Institute for Research on Public Policy

Institut de recherche en politiques publiques

The Physician Services Committee: The Relationship between the Ontario Medical Association and the Ontario Ministry of Health and Long-Term Care

Tom Archibald
Colleen M. Flood

CHSRF-OMHLTC Research Project
"Defining the Medicare Basket"

IRPP Working Paper Series
no. 2004-03

Working Paper No. 2 – Defining the Medicare Basket
CHSRF-OMHLTC Research Project "Defining the Medicare Basket" (RC2-0861-06)

2 March 2004

The Physician Services Committee – the Relationship between the Ontario Medical Association and the Ontario Ministry of Health and Long Term Care

By Tom Archibald* and Professor Colleen M. Flood**
Faculty of Law, University of Toronto

*** SJD Candidate, Faculty of Law, University of Toronto and Visiting Professor, Faculty of Law, University of Alberta**
****Canada Research Chair in Health Law and Policy, Associate Professor, Faculty of Law, University of Toronto**

Prepared for Principal Investigators: Professors C.M. Flood, C. Hughes Tuohy, and M. Stabile
This Research is funded by the Canadian Health Services Research Foundation (RC2-0861-06)
Research and editing assistance from Greig Hinds

1. Introduction[1]

In Canadian health care, accountability and evidence-based decision-making are emerging as first-order priorities. Not only do health policy experts insist on greater evidence of the effectiveness of health policy choices, they are also insisting on greater transparency and accountability in how these choices are made. Choices regarding the content of the Medicare "basket" of services are the most prominent and difficult decisions in Medicare. In this paper, we examine how these rationing choices are shaped by the bargaining relationship between physicians and the Ontario government. In particular, we examine the extent to which the decisions taken by the immediate parties to this relationship are informed by the principles of accountability and evidence-based decision-making. In this connection, we are not concerned with whether the individual officials we interviewed themselves believed in these values. In our view, there was no doubt that they did. Rather, we are concerned more with whether the institutional framework in which they operate – and which they fashioned – is conducive to decision-making regarding the basket of physician services that accords with accountability and greater reliance on evidence.

Our main findings can be briefly summarized. The joint decision-making process between the Ontario Medical Association (OMA) and the Ontario Ministry of Health and Long-Term Care (MOHLTC) seems at once to be a triumph of science over politics, but remains inadequate from an accountability perspective. Evidence-based decision-making seems to be playing a greater role in determining both fee increases and changes to the Schedule of Benefits. However, the process still remains quite private, shielded from public input and scrutiny, and one in which, for better or worse the medical profession continues to exert a significant control over the policy agenda and outcomes.

[1] This paper is based, in part, on interviews by Tom Archibald with several key players connected with the Physician Services Review Committee (PSC). They are: Susan Fitzpatrick, Director – Provider Services Branch, MOHLTC; Harvey Beresford, MOHLTC Counsel to the PSC; Mr. Mort Mitchnick, PSC Facilitator; and Dr. David McCutcheon, MOHLTC Co-Chair of the PSC. See also, *Defining the Medicare Basket* Working Paper No. 1 by

2. Physician-Government "Collective Bargaining" in Ontario

The starting point is the collective bargaining relationship between the MOHLTC and OMA. Though akin to a union-employer relationship, it is not – physicians are not employees and in any case cannot unionize.[2] Rather, the OMA is recognized by the MOHLTC, as a matter of policy[3], as the exclusive bargaining agent for physicians in Ontario.[4] The OMA's bargaining rights are backstopped by the *Ontario Medical Association Dues Act, 1991*,[5] which requires all Ontario doctors[6] to submit annual dues to the OMA as a condition of their right to practice, much like the "Rand" formula does in the traditional labour relations context.[7]

The MOHLTC prefers to deal with one organization representing all physicians, as the experience in 1996-97 showed that a fragmentation of physician organizations rapidly created instability and the prospects for wage spirals. Prior to the 1995 election, the relationship between the OMA and the government was negotiated through "Framework Agreements".[8] In 1995, the newly-elected government was concerned by evidence of a dramatic increase in the rate of medical service utilization. It concluded that this double digit spiral was driven by physician behaviour.[9] In 1996, it passed Bill 26, an omnibus piece of legislation that, among many other public sector reforms, nullified the pre-existing

---

Flood and Erdman titled "The Boundaries of Medicare: The Role of Ontario's Physician Services Review Committee".

[2] **student? LRA 1995 exclusion of doctors (s. 1(1)?)

[3] By "policy" we mean that the agreement between the OMA and MOHLTC creates contractual obligations on the government which it could theoretically over-ride by legislative fiat (as occurred with the Social Contract Act of 1993), but rarely does. As such, the "policy" of recognizing the OMA exclusively is technically not a matter of law, but contract.

[4] Agreement between Ontario Medical Association and Ontario (Minister of Health and Long-Term Care, April 1, 2000 to March 31, 2004 (the *2000 Agreement*), Art. 1.1.

[5] Ontario Medical Association Dues Act, S.O. 1991, c. 51.

[6] **just those participating in OHIP or all?

[7] The 'Rand formula' is a term of art in labour law describing a unionized employer's obligation to deduct union dues from their employees' pay and remit it directly to the union, regardless of whether or not one or more employees are actually members of the union., On.

[8] "Framework agreement" is a generic term for a commercial contract or agreement with suppliers, the purpose of which is to establish the terms governing contracts to be awarded during a given period, in particular with regard to price and quantity. In other words, a framework agreement is a general term for agreements with suppliers, which set out terms and conditions under which specific purchases (call-offs) can be made throughout the term of the agreement. In this case, the framework agreement sets the conditions for negotiating payments to physicians for their services under the OHIP scheme.

[9] Mark E. Geiger, *Mutual Gains Bargaining*. (February 1999) online: <http:// http://www.blaney.com/pubs_articles_labour.html> (date accessed: 3 June 2003).

framework agreements between the OMA and MOHLTC. In opposing the government's stance on the root causes of increased physician utilisation, the OMA replied that increased utilisation was not due to physician behaviour but rather to demographic changes, population growth, new medical programs and expanded use of medical technology.[10]

Notwithstanding these arguments, in 1995 the Conservative government opted no longer to negotiate with the OMA but instead to deal directly with groups of physicians either on a specialty-specific or interest basis. However, when the MOHLTC did not respond effectively or quickly enough, the newly established groups threatened to withdraw or reduce services, thereby forcing the Government to negotiate with the OMA. It is thus against this backdrop of threats and claw backs, the OMA and Government negotiated a new agreement in 1997.[11]

On May 14, 1997, the OMA Governing Council ratified the Physicians' Services Agreement (*1997 Agreement*). The purpose of the *1997 Agreement* was to construct a joint OMA-MOHLTC model of voluntary primary care reform. In s. 1.03 of the *1997 Agreement*, the parties acknowledged that "[c]hanges are necessary in order to meet the demands and needs of a changing Ontario population requiring health care services." However, the parties also recognized that the Government is under "substantial fiscal constraints … [and thus] changes must be attained within appropriate budgets established by the Government for the MOHLTC."[12] Furthermore, in s. 2.04 of the *1997 Agreement*, both parties acknowledged that "…growth in utilization, and its corresponding impact on the cost of physician services, can occur for a number of reasons. Accordingly, the parties have agreed to various initiatives for the purpose of, *inter alia*, lessening the impact of utilization growth."[13] Significantly, the agreement provided for an annual 1.5% increase in the pool of funds available for medical services, and

[10] The PSC has subsequently acknowledged that data used to attribute increased utilization rates to physician referrals were not of high quality and speculative at best -- C. I. Doris. "Ontario Association of Radiologists launches legal action against the Ontario Medical Association" *Forum*, CAR *FORUM* 1998; 42(4):1 (August 1998).

[11] *Supra* note [Geiger – mutual gains].

[12] OMA-MOHLTC Comprehensive Agreement 1997 – 2000 (Dec 1996), at s.10.3 [the *1997 Agreement*]. Available online at: <http:// www.oma.org/member/negotiat/agreemnt/agree.htm> (date accessed: 4 March 2003).

[13] *Ibid.* at s. 10.3.

confirmed that the 2.9% Social Contract claw-back on physician billings would expire on February 28, 1998.[14]

Thus, the result of this 'collective bargaining' is the OMA-MOHLTC Memorandum of Agreement (as concluded in 1997 and renewed in 2000). This agreement is a strictly economic contract between the OMA and MOHLTC prescribing fee increases, both across the board and targeted. In addition, it creates various committees – revolving around the Physician Services Committee outlined below - for a variety of purposes related to both fee increases and the fee schedule. Since many important policy decisions emerge from these committees, the Agreement itself is only part of the process.

3. The Physician Services Review Committee: The Hub of Fee Schedule Decision-Making

In terms of how it addresses the values of evidence-based decision-making and accountability, the real hub of the OMA-MOHLTC bargaining process is the Physician Services Committee. The most unique aspect of this committee is its explicit incorporation of research, peer review and other mechanisms to enhance the evidence-based nature of decisions taken at the bargaining table. Its main strength appears to be its insistence on integrating, rather than segregating, the very private process of physician contract negotiation and the undeniably public interest in explicit and evidence-based grounds for choices about what is "in" and "out" of the Medicare basket. This insistence, in our view, represents a welcome innovation in the bargaining framework for governments and physicians, and perhaps other provider groups as well.

In the 1997 Agreement, the Physician Services Review Committee (PSC) was established. Its most basic mandate is "developing a strong relationship between Ontario's physicians and the MOHLTC."[15]

[14] The Social Contract introduced a global ceiling on expenditures for medical services during the three fiscal years beginning with 1993/94. In 1993/94, the cap was set at $93 million below 1992/93 expenditures, and in the 1994/95 and 1995/96 fiscal years, the cap was $138 million below 1992/93 expenditures. Payments in excess of the ceiling were 'clawed back' by reducing each physician's billings by an equal across-the-board percentage. In 1993/94, the claw-back was 2.8%; in 1994/95, it was 7.5%; and for 1995/96, the claw-back was approximately 10.88%. Billings were said to be exceeding the cap for a variety of reasons: the cap was 3.5% below expenditures in 1992/93, and there was an increase to the Benefits (price) of 1 percent effective October 1, 1992. Even if medical service volume could have been held constant, expenditures would still have exceeded the cap by 4%. (Adapted from the OMA website, per http://www.oma.org/phealth/pcare/chapter3.htm, accessed 5 September 2003).

[15] 2000 Agreement, per Art. 2.1.

As Harvey Beresford (the MOHLTC's lead counsel on the PSC) remarked in an interview, the PSC has helped the OMA-MOHLTC bargaining relationship "get off the raging rapids and onto a quiet river".[16] After rancourous disputes between the profession and the government in 1996, which nearly provoked job action by physicians, the PSC was established as an on-going bilateral committee to monitor medical practice and costs, and take pre-emptive and innovative approaches to defusing potentially divisive problems. Its aim is to bring a more "interest-based" approach to bargaining, one featuring greater openness with information, greater use of expert information, and ongoing problem resolution. In this "labour relations" role, the PSC can be considered a mediative mechanism designed mainly to shepherd and stabilize the physician-government bargaining relationship.

However, it also occupies a central role within the broader listing/de-listing process, because of the various committees that report to it, such as those discussed below.

Its more particular goals are spelled out in the Agreement as follows:

(i) to build and sustain a strong positive working relationship between the Government of Ontario and the medical profession;

(ii) to receive and consider reports and recommendations as set out in this Agreement;

(iii) to advise the MOHLTC and the OMA in connection with the changing role of physicians within the health care system, including possible improved models of delivery of and compensation for services;

(iv) to develop recommendations, either on its own initiative or as a result of reports and recommendations received from committees reporting to it, to MOHLTC leading to the enhancement of the quality and effectiveness of medical care in Ontario;

(v) to work together toward identifying efficiencies and maximizing return on the funding provided for medical services;

(vi) to review utilization on a monthly basis and recommend to the MOHLTC and the OMA appropriate and effective steps to be taken to deal with utilization changes;

(vii) to develop and recommend patient education programs;

[16] Telephone interview with H. Beresford on 10 February 2003.

(viii) to review any disagreement arising out of this Agreement referred to it by either party and make recommendations to the parties regarding the resolution of the disagreement. However, the parties need not make such a referral as a pre-condition to commencing any other dispute resolution mechanism;

(ix) to study the report of the Physician Malpractice Insurance Expert Committee and to make recommendations to the parties as to how malpractice insurance for Ontario physicians should be provided effective January 1st, 2001; and

(x) to monitor the impact of hospital restructuring on utilization and the cost of physician services.

The PSC consists of 10 members, five each from the MOHLTC and OMA. It is chaired by a professional facilitator first by George Adams, now by Mort Mitchnick[17], both labour arbitrators and, in the case of Adams, a judge as well) who determines the agenda for the PSC in consultation with the parties. It meets twice a month.

The PSC is the hub of decision-making on fee schedule determinationdecisions, meaning decisions on the addition or removal of physician services from public coverage. It plays out this role by coordinating a wide array of standing and *ad hoc* subcommittees researching and advising the PSC on specific issues pertaining both to fees and to the content of the Schedule of Benefits. The functions of some relevant committees will be seen in the following discussion of how budgeting, fee determination and benefit schedule reform issues are channelled through the PSC and ultimately to the MOHLTC.

a. Budgeting Decisions:

Dr. David McCutcheon, the MOHLTC co-chair on the Physician Services Committee, described[18] three levels of budget rationing within the MOHLTC: *macro*, *meso* and *micro*. Budgeting decisions take place mainly at the *macro* level; rationing decisions on fee increases and benefit schedule reforms take place at the meso and micro levels, respectively. At the macro level, there is a fixed global fund that the parties have to work with. The size of this fund is determined by negotiation between MOHLTC officials,

[17] Mr. Mitchnick was interviewed on 14 April 2003.

those from other Ministries, and the various provider groups and committees, including of course the PSC, the OMA, and other professional groups. In this framework, it may be difficult to conclude that these macro budgeting decisions are completely unbuckled from economic considerations and the interplay of bargaining power at the *meso* and *micro* levels.

The meso level includes decisions about how to ration the funding among competing interests, including:

- Non-Physician OHIP Services (doctors being only a part of the OHIP budget)
- Providing Physician Compensation Increases
- Meeting Growth in Needs/Utilization in the System
- Fee Schedule Additions
- Other Targeted Physician Service Priorities (i.e. SARS-related measures)
- *Meso*-level decisions on key matters in physician collective bargaining can have a profound impact on macro-level budgeting decisions.

Most obviously, negotiated fee increases for physicians bear on the resources available for these other interests.

b. Fee Determination Issues

However, the PSC now plays a central role at the meso level in resolving matters of fee increases and benefit schedule changes. Fee increases are dealt with at the *meso* level in the unique PSC-driven collective bargaining relationship described above. For 2001-2004, the Agreement provides annual fee increases and, in 2003, provided a "re-opener" negotiation period for increases for the final year.[19] Fees are grouped into two categories. Professional fees are, simply, the basic rate for a given service as set

[18] Interview with McCutcheon on 17 April 2003 (the "McCutcheon interview").
[19] 2000 Agreement, Art. 3.1. Fee increases for 2000-2004 are 1.95%, and 2% per year thereafter.

out in the Schedule. Technical fees are fees for overhead and other costs.[20] While technical fees remain an important issue, the main focus is, obviously, on professional fees set out in the Schedule. Certain fine-tuning adjustments to the Schedule are made to respond to particular instances of over-utilization or other problems. For example, to address concerns that obstetricians were over-utilized, and to "maintain family physician involvement in obstetrical services", the Agreement gives a 50% premium to the Schedule tariff for doctors who have only one delivery in a calendar day.[21] Finally, the Agreement addresses controversial issues such as annual billing thresholds.[22]

In short, the Agreement sets the economic backdrop (fee increases) against which decisions about whether to add or remove a service from OHIP are made. Once fee increases are set, they must be implemented on an annual basis. Because the Schedule of Benefits under OHIP changes so frequently, a major issue for the parties is deciding how to allocate fee increases among the services in the Schedule. Here, the Resource-Based Relative Value Schedule Committee (RBRVSC) plays an important role. The RBRVSC is a three-person bilateral committee chaired by a neutral.[23] Its task is "to determine the relative value of services provided by physicians on a revenue neutral basis."[24] That is, it is to review the schedule of benefits and assign relative "weights" among services depending on factors such as effectiveness, utilization, and cost. As will be explained further below in connection with listing/delisting decisions, the RBRVSC's report bears directly on how fee increases negotiated in the Agreement[25] are to be allocated among the over 4,600 services set out in the Schedule.[26]

For instance, in 2001, the MOHLTC had to implement a 2% fee increase pursuant to the Agreement. In past, increases were allocated on an "across the board" basis (i.e., all service fees are increased 2%). But since the advent of the RBRVSC and a greater concern for cost-effectiveness, increases can now be targeted to address utilization problems, and more importantly to create room for additions to the

[20] 2000 Agreement, Art. 9.
[21] 2000 Agreement, Appendix G, "Patient Care Enhancements", subs. B(1), "Low Volume Obstetrics Incentive"
[22] 2000 Agreement, Art. 14.
[23] 2000 Agreement, Appendix E.
[24] 2000 Agreement, Art. 16.1
[25] 2000 Agreement, Art. 3.1. Fee increases for 2000-2004 are 1.95%, and 2% per year thereafter.
[26] 2000 Agreement, Art. 16.2: "The parties may agree that the implementation of the RBRVS be taken into consideration in deciding how to apply the percentage increases set out in Article 3 of this Agreement."

Schedule that may be recommended by the OMA. This creates opportunities for possibly adding benefits without increasing the overall costs.

c. Benefit Schedule Reform Issues

Benefit schedule reform issues take place at what Dr. McCutcheon described as the *micro* level. While the PSC decides at a *meso* level how to allocate increased funding to fee increases (or decreases) among *existing* services, it also plays a vital role in determining what those services are. However, such decisions almost always have their genesis in the OMA itself. The OMA has a wealth of economists and other researchers that gather evidence from other jurisdictions, clinical trials and other sources, and it produces annual reports recommending changes to the schedule of benefits. The committee within the OMA that does this is called its Central Tariff Committee (CTC). The CTC solicits research and submissions from a wide variety of medical specialists and struggles to come up with changes to the schedule that, in its view, are most appropriate. It is a 10-person committee, all physicians or physician economists. According to Dr. McCutcheon, it's the CTC's annual report is widely respected in the medical community and carries a great deal of weight with the Ministry and the various committees outlined above.

According to one Ministry of Health official, the CTC has been more "gun-shy" in recent years in recommending de-listing.[27] Much of this has to do with litigation by Ontario audiologists[28] and other groups to contest some of the de-listings that ultimately resulted. As such, the CTC has been wary of recommending de-listings, preferring instead in recent years to submit reports recommending additions to the schedule. In fact, according to the MOHLTC official we interviewed, since 1998 the CTC has not

[27] Interview with S. Fitzpatrick on 13 March 2003 (the "Fitzpatrick interview").

[28] *Shulman v. College of Audiologists and Speech Language Pathologists of Ontario*, [2001] O.J. No. 5057. Among other grounds, the applicant sought a declaration that the decision of the Ontario government to stop insuring costs of hearing aid evaluations and re-evaluations and to attach conditions to terms of payment to physicians for diagnostic hearing tests violates equality rights of persons with hearing disability as guaranteed by s. 15(1) of the Charter of Rights and Freedoms. The Court deferred to the government on policy-making grounds, concluding (at para. 43) that the "healthcare system is vast and complex. A court should be cautious about characterizing structural changes to OHIP which do not shut out vulnerable persons as discriminatory, given the institutional impediments to design of a healthcare system by the judiciary." In this case, the changes to the Schedule of Benefits were found not to discriminate within the meaning of s. 15(1) of the Charter and the application was dismissed on that ground.

forwarded a report to the OMA or PSC containing any de-listings. As well, difficult rationing decisions are made within the CTC before presenting its report, as it strives for a positive response by government officials.. For example, cost increases arising from technological advancements place a great constraint on the CTC's preparedness to expand the Medicare 'basket' of health goods and services.

Here, a key fact to note is that the CTC operates independently from the OMA-MOHLTC bargaining process. Unlike the PSC and other meso-level decision-making processes within the OMA-MOHLTC bargaining relationship, its mandate is not to take cognizance of budget estimates, nor of fee increases, in making its recommendations. Further, the CTC's fee schedule reflects that considered appropriate within the OMA, not the public fee schedule. According to one official, OMA fees are on average about 58% higher than those in the public schedule. As such, the CTC's report is received annually by the MOHLTC, which in turn considers it in consultation with the PSC and its subcommittees. In these committees,, however, only Ministry and OMA representatives participate in the review of the CTC's proposals. While it is never easy to assess, according to our MOHLTC official, the CTC's recommendations are generally well received by the parties, and often implemented.

Not surprisingly, physician fee increases can place a constraint on how receptive the MOHLTC can be to the CTC report. For example, a 2% increase in 2001 means that this 2% can be used to add more services or be an across the board increase for existing ones. This is where the RBRVSC and PSC come into play. These committees consider the CTC's recommended changes, and if they are approved, the MOHLTC presents them to Cabinet for budgetary approval and enshrinement in the schedule. In deciding how they will allocate each year's negotiated increase, the RBRVSC and PSC have shifted from across-the-board application of the increases (i.e. 2% increase in all service fees) to a more targeted application (i.e. increasing some fees but not others, at varying rates which in total equal the same overall fee increase as an across-the-board application). In 2000, the parties devoted 1% to across-the-board increases, and 1% to targeted increases. In the 2003 round of bargaining (technically, a re-opener round provided for in the 2000-2004 agreement), the parties may devote the entire 2% for 2003-04 to targeted increases.

Hence, the CTC at first, then the PSC and its subcommittees later, are the crucial "sites" of key listing/delisting decisions, decisions with profound implications for individuals or groups dependent on particular kinds of services. As noted, the CTC is comprised entirely of physicians, whereas the other committees are bilateral. In discussions with MOHLTC officials it was apparent that there are plans for another "bilateral" committee to receive and review the CTC report, though it is not clear right now how this will fit into the existing framework. Within this framework, there is little or no public participation, although evidence-based decision-making – albeit dominated by physician voices - seems to persist. For example, the terms of reference of the RBRVSC make no explicit provision for input into its decisions by actors besides the OMA or MOHLTC.[29] The sum total seems to be that, despite the current PSC-centred bargaining framework's integration of evidence with rationing choices, amendments to the schedule are ultimately treated by this framework as a largely private matter best left to the interplay of political and economic power between physicians and the government.

An interesting recent episode of rationing in the de-listing process was brought about by the requirement in the 1997 Agreement that the PSC find $50 million in savings in the overall cost of the Schedule of Benefits. The SOB Working Group created for this purpose, with many of its members being the same as those on the CTC, has an ongoing role and consults regularly with the Ministry. In preparing its first report in 1998, the SOB Working Group vetted its proposals with expert physician panels and focus groups.[30] In the next round, however, it did not do so.

According to Dr. McCutcheon, the CTC undergoes annual "marathon sessions" in which it solicits research and reports from groups within and outside the profession.[31] All these efforts are aimed at determining what is and is not "medically necessary". More often than before, cost-effectiveness is becoming a dominant factor, if not at the CTC level then certainly at the PSC level. Like the PSC, the

[29] 2000 Agreement, Appendix E: The Commission will continue to provide an adequate opportunity to all appropriate parties to make submissions at all remaining stages of its mandate.

[30] This may represent a form of consultation where de-listing decisions are concerned. It seems to contrast with the more closed process for adding benefits via the CTC-PSC route. This might suggest that the two parties give more concern to public values and evidence-based decision-making when delisting is concerned than where adding services is concerned. Perhaps this is an analogue in the rationing process to "defensive" medicine; reluctance to de-list for fear of litigation or other political problems.

[31] Interview with McCutcheon on 17 April 2003 (the "McCutcheon interview").

CTC often turns to established external research bodies for assistance, including more health economists. These include: the Institute for Clinical Evaluative Sciences, the Centre for Health Economics and Policy Analysis, the Canadian Health Economics Research Association, and other groups. Once the CTC completes its report, it is sent to the OMA for review and is then passed to the PSC.

At the PSC level, CTC recommendations are assessed on cost-effectiveness bases, particularly with respect to proposed new services involving new technologies (which are often very costly). This kind of review is important, according to Dr. McCutcheon, to avoid the political irrevocability problems associated with adding a service; that is, once a much-demanded service is added, reviewing it after its introduction for its real effectiveness in relation to cost may be futile because of the difficulty in acting on any findings that might suggest full or partial de-listing of it. For example, the PSC will carefully consider the cost-effectiveness of PET scans – newer, more thorough cancer detection methods – before following through on adding them to the Schedule. Before the days of the PSC, he said, this kind of analysis might not have been undertaken as rigorously. Evidently, from these comments, there is less government preparedness to engage in the tendency, noted by Barer and Evans[32], for governments to try to improve health by providing an ever-increasing array of health services, with little inquiry into the broader connection between these services and actual health outcomes (where these are even articulated). To what extent these considerations will raise tensions within the PSC or the CTC will never be known, because of the difficulty of knowing anything about what the PSC actually decided.

Interestingly, Dr. McCutcheon noted that the CTC used to be bipartite, and therefore less effective. When it was equally composed of physician and government members, he said, it lost some credibility with the Ministry because the Committee's deliberations – in particular, on whether to follow one or another group's research findings – tended to be perceived as politically tainted, a simple battle of payroll scientists. Now that it is once again dominated by the OMA, this political flavour has receded.

[32] R.G. Evans, Morris L. Barer and T.R. Marmor (eds.) *Why are Some People Healthy and Others Not? The Determinants of Population Health*, New York: Aldine De Gruyter, 1994.

4. Comments

In sum, the emergence of evidence-based decision-making is most welcome in meso-level decisions regarding listing/delisting of services. The PSC and its many expert subcommittees are, in this sense, a welcome innovation. It recognizes the intimate connection between private processes of negotiation between government and professional providers on one hand, and the comprehensiveness of services covered on the other.

However, the process still remains fundamentally unaccountable and lacking in transparency. Given the importance of changes to the OHIP schedule to the broader public interest, these are the main weaknesses of the current MOHLTC-OMA bargaining model. The process appears to gain peace for the parties at perhaps the cost of accountability to the public. Certainly, as Dr. McCutcheon noted,[33] the PSC has various valuable functions, not least of which is the voice mechanism it provides between vital stakeholders – physicians – and government. By improving labour relations, it creates a better climate for innovative structural reforms that result in more disciplined use of health care resources. It fosters an incremental approach to fee and schedule of benefits changes, because both sides are keenly aware of the immediate issues faced by the other at any given time, and increased trust fosters less incentive to seek "big bang" approaches to problems. In short, co-management along the PSC model seems to be improving accountability as between physicians and government on these issues.

However, accountability to citizens and patients remains lacking. Much of the shift to the PSC model has involved more concealment of the precise issues that are in tension between the MOHLTC, as representatives of citizens, and the OMA, as representative of its professional constituency. Certainly, these changes greatly facilitate smoother relations between the two parties, but result in less transparency for the process between them. In other words, improving labour relations by concealing them falls far short of meeting Canadian health policy demands for more accountability for key decision-making processes.

The fact that the CTC is now seen to work "better" because it is no longer bipartite and is shielded from *Privacy Act* intrusions is telling. Yet at the same time we see the "defensive medicine" approach of late

[33] McCutcheon interview.

by the CTC in being shy about delisting services. Were the CTC still bipartite, would the same occur? Or is it that the CTC essentially represents the consensus view (also not easy to reach within the OMA) of the OMA? It certainly lessens the risk of rancour and debate at the CTC, fostering an image of effectiveness, but does so at the expense of accountability and dialogue, pushing rationing decisions up the line to the PSC and the MOHLTC.

And at these levels, the current structure of PSC decision-making remains firmly within the grasp of the medical profession. The PSC certainly succeeds as a labour relations tool – and perhaps is instructive beyond the physician sector – but does so at a familiar labour law price: more money or more power. Where funding doesn't allow extravagant compensation increases, health care providers can still be rewarded in non-monetary ways. In this case, the PSC represents an innovative way to improve labour relations (that is, reduce conflict), one that does not simply involve buying peace with raw cash. In this model, the professional and economic interests of physicians are treated with equal importance, and professional interests accommodated through mechanisms like the PSC that foster greater "partnership" between a unique (and not legally recognized as such, except where it might shield decision-making from public scrutiny)[34] kind of employer, and a similarly unique kind of employees' representative (also not recognized as such). The OMA-MOHLTC relationship "quacks like"[35] collective bargaining; therefore, it is. If so, it is a relationship characterized by a much closer, more accommodating relationship as between the parties.

There is little participation in any of these processes by groups other than physicians, MOHLTC officials, physician experts and other private consultants. Focus groups as were used in the 1998 SOB Group process may be as close as one can come to finding any other voices. Certainly, as Susan Fitzpatrick noted,[36] hospitals, other OHIP beneficiaries and dependents of the MOHLTC all have

[34] See Order PO-1721 of the Ontario Information and Privacy Commissioner, in which the MOHLTC attempted to have certain records of the PSC's discussions exempted from disclosure on the grounds that, while the doctors are not directly employed by the MOHLTC, it is their source of income and, as such, is in the nature of an employer to them. Thus, the MOHLTC argued, the documents being sought were related to labour relations and therefore exempt. The Privacy Commissioner rejected this approach. See http://www.ipc.on.ca/scripts/index_.asp?action=31&N_ID=1&P_ID=4003, accessed 5 September 2003.

[35] McCutcheon interview.

[36] Fitzpatrick interview.

expressed keen interest in what happens in these processes, but to date have not been formally involved.

While labour peace is vital as between physicians and the government, particularly at a time when Canada faces severe doctor shortages and, more recently, it may be the case that accountability is seen as too risky an element to include in the broader decision-making institutions relating to the content of the schedule of benefits.