for general practitioners and the Government had pursued a particularly hard line, in contrast to Alberta, regarding a renegotiation of the second part, the increase from

1 January 1975, of a two year agreement negotiated before the full effects of the inflationary spiral of the early 1970's became apparent.

In Quebec, the situation was yet again different. The general thrust of the Government approach to fee negotiations, as related by both Government and Federation officals, was towards the eventual introduction of a form of salried medical service. As discussed in Chapter VIII the FMOQ was far more sympathetic than the FMSQ towards the Government's plan for the introduction of a public system of distribution of medical and paramedical services based on community health centres.

Again, the Government was prepared to take a very hard line in dealing with the profession (e.g. the specialist strike and the October crisis) and appears to have taken every opportunity to exploit the division of the profession into two groups - the FMOQ and the FMSQ. The agreements which included individual and total controls on the profession can be seen as further measure towards this objective and that of conditioning the profession to increased Government control of income.

The final feature of the fee negotiation process which requies detailed consideration is that of disparity corrections, or measures taken to correct the Fee and Income relativities between the various specialties. As part of the generalised discussion of the evaluation of fee schedules several points relevant to this concept were made; those were: -

- The pre-medicare fee schedule or a large set percentage of it was adopted as the payment or benefit schedule on the introduction of Medicare in each Province

- The pre-medicare fee schedule had an inbuilt allowance to cover bad debts etc. which varied from Section to Section
- Free market constraints operated in respect of both fee levels and the level of servicing

A striking feature of the negotiations in all Provinces was the essential commonality of approach to this problem. Although the detail varies, the Provinical Governments have all adopted a policy of allowing or requiring the medical associations to allocate negotiated overall increases between the Sections. Again, although the detail varies the medical associations have responded by attempting to allocate those fee increases in such a way as to reduce the disparities in the personal income component of total average income of the various Sections. The importance of disparity corrections in the context of this chapter is not the actual detail of how the corrections are made technically in each Province but rather the relevance of the general Canadian approach in terms of the four broad possible objectives.

The fundamental point in terms of all four possible objectives is that the common approach has been to place this function in the hands of the Medical Association. An immediate consequence of this is to divide the Medical Association; rather than the negotiations simply being an us and them situation, the individual Sections are required at some stage of the process to justify their claims for an increase before the other Sections within the context of some form of intersectional council (e.g. British Columbia).

Given that the individual Sections have to argue within the Association for an increase, then the requirement for data pertaining to the income/cost

structure of the individual Sections is reinforced. In addition, each Section under this approach also has an interest in keeping the other Sections honest; it is no longer a situation of the Government arguing regarding the validity of data presentation or interpretation but other 'experts' - the other Sections - critically examining data.

The Quebec Government has taken this process a little further by placing an upper limit on the total money available in forthcoming periods, thus placing pressure on each Section to keep a strict eye on its own members who may be overservicing or exploiting the system in some way and on the activities of the other Sections. While none of the other Provinces have proceeded as far along this particular avenue, the processes in British Columbia, in particular, Alberta and Saskatchewan could continue to evolve in a similar direction.

When this Canadian approach is viewed in the light of the Australian experience, where there is no such approach or policy in a sufficiently similar Medicare programme, the value of the disparity correction procedures cannot be overemphasised.

Attachment 1

Date	Location	Officer/Organisation
May 16, 1977	O.H.I.P. Toronto	Mr G.E. Featherstone - General Manager
	" "	Dr G. Gold - Director, Professional Monitoring
May 17, 1977	" "	Mr H.I. McKillop - Director, Data Development and Evaluation
	" "	Mr J.R. Harnett - Director, Enrolment
May 18, 1977	" "	Mr I. Searle - Director, Claims Services
	" "	Mr J.A. Sargeant - Executive Director, Ministry Information Systems
May 19, 1977	" "	Mr Bain - Director, Institutions
	" "	Dr Aldis - Executive Director, Personal Health
May 20, 1977	Queens Park, Toronto	Mr S. Dreezer - Executive Director, Finance
June 1977	Ottawa	Dr G. Wilson Mr J. Brandist - Canadian Medical Association
June 14, 1977	Montreal	Dr G. Boileau - Federation of General Practitioners of Quebec
June 17, 1977	Quebec City	Dr Andre Beaule Dr Edouard Beaudry Dr Pierre Bergeson - Regie de l'assurance-maladie du Quebec

Date	Location	Officer/Organisation
June 21, 1977	Montreal	Dr Robillard - Federation of Medical Specialists of Quebec
August 29, 1977	Vancouver	Mr Jack Paul (Director) Dr Hugh Stanfield (Assisstant Director Economics) - B.C.M.A.
August 30 and 31, 1977	Victoria	Dr D. Bolton Dr Findlayson - B.C. Medical Insurance Commission
September 1 and 2, 1977	Vancouver	Manpower Planning Group - U.B.C.
September 6, 1977	Regina	Dr D. Panman Mr B. Middlemas Mr P. Jmaeff - Saskatchewan M.C.I.C.
September 6 and 7, 1977	Regina	Dr D. Thomson - Director Research M.C.I.C.
September 8, 1977	Saskatoon	Dr E. Baergen - Executive Director S.M.A.
September 12, 1977	Edmonton	Dr Clark - Alberta Medical Association
September 12, 13 and 14, 1977	"	Dr B.M. Macleod - Chairman Mr K. Moore - Executive Director Mr J. Shaever - Systems Mr M. Cheung - Economies Dr Follet - Monitoring - Alberta Health Care Insurance Commission
September 26, 1977	Fredricton	Mr J. Tarrel - Eastern Canada Consulting
May 1978	Toronto	Ontario Medical Association
July/Aug 1978	Edmonton	Alberta Health Care Insurance Commission

ATTACHMENT 2

Fee Negotiations :

History from Government's point of view.

Medical opposition to co-operation.

Early statistics, how used and how effective.

Arguments used to convince Government.

Agreements - mode of negotiation - why this one ?

The use of actuaries.

Overseas experience.

Periods.

Effect of A.I.B.

Who really determines the increase, real dollars.

Role of the C.M.A. Quebec Medical Associations.

What would do if time over again, mistakes.

Statistics :

Early statistics

Profiles - review committee.

- disciplinary action.
- membership committee. powers.
- formulae.

Doctor identification.

Development of the system.

- role in the negotiation process
- importance - could it have been done without.

Limits on income

- how managed.

Patient identification - unique.

Statistics cont. :

Medical Association usage.

Role of the Federal Government.

Relativities between Specialities :

Income used as a basis of negotiation.

What is basis of determining an appropriate income for one specialty verses another.

M.F.I. , Life time earning, training etc.

History, Future, Now.

Taxation statistics, Specialist income statistics.

Physician Supply :

when and how to conclusion that too many costs number.

location - mechanisms. deliberate policy behind on part of Government.

"Never ever control demand from public , provide services and they will be demanded."

Others :

Diagnostic coding.

Pathology.

Local payment and claim centres.

The Future, Salary Honorarium.

Forms please - claim form

- doctors claim.