Fee-Setting: A Study of Decision-Making by the
Medical Profession in Ontario

by

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A thesis submitted in conformity with the requirements
for the degree of Master of Science

Graduate Department of Health Administration

University of Toronto

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Fee-Setting: A Study of Decision-Making by the Medical Profession in Ontario

M.Sc., 2001

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Department of Health Administration, University of Toronto

Abstract

Physicians' fee schedules have historically been established by a process strongly influenced by the commitment of the medical profession to collegiality and rational decision-making. A study of the effects of a shift from a distributive to a re-distributive role for the medical profession in the allocation of health care resources showed that what has been traditionally seen as a model of rational public policy decision-making conforms better to an incremental model. Although the current Resource-Based Relative Value Schedule Commission of Ontario to produce a new, resource-based relative value fee schedule is significantly different in from previous RBRVS projects, the assumptions on which it is based are similar to those used by its predecessors. The fee schedule resulting from the project might reasonably be expected to resemble closely the existing fee schedule.
Acknowledgements

My research and thesis supervisor, Professor Raisa Deber, provided stimulating discussion and guidance throughout the course of my studies. Rhonda Cockerill, as graduate coordinator and a member of my supervisory committee, provided timely advice and encouragement through the course of my studies. I am particularly indebted to Dr. John Wade, Chairman of the Resource-Based Relative Value Schedule Commission of Ontario, who gave generously of his time and thoughts during critical phases of my research, read and criticized my thesis, and confirmed for me the nobility of the profession of medicine. Dr. David Peachey, one of the RBRVS commissioners, spent hours with me, discussing the Ontario RBRVS project and collaborating on writing a series of papers for publication describing the project. Many others gave generously of their time and helped in various ways with this project. I am grateful to Brenda Gluska for facilitating the gathering of information related to the operation of the RBRVS Commission. Ron Smuckler, Peter Fraser, Ted Rumble, Jim Tsitanidis, David Mendelssohn, Michael Baird, Darrel Weinkauf, and Matt Borsellino all helped by describing their own experience with physicians' fee-setting and providing important insights into the process. The Ontario Medical Association allowed me access to numerous Board documents, particularly minutes of the meetings of the Central Tariff Committee, in addition to unpublished reports to the Association relating to fees for physicians' services. I am grateful to Ms Karen Lee, Coordinator, Library Services, and Ms Kathy Fur, Records Analyst, Corporate Information, of the Ontario Medical Association, for their help in locating documents and facilitating their use in my studies.

My wife, Cathy, provided moral support and more importantly, tolerated my abiding commitment to this project at the expense of her own needs.
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<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CMA</td>
<td>Canadian Medical Association</td>
</tr>
<tr>
<td>COE</td>
<td>Committee on Economics, Ontario Medical Association</td>
</tr>
<tr>
<td>COFM</td>
<td>Council of Ontario Faculties of Medicine</td>
</tr>
<tr>
<td>CPR</td>
<td>customary, prevailing, and reasonable</td>
</tr>
<tr>
<td>CPSO</td>
<td>College of Physicians and Surgeons of Ontario</td>
</tr>
<tr>
<td>CTC</td>
<td>Central Tariff Committee, Ontario Medical Association</td>
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<tr>
<td>HIA</td>
<td>Health Insurance Act, 1996</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>OAR</td>
<td>Ontario Association of Radiologists</td>
</tr>
<tr>
<td>OHIP</td>
<td>Ontario Health Insurance Plan</td>
</tr>
<tr>
<td>OMA</td>
<td>Ontario Medical Association</td>
</tr>
<tr>
<td>OMR</td>
<td>Ontario Medical Review</td>
</tr>
<tr>
<td>OSOG</td>
<td>Ontario Society of Obstetricians and Gynecologists</td>
</tr>
<tr>
<td>PSI</td>
<td>Physicians' Services Incorporated</td>
</tr>
<tr>
<td>RBRVS</td>
<td>Resource-based relative value schedule</td>
</tr>
<tr>
<td>RVS</td>
<td>Relative value of services</td>
</tr>
<tr>
<td>RVU</td>
<td>Relative value unit</td>
</tr>
<tr>
<td>SCO</td>
<td>Specialists' Coalition of Ontario</td>
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<tr>
<td>TEW</td>
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Introduction

The medical profession as a group occupies a position of enormous influence in our society. Positions taken by the profession on the organization and provision of health care services are invariably taken seriously and often determine the form and substance of public policy in these spheres. How policy decisions are made within the profession is, therefore, of considerable interest to society at large. This thesis is about public policy decision-making. The overall objective of the research is to examine the manner in which Ontario physicians, as a group, develop policy with respect to an issue that affects all members of the profession. The decision to focus on fee setting was based on the observations that the vast majority of Ontario physicians are remunerated on a fee-for-service basis. Moreover, because fees are the most important determinant of physicians' incomes, feelings about them tend to run high. Over the past several years, major legislative and organizational changes in relations between the profession and government have severely limited the options available for compromise, increasing the stakes for potential losers in the fee-setting process, and therefore intensifying debate. In Schattschneider's terms, therefore, the conflict within the profession is broad in scope, highly visible, and intense.

In this thesis, I propose to examine how the special agency relationship existing between the medical profession and society, along with the strong historical commitment to collegiality within the profession, have combined to determine what is taken into consideration in setting fees for physicians' services. I also propose to show how a shift from a distributive to a redistributive role in the allocation of health care resources has exposed what traditionally has been seen as a model of rational public policy decision-making to conform better to an incremental model. Finally, I will comment on what the implications are for the current fee-setting project.
Background

In the second half of the nineteenth century, allopathic medicine became entrenched as the societal standard among the healing professions in Canada and the United States, and alternative 'healers', such as homeopathy, naturopathy, and chiropractic, became marginalized or eliminated altogether from competition for clients. Payment for medical services was predominantly on a fee-for-service basis, with prices set entirely by the individual physician. In Europe, various forms of sick funds developed, as a strategy to ensure access to medical care and to spread the risk of the cost of illness. Many physicians contracted with the sick funds, particularly during economic hard times, to provide care for subscribers on the basis of a capitation.

Notwithstanding, simple fee for service remained by far the principal form of physician reimbursement (2). Towards the end of the century, groups of physicians began to develop schedules of fees for specific services to patients, in what amounted to an institutional move towards price fixing.

What changed dramatically during the middle half of the twentieth century was the growth, throughout Europe and North America, of private and public health insurance agencies as third party payers for medical services. As the involvement of third party payers grew, pressure mounted to codify services and fees for the purposes of administering cash benefits to be paid to physicians for their services. Ontario led the pack in Canada, and most provincial fee schedules, which emerged in the years following World War II, were modeled closely on schedules developed in this province. Although fee schedules became more comprehensive and complex, the principles on which they were originally based remained essentially the same.
Members of the medical profession, without significant participation by others, originally established fees, primarily on the basis of estimations of physician resource inputs required to provide specific services. This included the time taken to deliver the service, the technical skill involved, and some rough estimation of risk, i.e., the potential for a bad outcome, such as severe residual disability or death. The emphasis was on discrete services, which were more likely to be procedural than cognitive in nature. In the days when most medical services were paid for by patients, payment for procedural services, such as surgical operations, was more often delinquent than payment for cognitive services. Perhaps this was because surgical services were more often not elective; therefore, the client-patient had less control over the timing of the service and was often, therefore, unable to pay, while the surgeon, out of compassion, was unlikely to deny emergency medical care. As a result, however, procedural services were, in general, over-priced relative to other services, to compensate for delinquent accounts. The 'Robin Hood' principle was applied to other components of fee schedules, further distorting the original resource-based determination of prices.

**Medicine as an agent of society**

Policy with respect to the reimbursement of physicians is deeply institutionalized. Since the late nineteenth century, when allopathic medicine, rooted in the application of the scientific method, prevailed over homeopathic and other approaches to the management of illness, the profession has enjoyed a special and privileged position in society (3, 4). The relationship that developed between the profession and society is explainable, in some critical ways, by agency theory, originally developed to explain some aspects of the organization of business corporations (5).

We define an agency relationship as a contract under which one or more persons (the principals) engage another person (the agent) to perform some service on their behalf which
involves delegating some decision making authority to the agent. If both parties to the relationship are utility maximizers, there is good reason to believe that the agent will not always act in the best interests of the principal. The principal can limit divergences from his interest by establishing appropriate incentives for the agent and by incurring monitoring costs designed to limit the aberrant activities of the agent. In addition, in some situations, it will pay the agent to expend resources (bonding costs) to guarantee that he will not take certain actions which would harm the principal or to ensure that the principal will be compensated if he does take such actions.” ... “The dollar equivalent of the reduction in welfare experienced by the principal due to [divergences between the agent’s decisions and those decisions which would maximize the welfare of the principal] is also a cost of the agency relationship [residual loss]. (6, p. 308)

Control strategies emerged, typical of agency relationships in other environments. These involve both governance structures (auditing and formal control systems) and compensation schemes (budget restrictions and financial incentives which serve to identify the agent’s interests more closely with those of the principal) to ensure that the goals of the profession do not diverge significantly from those of society. The profession is constrained by a code of conduct that is not only rooted in a strong historical tradition of beneficence and non-maleficence, but is also mandated by statute and administered by the College of Physicians and Surgeons of Ontario (CPSO), constituted primarily of physicians, but responsible ultimately to the provincial Cabinet.

The evolution of control through compensation schemes has been more complex. Decisions about compensation deal with a series of linked issues, including: 1) how physicians should be organized into practices (e.g., solo practice, group practice, etc.), 2) the method by which they should be reimbursed (e.g., fee-for-service, salary, etc.), 3) whom those payments should come from (public insurance, private insurance, direct payments from patients, etc.), 4) whether these payments should flow directly to individual providers or be paid to provider organizations which in turn will reimburse physicians, 5) the total amount of resources which will be paid to physicians, and 6) the pricing of particular services. This thesis deals primarily with the last of these questions - that is, the setting of fee schedules. However, it is important to recognize that when physicians are reimbursed on a fee-for-service basis, their expected earnings are a function
of both fee levels and volume. In addition, the total amount which will be paid for physician services will also depend upon physician numbers. Accordingly, particular decisions about the those compensation issues beyond the scope of this thesis can have a major impact upon the policy levers available to government, and put additional pressure upon the process of setting fee schedules. Society has played a major role, primarily through legislation, in determining many of these issues (2, 7). In most industrialized countries, the welfare state has lead governments to seek universal access to needed healthcare services at an affordable price. Physicians, in contrast, have sought to maintain their professional and economic autonomy. In turn, this has led to disputes between governments and the medical profession (2,7,8). The right of doctors to receive payments directly from patients has even been incorporated into several medical codes of ethics on the grounds that economic independence (economic autonomy) was essential if physicians would remain free to make medical judgements on purely medical grounds (professional autonomy) (2, pp 90-100). In practice, however, physicians' fears that public payment would inevitably lead to public management of the practice of medicine have not been realized (8). Instead, the very lack of public management of medical practice in Canada, compared with the situation in the United States, for example, has been criticized by some health policy observers (9)\(^1\).

In contrast to the strong interest of society in having a voice in how physicians should be paid, almost all Western countries have entrusted the profession itself with determining the pricing of physicians' services, that is defining services and setting fees. This has been justified by the marked difference between the profession and the population served in specific knowledge about ............................................

\(^1\) Ironically, 'managed care', in which individual medical decisions by physicians are routinely reviewed by cost-conscious, non-physician managers, has become a prominent feature of medical practice in the United States, which has rejected universal national public health insurance plan out of fear of government control of medical decision-making [Kassierer JP. Managed care and the morality of the marketplace. N Engl J Med 1995;333:50-52].
the diagnosis and treatment of disease (11, 12). It is done on the understanding that the manner in which fees are set would ultimately benefit society. The benefit, however, involves a cost—the cost of entrusting the process to an agent, the medical profession, whose self-interest inevitably diverges from that of the society served.

The emergence of fee schedules did not change matters much: prices were still set by physicians, though the process of setting fees involved negotiation within the profession. There is little evidence that third party payers in Canada have exerted much, if any, direct control over pricing. The impact of indirect controls on pricing on physicians' incomes has been neutralized, to a large extent, by a lack of control over the volumes of services provided. As a result of asymmetry of information between the doctor and her patient, the physician-supplier becomes the ultimate judge of medical need, creating considerable potential for manipulation of demand by over-servicing or under-servicing the patient. It seems reasonable to regard 'supplier-induced demand', a generally accepted cause of excess cost of physicians' services (9, 11-13), as part of the agency cost of entrusting the medical profession with providing medical services funded on a fee-for-service basis. To the extent that the relationship between the medical profession and society is explainable by agency theory, some tension between the two is inevitable. Moreover, it will always be associated with costs.

Impact of the introduction of national health insurance

National public health insurance evolved in Canada in a manner similar to the way it evolved in Western Europe (7). The medical profession was generally opposed to government involvement in health insurance, except as a guarantor of payment for services to indigent patients according to fee schedules set by the profession (14). In every province, the profession
established insurance corporations, such as Physicians Services Incorporated (PSI) in Ontario, to sell health insurance to residents on a voluntary basis.

* Saskatchewan leads the way*

In spite of various attempts, in different parts of Canada, to introduce publicly funded, provincial health insurance plans prior to World War II, the first successful comprehensive plan for hospital-based services (which did not extend to physician fees,) did not emerge until after the war, in Saskatchewan. The Saskatchewan Hospital Services Plan, introduced in 1946, provided universal, compulsory, publicly administered and financed hospital care insurance for residents of the province. This plan became the model for the rest of Canada; the federal *Hospital Insurance and Diagnostic Services Act* (1957) provided federal cost-sharing for similar plans in all Canadian provinces. These hospital insurance plans did not include payment of physicians' fees. This had to await enactment of the Saskatchewan *Medical Care Insurance Act* in 1961, the first universal, tax-supported, publicly administered medical care insurance plan in North America. "From now on fee levels and percentage of fee payments would have to be negotiated with the Government rather than with the profession's own prepayment plans" (15). The plan led to a bitter strike by Saskatchewan physicians, which was eventually resolved by a compromise which allowed physicians to "extra bill" for their services, while making this relatively difficult to do in practice (15).

* The federal Medical Care Act (1966)*

The Saskatchewan experience with the introduction of comprehensive medical care insurance prompted the Canadian Medical Association and others to press John Diefenbaker, the Conservative Prime Minister of Canada, to appoint a committee to study the matter. He responded by appointing the Royal Commission on Health Services, chaired by Justice Emmett
Hall (the Hall Commission), in June 1961. One of the principal recommendations of the Commission, when it reported in 1964, was establishing Saskatchewan-style universal comprehensive publicly financed and administered plans across the country, cost-shared by the federal government. This led to enactment of the federal Medical Care Act of 1966, passed with the support of 177 of 179 MPs. Over the period 1968-1971, each province entered the plan by establishing medical care insurance plans meeting the federal criteria for cost-sharing; Ontario entered in October, 1969.

Enactment of the federal Medical Care Act, incorporating recommendations made by the Hall Royal Commission on Health Services (1961-64), led to the establishment of provincially funded insurance schemes throughout the country (15). Provincial government insurance plans, such as the Ontario Health Insurance Plan (OHIP), adopted the fee schedules set by the physician-owned insurance schemes, such as PSI. One of the most immediate effects of the implementation of the legislation was an increase in physicians' incomes (16, 17). A part of the increased income was no doubt the result of increased workloads resulting from the removal of financial barriers for patients seeking medical attention who previously could not afford the expense. In addition, however, the introduction of universal public health care insurance meant physicians were assured payment, according to the negotiated fee schedule. Following the compromise adopted in Saskatchewan after the their doctors' strike, physicians were also permitted to bill patients directly for the same services, so-called 'extra-billing', albeit under carefully controlled circumstances.

Although physicians have always had the option of opting out of the publicly funded national healthcare insurance scheme, within a few years of its inception, the vast majority stayed in and were receiving the bulk of their income from provincial public insurance plans (8, 18).
Nonetheless, despite periodic freezes on increases in fee schedules during the years that followed the introduction of medicare (19), physicians could theoretically continue to increase their incomes by taking advantage of the right to extra-bill for insured services. Only a small percentage of practitioners actually took advantage of the extra-billing option, probably because they were still free to enhance their incomes by manipulation of the volume, mix, and price of medical services. Support for extra-billing among members of the profession was primarily ideological (8, 18). This privilege was eliminated, despite the opposition of the Canadian Medical Association (CMA) and provincial governments, with the enactment of the Canada Health Act (1984).

Canada Health Act (1984)

Enactment of the Canada Health Act in 1984 marked a major legislative turning point with respect to the fee-setting process by the medical profession, for the Act penalized provinces financially if they did not eliminate the possibility of physicians augmenting their incomes by extra-billing patients for services also covered by provincial health insurance plans. Passage of the complementary provincial legislation in Ontario, the Health Care Accessibility Act (1986) was met with strong professional opposition, culminating in an abortive withdrawal of services in the summer of 1986 (20). Even though only about 10% of Ontario physicians participated in extra-billing, and the total billed accounted for only 2.4% of total physician billings under medicare (8), this move by government was widely regarded by physicians as a serious threat to their autonomy, particularly with respect to potential income generation. Under the Ontario legislation, physicians were still permitted to practice medicine outside the plan, billing patients directly for medical services; however, they were not permitted to charge more than the OHIP rate for rendering an insured service to an eligible insured person. The elimination of extra-
billing meant that physicians were limited by the OHIP fee schedule, which placed even greater pressure on the fee-setting process.

Provincial governments opposed the federal legislation for a variety of reasons (20). Some provinces opposed the measure on principle, viewing it as an encroachment on what they regarded as an exclusive provincial jurisdiction. Others seemed to see extra-billing as a safety valve, a way to allow selected physicians to enhance their incomes without any adjustments of the fee schedule that would end up costing the government more money. Physicians opposed the Act for similarly ideological or pragmatic reasons. Some were simply opposed to the role of government in the reimbursement of physicians, seeing it as a violation of their freedom to practice medicine as independent entrepreneurs, and others viewed it as an restriction on their potential for enhancing their incomes. No longer could disaffected physicians compensate for real or perceived fee schedule inequities by billing outside OHIP. The intensity of opposition to the proscription on extra-billing has been widely interpreted as more a response to the threat it posed to autonomy of the profession than an economic issue (20).

During this period, conflict with regard to physician reimbursement centred predominantly around negotiations between the profession, e.g., the OMA, and government. The principal issue, as far as the profession was concerned, was ensuring an adequate pool of funds to pay for physician's services. Conflict between the different specialty groups within the profession, in the course of developing schedules of fees, was minimal as long as the overall allocation of money to pay physicians was considered adequate or sufficiently open-ended to absorb increased volumes of services. The scope and intensity of conflict changed dramatically, however, with the introduction of fixed caps on payments to physicians.
As long as physicians were able to control incomes by adjusting volumes of services or by extra-billing, conflict regarding the fee schedule was relatively muted. Challenges to decisions by the OMA Central Tariff Committee (CTC) were rare. The situation changed when extra-billing was eliminated and the government placed hard caps on spending on physicians' services. The potential for conflict within the profession was increased by the combination of a freeze on the total allocation of public funds allocated for the payment of physicians and the shift from a distributive to a re-distributive role for the profession in resource allocation. The fee schedule suddenly became the only way specialty groups could enhance their personal incomes, and then only by getting a "bigger piece of the pie". Conflict within the profession over fees became much more heated with what amounted to a shift from distributive to re-distributive policies with regard to resource allocation, coupled with freezing of the total allocation for payment of physicians. These changes created potential winners and losers in the fee-setting process (21) (See Public policy decision-making, p.20-25).

The resource basis of fee-setting

One noteworthy historical consistency of the fee setting process has been the steadfast adherence to the principle of pricing services on the basis of resource inputs, such as time, intensity and practice costs related to the provision of a specific service (Table 1).

The time required to provide a service is easy to conceptualize and quantify, and it has traditionally been an important factor in the determination of price. However, even time as a resource is made complicated by the fact that the actual time spent with the patient is often only a fraction of the total time involved in addressing her problem. In some specialties, the time spent in contact with the patient (i.e., intra-service time) is often trivial compared with the pre-service and post-service time. Work intensity, another important determinant of price, is a composite of
special knowledge and judgement, interpersonal skills, technical skills, and the stress involved because of the risks associated with the provision of specific services. The difference in intensity is the justification, for example, for assigning a higher price to a high-risk procedure requiring extensive specialized knowledge and technical skills, compared with a simple, low-risk procedure taking approximately the same amount of time. The overhead costs of providing a service are the third resource component contributing to pricing of physicians' services. In some specialties, such as radiology, the cost of equipment required to provide services to patients is high, compared with the overhead costs of other specialty services, such as psychiatry. Specialty expertise, though not individual expertise, has been indirectly acknowledged in fee setting by including the opportunity costs of the extra years of training required by many specialties and years lost as a result of forced retirement. The calculation of opportunity costs has been a controversial issue. The current RBRVS Commission determined, by reference to data on physician's incomes during specialty training, that the opportunity costs today are actually negligible, and it has proposed eliminating this component from the calculation of the new RBRVS (22). Specialty groups who have historically justified fee differentials on the basis of the extended, poorly paid training demanded by the specialty have opposed this move.

The commitment to resource-based pricing is so entrenched in physicians' fee setting, that little thought is given to other ways of valuing medical services, ways that might have policy implications of potentially significant interest to the public and health policy makers (23). This has not always been the case. For example, the Code of Hammurabi, which included a schedule of fees for medical services, stipulated that a surgeon who failed to produce salutary results must pay by having one of his own fingers amputated. Similarly, the Visigoth Code specified that the
Table 1. Aspects of service taken into general consideration in pricing physicians' services to patients.

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<tr>
<th>Item</th>
<th>Relative importance&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Time</td>
<td>++++</td>
<td>Time taken to provide a service or perform a procedure, often divided into pre-service, intra-service and post-service components</td>
</tr>
<tr>
<td>Intensity</td>
<td>++</td>
<td>Includes consideration of knowledge, technical skills, stress (including emergency work, irregular hours, etc.), and risks</td>
</tr>
<tr>
<td>Practice costs</td>
<td>+</td>
<td>Overhead costs of office, equipment, salaries and supplies</td>
</tr>
<tr>
<td>Opportunity costs</td>
<td>+&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Lost income as a result of time spent in specialty training</td>
</tr>
<tr>
<td>Expertise</td>
<td>0</td>
<td>Refers to particular skills of an individual physician compared with others with the same specialty training</td>
</tr>
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<td>Experience</td>
<td>0</td>
<td>Years in practice</td>
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<td>Outcome</td>
<td>0</td>
<td>Refers to the individual patient benefit derived from the procedure</td>
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<tr>
<td>Public benefit</td>
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<td>Overall value of a procedure to society as a whole</td>
</tr>
<tr>
<td>Teaching</td>
<td>0</td>
<td>Contributions to medical undergraduate and postgraduate education</td>
</tr>
<tr>
<td>Research</td>
<td>0</td>
<td>Contributions to the advancement of knowledge through research</td>
</tr>
</tbody>
</table>

<sup>1</sup>Estimated from my review of the proceedings of the Central Tariff Committee of the OMA and the deliberations of the RBRVS Commission.

<sup>2</sup>Opportunity costs have been taken into consideration by the creation of specialty-specific fee codes and assigning them a relatively high value.
physician attending a patient who dies under his care should be handed over to the relatives to treat as they please (24). Modern fee schedules include no direct reference to outcome. In general, if treatment prescribed by a physician fails, requiring further treatment, the physician is paid not only for the initial treatment, but all subsequent treatment as well. To some extent, efficiency is rewarded by "bundling" services when establishing a fee. Thus, payment for many procedures includes the payment for services provided before, as well as after, the procedure, and time and other resources saved as a result of effectiveness and efficiency are rewarded.

Experience is not included in the computation of physicians' fees in Ontario. In its 1983 Report to Council, the Committee on Economics considered and rejected a suggestion that the seniority or years of experience of a physician be taken into account in producing the fee schedule\(^2\). The issue of was raised on only one occasion, with the CTC, in 1990, and it was quickly dismissed (25). The CTC considered that the experienced physician is adequately rewarded by increased efficiency, and no adjustment to the fee schedule is necessary to produce an appropriate income differential between the physician with many years experience and the tyro. The handling of this issue tends to underscore the preoccupation of the CTC with physicians' target incomes (26), despite the explicit directive from the OMA Council to abandon this approach to fee setting in the early 1980s.

The individual expertise of a physician, compared with the skill of other physicians in the same specialty, is not considered in the reimbursement of physicians according to modern fee schedules, including the Ontario fee schedule. The National Health Service in Great Britain did introduce a formal process for rewarding salaried consultant specialists on the basis of seniority

\(^2\) Committee on Economics, Report to Council, 1983: "...while it found that the net incomes of physicians exhibited a sharp decline after peak earnings had been reached (at about 15 years of practice), the corresponding reduction in hours was sufficiently large to cause an increase in returns per hour. ... The Committee on Economics therefore found that additional compensation for physicians was not warranted
and the quality of their work (2, pp 215-219); however, this principle has not been extended to physicians paid on a fee-for-service basis.

Like other modern fee schedules, the Ontario physicians' fee schedule makes no distinction between care producing a good outcome, however that may be judged, from that associated with a bad outcome, even when it is the result of differences in the clinical skills of the attending doctors. As part of the agency relationship between the profession and society, here represented by the government, sub-optimum outcomes occurring as a result of lapses of competence by physicians are dealt with by the CPSO. The College plays no role whatsoever in determining the fee paid to a physician for her services, short of suspension of her license to practice medicine on the grounds of professional incompetence, which is an extraordinarily rare occurrence.

Direct public input to physicians' fee setting is negligible. The extent to which the value of a procedure to society as a whole is considered in pricing specific services is determined entirely by physicians. The pricing of services in general no doubt reflects some global notion of value to society, but it is rarely if ever mentioned as an explicit determinant of the fee for a specific procedure.

Despite the preoccupation with physicians' incomes and the long historical commitment to pricing physicians' services on the basis of resource inputs, large disparities have persisted for decades between the incomes of equally hard-working doctors in different specialties. In fact, rectifying these disparities, which are demoralizing to members of the profession, has been one of the central preoccupations of the OMA and other provincial medical associations for as long as payment of doctors has been based on fee schedules.

The existence of significant income disparities among equally hard-working and dedicated groups of physicians has caused much anxiety. This anxiety has been translated, in most provinces, into attempts to use the fee schedule to reduce the disparities and to justify the
remaining disparities by length of professional training, degree of expertise and the extent of responsibility for the overall life and wellbeing of the patient. (27)

Attempts were made in Ontario in the 1970s to redress apparent income inequities by allocating a larger proportion of the global fees budget to lower earning specialties (a so-called fee-for-income approach). This had the paradoxical effect in some cases of rewarding specialties for decreases in income arising out of decreased demand, and the approach was ultimately abandoned (28). Renewed interest emerged in the late 1970s in developing a relative value fee schedule. The initiative gained momentum in the mid 1980s when the potential to enhance incomes by extra-billing was eliminated by enactment of the Canada Health Act and resulting provincial legislation.

Relative value in fee setting

In spite of the original and continuing commitment to the concept of relativity, the current OHIP Schedule of Benefits3 is widely regarded by physicians in the province to be flawed: important services continue to be under-priced, while others are over-priced, causing what are seen as unfair discrepancies in physicians’ incomes. In general, services involving surgical intervention or some other form of instrumentation have continued to be over-valued, and cognitive services, such as counselling, are under-valued. Some of the inequity appears to be historical. “In the early days the emphasis of the fee schedule was on surgical procedures. Traditionally, fee schedules have reflected the now out-dated expectation that not all services assigned a fee would be paid. Consequently, fee schedule items tended to compensate for those defaults, particularly with respect to surgical specialists, who usually experienced a higher proportion of bad debts than did other practitioners” (Dr. Edward Moran, former chairman of the

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3 The Schedule of Benefits is what OHIP pays doctors for services to patients; the Schedule of Fees is the fee schedule produced by the OMA reflecting the value placed on the same services by the Association. The Schedule of Benefits is based on the Schedule of Fees, prorated to control the total amount of money allocated for payment of physicians.
OMA economics and medical practice committee quoted by (29)). However, inequities have also developed as a result of important technological advances in the practice of medicine. Various studies on the resource cost of physicians' services have shown that time is the most important variable in determining cost, especially for the non-surgical specialties (30-32). Paradoxically, technological improvements have tended to make formerly difficult and time-consuming surgical procedures easier to perform in less time, while technological advances in the provision of cognitive services have little impact on the time required to service the patient.

Committed to correcting what were regarded to be serious residual inequities in physicians' incomes, the OMA was influenced by a major project undertaken in the United States to develop a sound methodology for the establishment of a formal resource-based relative value schedule (RBRVS). In the U.S., the establishment of fees and fee schedules occurred in a completely different environment from that in Canada. Physicians' fees were paid by private and public insurers by the 'customary, prevailing, and reasonable' (CPR) approach (also known as the 'usual, customary, and reasonable' method, or UCR), which made no effort whatsoever to generate comparable incomes for comparable workloads for different types of specialists. The CPR approach to setting fees is a uniquely American system of payment that aims to limit physicians' fees within the capacity of an organized insurance scheme, while allowing each physician to continue her unique pattern of charging, without the standardization of a fee schedule (33). According to this system, a physician submits claims to the insurance company (or Medicare) with the charges she would like to collect. Instead of being paid what she charged, the insurance carrier calculates a median charge for all services provided by the physician over the previous year (called the 'customary' or 'usual' charges). A 'prevailing' charge is calculated each year for each chargeable procedure among all individual physicians' 'customary' charges in
a particular geographic region. The insurance carrier pays the doctor the actual charge on the current bill, the customary charge over the past year, or the local medical profession's 'prevailing' charge over the preceding year, whichever is the lowest. The patient is expected to pay part of the bill, but never knows her liability in advance, and doctors often do not know what they will be paid.

The CPR approach to physician payment was recognized over 20 years ago to be inherently inflationary and discriminatory (34). Led by Harvard professor William Hsiao, a team of Harvard research investigators undertook, in the late 1980s, to develop, evaluate, and implement a methodology for an RBRVS, for the purposes of reimbursing physicians for services covered by Medicare (35, 36). The project involved a highly interactive process, involving respected elite representatives of various specialties drawn from major medical organizations, such as the American Medical Association, first to determine what physicians considered to be the most important determinants of their work input and other resource costs. They then developed methods of data collection to measure the various components of resource costs. The relevant resource inputs were time required to provide a service (resolved into pre-service, intra-service, and post-service components) and the intensity of effort involved (defined in terms of mental effort and judgement, technical skill and physical effort, and stress due to risk). The project differed from previous efforts to develop resource-based costs of providing medical services (primarily by medical associations and governments outside the U.S.) in the rigor applied to the quantification and validation of resource estimates. Practice costs associated with the delivery of services and the opportunity costs of training were also to be included. The method used for estimation of the work required to provide each of several reference services was magnitude estimation, a well-established means of measuring subjective perceptions and judgements (37).
The fee schedule that resulted from this monumental effort confirmed that procedure-based services had been over-priced by the traditional CPR approach to physician reimbursement in the U.S. Ironically, particularly in the light of the current Ontario RBRVS project, Hsiao considered one of the determinants of the success of the America project to be the similarity of the new RBRVS to the Ontario fee schedule (38).

The Ontario RBRVS project is taking place under much more restrictive political and financial conditions than those prevailing in the U.S. The RBRV fee schedule in the U.S. was originally intended to apply only to fees for services to patients covered by their national Medicare program, which insures only those over the age of 65 and individuals with particular designated health conditions, and in many cases allows physicians to charge even those patients above the fee schedule. As such, the US project would have affected charges to a relatively small proportion of the patients attended by most physicians in that country. In contrast, the Ontario RBRVS will apply to medical services provided to all patients, and the overall impact of any changes on incomes would, accordingly, be much greater. Moreover, enactment of the Ontario Health Care Accessibility Act (1986) has eliminated extra-billing for services covered by OHIP, further limiting the potential for enhancing income. Although physicians can and do bill patients directly for services, not covered by OHIP (39), such as filling out forms and writing letters to the Workers’ Compensation Board, the income derived from these administrative tasks is relatively small. Finally, the funds allocated to OHIP for reimbursement of physicians have been cut back and frozen since 1991, and no new money is expected to be allocated to OHIP for the reimbursement of physicians as a result of the RBRVS project.
Public policy decision-making

Decision-making is the stage in the development of policy, after agenda setting and policy formulation, when choices are made to adopt a particular course of action from a selection of alternatives, including the choice to do nothing (40). This stage of public policy development represents the most overt, though clearly not the only, expression of the communal values of a group. It is inherently political in nature. Unlike agenda setting and policy formulation, which involve a number of actors, the decision-making stage of policy development typically involves only those empowered to make authoritative decisions in the area in question. In the case of fee setting by the Ontario medical profession, the authority rests primarily with the Central Tariff Committee (CTC) and the Committee on Economics (COE) of the OMA.

Decision-making is constrained by a vast array of rules and historical precedents, constituting an institutional context, limiting the actions of decision-makers. Among the most important are legislative or regulatory constraints, which turn out to be particularly important in focussing pressure on the medical profession in decisions regarding the allocation of health care resources, such as payment for physicians’ services to patients. The institutional context also includes the organizational rules of operation of associations representing the stakeholders in the decision-making process, such as the Council, the Board of Directors, and the various committees of the OMA. In addition, the institutional context includes more intangible and amorphous constraints, like custom and culture. The traditional commitment of the medical profession to science, objectivity, rationality, and collegiality is a powerful constraining force in the policy decision-making process within the profession.

In my examination of decision-making by the Ontario medical profession, I propose to draw upon two major models of public policy decision-making articulated in the late 1960s, the
rational and the incremental models (40, pp. 137-152). Rationalist theories are based on the belief that the problems of society "ought to be solved in a scientific or rational manner, by gathering all relevant information on the problems and the alternative solutions to them, and then selecting the best alternative" (40, p. 140). It is in large part the power of a rational or positivist approach to questions relating to biology in general and medicine in particular that resulted ultimately in the triumph of allopathic medicine (4, pp. 134-140). The success of the rationalist approach to problem-solving no doubt plays a major role in the confidence physicians as a group have in applying essentially the same approach to non-medical problems, such as fee setting. However, the approach requires that decision-makers are able to identify and consider all possible options, to know the consequences of each decision in advance, and to be able to sort through various combinations of favourable and adverse consequences. On the basis of his analysis of the rational model of public policy decision-making, Herbert Simon concluded that decision-making in practice rarely attempted to fully maximize benefits over costs. Rather, it was not rational to invest the resources needed to be fully rational. Accordingly, even rational decision-making could usually be described as bounded rationality, meaning that it tends to satisfy whatever criteria decision-makers set for themselves under the circumstances in question, the so-called 'satisficing' criterion (40, p. 141; 41).

The incremental model of public policy decision-making, described by Charles Lindblom, consists of a set of simplifying stratagems:

a. Limitation of analysis to a few somewhat familiar policy alternatives...differing only marginally from the status quo;
b. An intertwining of analysis of policy goals and other values with the empirical aspects of the problem (that is, unlike rational decision-making, it does not require that values be specified first with means subsequently found to promote them);
c. A greater analytical preoccupation with ills to be remedied than positive goals to be sought;
d. A sequence of trials, errors, and revised trials;
e. Analysis that explores only some, not all, of the important possible consequences of a considered alternative;
f. Fragmentation of analytical work to many (partisan) participants in policy making (each attending to their piece of the overall problem domain). (42)

Gortner et al (43, p. 257) make the point that because bargaining requires distribution of limited resources among various stakeholders, it ends up to be easier to maintain the existing pattern of distribution instead of trying to create radically new proposals, an approach supported by the inherent tendency of bureaucracies to resist change. As a result, decisions tend not to vary substantially from the status quo. Policy decision-making in practice consists of some elements that are clearly rational and others that conform better to Lindblom's early incremental model, depending in part on how much knowledge decision-makers have at their disposal.

One problem with the incremental model is its lack of any kind of goal orientation. It is also inherently conservative. Dror has noted that incrementalism may work when a great deal of continuity exists in the type of problems policies are intended to address and the means to address them (44). It also tends to work better in relatively stable political environments, rather than during crises. With regard to fee setting by the medical profession, these types of relatively stable conditions might reasonably be understood to have obtained during the immediate post-medicare years and during the early 1980s, but not after enactment of the Canada Health Act (1984).

The pressure on the profession has increased enormously as reliance on negotiated fee schedules has increased and as hard caps on total public expenditures on physicians' services. The process conforms well to the theory of policy types originally proposed by Theodore Lowi (45) and subsequently integrated by Aynsley Kellow with analyses by Schattschneider, J.Q. Wilson, and Mancur Olson (21). Kellow describes public policies in which costs are widely dispersed (i.e., public) and benefits are narrowly concentrated (i.e., private) as distributive
Conflicts among recipients of the benefits are limited to the extent that shortfalls in the overall benefits to be distributed are met by subsidies or increases in the resources made available to the total group of beneficiaries. In contrast, public policies in which costs are public and benefits are also viewed as public are described as redistributive. In this case, each group of beneficiaries is regarded as only one of many potential groups of recipients of public spending. The scope of conflict is increased to the extent that each group must now compete with every other group of potential beneficiaries of public spending for its share of the total public purse. In practical terms, this eliminates the potential to limit conflict by increasing the total resources made available for distribution by one group of beneficiaries. Groups having to take a smaller cut of total tax revenues would naturally oppose increases in the benefits made available for distribution by one group, such as all practicing physicians.

So long as the costs of providing universal, unobstructed access to health care were public, and the benefit to physicians' incomes was manipulable, either by manipulation of the price of services or by the volume of services provided, the policy could be described as distributive. The conflict over physician reimbursement was, for the most part, involving the profession and the government; conflict within the profession was muted and tended to focus on the identification of specialties or services judged to be under-priced, ignoring completely the possibility that some services might be over-priced. When cost-conscious governments re-framed the problems of burgeoning health care expenditures as the responsibility, at least in part, of the medical profession and introduced limits on the total amount of public money to be spent on physicians' services became redistributive. Once the budget was fixed, any decision on changes in resource allocation necessarily involved the creation of a zero-sum game with winners and losers within the profession. Accordingly, although the identity of the parties involved in fee setting policy did
not change, conflict between the government and the profession became re-directed to a significant extent to conflict between specialty groups within the profession. On a fixed, limited budget, no service or specialty could be rewarded by increased fees without taking the money from some other service or specialty.

The shift is presented as a figure (Figure 1), taken from Kellow (21). In Schattschneider's terms, the outcome of any allocation process would also depend on the visibility, intensity and direction of the conflict (1). Because they are ultimately a critical, though not the only, determinant of physicians' income, conflicts over fees are highly visible and intense. Direction refers to the priority of conflicts among conflicts. With regard to decision-making over fees, resolution of conflicts causing division within the profession, as a result in the shift to redistributive policies, for example, would take precedence over conflicts between the profession and government, over distributive policies (21, 46). Under pressure that seriously threatened the solidarity of the profession as a whole and the personal incomes of its members, the OMA and other specialty organizations have directed much of their political efforts in recent years towards reversing this process. They have employed various strategies directed ultimately at re-establishing a distributive policy (i.e., removing caps from budgets), including attempts to expand the scope of conflict to include society as a whole by framing the issue as a societal concern, rather than one restricted to the medical profession. In some provinces, this has also included threats to withdraw services if physicians' concerns about fees and incomes were not met. However, this effort has been directed only against the size of overall budgets, not against fee setting, which has remained within the profession.

The potential for internal dissention and division among the different specialty groups, vying with each other for their share of the payment pool, poses a significant threat to solidarity within
the profession and the personal incomes of its members. The power of the medical veto in health policy matters, including physician reimbursement policies, is directly related to the fact that the profession has traditionally been able to speak to government and other institutions with one voice. Erosion of professional solidarity increases the possibility that the setting of fees might be taken over by some other body, such as government.

Collegiality

Members of the medical profession are bound together by a very strong historical tradition of collegiality, which is widely accepted to be fundamentally important to the preservation of the strong influence the profession has on health matters in society. In his penetrating exegesis on the medicine as a profession, Freidson pointed out three aspects of the occupation of medical practitioner that set it apart from other occupational groups: "the occupation has gained command of the exclusive competence to determine the proper content and effective method of performing some task, ... [t]he occupational group, then, must be the prime source of the criteria that qualify a man to work in an acceptable fashion, ...[and]...general public belief in the consulting occupation's competence, in the value of its professed knowledge and skill." (3, p. 10-12). The education and training of physicians includes the inculcation of students with values that are critically important in binding members of the profession together. The paramount values shared by virtually all members of the profession are, according to Freidson, the values of medical responsibility and clinical experience. Medical responsibility is seen as responsibility for the patient's well-being, and "the exercise of medical responsibility is seen as the basic and key action of the practicing physician". It is personal, direct and consequential. In short, tradition demands that the physician take final and sole responsibility for her medical interventions in the care of her patients. Clinical experience refers to actual hands-on experience in dealing with each
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<tr>
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Figure 1. Relationship between public and private assignment of costs and benefits (Kellow, 1988): shift from distributive to re-distributive policy types.
patient and her disease, which enjoys a primacy in the exercise of clinical judgement that is greater even than scientifically verified knowledge—no two patients are exactly alike, and at the end of the day, the physician is required to take full responsibility for her decisions and actions (3, p. 164-168). Together with the organizational characteristics that set the profession clearly apart from the rest of society, the commitment to medical responsibility and the technical primacy of clinical experience function to bind physicians together in a fraternal sense that transcends major technical differences in specialty interest and expertise. The importance of the values of medical responsibility and clinical experience also have a leveling effect on members of the profession—it is the one thing that all physicians have in common, regardless of background training, geographic location, nature of their medical practices, or even major linguistic or cultural differences. These values provide the underpinning for a particularly strong sense of collegiality among members of the profession.

Decision-making by groups of individuals bound together, like physicians, by a strong sense of collegiality have certain characteristics that tend to make the management of political cleavages easier, while paradoxically enhancing the potential influence of specific interest groups in the process. Collegial associations are characterized by a strong sense of democracy, to the extent that differences between members of the association are suppressed, at least as far as the affairs of the group are concerned. They tend not to be formally hierarchical, though in practice some members are clearly "more equal than others". Implementation of policy tends to be by persuasion rather than by prescription, and every effort is made to arrive at decisions by consensus.

The strong sense of collegiality within the profession also affects the outcome of the decision-making process. The importance of achieving consensus means that decisions are very unlikely
to be taken that are strongly opposed by groups of physicians, even when they represent only a small minority of the total membership. Since opposition is invariably strongest when the results of a decision are perceived to be damaging to a group within the membership, implementation of decisions involving any re-distribution of income is next to impossible. In its protracted attempts to achieve relativity between specialty sections, the CTC has invariably frozen fees for services that were considered to be over-valued, rather than cutting back fees for these services. The first effort to deal with over-valued services in a more direct fashion, in the late 1980s, precipitated a major out-cry from a handful of sections, effectively stalling the process and precipitating a crisis in the OMA. The existence of strong veto points gives considerable power to minorities within the profession, creates long delays in decision-making and favors incrementalism.

In situations in which possible losses (loss of professional autonomy) are perceived to be serious and potential gains (e.g., greater equity in the distribution of physician fee income) are perceived to be uncertain and relatively modest, interest groups are generally more likely to take risks in order to avoid the loss (47, p. 220-221). That being the case, Ontario specialty groups are likely to continue to cooperate, at least passively, with the RBRVS project. Because the project is being undertaken through existing political institutions, major changes in the fee schedule would seem to be unlikely to occur.
Questions

The questions to be addressed in this thesis are:

1. How has the strong historical commitment to collegiality within the profession influenced what is taken into consideration in setting fees for physicians' services and how fees are set?

2. How has a shift from a distributive to a re-distributive role for the medical profession in resource affected the decision-making process?

3. What are the implications for the current fee-setting project being undertaken by the joint Ontario Medical Association-Ministry of Health Resource-Based Relative Value Schedule Commission?
Research Approach

Documents and Literature

A number of scholarly works were reviewed for historical information relating to the medical profession in general and fee-setting in particular, including the seminal works of Freidson (3), Starr (4), Evans (12), and Glaser (2), dealing with the organization and evolution of medicine as a profession and physician reimbursement in general. With specific reference to Canada, the works of Naylor (14), Shortt (9), Taylor (15), and Tuohy (48) were studied. The Canadian Medical Association Journal contains a vast number of original articles and editorials reporting events in the relationship between the profession and government and the responses of the profession to government initiatives. With specific reference to the situation in Ontario, I undertook to review a number of documentary sources. Some of the most important of these are either private documents, such as the minutes of the Central Tariff Committee of the OMA, or are not indexed, such as the Ontario Medical Review and the Medical Post. These are described here in somewhat more detail because they bear significantly on the goals of this research.

Statutes, Regulations and Agreements

A number of statutes of the federal parliament of Canada and the Ontario legislature and formal negotiated agreements between the government and the OMA were reviewed. The most important of these were the Canada Health Act (1984), the Ontario Health Care Accessibility Act (1986), the 1991 Framework Agreement and Interim Agreement on Economic Arrangements between the Government of Ontario and the Ontario Medical Association, the Ontario Medical Association Dues Act (1991), the Ontario Health Insurance Act (1990), and the Ontario Physician Services Delivery Management Act (1996), and the mammoth Savings and Restructuring Act (1996) (also called the "Omnibus Bill").
Ontario Medical Review (OMR)

The OMR is a monthly publication of the Ontario Medical Association. Besides a wide range of articles of technical interest to practicing physicians, the journal publishes the annual Reports to Council submitted by the various committees of the OMA, including the CTC and the COE. It also provides interpretive articles for physicians, providing additional information on reports by committees, the proceedings of meetings of the Board of Directors and the Council of the Association, and new Association policies. The journal does not publish or maintain a publicly accessible index or cumulative table of contents. Many issues of the OMR contain editorials commenting on and critical of relations with the provincial government. By contrast, it is not possible, by reference to articles or editorials in the OMR, to gauge the nature or the intensity of the intra-professional conflicts of the early 1990s that precipitated the reorganization of the OMA. For example, the Specialists' Coalition of Ontario is hardly mentioned at all, though it was apparently instrumental in de-railing the first formal OMA effort to generate a resource-based relative value fee schedule.

Medical Post

The Medical Post is a tabloid-type newspaper, reporting on a wide variety of scientific and policy issues of interest to practicing physicians. Articles routinely appear reporting recent advances in medicine, the activities and achievements of prominent Canadian physicians and medical scientists, and employment opportunities. In addition, the newspaper regularly publishes commentaries on politically sensitive issues affecting the medical profession across the country. The paper is available on the Internet, and articles relating to fee setting, relative value scheduling, or the Ontario RBRVS were located by electronic searching. The contents of the
Medical Post are not indexed. Many of the editorials dealing with policy issues are written in a deliberately provocative style, designed to promote discussion and debate.

Minutes of the OMA Central Tariff Committee (CTC)

The minutes of the monthly meetings of the CTC, from 1970 to 1998, were reviewed, along with several unpublished reports to the OMA made by various consultants over the years and included with the written proceedings of the CTC.

Minutes of the OMA Committee on Economics (COE)

Permission to review the minutes of the monthly meetings of the COE, from 1990 to 1997, was denied by the Chairman. Instead of access to the minutes, I was given photocopies of two summary articles appearing in the Ontario Medical Review (28, 49).

Proceedings of the Ontario RBRVS Commission

The RBRVS Commission has generated several formal reports and periodic updates of the proceedings, all of which are accessible in hard copy or by the Internet (http://www.rbrvs.on.ca).

Interviews

After formal review and approval of the protocol by the University of Toronto Research Ethics Board, a number of interviews of key people involved in fee setting were carried out during the winter of 1999-2000. One of the purposes of the interviews was to attempt to identify and evaluate the impact of what Immergut called 'veto points', during the physicians' fee-setting process (7, p. 8). The individuals interviewed (Table 2) were selected because (1) they had specific personal experience with the fee-setting process; (2) they had wide experience with the functioning of the OMA in general, particularly with respect to economic issues; (3) they represented members of the profession who were unhappy with the RBRVS project; or (4) they
were considered to represent the observations and opinions of an "attentive public" (50, p. 125-126).

The interviews were all semi-structured and approximately 1 hour in duration. They were not tape-recorded. Instead, I took notes and later the same day of the interviews, I re-wrote them and fleshed them out. A list of the questions used as a guide for the interviews is shown in Table 3. For the most part, those interviewed were open and cooperative, though some were guarded in their responses to questions touching on areas of potential conflict. In some cases, two sorts of responses were identifiable, the official "party line" and more personal interpretations of issues, that were mutually inconsistent. In most cases, the interviews were supplemented by documents and other written material provided by the individuals interviewed.

Participant observer

I was permitted to observe the proceedings of two meetings of the RBRVS Commission. In addition, I had several meetings with the Chairman, Dr. John Wade, with one of the commissioners, Dr. David Peachey, and with Ms Brenda Gluska, a research assistant working for the Commission.
Table 2. Individuals interviewed.

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tr>
<td>Dr. John Wade</td>
<td>Chairman, RBRVS* Commission; academic anesthetist, former Dean of Medicine, University of Manitoba, and former Deputy Minister of Health of Manitoba</td>
</tr>
<tr>
<td>Dr. David Peachey</td>
<td>MOH-appointed RBRVS Commissioner; general practitioner, former Director of Professional Affairs of the OMA</td>
</tr>
<tr>
<td>Dr. Ted Rumble</td>
<td>OMA-appointed RBRVS Commissioner; orthopedic surgeon in private practice in Toronto</td>
</tr>
<tr>
<td>Mr. Peter Fraser</td>
<td>Retired, former CEO of the OMA</td>
</tr>
<tr>
<td>Dr. David Mendelssohn</td>
<td>Founder, SCO; academic nephrologist</td>
</tr>
<tr>
<td>Dr. Michael Baird</td>
<td>President, Ontario Association of Cardiologists; academic cardiologist</td>
</tr>
<tr>
<td>Dr. Ron Smuckler</td>
<td>OMA-appointed RBRVS Commissioner; general practitioner, member of several OMA Committees, member of OMA Council, past chair of the OMA Section on General and Family Practice.</td>
</tr>
<tr>
<td>Mr. Jim Tsitanidis</td>
<td>Former Director, Physician Reimbursement Policies, OMA</td>
</tr>
<tr>
<td>Mr. Matt Borsellino</td>
<td>National Editor, <em>The Medical Post</em></td>
</tr>
<tr>
<td>Mr. Darrel J. Weinkauf</td>
<td>Executive Director, Economics, OMA</td>
</tr>
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*Abbreviations: RBRVS, Resource-Based Relative Value Schedule; OMA, Ontario Medical Association; CEO, Chief Executive Officer; SCO, Specialist Coalition of Ontario
Table 3. Interview guide

1. Much of the current concern about the fee schedule seems to derive from unhappiness about disparities in income among specialty groups and the belief that these are caused by inequities in fee setting. What are your views on this issue?

2. In your experience, what ways have various specialty groups used in their efforts to influence the fee-setting process?

3. The Central Tariff Committee of the Ontario Medical Association has been focussing on relativity in the fee schedule for many years, without apparently achieving it. Why do you feel their efforts appear not to have borne fruit?

4. What role has the Ministry played in the process?

5. Relative value scheduling has been around for a long time. Why has it taken the establishment of the Resource-Based Relative Value Schedule Commission to get a Relative Value Schedule?

6. What was the role of the Ontario Medical Association Committee on Economics in the Relative Value Schedule process, and why did it not work out? Why should the present Resource-Based Relative Value Schedule project succeed when previous efforts to develop a Relative Value Schedule failed?
Results

Decision-making by the Ontario medical profession: The legislative context

Fee setting during the past five years in Ontario has occurred within an evolving legislative context that has fundamentally altered the stakes and the terms of the negotiations.

1991 Framework Agreement and 1991 Interim Agreement on Economic Arrangements

The 1991 Framework Agreement and Interim Agreement on Economic Arrangements resulted in a limit being placed by government on the total amount of money in the OHIP pool, though the distribution of the money for services to patients, i.e., the fee schedule, remained under the control of the profession. The Agreements also permitted the government to place caps on the total billings by individual physicians and to recover money billed in excess of these targets by so-called "claw-backs". In the 10-year interval between 1986 and 1996, legislative and regulatory initiatives by government eliminated any residual flexibility in the fee schedule as a means of enhancing physicians' incomes as a whole. The potential still existed to re-arrange the distribution of OHIP funds, by appropriate modifications to the fee schedule, providing the opportunity, at least in theory, to correct fee income disparities through the manipulation of the schedule. However, as far as the medical profession was concerned, it shifted the politics from distributive to re-distributive (21), drastically changing the scope, intensity and direction of conflict within the profession and increasing pressure on the fee setting process.

The 1991 Framework Agreement also resulted in the Rand formula being imposed on the profession (51), identifying it as the official bargaining agent for the profession in negotiations with the government. This required all licensed physicians in the province, including the approximately 20% who were not members of the Association, either to join the OMA or to pay
the equivalent of membership dues to the Association. Randing had two immediate effects: it increased OMA revenues by more than $1.6 million (52), and it also drew a large number of physicians with voting rights into the OMA political arena who might not have shared as passionately some of the values traditionally espoused by previous members. The characteristics of non-members drawn into the OMA by imposition of the Rand formula are not addressed in this thesis. However, an indication that they are different from previous members, at least in their commitment to the affairs of the Association, is provided by the results of the OMA referendum on the 1997 Interim Agreement with the government. Only 16% of non-members bothered to vote, compared with 45% of members (53).

Savings and Restructuring Act (1996)

In January 1996, the recently elected Progressive Conservative government of Ontario passed one of the most sweeping acts of the legislature in the history of the province (54). Among the many provisions of the Savings and Restructuring Act, often referred to as the "Omnibus Bill", were the suspension of all previous agreements between the government and the medical profession; amendments to the Health Insurance Act (HIA) empowered the government to prescribe physicians' fees by regulation, including the authority to assign a fee of zero for an insured service. Assigning a fee of zero meant that a service was still technically insured, so that it would be illegal for a physician to charge patients more than the amount payable under the fee schedule, a contravention of the Health Care Accessibility Act (1986). Since fee-less services would be unlikely to be provided, one might argue that this would contravene both the Health Care Accessibility Act and the Canada Health Act should such services nonetheless be deemed to be medically necessary. For example, some concerns have been expressed that a government could use this provision in effect to eliminate abortion services. In fact, government did not
choose to exercise this power. The Omnibus Bill also amended the *Health Care Accessibility Act* and gave government the right to adjust fees by regulation on the basis of the professional specialization of the physician, her professional experience, the geographic area in which the service is provided, and anything else it wished to include without consultation with the profession, if necessary (55). The Omnibus Bill also extended the powers of the General Manager of OHIP to withhold payment by withdrawing the need to show "reasonable grounds to believe" that billing for a particular service by a physician was inappropriate (55). In effect, the Bill freed the government, at least in law, from any dependence on the medical profession for setting fees for services to patients. Section I of the Bill, containing amendments to the *Physician Services Delivery Management Act*, also effectively terminated the right of the OMA to represent all physician groups, and prompting the OMA to drop the Rand formula. In practice, most of these extraordinary powers, as well as others the government gave itself over other parts of the health care system, were never used, and most were quietly allowed to lapse under the "sunset" provisions of the bill. Nevertheless, the Omnibus Bill gave the province coercive powers which it could use to threaten physicians, and thus signalled the potential for a significant change in the balance of power between government and the medical profession.

**Institutional issues**

**General observations**

The emergence of significant disparities in the incomes of different specialties in the years following the introduction of medical care insurance contributed to a perception that the fee schedule contained major inequities, spawning interest in adjusting the fee schedule to correct for income disparities (16). Specialty in this context includes general practice and family medicine as a specialty. At the top of the heap in terms of average net professional income in 1969 were
Otolaryngologists, with general practitioners, the largest specialty bloc in the country, were at the bottom. Ironically, however, the ratio of highest to lowest was only 1.75-to-1 in terms of average net professional income. The ranking was not changed, but the ratio fell to 1.42-to-1 when calculated on the basis of estimates of average 'lifetime disposable' professional income.

Nonetheless, the General Council of the Canadian Medical Association agreed with the CMA Council on Economics:

[t]hat because in general, the value to society of equally well-trained and hardworking doctors in the different branches of medical practice is similar, the average, net, lifetime earnings (after income tax) of doctors in general practice and the various specialties should also be similar.

However, because of differing length of average working life, annual incomes may differ significantly. (It is recognized also that emergency work, irregular hours and unpredictable working schedules, etc., are more frequent in some branches of medicine than in others, and merit greater reward.)

Fee schedules should be designed to produce this equitable similarity in average lifetime earnings. The task force recognizes, and approves, the fact that within a given branch of practice there will continue to be a wide variation of income between the busy and the less busy physician. [emphasis in the original] (16)

The CMA statement aptly captures the strong directing influence of the sense of collegiality within the profession at the time. In an effort to close the gap in Ontario, the Central Tariff Committee of the OMA undertook to develop a relative value fee schedule and instructed each of the specialty sections in the Association to produce RVSs for the services provided by their own members (56). The ultimate goal, which eluded every effort by the profession to achieve on its own, was the creation of a generally accepted relative value schedule across specialty sections. Defining the relative values of procedures within specialty sections was not regarded to be particularly difficult or controversial, and many sections succeeded in generating relative value schedules. However, "...the big problem comes not in determining the relative values of specific items of service within sections but in trying to equate services across sectional lines" (29). In
addition to efforts of the CTC to achieve some form of relativity in the fee schedule, the OMA Committee on Economics also proposed that the Association eliminate differentials in fees for the same service provided by different specialists. The latter policy initiative was particularly controversial, and differentials in the fee schedule continue to exist, in some form, even today.

In spite of "massive efforts to rearrange the Ontario fee schedule to bring the general practitioner into closer economic kinship with the specialty groups, GPs' incomes just seem to remain static" (27). Different observers have offered various explanations for this failure to redistribute incomes across specialties. One very important consideration was the general, though unwritten, OMA policy not to reduce any fee code. Instead, a code (i.e., a service) that was perceived to be over-valued tended to be frozen and other codes allowed to "catch up" in the course of the distribution of the annual negotiated settlement with government (57, 58). In the face of continuing income disparities, and in the spirit of the CMA policy with respect to physician reimbursement and incomes, the OMA subsequently embraced policy of fee-for-income. This involved a move to allocate any increases in the OHIP fee pool to various specialty sections on the basis of a formula specifically designed to compress income disparities. The goal was to achieve a range of average net professional incomes of 1 to 1.4, down significantly from the existing range of 1 to 1.8. The application of the formula led to significant differences in the block allocations of the OHIP fee pool to different specialty sections.

Decision-making by the Ontario medical profession before 1996 occurred in an institutional context that disproportionately enhanced the influence of small, well-organized, relatively homogeneous interest groups within the profession. Tuohy has made the point that in the immediate post-medicare years, specialists in academic health science centres tended to

---

4 Differentials existed, for example, in fees for the interpretation of radiographs and the administration of anaesthetics: general
dominate decision-making within the OMA (59, pp. 126-127). Committees of the Association responsible for the development of policy generally included physicians with academic appointments among the members and tended to draw heavily on advice from academic physicians.

*The Ontario Medical Association*

The importance of the principle of collegiality in professional relationships between physicians is reflected in the organization and operation of the Ontario Medical Association. The pre-1996 organization of the Association is shown in Figure 2. The 250 delegates to Council, the main governing body of the Association, were all elected by branch societies, which varied from less than 50 to over 2500 members in size. Each branch society was assigned a number of delegates to Council roughly proportional to the size of its membership. The branch societies were grouped together into 11 Districts. The Districts elected most of the 24-member Board of Directors, with 5 being elected directly from Council and another from the Council of Ontario Faculties of Medicine (COFM). Board members elected the 6-member Executive Committee of the Board. Representation on Council and the Board was based entirely on the geographic clustering of physician-members of the Association.

The interests of various clinical specialty groups were represented in the Association by 32 clinical sections, each with an executive elected from among members of the specialty distributed throughout the province. While the sections were active in fee-setting deliberations, primarily through negotiations and meetings organized by the Central Tariff Committee, they were not represented on the Council or Board of the Association. The geographic organization of
the Council was adopted specifically to permit it to consider the interests of the OMA as a whole, rather than becoming "a forum for competing special interests." (60)

The pressure created by the 1991 Framework Agreement and 1991 Interim Agreement on Economic Arrangements, negotiated between the Ministry of Health and the OMA, served to focus discontent among specialists over the way the OMA was organized, particularly claims that specialty interests were not adequately represented at the Council level.

From a [specialty] section point of view, the present structure is sorely lacking. Sections may attend Council meetings but need permission from the chair to speak and may not vote....In fact, the current structure has resulted in such frustration and bitterness that some sections have resorted to hiring legal counsel to defend themselves against their own Associations. Threats by various sections to leave the OMA if certain actions are taken are not unusual. As the health-care pie shrinks, it seems possible that sectional discontent may spread. [emphasis added] (60)

The organization of the OMA at the time mirrored the general emphasis on collegiality within the profession, even in the design of its governing institutions. The overall effort to achieve some form of representation by population, distributed geographically, rather than by specialty interest, would support this view. Council meetings were closed to the public, allowing OMA members to thrash out any differences in private. There existed a general tendency to try to work out differences by achieving consensus on specific issues, which had the effect of delaying decision-making and preserving the status quo.

A split between the Section on General and Family Practice and the other specialty sections of the OMA plays a defining role in the internal politics of the Association (26). The pre-1996 structure of the OMA, based entirely on representation by geographic areas, clearly favored general practitioners, particularly in comparison with medical specialties (Table 4) (60), who are more uniformly distributed around the province. Specialists, who are concentrated in urban areas, may dominate some branch societies, but in the majority, general practitioners would outnumber their specialist colleagues by a significant margin. In 1993, prior to the OMA re-
Figure 2. Organization of the OMA before 1996.

Abbreviations: COFM, Council of Ontario Faculties of Medicine; OMA, Ontario Medical Association.

<table>
<thead>
<tr>
<th>Specialty section</th>
<th>Number of members</th>
<th>Delegates to Council</th>
<th>Members-to-delegates</th>
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<td>171.0</td>
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<td><strong>Total</strong></td>
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<td><strong>Total</strong></td>
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</table>

Data adapted from Ref. (60). HSO, Health Service Organization
organization, 5 of the 6 members of the Executive and 5 of the 18 members of the Board were members of the Section of General and Family Practice. Not surprisingly, general practitioners resisted the changes proposed by the specialists. They tended to think of themselves as generally representative of medical practitioners as a whole and objected to the fact that with sectional representation, they would be nothing more than one of 32 clinical sections, despite the fact that half or more of the physicians in the province are general practitioners.

Pressure created by the 1991 Interim Agreement and a growing feeling among specialty sections that their concerns were not being adequately addressed by the existing organization of the OMA prompted the Council to direct the Board to establish a committee to examine the broad issue of representation (61). The resulting Representation and Restructuring Committee began deliberations, which culminated in 1996 in a major re-organization of the Association. The new OMA governance is a blended model, slightly shrinking the Council, retaining 170 geographic delegates, but adding 85 representatives from specialty sections. The new model also directly involved members, both through provision for direct election of the President of the Board by the OMA membership, and a requirement that any binding agreements with government be subject to ratification by the membership by referendum (Figure 3).

In spite of the strong commitment to collegiality and technologically sophisticated measures by the OMA to communicate regularly with members, participation of individual physicians in the affairs of the Association has been patchy at best, with attendance at branch society meetings being poor (62). Participation in referenda, conducted by telephone to facilitate input by members, typically draws no more that 35% of those eligible to vote, even on important issues, such as the decision whether or not to re-invoking the Rand formula in 1997. A detailed
examination of this phenomenon is beyond the scope of this thesis. However, it suggests that "...members view the society as too large and/or remote to meet their specific needs" (62).

Central Tariff Committee

At present, proposals for fees for specific services in Ontario are initiated at the level of the specialty section of the OMA (28). Each of the 32 clinical sections forwards recommendations for changes relating to their specific specialty to the CTC of the Association. Each section is invited to present its proposals for changes to the fee schedule at "marathon sessions" in the presence of other specialty sections in order to enable the CTC to consider the potential cross-specialty impact of the changes. For example, the sessions are expected to identify problems created by proposed changes in codes shared by two or more sections. The CTC is directed "to review fee relativity and to use its best judgment in establishing relativity improvements within the OMA Schedule of Fees while the RVS [relative value of services] work of the Committee on Economics is in progress" (63). Mechanisms exist for changes to the fee schedule, including the addition (or elimination) of fee codes (i.e., fees for specific services) and the price of the service.

Despite over 20 years of work and deliberations, the CTC was unable to develop a relative value fee schedule that satisfied the concerns of large segments of the profession in Ontario. The CTC is comprised of 10 practicing physicians chosen by the Chair, who is elected annually by the Board of Directors. Its terms of reference require it "to keep the Schedule of Fees under review...to maintain equitable fees within the Schedule". The "primary function of the Committee is to produce a Schedule of Fees each year based on recommendations of the Committee on Economics with respect to the global percentage increase in the Schedule and the percentage increase allocated to each clinical Section". The CTC interpreted its mandate to
Figure 3. Organization of OMA after 1996 re-structuring.
include the movement towards a relative value fee schedule, a project that appeared intermittently on the agenda of Committee meetings from before 1970.

The work of the Committee became more important after 1983, when the OMA abandoned the idea of fee-for-income, administered primarily through the Committee on Economics, and embraced a straight fee-for-service approach to redressing disparities in the incomes of various specialty groups of doctors. The fee-for-income approach, developed in response to the feeling that disparities existed in the incomes of different specialty groups, had a major impact on the global allocations to specialty sections during the 1970s and early 1980s. However, it did nothing to resolve the perception of continuing disparities. What was more important, it had had the paradoxical effect of rewarding services that were no longer in high demand (i.e., no longer remunerative) by increasing the fees assigned to them. New services or services in high demand (i.e., very remunerative) had tended to be undervalued by the fee-for-income approach.

The commitment to a strict fee-for-service approach to fee setting followed on the influential, though controversial, Mackenzie Report prepared for the OMA on "Time-Related Value of Physicians' Fees" (1982), which concluded that most of the disparities in physicians' incomes were explainable by differences in workload, not the result of problems of relativity in the fee schedule (64). This is not altogether surprising considering that time has been the most important determinant of workload in fee schedules that have traditionally based on resource inputs (see Table 1). The return to a fee-for-service approach placed enormous pressure on the CTC, pressure with which it was ill equipped to deal. The membership, drawn from practicing physicians in the province, tended to turn over quite rapidly, with terms of 3-6 years the average. Members were busy practitioners who had little time or formal preparation for the work. They depended heavily on OMA staff for guidance. The Chair generally chose members from different
disciplines in order to ensure a balanced membership. However, the members clearly understood that they were acting on behalf of the entire profession, not as representatives of their own specialty. This distancing of the members from what were seen as parochial disciplinary interests mirrored the pre-1996 geographic basis of representation on the Council and the Board of the Association.

A review of the proceedings of the CTC during the last 20 years showed that the workload of the Committee was overwhelming. Meetings with over 40 items on the agenda were common. Discussions of policy matters, including relativity in the fee schedule, were fragmentary and showing little or no continuity from one meeting to another. Despite the mandate to address the issue of relativity, the Committee spent hardly any time at all discussing the notion in principle. In addition to the more routine business of discussing fees for specific new services or adjustments of fees for existing services, the Committee was required to deal with appeals for decisions and action from a wide range of groups. A graphic representation of the environment in which the Committee operated is shown in Figure 4.

From time to time, the government, generally represented by the Assistant Deputy Minister of Health or the Director of OHIP, rejected CTC recommendations, especially for the introduction of new codes. Although the Medical Review Committee of the College of Physicians and Surgeons of Ontario made several representations to the Committee over the years, they were invariably appeals for definition and clarification of services, rather than formal challenges to the fee schedule. Similarly, the Workers' Compensation Board tended to limit its input to questions relating to the overall increase in the WCB Schedule of Benefits, rather than details of the fee schedule.
The most formidable interest groups facing the CTC have been the specialty sections that, until the restructuring of the OMA in 1996, had no official status among the major decision-making components of the Association. The lack of official political status may have increased the likelihood that a section would attempt to side-step the CTC by appealing directly to the Board in matters relating to fees. CTC efforts to achieve some sort of relativity within the fee schedule seemed to work reasonably well, at least among those specialty sections willing and able to do the necessary work, as long as it dealt only with relativity within sections. The situation was completely different in the quest for relativity between sections. The issue of "over/undervalued fees" appears frequently in the Minutes of CTC meetings. The Committee appears to have understood clearly that the matter of income disparities, at least to the extent that they were caused by anomalies in the fee schedule, would never be resolved until inter-sectional relativity was achieved. In an unprecedented display of political will, the Committee recommended that selected changes in the forthcoming fee schedule be made on the basis of its perception of over/undervalued fees. A small number of specialty sections, e.g., the Section on Ophthalmology, apparently saw themselves as losers in the proposed changes to the fee schedule and revolted. The CTC, completely frustrated, retreated and contemplated disbanding (65). "The straw that broke the camel's back was the threat of one section to institute legal action...The CTC requested the Board to support its suspension of all relativity work and to support the RVS work by the [Committee on Economics]". Further efforts by the CTC to review over/undervalued fees were abandoned "due to apparent lack of support at Council" (65).

From time to time, the tension between the various decision-makers in the OMA boiled up into open conflict. In the summer of 1994, in the wake of discussions relating to the establishment of
Figure 4. Inputs to decisions by Central Tariff Committee of the OMA.

Abbreviations: C.O.E., Committee on Economics (of the OMA); C.T.C., Central Tariff Committee (of the OMA); M.R.C., Medical Review Committee (of the College of Physicians and Surgeons of Ontario); O.H.I.P., Ontario Health Insurance Plan; W.C.B., Workers' Compensation Board. The shaded boxes are agencies outside the OMA that play some role in the fee setting process.
a mechanism for sections to appeal CTC decisions, "several members of the [Central Tariff Committee] felt that there was little point in carrying on with the task of addressing over/underweighted fees after the establishment of the Appeals Mechanism...[T]hey felt that it was a matter of great concern that their decisions should be subject to the scrutiny of an appeal body who might not have access to adequate information, documentation, or human resources to render meaningful judgements" (66). In a telephone conference call with the Chairman of the Board, Dr. John Gray of Peterborough, members of the CTC decried the "...Board's lack of support of the decisions of the CTC, lack of support in terms of leadership, philosophy and resources...[T]he lack of leadership and support [by] the Board had allowed pressure and lobbying by dissatisfied factions within the OMA to interfere with the function of the Central Tariff Committee" (66). The losers in what had become a re-distributive allocation process succeeded in swaying the Board by framing the issue in terms of collegiality, the need for unity within the profession pitted against government. Resolution of this conflict was viewed as critical in efforts to increase the total funds allocated for the payment of physicians and return to the traditional distributive politics that had characterized the fee setting process prior to the 1991 Framework and Interim Agreements.

Committee on Economics

According to OMA bylaws, the Committee on Economics is responsible for studying and making recommendations regarding the policy of the Association relating to a wide range of economic issues, particularly the global percentage increase to the OMA Schedule of Fees and the general distribution of the increase among the specialty sections, though not among specific services, which was the responsibility of the CTC. Members of the Committee are appointed by the Chairman and generally serve on the Committee for 4-5 years. The Chair is elected annually
by the Board of Directors and often serves 3-4 terms. The Committee is supported by an
administrative staff that includes health economists.

Recommendations regarding proposed increases to the Schedule of Fees were generally made
roughly in accordance with changes in the cost of living as measured by the Consumer Price
Index. In response to a strong feeling among members of the profession that the fee schedule was
responsible for serious disparities in income between different groups of physicians,
recommendations regarding the distribution of global increases among the specialty sections
during the 1970s were based almost exclusively on a fee-for-income methodology. The fee-for-
income approach to allocation was officially abandoned in 1984 (67), the CTC was directed by
the OMA Council to press on with its efforts to correct any residual problems with fee relativity
(67), and the COE turned its attention to allocating global increases in a manner that would
facilitate CTC efforts to improve the relativity in the fee schedule.

The Mackenzie study (See Central Tariff Committee, pp. 46-52), on which the decision to
revert to a straight fee-for-service approach to fee setting was considered by many to be flawed.
The sample size was small, and the methodology was widely criticized, particularly by low-
income specialty groups. In response to continuing dissatisfaction with income disparities,
particularly within the Section on General and Family Practice, the OMA struck a Special
Committee on Economic Disparities, in 1985, with the mandate to undertake a more
comprehensive assessment of inter-sectional relativity. The Special Committee tentatively
concluded in its report in the autumn of 1986 that earning differences among sections were not
due to inequities inherent in the fee schedule, but were largely attributable to differences in
demand for services or workload (49). In response to pressure from the specialty sections, the
OMA Council approved a major external study of the issue, this time by consultants from the
accounting firm, Thorne Ernst and Whinney (TEW). In their 1989 report, TEW concluded that the OHIP Schedule of Benefits did contribute to differences in physicians' incomes, that some sections, such as General and Family Practice and the medical specialties, were disadvantaged in relation to the surgical sections. The Special Committee recommended that the COE and CTC increase their efforts towards the development of a complete resource-based relative value fee schedule (68).

Until this point, the COE itself played virtually no role in efforts to achieve relativity in the fee schedule. The sudden hands-on involvement of the COE in the matter of RVS added to existing confusion about the responsibilities of the CTC and the COE, not only among the OMA membership, but also among the members of the respective committees [CTC, 1991 #603]. The overlap of activities, in practice if not in principle, was exploited by specialty sections who would sometimes direct their appeals for changes in the fee schedule through the committee they thought would be most likely to support them. In response to direction from the OMA Council, the COE and CTC met together, in the autumn of 1991, to develop a strategy for producing a RBRVS.

Some sections, convinced of the serious possibility that a Hsiao-like methodology [see p. 20-21] would be used, ultimately withdrew their support and petitioned the Board of Directors to suspend all activities relating to the development of a resource-based relative value schedule. It seems that many anticipated that a Hsiao-like approach would result in fee reductions similar to those recommended to the U.S. Medicare system. ...the withdrawal of some sections' support resulted in the suspension of RBRVS work in the latter half of 1990. (49)

Subsequent efforts to resurrect the project failed as a result of withdrawal of support, first by a small core of specialty sections that was also pressing for fundamental changes in the structure and operation of the OMA. Withdrawal of support by the Section on General and Family

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5 Cardiology, nephrology, ophthalmology, gastroenterology, respirology, and urology.
Practice appears to have been the final straw, and the project was abandoned completely. The current RBRVS activities are described below (See RBRVS Commission, pp. 65-).

As a result of 1991 legislation imposing the Rand formula on the OMA (69), the number of individual stakeholders involved in the affairs of the Association was suddenly increased by over 20%. The new members would have included individuals who did not share the confidence of previous members in the functioning of the Association. Simultaneous with the imposition of the Rand formula, pressure from the specialty sections resulted in an OMA Council resolution directing the Board to establish a committee, the OMA Representation and Restructuring Committee, "to pursue the specific issue of geographic restructuring of the OMA and the broad issue of representation of its members" (70).

Specialty sections

The various specialty groups, represented by specialty sections within the OMA, were by far the most important interest groups affecting decision-making by the CTC. The impact of specific specialty sections on decisions relating to fees was not at all proportional to the number of physicians represented by the sections.

The fee-setting process within the OMA is carried out according to certain guidelines with respect to formal submissions to the CTC and the format of the Marathon sessions at which specialty sections present their case for revisions to the CTC. Formal submissions are made according to a fixed written format that has undergone little modification over the past 25 years. Sections wishing to introduce codes for new services are required to fill out a form, generally done by the Tariff Committee of the relevant specialty section. This is submitted to the CTC, and the chairman of the Tariff Committee of the section is asked to defend the application in a
meeting with the CTC. The addition of new codes is one way by which sections have endeavoured to enhance the incomes of their members by manipulation of the fee schedule.

Fee codes are roughly divisible into those based on procedures, such as surgical operations, and those based on communication or counselling skills, often referred to as "cognitive services". In the case for the addition of new codes, procedure-intensive specialties have an advantage by virtue of the discrete nature of the services and the ease with which they can be defined and distinguished from other services performed by the specialty. The 1998 OHIP Schedule of Benefits lists 41 specialty-specific services billable by psychiatrists, including only one therapeutic procedure. In contrast, the number of services billable by general surgeons is in the hundreds—the number of codes for surgical procedures to the abdomen alone, excluding the urinary tract and gynecologic procedures—is over 300. A review of 1997-98 OHIP billing data showed that consultative and other so-called 'cognitive' services accounted for 96% of services billed by psychiatrists. Comparable services billed by general surgeons accounted for only 40% of total billings, the other 60% being billings for surgical procedures. Table 5 shows 1997-98 billing information for 5 specialties: psychiatry, pediatrics, internal medicine, general surgery and radiology. The data show the type, volume and billings for the four services accounting for the largest proportion of fee income of the respective specialists. The two specialties with the lowest per-doctor billings, psychiatry and pediatrics are remarkable in two respects: neither derives significant income from procedures, and in both cases, the top 4 codes account for 60-90% for billings. In contrast, the other 3 specialties each derive only 25-45% of their total billings for the top 4 codes, and procedures account for half or more of the top four billable services.
The billings shown in Table 5 do not include technical fees, a very important component of the fees billed by radiologist. Technical fees are what OHIP pays, separate from the fee for performance of a procedure and professional interpretation of the results. They are intended to enable the specialist, or facility providing the equipment (e.g., hospital or independent health facility), to recover the costs of the equipment and technical help required for the performance of procedures. Technical fees have been a controversial issue. The results of a 1996 examination of technical fees throughout Canada concluded that "[h]ow were the fees arrived at is anybody's guess, but like all fee schedules, they evolved from usual and customary fees that had been charged over the years" (71). Acting on a recommendation of the joint MOH-OMA Physicians Services Committee, the OMA Board adopted a proposal to attempt to control utilization of imaging services by cutting technical fees, prompting the OAR to launch a $675 million law suit against the OMA, Board of Directors, and others (72). The issue of technical fees is particularly complex, and the RBRVS Commission ended up accepting the CTC recommendation that technical fees be fixed at current levels for the time being, as would be predicted if they were indeed using an incremental decision-making process.

Sections have also enhanced the incomes of their members by appealing to the CTC for increases in the value of existing codes. Although many specialty sections have made progress on achieving relativity among the fees billed for services provided by their own section, the OMA has never succeeded in achieving relativity among the fees between different specialties. As a result, any changes in values assigned to codes shared by different specialty sections have the potential of distorting the relativity within different sectional fee schedules. For example, one specialty section may seek an increase in the payment for a particular service also performed by another specialty. However, granting the increase might seriously distort relativity of fees within
the second specialty—performing the service may become more remunerative than a more complex procedure performed only by the second specialty. Sections are more likely to succeed in efforts to increase the values assigned to codes, therefore, by concentrating on specialty-specific codes, ones that are not shared with other sections. Medical specialties, and general practice in particular, tend to use fewer codes overall, and the number of specialty-specific codes is much smaller than is the case for surgical specialties, especially the surgical subspecialties.

The experience and commitment of the members of the executive, and especially the Tariff Committee, of each specialty section play a significant role in the success of the section in achieving favorable modifications to the fee schedule. Sections in which the turnover of members doing the negotiating with the CTC is small are generally perceived to be more successful in deliberations over fees. Several observers have noted that the presence of a small number of highly committed members with extraordinary leadership skills is more important than the size of the section. In fact, smaller sections have some considerable advantages in this regard, for they tend to be more homogeneous with respect to the interests of the specialist members, communications are generally easier, and they have greater continuity of leadership. Smaller sections are generally comprised of highly specialized subspecialists, and the loss of one member of the section through emigration has a proportionately greater impact than the loss of a member of a large specialty section, such as Internal Medicine, especially when the specialty enjoys high public visibility.

Some sections have been successful in enhancing their position with respect to incomes by appealing directly to government to take action outside of the usual fee setting process, circumventing the OMA completely. An important example is the favorable deal struck by cardiovascular surgeons when patients with heart disease died while awaiting cardiac surgery.
Table 5. Examples of major sources of OHIP income of five specialties (1997-98).

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Four major services</th>
<th>% of Total services</th>
<th>% of Total billings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatry</td>
<td>K197 Individual outpatient psychotherapy</td>
<td>50.5</td>
<td>52.4</td>
</tr>
<tr>
<td></td>
<td>K198 Psychiatric care</td>
<td>22.7</td>
<td>23.5</td>
</tr>
<tr>
<td></td>
<td>K195 Family therapy (outpatient)</td>
<td>5.7</td>
<td>6.7</td>
</tr>
<tr>
<td></td>
<td>A195 Consultation (outpatient)</td>
<td>2.5</td>
<td>5.8</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>81.4</td>
<td>88.4</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>A265 Consultation</td>
<td>2.6</td>
<td>22.9</td>
</tr>
<tr>
<td></td>
<td>A007 Intermediate assessment, Well baby care</td>
<td>8.9</td>
<td>18.6</td>
</tr>
<tr>
<td></td>
<td>A263 General assessment</td>
<td>3.7</td>
<td>15.6</td>
</tr>
<tr>
<td></td>
<td>A264 General reassessment</td>
<td>1.8</td>
<td>5.0</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>17.0</td>
<td>62.1</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>A135 Consultation (outpatient)</td>
<td>3.8</td>
<td>20.2</td>
</tr>
<tr>
<td></td>
<td>J304 Pulmonary function*</td>
<td>0.8</td>
<td>11.6</td>
</tr>
<tr>
<td></td>
<td>G326 Hemodialysis, chronic*</td>
<td>1.8</td>
<td>5.5</td>
</tr>
<tr>
<td></td>
<td>A138 Partial assessment</td>
<td>4.3</td>
<td>5.0</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>10.7</td>
<td>42.3</td>
</tr>
<tr>
<td>General Surgery</td>
<td>A035 Consultation</td>
<td>14.7</td>
<td>17.3</td>
</tr>
<tr>
<td></td>
<td>S287 Cholecystectomy*</td>
<td>2.3</td>
<td>7.2</td>
</tr>
<tr>
<td></td>
<td>A034 Partial assessment</td>
<td>16.4</td>
<td>6.6</td>
</tr>
<tr>
<td></td>
<td>S323 Herniotomy, inguinal*</td>
<td>1.0</td>
<td>3.1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>34.4</td>
<td>34.2</td>
</tr>
<tr>
<td>Radiology</td>
<td>X091 Chest, 2 views*</td>
<td>16.1</td>
<td>9.7</td>
</tr>
<tr>
<td></td>
<td>X185 Mammogram, bilateral*</td>
<td>5.4</td>
<td>6.5</td>
</tr>
<tr>
<td></td>
<td>J135 Abdominal ultrasound*</td>
<td>3.9</td>
<td>6.1</td>
</tr>
<tr>
<td></td>
<td>J162 Pelvic ultrasound*</td>
<td>3.2</td>
<td>4.8</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>28.7</td>
<td>27.1</td>
</tr>
</tbody>
</table>

1Four most important services from the standpoint of income generation. 2Professional component only—separate technical components in some cases. 3Skin testing for allergies accounted for 65% of services billed by pediatricians. 4Skin testing for allergies, the single most commonly billed service billed by internists, accounted for 22% of services billed by that specialty.
Agreement was reached directly with government to increase the resources available to do cardiac surgery, resulting in more operating room time and more income, without necessarily requiring any change in the fee schedule. The initiative may have succeeded because the goal could be achieved by manipulating volumes, i.e., the resources necessary to perform complex procedures, rather than fees. Another example is the agreement reached between the government and obstetricians in the province when changes in the premiums paid for malpractice insurance made the provision of routine obstetrical care unprofitable for this group of specialists. Again, government agreed to pay a portion of the malpractice premiums rather than altering fee schedules to reflect these increased costs.

In addition to adding new codes as a strategy to enhance income, sections have pressed to have some services removed from the fee schedule (i.e., delisted) to permit physicians to bill patients directly for the relevant procedure. Provincial governments have actually encouraged this strategy in the case of certain services (20). However, such de-listing might be challenged under the terms of the Canada Health Act, which requires provincial health insurance plans to be comprehensive, i.e., covering all necessary medical services provided by physicians. No province has encountered resistance to de-listing cosmetic surgery, for example. However, de-listing of cataract surgery would probably be considered in contravention of the Act.

The various specialty sections of the OMA seem to be united in their perception that the current fee schedule is seriously flawed and unfair. They are also solidly united in their conviction that disparities ought to be redressed by the infusion of more money into the physician payment pool. In other words, they are resolute in their resistance to becoming involved in a re-distributive function with significant potential for serious internal conflict; the

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government of Ontario is apparently equally committed to the RBRVS project outcome being budget neutral. In this situation, specialist groups, aware of the possibility that they may turn out to be losers in the RBRVS project, would likely see little to gain from participation, compared with the potential to lose income as a result of adoption of a new, resource-based fee schedule. On the other hand, the price of non-participation could include the loss of financial autonomy—the government may take over all aspects of physician reimbursement, including generation of the fee schedule.

Besides the well-recognized GP-specialist split, my studies revealed a major, long-standing split within the specialty group, between surgeons, physicians, and diagnostic technical specialists (e.g., radiologists and pathologists). In this split general practitioners tend to identify more with physicians than with surgeons or diagnostic technical specialists. Within the medical specialty group, some specialties benefit more than others do from historical distortion of the fee schedule favoring procedural interventions (e.g., cardiology and gastroenterology) over cognitive services (e.g., psychiatrists and pediatricians). In this split, the procedural specialists often find themselves allied more closely with surgeons than with their colleagues in medicine. Some specialties are divided by a split between those practicing in academic health science centres and those sustained at first by the sense that disunity would compromise what was viewed by the profession as an adversarial relationship with government. The potential exists for a variety of political cleavages, depending on how the issues at stake are framed.

Other specialty associations

Over the years, various specialty groups have organized associations to advocate on behalf of their members. Most of them, like the Ontario Association of Radiologists and the Ontario Association of Cardiologists, represent and promote the interests of specific medical specialties.
Because they are independent of the OMA, they are less constrained than specialty sections of the Association. Some of them, like the Ontario Society of Obstetricians and Gynecologists (OSOG), have been very successful in galvanizing public support in confrontations with the government.

The political turmoil of the 1990s has spawned various groups of physicians, united in each case by ideological concerns. The 574-member Ontario Physicians Alliance and the 200-member Medical Reform Group are right- and left wing examples, respectively, of such organizations. Each is small, and I encountered no evidence that they had a noticeable impact on fee setting. One of the most recent and most influential of the new groups to emerge is the Specialists' Coalition of Ontario (SCO), formed in 1992 in response to the feeling of a small core of specialty sections that they were not represented adequately by the OMA in its dealings with government, particularly in negotiations over fees (See Committee on Economics, pp. 52-55). This relatively small association, with a current membership of 1400, has had a major impact on decision-making within the OMA in general. It is well-organized and led by dedicated individuals, with considerable organizational skills, particularly with respect to communications with the membership. Although it has been critical of the work of the RBRVS Commission, the criticism predictably has focussed primarily on methodological issues and objections to the requirement that the project be budget-neutral (see RBRVS Commission, pp. 64-70).

_Institutional collegiality_

Much has been made from time to time of political divisions within the medical profession, especially between generalists and specialists and between academic and community-based physicians (26, 59). On the other hand, almost all physicians, irrespective of specialty or political persuasion, are united by common values deeply rooted in the history and culture of modern
medicine (3) (Table 6). One of the strongest arguments made against the proposal for restructuring of the OMA, with specific representation by specialties on the Board and Council, was that it would undermine the collegiality of the Association. Representatives to the Council were expected to set aside their parochial sectional perspectives and consider what was best for the profession as a whole (60). At a 1994 meeting, the CTC formally rejected a proposal from the Section on General Surgery to include a surgeon on the Committee on the grounds that "...physicians are not elected to represent only their own interests nor the interest of their Sections" (66). Official records of the memberships of OMA Council and committees of the Association do not routinely include specialty certification of individual members. The apparent domination of Association affairs by a relatively small, academically based, group of specialists is a reflection of their geographic concentration in urban centres, special interests, and organizational experience, rather than official policy of the OMA. With the shift from distributive to re-distributive policies of resource allocation by the profession, the commitment to collegiality has been severely tested (60).

*Ministry of Health and other government agencies*

Although the Ministry of Health has historically had a powerful influence on the reimbursement of physicians for services to patients, this has almost never extended to manipulation of the fee schedule. Instead, government has limited its input to setting the global allocation of public funds for the payment of physicians, leaving the distribution of the money among the various specialty groups to the profession through the OMA. For a short time in the early 1990s, the CTC membership included a representative of the MOH; however, this was

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7 CTC, March 30, 1993; Dr. Ewen Mackenzie (MOH) was made a formal member of the CTC. He was subsequently removed on direction from OMA Council on February 27, 1996.
merely to facilitate communications between the Committee and government, not as a policy-generating initiative.

*Informed public*

There is no evidence that the non-medical public has ever played a significant role in decision-making with respect to physicians' fees. On the other hand, the public has been courted, from time to time, by the well-orchestrated publication of specific conflicts with government, to generate public pressure to put more resources into specific areas, such as restoration of reimbursement of malpractice insurance premiums for obstetricians (75). Public participation in these efforts is invariably reactive and poorly organized.

*RBRVS Commission*

Dissatisfaction with historical distortions in the physicians' fee schedule, along with the failure of the internal attempt by the OMA to develop a new schedule, prompted the Ministry of Health (MOH) and OMA to appoint a joint 5-person Resource-Based Relative Value Schedule (RBRVS) Commission in 1997 to evaluate and make recommendations on a revised benefits schedule based on physician resource inputs (76). The establishment of the Commission was among the terms of the 1996 Interim Agreement between the OMA and the MOH. An important feature of the mandate of the Commission was that the schedule of benefits they produced must be "budget neutral", that is it *must not* require the infusion of more money into the physician payment pool.

The Commission, chaired by Dr. John Wade, former Dean of Medicine and Deputy Minister of Health of Manitoba, was strongly influenced by a similar project, undertaken during the late 1980s under the direction of Harvard scholar, William Hsiao. The Harvard research team
Table 6. Collegiality: a central institution governing inter-specialty relations and decision-making by the medical profession.

<table>
<thead>
<tr>
<th>Principle</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common values</td>
<td>The paramount values shared by virtually all members of the profession are the values of medical responsibility and clinical experience. Medical responsibility is seen as responsibility for the patient's well being, and &quot;the exercise of medical responsibility is seen as the basic and key action of the practicing physician&quot; (3). Tradition demands that the physician take final and sole responsibility for her medical interventions in the care of her patients. (See p. 27-28)</td>
</tr>
<tr>
<td>Suppression of differences</td>
<td>The commitment to resource-based pricing of medical services is a reflection of the commitment to suppression of differences between individual physicians. With specific reference to fees, the OMA has pursued a general policy of the elimination of fee differentials for almost 30 years despite opposition from some specialties, such as anesthesia and radiology.</td>
</tr>
<tr>
<td>Non-hierarchical</td>
<td>Representation on Council of the OMA was, until the 1996 re-structuring, based entirely on geography—no official special status was assigned to any subgroup within the profession (60). Representation since the re-structuring is still predominantly based on geography (Fig 3), with specialty sections represented through specialty blocks.</td>
</tr>
<tr>
<td>Decision-making by consensus</td>
<td>Most of the decisions made by the Central Tariff Committee are made by consensus; those decisions confirmed by formal resolution were generally unanimous. Opposition by small specialty groups was often sufficient to block OMA initiatives, such as fee adjustments with the potential for creating winners and losers and the internal RBRVS project of the early 1990s. (See p. 50-51)</td>
</tr>
</tbody>
</table>

1For examples of discussions of the issue, see (56, 73, 74).
produced a RBRVS, legislated into effect in 1992, for use in the payment of physicians for services to medicare patients in the U.S. (36). As previously noted, the context of the Ontario project is very different from that of the American RBRVS project (Table 5). The primary motivation of the Ontario project arose within the medical profession over concerns about continuing disparities of income between different specialty groups. Government support and cooperation grew out of its interest in cost control. In the U.S., the order of motivation was reversed: the RBRVS project was the result of an act of Congress, motivated almost entirely by mounting concerns over the costs of medicare in that country. The impact on physicians in the U.S. was also different from the impact of the Ontario RBRVS project. Despite long-standing expressions of concern over income disparities among Ontario physicians, the difference between a relatively high-income specialty, like general surgery, and a low-income specialty, such as pediatrics, is quite small compared with the situation in the U.S. (Table 7). This is no doubt a reflection of the long, historical commitment in Ontario to use relative values of services as the basis for the fee schedule. In the U.S., the traditional "customary, prevailing, and reasonable fee" approach is inherently inflationary and tends to perpetuate and exacerbate inter-specialty distortions of physicians' incomes (34). Because of the government monopsony with respect to physician payment in Ontario, the effect of any adjustment of the fee schedule would be powerful and would be felt by all fee-for-service physicians in the province. In contrast, the proportion of physicians' incomes derived from services to medicare patient in the U.S. is relatively small, though growing, and the impact on the profession would be strongly influenced by inter-specialty variations in the proportion of patients who qualify for medicare benefits. This
situation is changing as the U.S. medicare RBRVS is adopted by other agencies, including commercial health care plans (77).

Despite the major differences in context, the Ontario Commission proceeded using the same general approach employed by the Americans, drawing heavily on input and advice from practicing physicians to establish the relative value of services provided by physicians, both within and between specialty groups. However, it was sensitive to criticisms of the American methodology, and began work by developing and evaluating various alternative approaches, particularly for the measurement of intensity. In a pilot study involving 30 specialists from each of four clinical sections of the OMA, a formal comparison was undertaken of global and composite approaches to assessment of work intensity. Neither approach was found to be significantly better in terms of reliability than the other, and the Commission opted for a combined, iterative process that in their view included the best features of both methods, in addition to other relevant considerations. Input into the development of relative value units (RVU) for service-specific resources was sought by interviews with clinical sections, additional pilot studies, and a national advisory committee made up of 24 physicians from outside Ontario. The Commission has not yet issued a final report. Details of implementation have yet to be worked out. The overall approach taken by the RBRVS Commission was firmly grounded in the tradition of rational decision-making so familiar to members of the medical profession. In order to avoid problems that ultimately de-railed earlier efforts by the OMA and by the medical associations of British Columbia and Alberta, extraordinary efforts were made to ensure that the process was clear and easily understood. The Commission issued regular progress reports to all

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8 Internal medicine, general surgery, pediatrics, and radiology.
9 Nominated by the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada.
10 As of August 2000.
members of the profession in Ontario, and the chair, in particular, met with many specialty
groups to discuss the project.

The work of the Commission progressed steadily, though slowly, taking much longer than
originally anticipated. Individual specialty groups who apparently anticipated they would be
among the losers when the new RBRVS is introduced showed their unhappiness and tried to de-
trail or modify the process in various ways. The Ontario Association of Radiologists (OAR)
launched a major lawsuit, not specifically targeting the RBRVS project, but challenging the
legitimacy of the OMA in matters relating to the pricing of services (81). In a 9-page list of
alleged breaches of duty by the OMA, the OAR statement of claim includes the charge that the
Association failed to explain that the RBRVS Commission would be operating on the basis of no
additional money being allocated to the billings pool, and that this would "necessarily involve
pitting physicians against physicians in competition for limited funds" (81).

One small, but influential, specialty group11 tried to sabotage the assignment of intensities of
the services provided by rating all their services as high and equal intensity. Three others12
withdrew from the project altogether. The Specialists' Coalition of Ontario convened a special
workshop13 to discuss the project, resulting in a strongly worded statement criticizing the
methodology employed by the Commission and requirement that the outcome be budget neutral.
All specialty groups seem to be united in agreement that the existing fee schedule is flawed;
however, many consider that all physicians' services are undervalued, a problem correctable only
by infusing more money into the physician payment pool.

In what amounts to a particularly mordant irony, the authors of the enormous, protracted, and

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11 Ophthalmology
12 Radiology, nuclear medicine, and cardiology.
Table 7. Differences between the Ontario and the U.S. resource-based relative value schedule projects.

<table>
<thead>
<tr>
<th>Item</th>
<th>Ontario</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary motivation</td>
<td>Correct income disparities¹</td>
<td>Control costs</td>
</tr>
<tr>
<td>Legislative direction</td>
<td>Indirect, by commission</td>
<td>Direct, authoritative²</td>
</tr>
<tr>
<td>Net income disparities³</td>
<td>Relatively small (1.3)⁴</td>
<td>Relatively large (7.4)⁵</td>
</tr>
<tr>
<td>Previous basis of fee-for-service</td>
<td>Relative value for services (RVS)</td>
<td>Customary, prevailing, and reasonable (CPR)</td>
</tr>
<tr>
<td>Proportion of income affected</td>
<td>Almost 100%</td>
<td>Overall small (21%) (78)</td>
</tr>
<tr>
<td>Distribution of effect among physicians</td>
<td>All physicians</td>
<td>Impact greatest on physicians with high proportion of Medicare patients</td>
</tr>
</tbody>
</table>

¹The initial and primary motivation within the medical profession for the creation of a resource-based relative value schedule (RBRVS) was correction of income disparities; the primary interest of the government was cost control. In the U.S., the RBRVS project was motivated primarily by government interest in cost control (79), though supported by the American Medical Association because of concern about underpayment of cognitive services.


³The figures represent ratios of the high-income specialty to the low-income specialty. For the purposes of comparison, the annual incomes for general surgeons (high-income) were compared with the incomes of pediatricians (low-income). Specialties with small numbers of very high-income physicians and physicians paid by salary or capitation were deliberately left out because they are not considered representative of the bulk of practicing doctors.

⁴Calculated from OHIP billing data for the year 1995-96, assuming practice expenses of 40% of gross income.

⁵Hsiao et al. (80) report simulated net incomes if all payers had paid in accordance with physicians' charges, i.e., billings, submitted to private insurance companies. The comparable ratio for billings for Medicare-funded services was 4.8.
complicated American RBRVS project considered their project a success by showing that their newly developed fee schedule compared closely with the Ontario fee schedule (38). Long-time student and critic of physician reimbursement schemes, William A. Glaser, went further:

…the [Harvard research group] comparison validated the OMA Schedule of Fees, made it a leading candidate for immediate adoption by the United States, and made unnecessary the renewal of the Harvard project. The OMA Schedule had not been created by an expensive research project; it had evolved out of prolonged negotiations between the OMA and the Ontario Ministry of Health and within the OMA's internal committees…When all of Canada adopted its Medicare after 1969, other provinces (such as Quebec) copied the Ontario Schedule. American Medicare could have adopted such a solution at any time in the past and could do so now. (82)
Discussion

Decision-making within the medical profession has received little scholarly attention since Garceau's careful study of the internal politics of the American Medical Association in 1941 (83). As public policy makers have introduced measures to control the burgeoning costs of health care in general and medical care in particular, the profession has been required to assume greater responsibility for decisions relating to health resource allocation on increasingly restrictive terms. In their review of responses of the profession to newly imposed caps on expenditures on physicians' services in Ontario, Alberta, and British Columbia, Katz et al (26) found that all three bodies had created specialty sections to represent the economic interests of the various specialties. In every case, the specialty sections were granted no specifically identified voting power in their respective provincial medical associations, though they exerted considerable influence through well-organized representation at council, board, and committee levels. They went on to show how decisions regarding the allocation of overall fee increases were made by committees, like the OMA Central Tariff Committee, where the sections were invited to make representations, including participation in marathon sessions, called "bear pits". This process has been explicitly regarded by physicians as an income allocation process, and income targeting played a major role in earlier efforts to establish relative values of fee items (82, 84).

In their analysis of fee setting in Ontario, British Columbia, and Alberta, Katz and colleagues reported that the fee allocation process tended to favor general practitioners, observing that they were, as a group, "far more cohesive than their specialist colleagues, because they shared a similar scope of service oriented toward ambulatory care" (26). The authors do not comment on the apparent discrepancy between the alleged concentration of power among general practitioners within the medical associations and the failure of continuing efforts over the past 30
years to correct income disparities between general practitioners and specialists. Nor do they comment on Tuohy's observation that decision-making within the OMA was dominated by specialists in academic health science centres (59, pp. 126-127). The results of my research indicate that the political cleavages affecting decision-making within the profession are more fluid and complex than the simple split between general practitioners and specialists reported by the McMaster group (46, pp. 60-75).

**Political cleavages exposed by change from distributive to re-distributive role**

Conflict between specialty groups over the fee schedule is not new. The introduction of medicare in the 1960s virtually eliminated unpaid accounts receivable, resulting in significant increases in income for all physicians. It also provided accurate data on physicians' billings and incomes, which confirmed the long-held belief that major disparities in incomes existed among the various specialties. In the 1970s, the overall conflict over fees and incomes consisted of two components. The profession as a whole, represented by the OMA, negotiated with government over the total amount of money to be allocated for payment of physicians. The profession was strongly united in these negotiations and spoke firmly with one voice in advocating for increases in the total amount of public money to be allocated to OHIP for the payment of physicians for services to patients. Meanwhile, within the profession, different specialty groups negotiated among themselves for their share of the OHIP pool of money. Efforts were made to correct income disparities by manipulation of the percentage allocation to each section. However, the manipulation applied only to *new* money allocated by the government for the payment of physicians. Because the amount of new money was relatively small and generally decreasing, the impact of the COE allocation process on physicians' incomes was small. The process was abandoned in the early 1980s and replaced by a straight fee-for-service approach, according to
the belief that, coupled with the development of a truly relative value fee schedule, this approach would ultimately correct any unwarranted income disparities.

The scope and intensity of conflict and resulting political cleavages vary according to the issue and the interests of the different stakeholders (46, pp. 60-75). Some idea of the nature of the splits affecting fee setting in Ontario during the 1990s is shown in Figure 5. Although a variety of measures were taken to facilitate negotiations with government, including appointment of a government representative to the CTC, little attention was paid to organizational issues relating to inter-specialty relations, until the "circle around physician expenditures" was closed in the early 1990s. Under expenditure caps imposed in the early 1990s, the OMA found it increasingly difficult to resolve inter-specialty conflicts over the allocation of funds through adjustments of the fee schedule. The Association was specifically unsuccessful in its efforts to distribute specific fee decreases, as it evolved from a distributive to a re-distributive process (85, 86).

As pressure mounted on the profession to take on a re-distributive, rather than a distributive, role in the payment of physicians, the intensity of conflict between various interest groups within the profession also grew more bitter. The pressure from specialists to re-organize the OMA, granting formal sectional representation on the Council and changes in the Board, is one indication of erosion of collegiality as a way of doing business. The emergence of new associations, like the SCO, is another.

**Collegiality promotes incrementalism**

Some of the main features of the fee setting process are shown in Table 8. The entire process...
Figure 5. Evolution of political cleavages over fee-setting.
Table 8. Traditional fee setting process.

- Process dominated by collegiality (suppression of differences, decision by consensus)

- Entirely by the medical profession

- Resource-based

- Inter-specialty allocation according to historical base derived from pre-medicare fee schedules

- Adjustments made by manipulation of *increases* only, no manipulation of base

- Primarily done by committee (Central Tariff Committee), with major input by specialty sections, influenced by COE, Board and Council of the OMA

- Preoccupation with correcting income disparities

- Determination to avoid creating "losers"
was traditionally dominated by the principal of collegiality, which suppressed differences between potentially conflicting interest groups and strove assiduously to make decisions by consensus. Decisions with regard to physicians' fees were made entirely by the medical profession, in private and with no formal or direct input by the public. Fees were based entirely on resource inputs, especially time and intensity, in keeping with the notion that doctors were more alike than they were different from each other, regardless of training, age, experience, expertise, outcome or value to the individual or society (See Table 1). Inter-specialty allocations were made according to a historical base derived from pre-medicare fee schedules. Modifications to the base were made almost exclusively by addition of new fee codes; codes were only dropped from the fee schedule if the service was no longer provided. Adjustments undertaken in efforts to correct income disparities between specialty groups were made by manipulation of increases only, either by variations in global increases to entire specialty sections or increases in the fees associated with existing codes, i.e., services. In fact, experienced specialty sections were aware that one of the most reliable ways to enhance income by manipulation of the fee schedule was to opt for the addition of new codes, rather than fight for adjustments to base codes. Manipulation of the base tended, therefore, to be small, and never downward. The process was primarily in the hands of committees, such as the CTC, with major input by the tariff committees of the various specialty sections, influenced by the COE, Board of Directors, and Council of the OMA. Throughout, those making decisions were preoccupied with correcting income disparities and avoiding decisions that would create "losers", rather than trying to achieve some particular good.

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14 As pointed out elsewhere, specialty training was taken into consideration by manipulation of the structure of the fee schedule, restricting payment for certain procedures to specialists specifically qualified by training to perform them. On the other hand, the OMA has for decades been committed to the elimination of fee differentials, i.e., they wanted different physicians to be paid the same fee for performing the same service, irrespective of differences in specialty training.
Throughout the process, decision-makers regarded what they were doing as "scientific" and "rational", a theme that recurs repeatedly in the record of the deliberations of the CTC. Studies undertaken or commissioned to examine the extent and cause of income disparities were invariably described as "scientific". However, the process, strongly dominated by a commitment to collegiality, conforms much more closely to Lindblom's incremental model of decision-making (p. 20). To reiterate, the strategy is limited to analysis of only a few policy alternatives, i.e., variations on the definition of resource inputs required for the provision of specific services, and these are deeply rooted in tradition. In the end, the outcome of policy analysis with respect to fees was an amalgam of principles applied to specific services, e.g., a careful analysis of time, coupled with concern about the impact of any proposed change on income. In spite of the abandonment of fee-for-income as a principle for allocating money to different specialty sections, and the explicit commitment to a strict fee-for-service approach to fee-setting, the CTC in particular and the OMA in general continued to be impelled by concerns about physicians' incomes. The dominant preoccupation of the COE, CTC, and OMA in general was with correcting disparities in physicians' incomes as though this were a positive goal in itself. The process proceeded in general by a series of trials and errors, featuring changes in fees, usually small, appeals, and revisions, all occurring over a period of several months or years. Analysis of the outcome of various fee-setting decisions was often, though not always, limited to the overall impact on the OHIP pool and the distribution of income among the various specialties. The overall process of fee setting is fragmented, with confusing overlap in the mandates of the various participant committees, such as the CTC, the COE, the Appeals Board, etc. Contrary to expectations, based on "rational" analysis of the relationship between fees and incomes, the
outcome of the fee setting process has, over the years, invariably produced little change in the status quo, at least with respect to the correction of income disparities.

The current RBRVS project: new wine in old skins

During the last 20 years, Ontario medicine has embarked on numerous projects directed at resolving disputes over fees, the most recent being the first independent project and by far the most expensive of them all. The 1982 Mackenzie report and the TEW report produced 5 years later were primarily descriptive. The former concluded that most of the disparity in incomes among the various specialties was explainable by differences in workload expressed primarily in terms of time. Unhappiness with the conclusions and criticism of the methodology prompted the TEW study, which came to quite different conclusions and spawned the internal OMA RBRVS project under the direction of the Committee on Economics. The OMA RBRVS project failed, and was replaced by the appointment, in 1997, of the current joint OMA-Ministry of Health RBRVS Commission.

The current RBRVS project differs in some important ways from its predecessors. First, it is the first independent commission, supported jointly by, but at arms length from, both the government and the OMA. Two of the commissioners, Dr. David Peachey and Dr. May Cohen, both family practitioners, were appointed by government. The other two, Drs. Ted Rumble and Ron Smuckler, were appointed by the OMA. The chair was selected by government in consultation with the OMA. More information on each of the commissioners, as well as the names and titles of the support staff of the commission, are provided in Appendix I.

All the experts consulted in the course of my research regard this as one of the most important between this project and others undertaken by the OMA. The commissioners are highly respected physician representatives of the profession with extensive experience in the practice of
medicine and organizational affairs. Although only one of the four is a specialist (Dr. Ted Rumble, an orthopedic surgeon), I was unable to unearth any evidence that criticism of the Commission by any interest group was related to the specialty orientation of the commissioners or their personal expertise. Different stakeholders appeared to be satisfied with the commitment and ability of the commissioners to remain objective and comprehensive in their perspective on the task at hand.

The present RBRVS project is also characterized by a more careful development and assessment of methodology than any of its predecessors, backed by consultants with international reputations for excellence in epidemiology. The Commission has also drawn extensively on the skills of highly reputable consultants, including a very impressive National Advisory Committee comprised of highly respected physicians from across Canada.

Despite occasional claims to the contrary, especially by officers of the SCO, communications with stakeholders have been open and regular, with a mixture of electronic, printed, and personal contacts and extensive opportunities for feedback. The Chairman, Dr. John Wade, is a former Dean of the Faculty of Medicine of the University of Manitoba, and former Deputy Minister of Health of that province. He has traveled extensively to address various specialty groups in person. His openness and candor, along with his strong background in medical practice, academic medicine, and government (in Manitoba), combine to enhance his legitimacy and his overall effectiveness.

The context of the deliberations of the current RBRVS Commission is also quite different from previous RBRVS projects. Specifically, the power assumed by government, by enactment of the Savings and Restructuring Act (1996), to create a fee schedule without any consultation with the medical profession, if need be, increases significantly the potential cost of failure of the
present project. Unlike most other legislation relating to physicians' fees and incomes, the Act, along with the unambiguous right of government to act on it, has tended to suppress political cleavages within the medical profession, promoting cooperation with the Commission.

The present RBRVS Commission is, therefore, significantly different from previous projects of the same type in ways that would appear to ensure cooperation and acceptance by the medical profession. On the other hand, successful implementation of any recommendations of the current RBRVS project is based on assumptions that may not hold when all is said and done. Foremost among these is the assumption that the traditional "scientific" and "rational" approach taken by the Commission, albeit thorough, will, by itself, generate a "rational" response from the various stakeholders affected by its recommendations. Despite claims that policy formulation with respect to fees, like many decisions made by doctors, has traditionally conformed to a rational model of decision-making, and that the response to decisions has pari passu been "rational", the evidence is overwhelming that it conforms more closely to an incremental model. The role of reason is, therefore, questionable, and the expectation that the response of stakeholders would also be reasonable is problematic.

Another assumption that may not hold up is that government would actually use the sweeping powers it vested in itself, through the Savings and Restructuring Act, to force implementation of Commission recommendations. For the government to act in so high-handed a manner would be risky, depending on how potential losers are perceived by the rest of the profession. The outrage expressed by the medical profession at implementation of the Health Care Accessibility Act (1986), more over the issue of autonomy than money, would suggest, however, that unilateral action by the government would weld the profession together in opposition to the action, suppressing political cleavages that currently divide it. At least one observer opined that the 1996
legislation gives government no more power than it has always had—they are no more likely to use it now than before.

One possible outcome of the current RBRVS project is confirmation that the present fee schedule is actually sound, at least to the extent that it accurately reflects resource inputs required for the provision of most services. This is not an unrealistic possibility. The results of most of the studies undertaken of the fee schedule and physicians' incomes have concluded that the problems were relatively small. As mentioned elsewhere, prominent American health policy experts have pointed to similarities between the outcome of the enormous RBRVS project in that country and the Ontario fee schedule as confirmation that their project succeeded. Therefore, within the relatively narrow limits set by adopting a traditional approach to what should be included in the fee schedule, as set out in Table 1 on p. 11, the RBRVS produced by the current RBRVS Commission might realistically be expected to resemble the present fee schedule quite closely. In other words, it will be the product of an extension of the incremental approach taken in the past, with the same modest changes that have characterized previous manipulations of the fee schedule.

However, the various specialty sections of the OMA seem to be united in their perception that the current fee schedule is seriously flawed and unfair. At the same time, they are also solidly united in their conviction that disparities could and ought to be redressed by the infusion of more money into the physician payment pool. In other words, they are resolute in their resistance to becoming involved in a re-distributive function with significant potential for serious internal conflict. It is tempting to speculate that concerns expressed so strongly by specialty sections about the present fee schedule would be silenced by the infusion of a significant amount of

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public money into the OHIP pool, with little more than further incremental changes in the fee schedule.

The astute observer will not have failed to consider that much of the income disparity among the various specialties might be explainable by inequities based on gender. Male physicians are markedly over-represented on the CTC, the Board, and on the Council of the OMA. The dominance of male physicians and managers in the fee setting process is reflected by the fact that the list of the elite interviewed in the course of the research reported in this thesis contains not a single woman. At a more fundamental level, one cannot help but be struck by the observation that women in medicine are concentrated in the lowest income specialties in the province, e.g., general practice and pediatrics; the highest income specialties, e.g., cardiovascular surgery, orthopedics and neurosurgery, tend to be dominated by men. This may reflect a societal bias with regard to the value of work performed by women as opposed to that done by men. It is a most important issue that is, however, beyond the scope of this thesis.

A similar societal bias seems to exist, apparently independent of gender, with respect to the difference in status between general practitioners on the one hand and specialist physicians on the other. Specialty practice enjoys and benefits in terms of income from a cachet associated with being a specialist. Even within the groups of specialists, some specialties are accepted to be of higher status than others. Like the gender issue, the difference in prestige experienced by the various specialties seems to reflect societal values, but is also beyond the scope of this thesis.
Conclusions

Physicians make a living by being paid for the services they provide for patients, and the vast majority of physicians in Ontario are paid on a traditional fee-for-service basis. The pricing of services, as reflected in the fees charged, has undergone a major transformation over the past 50 years. It has evolved from an open-ended, competitive free-market system to a monopsony, in which the government increasingly became the sole purchaser of services and paid for services to patients according to a negotiated schedule of fees set predominantly by the medical profession itself. Enactment of the Canada Health Act (1984) eliminated even the rarely used opportunity for physicians to enhance their incomes by billing patients outside the government health insurance plan, further increasing the influence of the structure of the fee schedule on physicians' incomes. The importance of the fee schedule increased even more when, in the early 1990s, restrictive, government-imposed limits on the total amount of public money allocated for payment of physicians converted what was formerly a relatively open-ended payment system into a zero-sum game, with physicians dividing up a pool of fee-derived revenue that has not kept pace with inflation-driven increases in the costs of medical practice. The medical profession, traditionally characterized by a strong sense of collegiality, was forced to make major decisions, having a direct impact on the incomes of almost all practicing physicians in the province. How fees are set, therefore, became a particularly attractive model for examination of how the profession in general makes decisions affecting its members. The pressure on the profession to make very difficult fee-setting decisions was made even more intense by enactment of the Savings and Restructuring Act (1996), granting government the unambiguous, statutory power to set the fees for medical services to patients without consultation with the profession.
An examination of the fee-setting process in this pressure-cooker political environment showed that decision-making by the profession is characterized by a rational component, in which very technical, often highly sophisticated, approaches are used to quantify physician resource inputs involved in the provision of a vast array of medical services. A similarly rational approach has been successfully employed by each medical specialty group to determine the relative values of various medical services performed by that specialty. However, decision-making is done in a restricted context in which assumptions about what is appropriately included in the fee schedule, coupled with the professional commitment to collegiality, has created a policy decision-making approach that more closely resembles Lindblom's incremental model.

Specialty groups that have already opted out still participate actively in discussions of the process, indicating a continuing interest in the issue and a concern for unity within the profession. Some changes in the fee schedule may be made, particularly in cases where major and obvious advances in technology have produced gross inequities in income. However, specialists have expressed strong resistance to participating in the linkage component of the RBRVS project, which weighs the fees for procedures carried out by one specialty group against the fees for those carried out by another group. Even these changes are, therefore, likely to be relatively small. Although the current, joint OMA-MOH RBRVS Commission project to produce a new, resource-based relative value fee schedule, is significantly different from previous RBRVS projects, the fundamental assumptions on which it is based are similar to its predecessors. The fee schedule resulting from the project will likely resemble closely the existing OMA fee schedule.

Adjustments in the fee schedule, no matter how sound they may be from a methodological standpoint, are unlikely to alleviate the inter-specialty tension and potential for conflict caused
by the shift to a re-distributive role in the allocation of funds by the profession for the payment of physicians. Resistance within the profession to this shift is likely to prompt various initiatives designed to restore a distributive policy. One measure that is currently being pursued actively by the profession is to expand the scope of conflict by framing the issue to make the total allocation of money for the payment of physicians the central concern. Critics of the current RBRVS project agree almost unanimously that it will not work unless more money is put into the system, i.e., society allocates a larger share of provincial wealth to the payment of physicians, whether through government paid insurance or through the easing of restrictions of privately funded payments for physicians' services.

Another strategy for avoiding the conflicts created by the shift to a re-distributive resource allocation policy is to shift components of the inter-specialty conflict outside the re-distributive arena created by the current allocation process. For example, we may expect to see more specialty-specific appeals to government, such as the appeal by the obstetricians for enhanced reimbursement for delivering babies and the appeal by cardiovascular specialists for the provision of more resources for the treatment of serious heart disease. In the long run, the dominance of fee for service as the primary mode of reimbursement of physicians is likely to become diluted by the introduction of other forms of reimbursement, such as capitation (especially for general practitioners) and salary (for many forms of specialty medical services).

In this thesis, I have attempted to show that an examination of the results of a shift from a distributive to a re-distributive role for the medical profession in the allocation of health care resources, occurring as a result of restrictions on public expenditures on physicians' services, has revealed much about decision-making within the medical profession of Ontario. What has been traditionally seen as a model of rational public policy decision-making conforms better to an
incremental model. Although the current, joint OMA-MOH RBRVS Commission project to produce a new, resource-based relative value fee schedule is significantly different in some ways from previous RBRVS projects, the fundamental assumptions on which it is based are similar to those used by its predecessors. The fee schedule resulting from the project might reasonably be expected to resemble closely the existing OMA fee schedule. By intensifying the importance of political cleavages within the profession, the shift from distributive to re-distributive resource allocation policies poses a serious threat to the institution of collegiality that has unified the medical profession for almost a century.
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Appendix I: RBRVS COMMISSION MEMBERS

DR. JOHN WADE, Chair

Dr. John Wade has been a practicing anesthetist who, after receiving his medical degree in Manitoba, began with a rural general practice in Alberta. Since then he has served in a number of capacities in Manitoba, including Chief of Anesthesia at the Health Sciences Centre in Winnipeg and Professor and Chair of Anesthesia at the University of Manitoba. He has been Vice President of Medical Services at the Health Sciences Centre in Winnipeg and Dean of Medicine at the University of Manitoba. Dr. Wade served as Deputy Minister of Health in Manitoba from 1995 to 1997. He is currently Professor of Community Medicine at the University of Manitoba.

DR. MAY COHEN, Government-Appointed Member

Dr. May Cohen is a family physician. She has been a member of the Department of Family Medicine at McMaster University since 1977 and is currently a professor emeritus. Dr. Cohen also served as Associate Dean of Health Services with the Faculty of Health Sciences at McMaster University from 1991 to 1996. Her active participation in many committees spans issues of women’s health, academic medicine and health planning. Dr. Cohen has been President of the Federation of Medical Women of Canada and a member of the OMA Board of Directors. She has written and presented an extensive number of publications and presentations pertaining to women’s health and other issues. She has been the recipient of a number of professional awards, including a Governor General’s Award in 1995.

DR. DAVID PEACHEY, Government-Appointed Member

Dr. David Peachey has been a family physician for 25 years, including 10 years as Director of Professional Affairs at the Ontario Medical Association. His positions as President of Health Intelligence Inc. and Principal of Clinical Management Technologies Inc. have included
consulting roles with major areas of interest that include: evaluation of health care quality and resource use, applications of geographic information systems to health care delivery, and professional compensation and governance, all within a comprehensive management context.

DR. TED RUMBLE, OMA-Appointed Member

Dr. Ted Rumble is an orthopaedic surgeon, engaged in private practice in North York. He has served on the Executive Committee of the Ontario Orthopaedic Association for many years and is a past President. Dr. Rumble is a long-standing delegate to OMA Council and has sat on a number of hospital committees. Dr. Rumble was previously a member of the executive of the Specialists Coalition of Ontario.

DR. RON SMUCKLER, OMA-Appointed Member

Dr. Ron Smuckler runs a private fee-for-service family practice. He has been active on a number of OMA Committees since 1983 and has served as a member of OMA Council since 1987. Dr. Smuckler is co-chair of the Institute for Primary Care Informatics. He is past chair of the OMA Section on General and Family Practice.

RBRVS COMMISSION SUPPORT

Ms Judith Davidson-Palmer, President, Davidson-Palmer & Associates Inc. (extensive work in field of Job Evaluation in both private and public sector, including pay equity)

Ms Bernita Drent, Policy and Communications Advisor, Drent Consultants Inc. (formerly of Public Affairs Dept of OMA. Served on negotiations committee for MOH in last round of negotiations with the OMA)

Ms Nora Gillespie, Legal Counsel, Genest Murray DesBrisay Lamek

Joan Hutchings, Epidemiologist, Senior Research Analyst, Ontario Ministry of Health (our link with OHIP – coordinates requests for billing and code data)
Mohammed Agha, Epidemiologist, Biostatistician, Research Coordinator (also works at ICES, coordinates our analyses and advises on methodological issues)

COMMISSION STAFF

Ms Brenda Gluska, Project and Administration Manager

Ms Linda Moran, Administrative Assistant