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ABSTRACT


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The decision by the Ontario and California governments in the 1960s to establish government-sponsored programs of medical care insurance challenged the traditional guild model of medicine that entailed private, solo or small group practice, negotiated payment between physicians and patients on a fee-for-service basis and professional licensing and discipline. This dissertation addresses the question of why physicians have retained more of their policymaking influence under the public health insurance model in Ontario than under the managed care approach of California. It explains the differences in the degree of influence of the medical associations on policymaking by focusing on the importance of interests and institutions (including previous policies) as independent variables. It highlights the ways that these factors alter the structure of opportunities that exist for interest groups to successfully promote their political agendas. Ontario and California were chosen as sites for the comparison because, although they have significant social and cultural similarities, they have developed dissimilar government/society relationships and capacities for state intervention that have affected their health policy outcomes.

The central argument of the dissertation is that in Ontario the early decision to establish a governmental health insurance program and the use of policy instruments like
the federal spending power and the Canada Health Act helped the state to maintain a relatively stable concertation relationship with the medical profession. The Ontario government and organized medicine have cooperated in long term policy deliberations that have enabled physicians to preserve much of their autonomy and political influence, although they have a lower mean net income than California physicians.

In the United States, such devices as the separation of powers and federalism have made it difficult to establish a universal system of publicly funded health care. The dispersal of authority between many state actors and antitrust regulations that prevent physicians from engaging in collective bargaining have led to the development of a pluralist policy network in the California health sector. They have weakened physicians' corporate, clinical, economic and organizational autonomy and dominance by fragmenting their interests in a predominantly managed care environment.
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Many doctors in Canada and the United States have lobbied against the extension of publicly financed universal health insurance. They have associated it with a host of undesirables – higher taxes and mediocre health care for the populace, and a loss of professional freedom and inadequate reimbursement for physicians. They have considered it inefficient and unfair that, if governments underfund health care technology and research, patients may lose access to life-saving facilities and services, even if they would willingly cover the costs out of their own pockets. Some would say that the "toxic" environment of the Canadian health system embodies their worst fears. Health care providers have become frustrated with years of staff shortages and waiting lists brought on by poor planning and budget cutbacks. Some physicians have looked south of the border in the hopes of finding better working conditions. However, this thesis refutes the argument that physician autonomy is better preserved in a two-tier or multi-tier system than in a single-tier system, where all citizens are promised access to medically necessary services.

The thesis argues that Canadian physicians have retained more of their corporate and clinical autonomy and influence over the allocation and organization of health care resources than have United States physicians. Canadian physicians have also retained more of their economic autonomy than physicians south of the border. Although their incomes are generally lower than American physicians, they have more control over their method of payment, more freedom to negotiate collectively fees with the government, more
freedom to accept gifts from industry and make self-referrals, and more fraud and abuse protections under the billing system.

The thesis adds to a body of literature that compares health policy in Canada and the United States because these two countries represent different models of health care organization. Canada relies mainly upon a system of compulsory health insurance, which is financed by provincial and federal taxes. In contrast, the United States health care system is pluralistic, involving federal and state coverage for individuals that meet certain criteria, and a wide range of commercial and not-for-profit insurance arrangements paid for by individuals and employers. As Carolyn Tuohy, professor of political science and deputy provost at University of Toronto, argues, Canada and the United States represent different ideal types. Canada has a system that gives predominant weight to medical professionals and collegial mechanisms, whereas the United States has a system that is heavily weighted to private finance and market mechanisms.

I examine two of the largest subnational entities in Canada and the United States, Ontario and California. The purpose of the comparison is to gain an understanding of the effect of different institutional settings and policy network configurations on the policymaking influence of medical associations in these two countries, in the 1960s, when physician influence was at its peak, and in the late 1990s, when it has declined, most substantially in the United States. I chose to focus the comparison at the subnational level because, in Canada and the United States, health policy lies primarily, although not exclusively, in the provincial and state jurisdictions.

Ontario and California are used as the focal points for the comparison since they represent the two jurisdictions that may have been the most similar prior to the
establishment of governmental health insurance, but, since then, they have become the most different. California is the state that came closest to establishing a universal health system like that of the Canadian provinces, but the managed care model that has become predominant is much more competitive than the public health insurance model that has developed in Ontario. Lessons learned in one jurisdiction may be important for the other. Ontario is experimenting with some approaches to health policy reform that California has adopted earlier (e.g., capitation, managed competition and integrated delivery systems). (These concepts are defined in the Glossary at the end of the thesis). It is important to study the managed care system that has developed in California because other states are beginning to replicate the model, and the federal government is encouraging the adoption of managed care techniques in its Medicare and Medicaid programs. Another reason for comparing Ontario and California is that these two jurisdictions have the largest number of doctors in their respective countries. More importantly, both jurisdictions have powerful medical organizations that played a decisive role in policymaking in the 1960s. However, organized medicine in California has experienced a drastic decline in its policymaking influence relative to insurers, whereas organized medicine in Ontario has retained much of its policymaking influence.

This dissertation discusses the irony that doctors on both sides of the border opposed public health care on the grounds that it would compromise their autonomy. In Ontario, where they failed in their opposition, they succeeded reasonably well in protecting their professional status and autonomy. In California, where they succeeded in their opposition to proposals for a single payer health system, they failed to protect their autonomy. This thesis tackles the broad research question: Why have physicians retained
more policymaking influence under the public health insurance model of Ontario, than under the managed care approach of California? I develop a framework for the analysis of physicians' autonomy and policymaking influence, in order to assess the differences across countries and over time (comparatively and historically). The explanatory model that I use to account for the greater decline of physicians' autonomy in California, as compared to Ontario, draws attention to the differences in the financing of the health systems, as a result of the historical development of the political policies and institutions, and the configuration of the policy networks. California's failure to develop a universal single payer system for financing health care has provided an opportunity for a small number of big managed care institutions to set the terms of physician employment and patient care. It has prevented the emergence of a "concertation network" in the health field between physicians and government, as is the case in Ontario, where a single association in the health sector (the Ontario Medical Association) engages in long term policy deliberations with a state that has concentrated authority. William Coleman and Grace Skogstad have defined policy networks as "the properties that characterize the relationships among the particular sets of actors that form around an issue of importance to the policy community." The historical institutional and policy network theories will be discussed in detail at the end of this chapter.

There is a strong argument for studying the nature and degree of influence of organized medicine. Physicians, who play the central role in the delivery of health services, care deeply about their autonomy and policymaking influence. Their job satisfaction depends on their perceived level of autonomy and the characteristics of their job, including their level of compensation. Canadian and American studies provide
evidence that physician satisfaction is of fundamental importance to a properly functioning health system. In his study of the Canadian case, Ronald Burke determined that physicians' satisfaction with their work and professional practice, along with individual demographic variables, practice characteristics and work stressors, "were significant and independent predictors of physician militancy."14 If physicians withdraw their services in the wake of inadequate income settlements or participate in other organized job actions, patient care can be severely disrupted.

In the American case, there is evidence that physicians may provide better quality health care, if they are satisfied with their patients, practice environment and rewards of practice.15 A recent study in the United States has found that physicians, who are more satisfied, (which has been shown to be partially a function of the value that they place on universalism), are more likely to provide care to the indigent.16 A report from the MEDSTAT Group of health consultants has found a direct link between the level of physicians' satisfaction and the likelihood that they would stay with their health plans, thereby offering a stable therapeutic relationship to their patients.17 The level of physician satisfaction may also directly influence patients' behaviour, including their adherence to treatment recommendations.18 If patients perceive that their physicians do not have the clinical autonomy to spend sufficient time treating them, they may turn to complementary and alternative medicine, which is often not solidly based on scientific evidence.19

The policy significance of this study is that it provides governments with reflections for balancing physician autonomy with other policy objectives like cost containment and the autonomy of allied health professionals20 including nurses, midwives, pharmacists, nurse practitioners, osteopaths, and chiropractors. (See the Glossary for definitions of these
terms). The assessment may be useful to governments in their health care planning, and to physicians, as they undertake negotiations to improve their working conditions and strengthen their autonomy.

There are insufficient resources available to satisfy the public’s desire for health care; therefore, every health system must employ some types of rationing mechanisms. In the professional model, physicians, rather than insurers, decide whether the risks associated with treating a patient are likely to outweigh the benefits. In Ontario, physicians make their decisions within the constraints of government-imposed expenditure controls. These may include global budgets, which are comprehensive plans for financing health programs over a set period of time, and/or caps on their individual and collective income (i.e., fixed limits or expenditure targets on their total expenditures for a given year).

Although treating physicians are responsible for their own medical decisions, other members of the profession watch to ensure that ethical and legal standards are met. California has adopted an economic model of accountability, where health care services are rationed according to the patients’ insurance status and ability to pay. Third-party payers and medical administrators scrutinize more carefully the costs associated with treating individual patients, than is the case in Ontario. This thesis will draw lessons about the relative merits of cost-cutting measures employed in Canada and the United States. Some of the most promising techniques may be transferable.

Physicians’ pursuit of autonomy may interfere with the struggle of other health care professionals, who seek to increase their share of the public’s resources that are available for health care. Conversely, the attempts of other health care professionals to improve their working conditions may bring them into direct conflict with doctors, who have traditionally
had a lot of control over “their” patients’ treatment, and may still maintain a role in the training and licensure of other health professionals. Thus, the health care field is a microcosm of a society’s political struggles. “Who gets what, when and how” matters immensely for patients and health care professionals alike. Government legislation and regulations establish the extent of the health care safety net for patients. A lack of adequate health insurance can mean a lack of access to medically necessary services and substandard care for patients. It can deplete the financial resources of patients and their families, as they struggle to cover out-of-pocket expenses. Political decisions also define the scope of practice and opportunities for remuneration for different types of health care professionals.

I spend the first part of this chapter reviewing the literature on professionalization and policymaking influence. Second, I describe the evolution of the publicly funded model in Ontario and the managed care model in California, and identify the key actors in the health care field in both of these jurisdictions. Third, I describe the political contexts and the major factors that affect the influence of interest groups. Fourth, I identify the theoretical framework used to guide the dissertation, and then I provide an outline for the remaining chapters.

PROFESSIONALIZATION AND POLICYMAKING INFLUENCE

The literature on professionalization and policymaking influence will be used to set the larger theoretical context of my research questions. Professionalization theory posits that the distinguishing feature of professions is their government-granted autonomy. Doctors have the right to regulate key aspects of their work without the interference of third parties, such as government, insurance companies, health plans, or patients. Eliot Friedson,
one of the chief proponents of this theory, suggested that physician autonomy is their
“control over the technical and social organization of work, and the economic terms of
work.” Physicians exercise their autonomy in a variety of ways such as by participating
in organizations that license and/or certify individual practitioners, negotiate fees, establish
clinical guidelines and codes of ethics, discipline errant doctors and, in some cases, oversee
the work of other health care professionals. Much of the debate in the literature lies in the
extent and trajectory of the autonomy of the medical profession and hinges on the
definition of “autonomy” that researchers adopt. Friedson argues that the medical
profession has sustained its dominance over allied health professions since the 1970s, by
maintaining its technical control in the sphere of work, if not its socio-economic control
over budgets and institutions.

Researchers like Marie Haug and John McKinlay have challenged this theory of
professional dominance by showing that recent social developments have seriously
undermined the power of the medical profession. These include:

(a) deprofessionalization, with its connotation of consumer revolt and profound
cultural change; (b) proletarianization, with its emphasis on the inevitable
expansion of capitalist exploitation; and (c) corporatization, with its tragic sense of
swallowing up professional work.

Donald Light criticizes Friedson’s model of state-profession relations for not incorporating
more players, such as the medical-industrial complex and patients. Friedson’s assertion
that physicians have remained professionally dominant does not capture the enormous
changes that have taken place in the past three decades, particularly in the U.S. health
system. It does not reveal the extent to which the autonomy of the medical profession has
been circumscribed by the powers of employer-purchasers, insurers, government, hospitals,
allied health professionals and consumers. I will examine the autonomy of the medical
profession in this wider context, where many societal groups vie for government support of their agendas. The various levels of government play multiple roles, establishing the bargaining structure in which the players negotiate, and acting as countervailing powers as well.

I treat policymaking influence as a broad term that encompasses physicians' corporate, clinical, economic and organizational autonomy. I first provide substantive definitions of the dimensions of autonomy, and then explain my operational distillation of the terms. Corporate autonomy is the legitimate authority of the medical profession to set the terms of its work. Organized medicine seeks to preserve its control over the activities of doctors in the macro context of the economic, political, and social structures of society, and in the meso institutional context of the hospital. Clinical autonomy is the ability of individual physicians to control their activities in the micro context of their relationships with their colleagues and patients. Economic autonomy is the right of the medical profession to control physician payment without outside interference. Organizational autonomy and dominance is the influence of physicians on the allocation and organization of health care resources, and their right to oversee other health care professionals.

Corporate autonomy refers to the ability of the medical profession as a whole to determine who can be a physician by setting the terms for recruitment (i.e., the number of physicians, their choice of specialty, practice location and training conditions), licensure (i.e., scope of practice) and accreditation. Corporate autonomy also involves doctors’ rights to set the standards for medical practice by establishing clinical guidelines and a code of ethics, evaluating care (i.e., peer review and discipline), and bargaining collectively (i.e., choosing representatives to negotiate their contracts on their behalf with their
employers). Clinical autonomy refers to the ability of individual physicians to select or reject patients and to control their diagnosis, treatment and medical records. Economic autonomy encompasses the ability of physicians to determine the level and method of their remuneration. As well, economic autonomy entails the right of physicians to be free from economic incentives that interfere with their ability to care for their patients; their right to accept gifts and make self-referrals at their own discretion; and their right to fraud and abuse protections under the billing systems. I regard physician autonomy as a characteristic of the medical profession, which determines and reveals its political leverage with the state. The policymaking influence of physicians is their ability to use their political resources to maintain their autonomy in all its dimensions.

Medical associations are the interest groups that will be examined in this thesis because they are widely viewed as powerful. The medical profession has received a lot of attention in the interest group literature because much of it has been written in the United States, where the American Medical Association, the largest physicians' association, has played a decisive role in society, as one of the most powerful professional organizations.32 Clive Thomas and Ronald Hrebenar ranked the state medical associations among the top ten most powerful interests in the early 1980s and again in 1998.33 They considered them very or somewhat effective in 31 states, including California.

The success of organized medicine in discouraging government from introducing a single payer universal health system is well documented in the American case, where doctors have concentrated their lobbying efforts on individual members of Congress and the Senate. In the Canadian case, the medical profession failed to prevent the establishment of national health insurance partially because the political parties are more disciplined.
Individual members of parliament did not have the same opportunities to veto the legislation as their counterparts in the U.S. Malcolm Taylor stated, in 1953, that no other group in Canada has had as much input into public policy as the medical profession. It is important to note that he made that observation prior to the establishment of a universal system of public health insurance, when relations between government and interest groups were more restricted than they are today. Since then, the interest group system in both countries has become more competitive and open at the sectoral level, as A. Paul Pross argues.

The determinants of interest group influence on government are generally assumed to be a mixture of organizational factors, such as the size and cohesiveness of the groups, and environmental factors, such as structural/institutional and cultural factors. It is difficult to measure the autonomy and policymaking influence of the medical profession because there are so many variables involved. Therefore, much of the literature is theoretical rather than empirical. One of the primary ways of understanding the extent of the autonomy and policymaking influence of the medical profession is by examining the limits. However, the limits that have been identified in the American context are not always directly applicable to the Canadian situation. Here, I identify some of the limits of physician autonomy and policymaking influence, but I explore them in greater detail in later chapters.

The following is indicative of the type of challenges that physicians face, but is by no means an exhaustive list. The corporate autonomy of the medical profession may be challenged by efforts by government and/or business to influence the physicians’ choice of specialty and/or location. Private and public bodies can limit corporate autonomy by
setting the terms of accreditation, establishing clinical practice guidelines to “assist practitioner and patient to make decisions about appropriate health care for specific clinical circumstances” and publishing the details of disciplinary actions against physicians. Dissatisfied patients can use malpractice litigation as an alternate forum for evaluating physicians’ performance by judge or jury, instead of peer review. The clinical autonomy of individual physicians may be limited by the review of managed care organizations over their treatment decisions, since utilization review can interfere with a physician’s ability to make diagnostic and therapeutic decisions without external control. The economic autonomy of physicians may be challenged by governments’ efforts to clamp down on fraud and conflicts of interest, by third party payers’ refusal to provide doctors with timely reimbursement, or by patients’ inability to pay for medical procedures. Physicians’ ability to determine the allocation and organization of health care resources may be impeded by the cost-cutting efforts of managed care companies or government, the prevailing financial climate in the country, and competition from allied health professionals.

I argue that physicians, in the publicly funded system in Ontario, have retained more of their corporate autonomy than have California physicians, because their regulatory boards are further removed from government oversight, and the frequency and expense of malpractice litigation is much lower. Doctors, who are sued in a managed care environment, may have the burden of defending not only their clinical judgement, as would be the case in a fee-for-service context, where they are reimbursed for each service that they provide, but also their economic motivation, since capitation gives physicians a financial disincentive to provide health services to their patients. The medical profession in Ontario has greater autonomy to determine how quality assurance techniques will affect the
clinical decisions of individual doctors than in California, where external entities achieve quality assurance by controlling physicians’ clinical decisions. Ontario physicians have more freedom than California physicians to negotiate collectively changes in their fees and working conditions without contravening antitrust laws. Antitrust laws are currently interpreted by the U.S. Federal Trade Commission and Department of Justice to require that physicians be clinically and functionally integrated in order to bargain collectively with a health plan.

Ontario physicians have retained more of their clinical autonomy since they do not have to contend with managed care companies overriding their treatment decisions. They have preserved more of their economic autonomy, even though their salaries are generally lower than those of California physicians - witness the popularity of fee-for-service medicine, which is traditionally organized medicine’s preferred mode of payment. Ontario physicians are not exposed to the same level of government review of their billing practices, in the name of fraud and abuse prevention.

They have more control over the allocation and organization of health care resources. Ontario doctors are not forced to take into consideration their patients' health care coverage, when they recommend a preferred course of treatment. California physicians may face personal financial restraints that prevent them from treating patients, who are unable to pay for health care services. Ontario physicians influence the organization of health care resources by cooperating with government representatives to design joint projects such as primary care reform (PCR), which is intended to improve the delivery of basic health care services. California physicians are less likely to be called upon by government to help make changes in the health system, in part, because
government plays the more nominal role of setting the context for groups to compete, and in part, because the medical profession is much more fragmented.

The concept of policymaking influence has presented an almost intransigent problem to researchers because it is difficult to measure. Conversations between interest group leaders and government officials often take place in private and do not generate a paper trail. Hence, it is almost impossible to know when bureaucrats and legislators are pursuing a course of action that is purely of their own volition, and when they have been significantly influenced by their contacts with interest groups.41 Similarly, it is difficult to establish whether politicians' decisions to support or reject bills would have been made in the absence of funds and information from particular groups. Physicians do not always provide a reliable interpretation of their influence on bureaucrats, legislators and party leaders because they may inadvertently understate or exaggerate it, depending on the circumstances. Overt political participation by the medical associations may be evidence of their declining power rather than their strength.42

Keith Mueller has identified two principal strategies for empirically analyzing the influence of American interest groups in developing policies. One is examining the evolution of a particular piece of legislation, in order to determine the importance of various factors, like interest groups, in shaping policy. The other is analyzing aggregate votes in the U.S. House, Senate and state legislatures, using measures of interest group strength as independent variables, and controlling for other potential influences.43 Instead of this focused quantitative approach, I provide a qualitative historical analysis of policymaking influence. In the process of telling the story, I will weigh the importance of
different variables for explaining differences in the level of physicians’ political influence in the two jurisdictions.

**DESCRIPTION OF THE EVOLUTION OF THE HEALTH CARE MODELS**

**The Ontario Case**

Ontario and California had similar health care systems prior to the introduction of universal government-financed health insurance plans in Canada. Since then, they have developed in radically different ways. Until the introduction of public health insurance, most Ontarians, like Californians, were insured by physician-sponsored or commercial health plans. Public health insurance was enacted in Ontario in incremental stages. Hospital coverage came first, in 1957, under the leadership of Conservative Premier Leslie Frost, a decade after it had been adopted in Saskatchewan and British Columbia. In 1966, the provincial government established the Ontario Medical Services Insurance Plan to operate alongside the already existing private plans. The Ontario Medical Services Insurance Plan covered citizens who could not afford their own private insurance. It had the support of doctors, who were in favour of limiting the government’s role to paying for indigent patients.44

It was not until 1968 that the Ontario government, under the leadership of Premier John Robarts, opted to join the national health plan, despite the strong reservations of the private insurance industry and the medical profession. At that point, Ontarians began to be covered by medical insurance, in addition to the hospital insurance that they had already obtained. Private insurers and doctors resented the government’s assumption of an interventionist role in the health care sector because it meant that they would no longer play
as dominant a role in the policy community as they had in the past. Although Premier Robarts was personally opposed to joining the national plan, he felt that he had had little choice. He was coerced into taking this action by the minority government of Prime Minister Lester Pearson, which was supported by the New Democratic Party. By joining the federal government’s plan, Ontario was able to receive approximately $170 million in transfer payments annually, that it would have lost by refusing to cooperate with the federal government.

Malcolm Taylor, who was a consultant to the Ontario and federal governments that established health insurance, reflected on the importance of institutional factors for explaining the passage of these legislative acts. He attributed the creation of public health insurance in Canada to the fact that there are far fewer leverage points “than in the American system, that one minister is responsible, and that only one committee of Parliament, the Cabinet, is ultimately responsible.”

An early decision leading to the divergence of the Ontario and U.S. health systems was the introduction of the global budget, as a method to allocate funds in hospitals in 1969. A global budget is a comprehensive plan for financing a health program over a set period of time. Over the next three decades, the provincial governments were able to keep a tighter rein on costs, than governments in the United States. The provincial governments determined the annual budgets for hospitals and physicians’ fees through negotiations with the health care providers, rather than allowing the private markets to be the predominant mechanism of resource allocation.

Another landmark event that took Ontario further away from the U.S. health care model was the introduction of the Canada Health Act in 1984. The Canada Health Act passed with the approval of all parties at the federal level, but it faced provincial
opposition. The federal government limited the growth of a privately funded health care system by threatening to withhold payments to the provinces if they did not meet the requirements of the Act that health care be universal, accessible, comprehensive, portable and publicly-administered. Ontario physicians lost their right to extra bill in 1986 when the minority Liberal government, supported by the New Democratic Party, announced that Ontario laws would be brought into conformity with the Canada Health Act. The Ontario Medical Association (OMA), which represented most physicians in the province, mounted a 25-day strike to try to prevent the enactment of the Health Care Accessibility Act. However, the OMA’s efforts to derail the passage of the Health Care Accessibility Act proved futile, and it was ultimately passed. The OMA’s strike was a public relations disaster, with the media denouncing the medical profession for seeking its own economic interest, rather than the public interest.

Changes in the delivery of health services in Ontario have taken place on a much smaller scale than in California. As of 1996, most medical care (95 percent of total Ministry of Health (MOH) physician expenditures) continued to be delivered on a fee-for-service basis. However, some programs have been set up by the provincial government to experiment with alternate ways of organizing health services, such as health service organizations (HSOs), community health centres (CHCs), comprehensive health organizations (CHOs) and primary care reform. These programs operate under the Ministry of Health and Long Term Care’s Alternate Funding Plan and they reimburse physicians on a capitated or a salaried basis, rather than a fee-for-service basis. They will be described in more detail in chapter 5.
In Ontario and California, there has been an effort to restructure the health system so that more attention is given to primary health care, patients are treated closer to their home and hospitals are viewed as institutions of "last resort." The Conservative government, under the leadership of Mike Harris, set up the Ontario Health Services Restructuring Commission (1996-2000) to restructure hospitals. Critics of the HSRC charged that the government should have given it a broader mandate to restructure health services, so that efforts to reform the primary care system would have taken place at the beginning of the restructuring process rather than at the end. Patients are being discharged from the hospitals earlier and sicker, and many are finding that the continuum of services offered in their community is not sufficiently developed to meet their needs. Patients are expected to bear the cost of drugs that, formerly, would have been provided to them free of charge in the hospital setting.

The California Case

The California health care system is much more complex than that of Ontario. In Ontario, there is a single payer system and the government holds a monopsony as the purchaser of most health care deemed medically necessary by doctors and/or in hospitals. In contrast, California has multiple payers, both public and private, that cover health care costs. To provide a context for a description of the current state of health insurance coverage, it is necessary to trace briefly the history of reforms in the financing and delivery of health care in the United States and California.

Organized medicine has generally opposed universal health insurance at times when it has become an important political issue at the federal and state levels. The American
Medical Association has waged six battles against public health insurance. It has lost only one, in 1965, when the U.S. Congress passed Medicare, a nationwide health insurance program for the elderly and disabled, despite physicians’ protests. The AMA initially took a strong stance against Medicare, fearing that it would be a first step towards national health insurance. According to Nicholas Laham, the AMA opposed national insurance for three reasons: “it believed that the program would reduce physician incomes, deprive doctors of their professional and entrepreneurial freedoms, and reduce the quality of health care.” The federal government was forced to make concessions to doctors, hospitals and private insurers to temper their resistance to Medicare. These concessions were more extensive in the United States than in Canada. Physicians were permitted to charge Medicare according to customary, prevailing and reasonable costs and to extra bill patients. Hospitals could include the costs of capital depreciation in their operating budgets. Private insurers could act as fiscal intermediaries on behalf of hospitals for the administration of their participation in Medicare.

In contrast to Medicare, which was strongly opposed by the American Medical Association, Medicaid was the AMA’s own bill. In 1965, during the presidency of Lyndon Johnson, the U.S. Congress passed Medicaid, which was a program for the poor, funded partially by the federal government, but operated by the state. Like Medicare, Medicaid was designed to supplement the “employer-based, tax-subsidized system.” In 1965, California’s legislature created the Medi-Cal program, which is the state’s version of Medicaid, and is funded by both the federal and state governments. Physicians enthusiastically embraced Medicaid because the program allowed them to charge the
federal government for care of some indigents that they had previously treated as charity cases.

The American Medical Association has gradually softened its opposition to a universal system of health insurance. In the 1990s, the AMA actually reversed its opposition to universal health care, at a time when it seemed possible that President Bill Clinton's proposal would pass, and other physician organizations, including the American College of Surgeons and American Academy of Family Physicians, were declaring their strong support for a single payer system. Pressure from the Republican leadership in Congress led the AMA to retract its support of the administration's reform proposal. The AMA now favours its own version of universal health care that would allow for competition between multiple payers and provide tax credits to individuals. Physicians, particularly in California, stand to benefit from a universal health system. Such a system would make it easier for them to provide services, and receive reimbursement for treating the 25 percent of residents that are currently without health insurance in that state.

At the state level, the California Medical Association (CMA) has occasionally taken a more progressive approach than its parent organization, by supporting a government run single payer system, or taking a neutral stance. Nevertheless, universal health insurance has not been adopted in California because it has not been politically feasible. Opponents have argued that the cost for such reforms would be too high. Citizens would be required to pay higher taxes and would lose their individual freedom, as authority would need to be yielded to government or some form of health commissioner to run a single payer plan.

Instead of universal health insurance, California has incrementally adopted legislation that provides coverage for some constituents and leaves others uninsured.
the 1990s, a number of new programs have been established to extend coverage to uninsured Californians who are not eligible for government programs, like Medicare and Medi-Cal. For example, Access for Infants and Mothers Programs was established in 1992, to provide low-income pregnant women and their children with health insurance. In 1993, the California legislature passed the Small Group Reform Act, to make it easier for employers with fifty or fewer employees to offer health care coverage. The Act created the Health Insurance Plan of California, as a mechanism whereby small employers can aggregate their purchasing power to negotiate better rates from managed care organizations, such as health maintenance organizations, preferred provider organizations, point of service plans and exclusive provider organizations. (See the Glossary for definitions of these terms). Other purchasing groups, that have been created to hold down premiums, include the California Public Employees' Retirement System (CalPERS), which was formed in 1997, and provides health insurance for more than one million public workers, and the Healthy Families pool for children.66

Despite the new programs that have been created to try to extend insurance coverage, California's rate of non-elderly uninsurance remains high compared with the national average (24.4 percent compared with 18.3 percent in 1998),67 and is increasing. A recent report by the Kaiser Family Foundation, entitled Health Care Trends and Indicators in California and the United States is the source of the uninsurance statistics. (For an overview of other key health care facts in Canada and the United States, which the report identified, see Appendix A). Earlier data (1996) showed that the 6.5 million uninsured Californians were disproportionately young adults, especially males. Most were part of families where the primary breadwinner worked at a lower-income job. Most (84 percent)
were in families with at least one working adult, and 49 percent were in families with at least one adult working full-time for the whole year.\textsuperscript{68} There was an overrepresentation of Latinos, Asian Americans and African Americans. The high rate of uninsurance in California is unfortunate because, if patients lack adequate health insurance, they may forego needed care altogether due to the cost, or they may be forced to depend on the government for indigent health care. Although uninsured patients cannot be denied emergency care in hospitals, if their conditions are sufficiently serious, they may remain liable for the costs.\textsuperscript{69}

In contrast to Ontario, where individuals have health insurance by virtue of their citizenship or landed immigrant status, in California, the criteria for eligibility in health insurance programs are much more stringent. In 1997, fifty-seven percent of non-elderly Californians received health insurance through their employment. (The federal government provides companies with an incentive to give their employees health insurance and pension benefits by heavily subsidizing them. Companies' expenditures for these purposes are tax deductible.)\textsuperscript{70} Thirteen percent of non-elderly Californians received Medi-Cal. Six percent purchased their health insurance privately, and two percent relied on other public programs (such as Medicare, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Veterans Administration, or the Indian Health Service).\textsuperscript{71}

The health care system in California has been transformed in the three decades since Medicare and Medi-Cal were established. In fact, Stephen Zuckerman and his colleagues at the Urban Institute have suggested that California's health care delivery and financing systems “may have been the most extensively reorganized of any in the country.”\textsuperscript{72} Traditional indemnity insurance, that pays physicians on a fee-for-service basis
and is still common in Ontario, has largely been replaced by managed care in California. In fact, only a miniscule number of California physicians do not pursue managed care contracts at all,\textsuperscript{73} and focus instead on attracting affluent patients who can pay out-of-pocket for their services.\textsuperscript{74}

California physicians typically contract with 15 different managed care plans that have unique referral requirements and formularies.\textsuperscript{75} The main types of managed care plans are listed in the order of most restrictive to least restrictive from the standpoint of the patient.

- Health maintenance organizations (HMOs) receive premiums on a capitated basis for offering a comprehensive set of health services. That is, the health plan is paid a monthly fee for delivering care to each enrollee regardless of the type of care that is actually provided. Health maintenance organizations provide almost no coverage for services that patients receive outside their premises.

- Point-of-service plans are managed care plans that allow enrollees more choice of providers than health maintenance organizations but not as much as preferred provider organizations.

- Preferred provider organizations are discounted fee-for-service plans that offer financial incentives to induce enrollees to obtain health services from a preset list of physicians and hospitals.\textsuperscript{76}

In the model of managed care that is more common throughout the United States, the health maintenance organizations often employ physicians on staff, or contract exclusively with one group of providers.\textsuperscript{77} In the California model of managed care, physicians typically organize themselves into medical groups and independent practice associations.
(IPAs) that assume financial risk for the costs of medical care from managed care plans. As James Robinson, professor at the School of Public Health, University of California, Berkeley, notes, independent practice associations “bring physicians together for purposes of managed care contracting, credentialing, claims payment, and medical management while leaving them independent for purposes of owning and operating their offices.” Physicians, who belong to IPAs, may share responsibility with managed care plans for other aspects of patients’ health care besides physician services, such as institutional and pharmaceutical services. This is called “global capitation” or “full-risk contracting.” California’s Knox-Keene Act of 1976 initially required that all prepaid contracts be administered by health maintenance organizations, making it difficult for physician groups to assume full risk for the services provided by others. However, the Department of Corporation’s implementation of the Act gradually became less restrictive until the Department introduced “limited Knox-Keene licenses” in the 1990s, allowing provider organizations to sign full risk contracts with health maintenance organizations. Many physicians have chosen to join independent practice associations in order to gain HMO contracts (and hence patients), while remaining in their own practices. However, some physicians have found that independent practice associations have not lived up to their promise of strengthening physicians’ autonomy, since the few HMOs that dominate the market have been able to drive hard bargains with the IPAs, making physician reimbursement untenably low.

The California healthcare marketplace has become extremely volatile. In the past ten years, large employer purchasing groups, such as the Pacific Business Group on Health and the California Public Employees’ Retirement System (CalPERS), have placed
enormous pressure on insurers and health plans to keep their costs down. Health plans, in turn, have negotiated stricter capitation rates with physician organizations, so that physicians receive a lower level of periodic fixed payments, regardless of the volume of services they provide. It has been difficult for physician groups, independent practice associations and physician practice management companies, which are publicly traded companies that manage the business side of physician practices, to remain solvent in the highly competitive marketplace.\textsuperscript{83} In fact, according to a PricewaterhouseCoopers study that was conducted for the California Medical Association, “115 physician groups in California have declared bankruptcy or disbanded since 1996” and 75 to 95 percent of the remaining medical groups are “in serious financial trouble.”\textsuperscript{84} The medical groups are under extreme pressure because they are receiving a low level of reimbursement from health maintenance organizations, at the same time as the costs of prescription drugs are rising. Many of the medical groups bear the financial risks for patients, who continue to expect the same level of service as they had under fee-for-service medicine, but at a much lower cost.

Some physicians have felt powerless in seeking to improve their payment policies and patients’ quality of care because federal and state antitrust laws prevent them from engaging in joint negotiations with managed care organizations. As we shall see in chapter 2, medical associations and unions have tried to counteract the power of the managed care organizations by lobbying to change the antitrust laws so that physicians in independent practice can bargain collectively on their own behalf and on behalf of their patients.\textsuperscript{85} There are several reasons that collective negotiations bills have stalled in all the legislatures where they were introduced, with the exception of Texas. Consumer groups have resisted
extending physicians' powers; organized medicine has divided its lobbying efforts between the state and federal levels; and lawmakers have not been willing to embrace an untested policy in the year 2000 when the election has been pending.86

In 1997, Republican Governor Pete Wilson appointed a State Managed Health Care Improvement Task Force to assess managed care in California and make recommendations for its improvement.87 Although few of the Task Force's 100 recommendations were enacted into legislation, it still played an important role by revealing physicians' and patients' primary problems with managed care. The survey, commissioned by the Task Force, found that 42 percent of consumers had problems with their health plans in the past year. The most common problems varied depending on their type of health insurance. Consumers, who were associated with health maintenance organizations, complained of "not receiving appropriate or needed care, having difficulty with referral to specialists and being forced to change doctors." Members of preferred provider organizations reported "problems with billing, premium, or claims payment and misunderstandings over benefits and coverage."

The California Medical Association voiced its concerns that patients have little real choice about the health plans that they join. The CMA quoted the Employment Development Department, which calculated that "more than half of California employees covered by health insurance at the workplace do not have a choice of health plans." In order for patients to be able to make a meaningful choice, the CMA suggested that comprehensible information about health plans should be more readily available; and patients should be assured that their physicians would not be deselected, or terminated, without cause.88 In California, it is the employer-purchasers that tend to limit their
employees’ choice of health plan and doctors, whereas in Ontario, it is the government that limits citizens’ access to private health care. The medical profession’s role in the allocation and organization of health care resources will be explored in more detail in chapter 5.

DESCRIPTION OF KEY ACTORS IN THE HEALTH CARE FIELD

Physician Groups

It is necessary to compare the relationships between the medical associations and other actors in the health policy field in Ontario and California, in order to set the context for a discussion of the factors that affect physician influence. The Ontario Medical Association was founded in 1880 to represent the political, clinical and economic interests of the province’s physicians, residents and students. The OMA is a provincial division of the Canadian Medical Association (CMA). The Canadian Medical Association is a voluntary organization that is autonomous and claims to express “the voice of Medicine in Canada as a whole.” In 2000, 48,000 physicians or 84.2 percent of the total Canadian physician population were members of the Canadian Medical Association. The OMA represents just over half of the physicians in the Canadian Medical Association and just over a third of Canada’s total number of physicians. By virtue of the OMA’s large membership, it is one of the most powerful medical associations in the country.

The OMA is not technically considered a union under the Labour Relations Act, but it is remarkably similar to one. It negotiates with the Ministry of Health to improve doctors’ working conditions and remuneration. As Dr. Bernard Davis observed, the OMA shares some of the “quintessential defining factors of a union.” It is “closed shop” and the “sole bargaining agent.” Moreover, the OMA can seek the protection of the RAND
formula, which requires doctors to pay dues even if they do not voluntarily become members, since the OMA reaches collective agreements with government on behalf of the province’s doctors.94

Representatives of the Ministry of Health have suggested that its current relationship with the Ontario Medical Association “is analogous to an agreement between employers and employees arrived at through collective bargaining,” although they admit that the Ministry does not directly employ physicians. As in a more conventional labour/management relationship, the OMA submits its tentative agreements with the Ministry to its membership before they are considered final.95 The Ministry of Health and the Ontario Medical Association unsuccessfully drew attention to the similarities between their relationship and a conventional labour-management relationship, in order to deny a requester access to documents related to travel immunizations under the Freedom of Information and Protection of Privacy Act. Tom Mitchinson, the Assistant Information and Privacy Commissioner of Ontario, ruled that there is no direct employer-employee relationship between the Government of Ontario and the members of the OMA that would exclude the documents from the scope of the Act. Hence, the requester was granted access as he wished.

In the past three decades, the OMA has exhaustively discussed the pros and cons of seeking certification under the Labour Relations Act, as chronicled by Dr. John Gray, OMA President in 1998.96 The OMA has rejected unionization on the grounds that physicians are essentially self-employed and in competition with each other. They do not have the common interests of employees. Strikes, which are labour’s ultimate weapon, are
not an attractive option for doctors because they put their patients’ health at risk, although Ontario doctors have occasionally withdrawn all but their emergency services.

The Professional Association of Internes and Residents of Ontario (PAIRO), which has about 2,400 members, is the organization that has represented Ontario doctors-in-training, since it was founded in 1968. The interests of PAIRO and the OMA often overlap, although the OMA has been more willing to accept billing number restrictions for new doctors than PAIRO.97

The medical profession in Ontario is much more unified than its counterpart in California. Nevertheless, there are a number of small, but vocal, breakoff groups that function as watchdogs of the OMA. The Medical Reform Group (MRG), on the left of the political spectrum, advocates a continuation of the role of government in funding and organizing health care and an expansion of experiments with alternate methods of payment for physicians. The MRG’s progressive approach to health care, since it was constituted in 1979, sometimes brings it into conflict with the more conservative medical establishment. Some members of the MRG continue to be members of the OMA, which is an organization that includes the full range of political perspectives.98

In Ontario, there are other splinter groups that have distanced themselves from the Ontario Medical Association, and have tried, with varying degrees of success, to negotiate independently with the provincial government. These include the Society of Obstetricians and Gynecologists and the Association of Orthopedic Surgeons. The 668-member Ontario Association of Radiologists (OAR) made the newspaper headlines in 1998, when it sued the OMA for $675 million for forcing radiologists to accept $100 million in fee cuts in the wake of government-OMA negotiations. The Coalition of Family Physicians of Ontario
(COFP), founded in 1996, claims to have 3,000 members. Along with the 603-member Ontario Physician Alliance (OPA), the COFP has opposed the payment of mandatory dues to the OMA, which amounted to approximately $990 in 1998, even for physicians who would have preferred not to be members.99

The California Medical Association100 and the Ontario Medical Association are in similar relationships with their national groups: the American Medical Association and the Canadian Medical Association. They belong to federated organizations and, as autonomous bodies, do not have to embrace all of the policies of their parent body. In 1999, the American Medical Association had 292,700 members,101 including medical students, residents, young physicians, and military doctors, who pay reduced fees or none at all.102 AMA members comprise about 39 percent of American doctors. Thus, a much smaller proportion of physicians belong to the American Medical Association than belong to the Canadian Medical Association. The American Medical Association has recently set up Physicians for Responsible Negotiation, which is an organization that resembles a traditional labor organization, with several important differences. Membership is not required as a condition of employment, which is the case with most labor unions, and members are not expected to honour picket lines or take part in strikes.103

In California, it is common for physicians to be part of groups other than the state medical association. Some doctors have a stronger allegiance to their specialty associations or medical groups. Others have joined unions. Medical associations and unions are both dedicated to improving their members' wages, benefits and working conditions, but the mandate of medical associations is broader, since they aim "to promote high standards in medical education and practice, science and ethics."104 In the United States, unions, unlike
medical associations, have the legal right to engage in collective bargaining over remuneration and to strike. Until recently, the National Labor Relation Act has stipulated that only salaried physicians can join unions. It was considered "illegal price-fixing under the antitrust laws" for self-employed physicians to engage in collective bargaining. However, self-employed physicians have recently gained more powers to negotiate collectively, since the Federal Trade Commission and U.S. Department of Justice have issued antitrust guidelines that enable them "to form ‘networks’ and bargain with health plans through ‘third-party messengers.’" A 1999 ruling by the National Labor Relations Board has made it possible for medical residents, interns and fellows to bargain collectively.

The issue of whether a physician is an employee or an independent contractor is complicated, in California, by the fact that an individual physician may participate in many different types of employment arrangements. The National Guild for Medical Providers, Office and Professional Employees International Union has identified ten factors that it advises the National Labor Relations Board to use to determine the employment status of doctors. The National Guild for Medical Providers takes the view that doctors should be given the bargaining rights of "employees," if they have any contracts with managed care organizations in which they meet the legal criteria for "employee" status, even if most of their practice is devoted to private patients.

The largest physician union in the United States is located in California. The Union of American Physicians and Dentists (UAPD), founded in 1972, has 6000 members. The UAPD is composed largely of state or local government employees, but it also seeks to attract private-practice physicians. The California Medical Association has experienced a
decline in its numbers unlike the Ontario Medical Association, which has had a steady increase in membership. The California Medical Association's numbers fell from a high of 38,000 in the late 1980s to about 34,000 at present. In contrast, the membership of the UAPD has been increasing by about 15 to 17 percent annually, as more doctors have become salaried. Some physicians have been drawn to medical associations and unions to seek assistance in defending their interests in a managed care environment. Conversely, other physicians have found it less important to join a professional association if they are employed by a managed care organization (MCO) because they can purchase their malpractice insurance through their MCO, and therefore have no need of a medical association to receive it at a competitive price. Nor are physicians as reliant on medical associations for professional contacts and hospital privileges as they were in the past. Physicians may also have lost some of their interest in joining medical associations because they may doubt that medical associations can defend their interests from managed care organizations, which can impose low payment structures and override physicians' long established methods of practicing.

The medical associations at the county, state and national level have become increasingly interested in forming their own unions, but legal hurdles remain before they can be officially recognized. The American Medical Association has thrown its support behind the Quality Health Care Coalition Act of 1999 (HR 1304) to give physicians more clout when they bargain with health maintenance organizations. Not surprisingly, the Health Insurance Association of America (HIAA), which represents 269 private member companies, argued that the Quality Health Care Coalition Act should be rejected on the grounds that it would raise consumers' costs. According to HIAA, the legislation was not
needed because the application of antitrust laws was already flexible enough to allow physicians to collaborate when it was pro-competitive for them to do so. HIAA pointed out that health plans would also be subject to antitrust scrutiny if they tried to form a monopsony to force providers' premiums down.\textsuperscript{113} The history of California physicians' participation in unions will be explored in more detail in the next chapter on their corporate autonomy.

**Regulatory Bodies**

The medical profession is self-regulating in Ontario to a greater extent than it is in California. The College of Physicians and Surgeons of Ontario (CPSO), which is the professional standards body for the medical profession in Ontario, has jurisdiction over complaints, discipline and the licensing of physicians, but not of allied health professionals. The Medical Board of California (MBC), which is the regulatory body charged with disciplining doctors in California, is much more closely associated with the government than CPSO, and has jurisdiction over a number of other healing arts besides physicians. The MBC is one of 38 boards within the California Department of Consumer Affairs. It has direct responsibility for regulating medical assistants, midwives, research psychoanalysts and registered dispensing optician firms. The MBC shares responsibility with other boards for regulating some healing arts such as psychology and podiatry.\textsuperscript{114} Unlike the CPSO, it does not bring formal accusations of wrongdoing against physicians. The MBC conducts investigations and passes the suspicious cases on to the Office of the Attorney General for its review.
Allied Health Professionals

Allied health professionals, such as nurses, midwives, pharmacists, nurse practitioners, physician assistants, acupuncturists, osteopathic doctors and chiropractors, have more status in Ontario and California today, than they had in the 1960s, although it is still less than the status that medical doctors enjoy. Walter Wardwell has distinguished between five types of health occupations, depending on their relationship with allopathic medicine (i.e., the type of medicine most often practiced by the medical profession in Canada and the United States). These are useful for categorizing the allied health professionals in Ontario and California. They include:

- **ancillary workers** who provide support services and are controlled by allopathic medicine (e.g., nurses, laboratory technologists etc.);
- **limited medical practitioners** who have reached a position of accommodation with allopathic medicine (e.g., dentists, optometrists, pharmacists);
- **marginal practitioners** who offer an alternative to allopathic medicine, (e.g., chiropractors, naturopaths etc.);
- **quasi-practitioners** who have a different epistemological and metaphysical base (e.g., Christian Scientists); . . . [and] **parallel professions** which refer to the "near-equal of medicine" (e.g., osteopathy).

Some allied health professionals do not fit easily into the above categories. For example, nurse practitioners strive to be limited medical practitioners and have won a certain degree of legislative autonomy for themselves. Nevertheless, most of their activities are still controlled by allopathic medicine. Nurses and midwives have been marginally more successful at carving out a niche for themselves in Ontario, but most of the other allied health practitioners have had more success at expanding their scope of practice in California.

The organizations of allied health professionals have tried to strengthen their autonomy by lobbying government to set up licensing procedures and independent regulatory boards, and include their services in publicly insured programs. They have
typically wanted to broaden their scope of practice, gain hospital privileges, and achieve professional liability insurance for their members. They have had varying degrees of success in meeting these goals. The Ontario government has taken a very proactive role in defining the scope of power of the professions. It has expanded the power of allied health professionals vis-à-vis physicians, but has subordinated both to the power of the state, by using the professional colleges as one means to control them. In California, the rise of managed care has marginally increased the autonomy of allied health professions at the expense of physicians. Health care corporations have been eager to replace physicians with cheaper labour in order to increase their own profit margins. This "deskilling of care" has given allied health professionals an opportunity to expand their clientele and become more closely associated with mainstream caregivers. At the same time, it curbs some of their autonomy because they, like doctors, must deal with the administrative hassles associated with managed care.

The primary pieces of legislation that have regulated allied health professionals in Ontario are the Drugless Practitioners Act of 1925, the Health Disciplines Act of 1974 and the Regulated Health Professions Act (RHPA) of 1991. Premier John Robarts' Conservative government replaced the Drugless Practitioners Act with the Health Disciplines Act because the former was considered a confusing, chaotic and sloppy piece of legislation. Critics charged that the Drugless Practitioners Act gave the government too little power and the professions too much independence. A few decades after the Health Disciplines Act of 1974 was enacted, it too was changed, this time because the legislation did not adequately cover the "minor disciplines." Larry Grossman, the Conservative Minister of Health in 1983, launched a Health Professions Legislation Review (HPLR),
with lawyer Alan Schwartz as its coordinator. The HPLR laboured until 1991 to overhaul the legislation regulating all the health professions in Ontario\(^{121}\) by redefining the designated controlled acts each health profession would be legislated to perform. The professional associations were asked to enter submissions to the HPLR, defending their arguments in favour of self-regulatory status for their groups on the grounds that it would be in the public’s interest.\(^{122}\)

The Ontario government used the arm’s-length review process to impose its own solution of increased restraints on health care practitioners. Instead of entering into a relationship of elite accommodation with the OMA and the CPSO as it had done in the past, the government treated the medical profession as if it had no more influence than the other groups of health care professionals. Twenty-four professions of the original seventy-five that applied were regulated under the RHPA, which specified the dangerous acts that they could legally perform. The legislation allowed each of the professions to be responsible for its own regulation, within strict boundaries. Each of the Colleges had to include 40 percent lay representatives on its governing council. The RHPA gave the Minister of Health express authority to require the Colleges to take specified actions. Thus, the Health Professions Legislation Review served to reduce the status of the medical profession by making it just one profession among the many with regulatory colleges. At the same time, the HPLR subjected the colleges to greater control by the public and the state.\(^{123}\)

The Ontario experience of regulating health professions has been cited approvingly by the Pew Commission in California: “both the content of its new legislation and the process by which it was achieved, holds lessons for others interested in regulatory
ref~rm. In California, interest groups typically try to advance their cause in the legislature, but the Pew Commission has suggested that professional turf battles could well be dealt with more productively in another forum, like before a national advisory body. At the moment, the political will to set up a national advisory commission for health care professionals is lacking.

Nurses, who are ancillary workers according to Wardwell's classification, have struggled to become free of medical, hospital and state dominance and to gain a measure of occupational autonomy in both jurisdictions. However, it has been difficult for them to escape their subordinate status as a predominantly female occupation. Unlike physicians who are considered independent entrepreneurs, nurses, who are employed by hospitals, are hospital staff and are much more vulnerable to layoffs. Nurses faced trying working conditions in Ontario and California in the 1980s and 1990s. They became increasingly militant in order to protest their poor working conditions and lack of job security. A large number of full-time Ontario nurses left their profession, switched to casual or part-time work, migrated or retired in the wake of deficit hysteria and hospital restructurings. Few young nurses were trained to take their place. As a result, Ontario lost 10 percent of its nurses between 1992 and 1997. Nurses, in California, waged almost continuous public relations campaigns against their employers throughout the 1990s to protest the deskilling of the workforce, whereby health care corporations replaced them with less qualified workers. For example, Kaiser Permanente hired "Teleservice Representatives" (TRs) to operate triage systems and make the crucial decisions about whether patients could speak with a nurse or physician. Although the working conditions for nurses are less than
optimal in both jurisdictions, the associations that represent nurses favour a single payer system of universal health care on the grounds that it is more just for their patients.\textsuperscript{128}

Ontario midwives are an example of limited medical practitioners, according to Wardwell's classification, because they have achieved self-regulation, an expanded scope of practice and a measure of independence from the medical profession.\textsuperscript{129} California midwives are an example of ancillary workers, since they are required by law to work under the control of the medical profession. Midwives are one of the few allied health professionals that currently have more autonomy in Ontario than they do in California. This is surprising because midwifery was legalized much earlier in California. It was not until 1991 that midwifery became legal in Ontario. Nurse-midwifery has been legal in California since 1975, but lay midwives were legalized in 1993,\textsuperscript{130} after seven legislative attempts that were opposed by the California Medical Association. Ontario had approximately 70 midwives in 1993. In contrast, California had approximately 682 certified nurse midwives in 1996 and 85 lay midwives. Ontario midwives have a broader scope of practice than California midwives, since they can work both in homes and hospitals. Ontario midwives have their own regulatory college unlike California midwives. The California Midwifery licensing committee is part of the California Medical Board and does not have any midwife representatives.\textsuperscript{131} No California physicians are willing to supervise midwives because the liability issues are unresolved, although the law requires midwives to practice under their supervision. Therefore, midwives practice in legal limbo.

Ontario midwives have been comparatively successful in advancing their professional interests, in the 1990s, because there has been a shortage of general physicians and obstetricians who were willing to deliver babies, when faced with the rising costs of
malpractice insurance and the relatively low level of reimbursement for work that requires them to be available around the clock. Ontario midwives have been eager to perform the duties that many physicians no longer pursue. One of the reasons that California midwives have had an uneven legal history, besides the resistance of the medical profession, is that midwifery is not a unified profession in the United States. Nurse-midwives and lay midwives have jockeyed to expand their scope of practice, sometimes at the others' expense.\footnote{132}

Pharmacists, nurse practitioners, physician assistants, acupuncturists and osteopathic doctors have been less successful at improving their professional status in Ontario than in California. Ontario pharmacists do not have the expanded rights to prescribe pharmaceuticals\footnote{133} that California pharmacists have recently won. In 1998, California pharmacists gained the authority to initiate prescription or patient consultations outside their pharmacy premises and to provide refills without authorization from a physician.\footnote{134}

In Ontario, there are approximately 94 nurse practitioners as compared with 8,400 in California. Nurse practitioners are uncommon in Ontario because it is more difficult to find a way to reimburse them under a fee-for-service system than under managed care. Critics suggest that their services duplicate physicians' and add to medical expenses.\footnote{135} Even though a course was established for them in 1973 at McMaster University, it was hard for them to carve out a niche for their work with the active cooperation of only a few physicians.\footnote{136} It was not until 1998 that extended class nurse practitioners gained the right to diagnose and treat common diseases without a doctor's approval, as well as to order certain ultrasounds, laboratory tests and x-rays. California nurse practitioners identify their
current occupational barriers as reimbursement difficulties and a lack of prescriptive authority, support from physicians, and public awareness.¹³⁷ Physician assistants are virtually unheard of in Ontario. However, they have firmly established their presence in California, where they numbered about 2,556 in 1996. Unlike nurse practitioners, they do not present a challenge to the supervisory role of physicians.¹³⁸

Acupuncturists, who could be considered marginal practitioners according to Wardwell’s classification, have practiced freely without undue intervention in Ontario since 1984. The Chinese Medicine and Acupuncture Association in Ontario managed to obtain professional liability insurance for its members in 1994. Nevertheless, acupuncturists were not included in the Regulated Health Profession Act of 1991 and have little status compared with the major health professions. Acupuncturists have achieved greater status in California than in most other North American jurisdictions. California was the only state that licensed acupuncturists in the late 1970s. Today, approximately 3,250 acupuncturists, or half the acupuncturists in the United States, practice in California.¹³⁹ They have been covered by Medi-Cal since 1989, and by Workers’ Compensation since 1998. In that year, they also established their own regulatory board that was independent of the Medical Board of California.

Osteopathic doctors are an example of a parallel profession. They are rare in Ontario. In the early 1980s, there were only 32 osteopaths in Ontario, but their numbers have since risen with the establishment of a Canadian training centre in 1992.¹⁴⁰ Patricia O’Reilly notes that the medical profession prevented them from gaining recognition under the Regulated Health Professions Act of 1991.

Osteopaths were included under a special provision of the Medical Act in the 1991 version of the legislation, however, by final proclamation in 1994 they have been
taken out of the Medical Act at the request of the medical profession and have since remained outside the RHPA, once again governed under the DPA.¹⁴¹

Osteopaths have a long and colourful history in California. In 1961, the California Osteopathic Association effectively "merged" with the California Medical Association under Proposition 22.¹⁴² Osteopathic physicians, who had similar training to medical doctors, were offered medical degrees for $65. The majority bought them. Members of the osteopathic profession were granted M.D. degrees on the condition that they consent to forego their right to issue licenses through the Board of Osteopathic Examiners.¹⁴³ In 1974, the California Supreme Court ruled that the 1962 merger was unconstitutional and osteopaths won the freedom to rebuild their profession. In recent years, they have expanded their numbers and built new medical schools. The American College of Physicians observes with disapproval that the number of new osteopathic doctors in the U.S. has grown steadily, whereas the number of new allopathic doctors has remained constant so as not to aggravate the problem of an oversupply of physicians in the marketplace.¹⁴⁴

Chiropractors are an example of marginal practitioners that have successfully become integrated into the health care system in Canada and the United States.¹⁴⁵ Since the late 1960s, Canada’s universal health insurance plan and the United States’ Medicare and Medicaid plans have covered chiropractic services.¹⁴⁶ However, chiropractic has had a more acrimonious relationship with the medical profession in the U.S. In 1987, the American Medical Association, the American College of Surgeons and the American College of Radiology were all found guilty of having conspired to destroy the chiropractic profession in the United States.¹⁴⁷ Evidence in the case showed that these associations had organized a national boycott of chiropractors in the mid-1960s. The American Medical
Association's Committee on Quackery, which was disbanded in 1974, had engaged in a massive propaganda campaign to discredit chiropractic. Chiropractors have managed to improve their legitimacy by lowering their aspirations. Instead of portraying themselves as a parallel profession that is a near equal and alternative to allopathic medicine, they have accepted a lesser role as members of the health care team that specialize in spinal manipulation for particular ailments. The California Medical Association successfully opposed their latest attempt to expand their scope of practice to delivering babies. Thus, although the allied health professionals have benefited from the curbing of doctors' power under socialized medicine in Ontario and corporate medicine in California, their autonomy still does not rival that of the medical profession. The medical profession's relationship with allied health professionals will be explored in more detail in chapter 5.

CONSTITUTIONAL, INSTITUTIONAL AND POLITICAL ENVIRONMENT

In order to understand the changes in the policymaking influence of physicians in Ontario and California since the 1960s, it is necessary to examine the constitutional, institutional and political environment in which the medical associations lobby. Political theorists of the institutionalist variety posit that institutions structure the nature of limits and opportunities for policy changes.\(^{148}\) The evolution of political institutions is based upon decisions made in the past that influence the type of decisions that will be politically feasible in the future. In this sense, the development of political institutions and public policy is path dependent. I will highlight the essential differences in the policymaking environment in Ontario and California, which set the boundaries for the type of policy
changes that are likely to take place when the medical profession puts pressure on government to address its grievances and lobby for changes in the health system.

**Constitutional Environment**

One might expect that it would be difficult to set up a single payer health care program in Canada and the United States because they both have a decentralized federal system, which provides interest groups with many opportunities to block legislation. Nevertheless, the existence of a parliamentary system, rather than a congressional system, made it easier in Canada because it meant that there were fewer policy decision points, as we shall discuss below.

The constitutional environment in California impeded the introduction of a government-run national health plan, which would have provided a more secure environment for protecting the autonomy of physicians than a system of market competition over health insurance. The states' autonomy to enact major health reform is more limited than provincial autonomy due to the revenue-raising constraints that they face. As Richard Simeon, professor of political science at the University of Toronto, noted,

[They] tend to have less revenue-raising capacity than Canadian provinces and in many cases have constitutional limits on their ability to spend more than they raise. In addition, citizen participation in initiatives and referenda on taxation and other matters has limited states' ability to raise revenue, thus focusing restraint even more on the expenditure side.

The California constitution requires the budget to be balanced, which means that the state has less flexibility than the federal government to allocate funds to health care, particularly in the event of an economic downturn.
The constitution also allows for instruments of direct democracy like initiatives, which are direct democracy devices that allow registered voters to draft ballot measures, if they can provide the required number of signatures.\textsuperscript{152} Two ballot initiatives stand out as being particularly restrictive of the state's ability to raise taxes. Proposition 13, passed in 1978, capped future increases in property taxes and Proposition 4, the Gann Initiative, passed the following year, limited per capita increases in state spending.\textsuperscript{153} Voters gained the authority to veto any increase in local taxes. If an increase is designated for a specific purpose, two-thirds of voters are required to approve it.\textsuperscript{154}

The judiciary in the United States has assumed a more activist role in the policy process than is the case in Canada.\textsuperscript{155} The states' ability to regulate private health insurance and enact comprehensive health reforms has been constrained by the judiciary's interpretation of the federal Employee Retirement and Income Security Act (ERISA) of 1974.\textsuperscript{156} ERISA exempts California firms from lawsuits under state law, giving them a strong incentive to self-insure. (ERISA will be discussed in more detail in chapter 2). As long as the law is in place, it is impossible for the state to set up a comprehensive insurance program. Charles Brecher notes that ERISA has had two consequences for state-level insurance regulations:

First, it effectively exempts employers who choose to self-insure from minimum benefit standards as well as premium taxes. As a result, many large firms now self-insure rather than purchase group health insurance. Second, it prohibits states from mandating that employers provide health insurance to their workers.\textsuperscript{157}

I emphasize the ways in which the constitutional environment makes it difficult to introduce a single payer health system in California. Others might expect that the existence of the initiative process in California would make it easier to enact a single payer system and patient protections than in jurisdictions where the ballot initiative is not an option. The
initiative process allows supporters of universal health insurance to bypass the state legislature, where a two-third majority would be required to pass a single payer bill. Obtaining such a large majority in support of a single payer system would be difficult in a legislature such as California's that is heavily financed by insurance company campaign contributions.

Supporters of a universal health insurance system have not used the ballot initiative as effectively as its opponents, who have devoted their vast financial resources to derail single payer ballot initiatives. The lobbyists behind Proposition 186 in 1994 including "the California Teachers Association, United Auto Workers, California Council of Churches, California Nurses Association, Consumers Union and the League of Women Voters," hoped that citizens would embrace the opportunity to signal their support of a strong public health care system, but they underestimated the extent to which the anti-government rhetoric of the insurance industry and hospitals would appeal to the public. The vast majority of voters (5.5 million) rejected Proposition 186; only 2 million voters supported it. Latinos and blacks, who are more likely than the rest of the American population to support universal health care, are less likely to be politically active, and therefore did not take part in the California initiative process in large enough numbers to pass the ballot.

Interest groups engage in the initiative process because, whether or not they win, it provides them with an opportunity to inform the public about issues and make legislators aware that their concerns are widely shared. There is some evidence that groups in favour of consumer protections gained long-term benefits from using the initiative process in the November 1996 election, even though their efforts proved futile in the short-term. Labour organizations and other public interest groups failed in their attempt to pass Propositions
214 and 216. These were similar consumer protection initiatives, which would have made it more difficult for health care companies to discourage physicians from recommending treatments that were not covered by the managed care plans, and would have banned financial incentives for withholding medically necessary services. Nevertheless, the labour organizations and other public interest groups ultimately succeeded in their goal of tightening HMO regulation. As Elisabeth Gerber, associate professor of political science at the University of California, San Diego, observes:

In the twelve-month period before the 1996 election, only one HMO regulation bill was introduced in the state legislature. In the three months immediately following the election, by contrast, 27 HMO regulation bills were introduced in the legislature, many containing provisions of the failed initiatives.160

Opponents of compulsory universal health insurance have successfully threatened to use the initiative process to prevent supporters from launching a campaign to introduce a universal health insurance ballot initiative. As Eugene C. Lee, professor emeritus of political science at University of California, notes,

In 1991, an alliance of health insurers and small business groups engaged in a $300,000 lobbying effort – including the threat of a counter-initiative – whose sole purpose was to intimidate the California Medical Association from putting a universal health insurance initiative on the November 1992 ballot. The CMA abandoned its plans.161

Some “narrow” economic interest groups (e.g., insurance companies and small business groups) have the advantage that they can afford to hire signature gatherers and consultants to oppose single payer health insurance and patient protection initiatives, by framing them as proposals to expand government and raise taxes. “Broad-based” public interest groups (e.g., political reform advocates)162 are at a distinct disadvantage in their attempts to reform health care since they may lack or be unwilling to commit sufficient funds to compete in the costly initiative process.
**Institutional Environment**

The major institutions involved in policymaking are the executive, legislative and judicial branches of government. Canada has a parliamentary executive where the fusion of powers between the prime minister, cabinet and bureaucracy make it much easier for government to enact its policies than in the presidential style of government in the United States. The American presidential system is based on a separation of powers principle, meaning that power is fragmented between the executive, legislative and judicial branches. In the Canadian parliamentary system, there is a tradition of strong party discipline, because if party members break rank on important pieces of legislation, they can collectively lose their right to govern. Canadian interest groups concentrate on lobbying the prime minister, premiers, cabinet ministers and senior bureaucrats. They put little effort into lobbying backbenchers, since they rarely take a voting position that is independent from the rest of their party.

The combined constitutional and institutional environment in Canada has been conducive to the development of a single payer system because, as Antonia Maioni, professor of political science at McGill University, has convincingly argued,

> [P]arliamentary government and federalism encouraged the formation of a social-democratic third party that shaped the health reform agenda and provided tangible evidence of the viability of such reforms.\(^{163}\)

In a parliamentary system, a third party can exercise an important role in the development of public policy, even if it is unlikely to form the government at the federal level. In the U.S. congressional system, only two parties wield significant political power, the Democrats and Republicans, and neither has provided an attractive base for the public
health insurance platform. Saskatchewan, with the Co-operative Commonwealth Federation-New Democratic Party at its helm, took the lead in establishing publicly funded hospital insurance (1947) and medical insurance (1962). The federal government proceeded to try to enact nationwide programs, when it became obvious that Saskatchewan was able to muster public support for its health insurance programs. The federal government had to rely on an indirect method to intervene in the field of health care, which is primarily a provincial responsibility. It offered to provide 50 percent of the funds to the provinces whose health care plans met its standards. Even though the Ontario government, insurance industry, and medical profession resisted joining the national plan, through Prime Minister Pearson’s use of “coercive federalism,” Ontario was brought into it.  

Party discipline is weaker in the United States, meaning that members of the same party can take radically different stances on policy proposals, reflecting the diverse interests of the people that they represent. Interest groups have an incentive to concentrate their efforts on leaders in key positions in several branches of the state and federal government, in order to interfere with the passage of legislation that they oppose. Even though Presidents Truman, Kennedy, Johnson and Clinton promised to restructure the financing and delivery of health care to make it more universally available, their proposals were defeated because societal groups used the many veto points in Congress and the executive branch agencies to contest them.

The dispersal of authority to more numerous committees and subcommittees in both chambers of the legislature in the United States makes pork-barrel politics a way of life. In 1990, power became even more dispersed in the state legislature when Californians approved Proposition 140. This initiative limited legislative service in the Assembly to six
years (three terms) and the Senate to eight years (two terms). As a result, Raymond La Raja and Dorie Apollonio have speculated that interest groups will need to increase their spending to reach more members than was formerly required, since legislative leaders are likely to have less control. Shorter term limits will mean that lawmakers are more reliant on interest groups for advice because they will be less familiar with the policy processes and history of the debates. La Raja and Apollonio traced institutional contributions between 1986 and 1996, and noted less money was being directed to the Assembly and more to the Senate, reflecting a shift in power from the lower to the upper chamber. The institutional environment is structured in such a way that assembly members and senators must cater to the groups of constituents that support them in order to strengthen their political power. This brokerage style of politics has created a health system that is "made up of multiple 'little governments' and 'little empires' that pursue their own goals and interests. This, in turn, generates health policies that are vaguely defined and designed to serve 'special publics.'" Interest groups and political action committees have had more success at blocking bills that they oppose in the state and federal legislatures than at facilitating the approval of major changes because political power is so fragmented.

Another important institutional difference is that the judiciary takes a more active role in policymaking than its counterpart in Ontario. The California Medical Association sometimes uses litigation to influence policy. More often, the CMA files an amicus curiae – or friend of the court – brief, on behalf of physicians, to signal its support of one of the parties involved in a lawsuit. That way the CMA can avoid the potentially enormous cost of launching its own lawsuit, and clarify some of the larger health care issues surrounding a case.
Political Environment

A political culture reflects the unique historical and economic experiences of a state or province, and affects the institutions and policy networks that are likely to develop within its borders. Sid Noel has provided a working definition of political culture:

it refers to a set of widely shared outlooks, beliefs, and sentiments that a people holds over some extended period of time and that broadly conditions their [sic] political behaviour.¹⁷⁰

He has distinguished between the “ideational” and the “operative” elements of political culture, the latter being more important, in his view, for understanding politics in Ontario.¹⁷¹ Noel defines the ideational elements as “the ideologies, principles, and theories about government and politics that are present in the intellectual discourse of a society.” He suggests that the people in Ontario share core political beliefs. Although Ontarians have remained fairly supportive of a universal publicly funded health care system, their endorsement of other aspects of a social welfare state declined in the 1990s.

I would characterize California as more divided ideologically than Ontario, with a minority on the left, who would welcome a larger role for government in society, and the majority on the right, who distrust government and want to see it constrained. California is usually perceived to be conservative on issues like taxes, smaller government and social spending, especially if it involves aid to the poor.¹⁷² Historians and political analysts have coined the phrase “the politics of resentment” to describe contemporary Californian culture. California is about to become an ethnically “minority-majority state.”¹⁷³ Some politicians feed on the fear of Caucasians, who realize that they may lose economic and political power when members of other ethnic groups outnumber them. Governor Pete
Wilson, particularly, was accused of using “wedge politics” to win the support of swing voters to his cause. He made universal health care less palatable to many voters by suggesting that the extension of health care to foreigners and the needy would be at the expense of middle-class taxpayers. In 1993, Governor Wilson called for an end to public education and health care for illegal immigrants and demanded that citizenship not be automatically given to their children. In 1995, he dissuaded the University of California Board of Regents from giving minority and gender preferences to university applicants. Wilson was also behind the Proposition 209 initiative to overturn state and local government affirmative action programs in 1996. As a result, the number of ethnic physicians being admitted to medical school has dropped dramatically.

Much of the discussion in the literature on political culture highlights differences between Canada and the United States at the national level, rather than seeking to make more subtle distinctions between the provinces and states. It portrays Canada as a collectivist society relative to the more individualistic and liberal American society. Recent surveys show a high level of convergence between values in the two countries, but they indicate that social, racial and political intolerance is stronger in the United States.

Canadians today are more committed to their own publicly funded health system than are Americans to their market-oriented one. A 1992 Gallup Report found that 97 percent of Canadians preferred a Canadian style health system, whereas 57 percent of Americans favoured their own health system. Faith in the Conservative government’s ability to run the Ontario health care system has reached a low-point under Premier Harris’s leadership. A 1999 Angus Reid poll shows that 60 percent of Ontarians surveyed disapproved of the way the province handled the health system. Another recent poll
shows a high level of interest in private health care among Canadians. A 1998 survey conducted by Pollara for Merck Frosst, a pharmaceutical company, found that 96 percent of Canadians believe the health system needs major repairs, and 63 percent of those surveyed thought that they should be able to purchase private health care. Canadians seem to want to preserve public hospital and medical insurance and, at the same time, gain personal access to a private medical system. Don Guy, Pollara vice-president, interprets these puzzling results to mean that Canadians soundly reject a two-tier system at a societal level, but want it on a personal level. Ontarians' support for a universal publicly funded health system is not so deep that it could not change in the future if the quality of care significantly declines.

**MAJOR FACTORS AFFECTING THE INFLUENCE OF THE MEDICAL PROFESSION**

Clive Thomas and Ronald Hrebenar have created a theoretical framework of interest group power in which they identify twelve major factors that determine the influence of individual interest groups. Their framework recognizes the importance of internal and external resources for successful collective action. It draws on insights from two theories of social movements. The first is resource mobilization theory, which focuses on the interest groups' leadership and organizational resources as the source of their political influence. The second is political process theory. Political process theory draws attention to the ways in which the changing structure of opportunities and constraints within the state determine the type and effectiveness of group mobilization.
Thomas and Hrebenar suggest that an interest group's influence is dependent on, first, its internal resources. These could be defined as 1) the political, organizational, and managerial skill of group leaders, 2) the group's financial resources, 3) the size and geographical distribution of its membership, and 4) the political cohesiveness of the membership. Secondly, the general policy goals and potential opposition/support of other groups are important such as 5) whether the group's lobbying focus is primarily defensive or promotional, 6) the extent and strength of group opposition and 7) the potential for the group to enter into coalitions. Thirdly, the state political climate, meaning 8) the timing of a changing political agenda and 9) the partisan and ideological make-up of the executive and legislature, affects the influence of interest groups, as does 10) the public perceptions of issues and groups. Fourthly, interest group influence depends on long-term group relations with public officials, most especially 11) the necessity of group services and resources to public officials and 12) the relations between lobbyists and policy makers. Thomas and Hrebenar's framework will be applied in the Ontario and California cases, in order to draw attention to the internal and external resources that affect physician influence.

I. Group Internal Resources

1. Political, Organizational, and Managerial Skill of Group Leaders.

The medical profession in Ontario and California has considerable internal resources. If organized medicine in California has suffered from declining policymaking influence, there is little evidence to suggest that is due to an ineffective leadership or a lack of organizational strength. Press accounts and internal surveys indicate that the leaders of the California Medical Association may
have stronger political, organizational and managerial skills than the leaders of the
Ontario Medical Association.

In Ontario, the medical profession has engaged in a relationship with the state
that is based on "tenuous accommodation, punctuated by periodic conflict."
Carolyn Tuohy's description of the location of the most politically powerful group
of physicians is, I believe, worth quoting in full, because it shows that the leaders of
the medical profession are based in a number of organizations:

The linchpin of this accommodation is the relationship between the state and the
'strategic minority' of physicians, primarily based in the medical schools and
the licensing body, the College of Physicians and Surgeons of Ontario (CPSO). These strategically placed physicians are prepared to collaborate with the state on the condition that clinical discretion and professional autonomy are preserved. Given the vagaries of medical politics, the position of this minority within the executive ranks of the Ontario Medical Association (OMA) has varied over time and so, accordingly, has the political stance of the OMA.184

The College of Physicians and Surgeons of Ontario and the Ontario Medical
Association have more than their fair share of critics from within their rank and file. One of the most damaging and frequent charges is that these groups are too closely aligned with the government to adequately defend the needs of the profession.185

The Ontario Medical Association courageously conducted a survey of its members subsequent to the disastrous strike of 1986. The survey showed that respondents were much more negative about the organization's externally oriented services than its internally oriented services. Doctors gave barely passing grades to the OMA's efforts to "serve as the political voice of the profession in the province" and "to conduct negotiations on behalf of doctors with government and other groups," whereas they were satisfied with the OMA's group insurance, benefit plan and
publications.\textsuperscript{186} Leadership failings of the OMA do not go unnoticed in the press. The Medical Post is the self-appointed watchdog of the organization. The newspaper launched an eight part "circling the wagons" series in 1992 that criticized the leaders for failing to come to the defence of individual physicians, like pro-choice activist Dr. Henry Morgentaler,\textsuperscript{187} when they were under attack, and for developing too cosy a relationship with the NDP government.\textsuperscript{188} The California Medical Association has never been subjected to a comparable barrage of criticism by the press. Its leaders have more often attracted positive commentary.\textsuperscript{189}

The California Medical Association is the only association in California that claims to represent doctors from all modes of practice. It has been blessed with the quality and longevity of its leadership. For example, Howard Hassard served the California Medical Association for forty years as its legal counsel, and for nine of those years as its Executive Director.\textsuperscript{190} Jay Dee Michael was a long-time lobbyist for the association, having previously represented the University of California in Sacramento. He served the CMA's Division of Government Relations for a decade before Steve Thompson replaced him in 1992. Michael established the Californians Allied for Patient Protection (CAPP), which is effectively an issue political action committee for the CMA. CAPP is a coalition of organizations that defends the Medical Injury Compensation Reform Act (MICRA) of 1975, which is legislation that places a $250,000 ceiling on compensation for a patient's pain and suffering if he/she has suffered injuries at the hands of a physician or other health care professional in the course of medical treatment. (MICRA will be discussed in more detail in chapter 2). In 1998, CAPP contributed $329,568 to state political
campaigns. Before becoming the California Medical Association’s chief lobbyist, Steve Thompson worked as chief of staff for Willie Brown who, as Assembly Speaker from 1980 to 1995, has been called “perhaps America’s most powerful black elected official.” Thompson also headed the California State Assembly’s office of research. John Lewin, the former director of health for Hawaii (1986-1994) and current executive vice president of the CMA, has played a vital role in defending physicians’ professionalism in a for-profit managed care environment. The doctor-run managed care organization, California Advantage, which John Lewin helped to form in 1995, was forced to claim bankruptcy in 1998. However, Lewin has managed to draw attention to the medical group solvency crisis in California and has worked diligently to recover physician payments of over $50 million from MedPartners, an intermediary that contracted with health plans before its bankruptcy in 1999.

While California has no lack of capable leaders in the medical profession, physicians have not formed a cohesive group and followed them. Some observers have noted that physicians by nature are difficult to lead because they prefer to pursue their own goals rather than nurture others’ leadership. As CMA past-president Eugene S. Ogrod (1994-95) said,

We don’t handle vertical structures and orders very well . . . Doctors have been taught to distrust the doctor who saw the patient before they did. This attitude carries over to a distrust of the people they elect to manage their organization.

The survey data on the effectiveness of the California Medical Association’s lobbying efforts shows widely disparate opinions. A mail-in survey by the CMA News in 1980 found that only about “50 percent thought that the CMA was doing a
good job in legislative lobbying." However, a random-sample survey conducted four years later by the CMA's Bureau of Research and Planning showed that respondents rated legislative lobbying very positively.198

2. **Group Financial Resources.**

Both the Ontario Medical Association and the California Medical Association have extensive financial resources. In 1994, the Ontario Medical Association's annual budget amounted to approximately $15 million.199 The Ontario government has more influence over the Ontario Medical Association's financial resources than the California government has over those of the California Medical Association. Since 1991, the Ontario government has given the OMA the opportunity to expand its revenues by as much as $3 million,200 by granting it the right to adopt the RAND formula.201 When the OMA has adopted the RAND formula, physicians have been required to contribute membership fees to the organization, even if they have not chosen to become members. Supporters of the RAND formula argue that it is only fair that non-members help to cover the costs of the OMA's initiatives. Members and non-members alike share the benefits of having the OMA represent their interests in government negotiations.202 However, physicians, who oppose the RAND formula, assert that they should be able to withhold their dues payment to show their dissatisfaction with the agreements that the OMA negotiates.203 (The RAND formula will be discussed further in chapter 2).

The Ontario Medical Association receives money from the government to offset the cost of its members' fees in the Canadian Medical Protective Association (CMPA), which is a physician-owned and operated mutual-defence organization.
In 2000, these will amount to $73 million. In 1992, the government appeared to put pressure on the OMA to discourage the CMPA from defending physicians who were in disputes with the Ontario Health Insurance Plan (OHIP) for overbilling, on the grounds that it would be counterproductive for the government to pay doctors to fight against it. The OMA complied with the government’s request even though the CMPA members were overwhelmingly in favour of giving legal assistance to these doctors. Thus, there is some evidence that the OMA’s dependency on the government for malpractice subsidies can compromise the ability of its leaders to represent its members’ interests.

The California Medical Association is discreet about its financial resources. Jay Michael recognized that flexing its political and economic muscles might alienate others outside the association with different views. He therefore advocated exercising humility. However, Franklin Glanz noted in May 1986 that the California Medical Political Committee (CALPAC), the political arm of the California Medical Association, which was formed in the early nineteen-seventies consistently ranked “among the nation’s top 10 political action committees representing profession and trade associations.” In 1975, CALPAC contributed $246,700 to state legislative campaigns, and by 1998, its contribution to state political campaigns had risen to $1 million. The lobbying expenditures of the American Medical Association ranked the highest of any professional organization in the United States in 1998 at $16,820,000.

The California Medical Association launched a challenge against the Federal Election Committee that proceeded as far as the Supreme Court in 1981 to try to
increase the funds that it could contribute to CALPAC beyond the $5000 limit. The CMA argued that the $5000 limit restricted its ability to engage in free speech. Moreover, there was little danger that the lawmakers would be corrupted since the money was being given to a committee instead of a single candidate. The medical association’s arguments were rejected. Although the restriction remained in place, interest groups that have a lot of financial resources are still at a distinct advantage in California today, because there are few limits on campaign finance. Californians for Political Reform has noted that there are currently no contribution limits for most political races, no limits on candidate-to-candidate transfers of funds from one political campaign to another, no limits on when contributions can be received, and no spending limits on state-wide races. In addition, there is no public funding of candidates that would help even the odds for candidates that are not backed by affluent groups or individuals. Thus, the CMA is well endowed with financial resources that it can use to bolster physician autonomy, but so are many other groups that may counter its lobbying agenda.

3. **Size and Geographical Distribution of Group Membership.**

   An interest group’s members are critical to its success because they raise monetary resources and volunteer their time and energy to advance its agenda. Physicians have consistently been one of society’s more respected groups of professionals, because people are dependent on their medical skills during the most vulnerable moments in their lives. As Jay Michael explains in slightly exaggerated terms, “all of the muscle that medicine has flows from a single source: the value the public places on the medical services they receive from doctors.” If most
physicians in a province or state belong to a single medical association, that medical association can make a stronger claim that its pronouncements should be recognized as representing the voice of medicine in that jurisdiction.

The Ontario Medical Association has a smaller membership than the California Medical Association, but its organizational density is much greater. The OMA's membership has grown dramatically over the years from 6,200 in 1960 to 8,900 in 1970 to 15,000 in 1980 to 19,000 in 1990 to 24,000 in 2000. All Ontario physicians are currently required to pay membership fees to their medical association, although only about 90 percent are members. However, membership fees were paid to the OMA on a voluntary basis until 1993 and then again from 1995 to 1998. The OMA has a professional staff of 160.

The California Medical Association is comprised of about 34,000 physicians, or 40 percent of the physician population. The California Medical Association's growth rate has not been as dramatic as the Ontario Medical Association's since in 1967, it already had 22,600 members. The Ontario Medical Association's membership has almost tripled since 1970, whereas the California Medical Association's membership has not come close to doubling. The proportion of Californian physicians involved in the California Medical Association has declined dramatically since 1971, when its 25,000 members represented 63 percent of the physician population. In 1997, the California Medical Association had approximately 160 employees, the same number as the Ontario Medical Association, but John Lewin recently eliminated about 40 staff positions to make it a leaner organization. CALPAC operates on a much larger scale than the OMA's
local political action committees, which exist to promote dialogue between doctors and members of parliament or other local candidates. In 1986, 8,763 physicians joined CALPAC and 800 physicians acted as key contacts with legislators. In contrast, only about 100 physicians take part in the OMA’s program linking physicians with their elected representatives.

4. Political Cohesiveness of the Membership.

Physicians in Ontario are much more politically cohesive than their counterparts in California. Physicians of various political stripes work together to promote the goals of the organization. When the RAND formula is in place, the government officially recognizes the OMA as the voice of Ontario doctors. The Ministry of Health and senior legislative representatives undertake fee negotiations with a unified profession rather than employing a divide-and-conquer strategy of negotiating with each specialty separately.

The California Medical Association endeavours to unite the various voices in medicine, but there is much stiffer competition among California doctors and hospitals than there is in Ontario. Many doctors choose to forego affiliation with an association altogether, because they feel overburdened with the demands of maintaining their practices, or because they are disillusioned with the ability of organized medicine to lobby effectively. Others have joined groups that they think better represent their unique interests such as the American Association of Independent Physicians, the National Independent Practice Association Coalition, specialty groups, unions and medical associations that are based on the ethnicity or sexual orientation of their members.
II. General Policy Goals and Potential Opposition/Support of Other Groups

5. Whether the Group’s Lobbying Focus is Primarily Defensive or Promotional.

The institutions within which policy decisions take place influence the lobbying focus of interest groups and their capacity to promote or block legislation. Interest groups that have a defensive focus (e.g., medical associations) have a distinct advantage over those with a promotional focus (e.g., allied health professionals) because the state and the public recognize their dominance of the health policy arena. Medical associations represent a privileged group, since governments have traditionally granted doctors the right to self-regulate. Allied health professionals face the ongoing challenge of trying to increase the number of tasks that they are licensed to perform.

Critics might dispute the leadership’s claim that the Ontario Medical Association adequately defends doctors’ interests. Dr. Karen McIntosh, a family practitioner, who is one of the founders of Physicians for Quality Health Care of Ottawa-Carleton, suggested in 1995, after reviewing the results of a survey, that OMA members generally felt the organization had abdicated its primary responsibility. She said, “the sense now is that the OMA has become a mediator between the government and, like any good mediator, they ... don’t care what the answer is as long as everybody agrees.”222 On the other hand, OMA backers argue that its leaders have played an important role in increasing the attractiveness of the organization in the eyes of the public by encouraging its members to become involved with local health associations and district councils.223 In the 1990s, the
OMA boosted the image of doctors by setting up health policy committees so that physicians could collaborate with community groups on initiatives that addressed broad social fields and clinical topics.\(^{224}\)

Interest groups are expected to have an easier time defending the status quo than promoting change. The latter requires raising broad-based support from outside the group. It is particularly difficult in the California political context to enact major reforms because so many legislators must be convinced of their value. Perhaps the most important goal of the California Medical Association is to prevent the repeal of the Medical Injury Compensation Reform Act. If that is the CMA's only accomplishment, it will have justified its existence. MICRA's $250,000 cap on compensation for non-economic damages to patients saves California physicians millions of dollars each year. The California Medical Association has been less successful at promoting new policies like universal health insurance, which may not be as important to most of its members as the cap on malpractice premiums.

6. The Extent and Strength of Group Opposition.

Physicians as a group generally do not have a lot of enemies. In Ontario, doctors sometimes view government officials and health economists as their chief critics. These two groups at times portray physicians in a negative light in order to make way for a new, and in their view, better system. For instance, government officials and health economists may favour more Medical Review Committee audits of payment, in order to combat fraud, even if it means physicians would face more oversight, or they may contemplate a greater role for allied health professionals, even if physicians would lose their supervisory positions. Similarly, some of them
have supported the Advocacy, Consent and Substitute Decision-making legislation, even though it may subvert the doctor's advocacy role.225

Some doctors believe the media opposes their interests. They blame the media for reporting their gross, instead of their net, incomes, thereby giving the false impression that their salary is much higher than it actually is when office overhead expenses are taken into consideration.226

Group opposition to physicians is more extensive and organized in California, making it harder for physicians to achieve their goals. The California Medical Association is engaged in perpetual squabbles and deal making with three industries that outspent their $1 million campaign contribution in 1998. The tobacco industry spent $30.4 million, the insurance industry spent $6.7 million, and the trial lawyers spent $5.5 million, as compared to the health care industries $4.9 million campaign donations, to buy access to political leaders in order to influence state legislation.

The California Medical Association’s relationship with the tobacco industry has been complex.227 Although physicians and tobacco lobbyists would appear to be on opposite sides of the health fence, representatives of the tobacco industry have plotted to make allies of the CMA, which they have considered to be a key player in the war over tobacco tax rates.228 The tobacco industry has consistently directed campaign contributions to California to block the passage of strict tobacco control legislation, which they fear would be reproduced in other states. The California Medical Association has been at the forefront of efforts to make the state’s anti-smoking laws the toughest in the world. The CMA’s chief lobbyist, Steve Thompson, praised the organization for being responsible for a 2-cent increase in
tobacco tax enacted in 1993 to pay for breast cancer research. The CMA promoted a 17-cents-a-pack increase in 1995.\(^{229}\) The CMA called for a ban on smoking in the workplace and public places, and, in Thompson’s words, it was “almost solely responsible for the ban on the distribution of tobacco samples.”\(^{230}\)

The California Medical Association has not been without its critics, who have been puzzled by the mixed signals that the organization sometimes sends about where its primary allegiance lies. They raise awkward questions like, “what contacts were going on with the CMA that led them to withdraw financial support for the [California tobacco tax] initiative after it qualified for the ballot [in 1987]?”\(^{231}\) Confidential memos show that A-K Associates Inc., a tobacco industry lobbyist, helped dissuade the CMA from directing $1 million to a tobacco tax initiative. Instead, the CMA decided to “tokenize” its support by making a $25,000 pledge. However, Steve Thompson, who did not join the organization until 1992, argues that the CMA never made a firm commitment to give a million dollars. Others have speculated that the tobacco lobbyists “neutralized the CMA by sidestepping its elected leaders and by threatening to support ‘anti-medicine initiatives.’”\(^{232}\) Critics\(^{233}\) also ask: why did the CMA support the state’s appointment of Kim Belshé as the director of the Department of Health Services? She had been “chief spokeswoman in Southern California for a public relations firm hired by the tobacco industry in the unsuccessful campaign to defeat Proposition 99,” the initiative that raised the tobacco tax by 25 cents in 1989\(^{234}\) Why did the CMA support the diversion of $73 million a year from Proposition 99’s tobacco control program to indigent health care?\(^{235}\)
The California chapter of the American Heart Association and Americans for Nonsmokers Rights were incensed that the CMA seemed to be playing into the hands of the tobacco industry. They sponsored an advertisement in the *Sacramento Bee* on January 30, 1996 to nominate Governor Pete Wilson and the CMA’s chief lobbyist for induction into the tobacco industry “Hall of Shame.” Although drawing attention to the link between physician and tobacco interests was a low blow, after the negative publicity, the CMA seemed to change its strategy. The CMA indicated that it was no longer interested in pursuing legal action to divert Proposition 99 funds.

The California Medical Association’s relationship with the trial lawyer association has been similarly characterized by behinds-the-scene politicking. The CMA has strongly opposed the trial lawyers’ efforts to change the MICRA legislation. Physicians have charged that trial lawyers have been intent on raising the cap on pain-and-suffering awards in malpractice judgements in order to increase their own salaries. Physicians perceive that, if trial lawyers were successful in overturning the MICRA cap, individual practitioners would be saddled with higher malpractice insurance premiums, and consumers, would find it more difficult to purchase affordable health insurance. Doctors, in all modes of practice, have been united in their opposition to trial lawyers’ attempts to change the MICRA legislation.

In 1987, at Frank Fat’s Restaurant in Sacramento, doctors, trial lawyers and tobacco companies entered into a legendary agreement at State Senator Bill Lockyer’s instigation that was to last until 1993. Lockyer outlined the terms of the
"nonaggression pact" on a cloth napkin. The various parties, who were represented at the table, agreed to cease their public squabbling over malpractice reform. In the *Washington Monthly*, Paul Glastris described the gains that the interest groups reaped from the napkin deal:

One provision raised the standard of proof an injured person must meet to obtain damages. Another granted virtual immunity to "inherently unsafe" [sic] products, such as tobacco. The California "compromise" gave something to everyone at the table. Manufacturers got protection from lawsuits. So did insurance companies, which also won relief from threatened regulation of their industry. Doctors got a promise that they wouldn't lose lawsuit protections they already had. Trial lawyers, long opposed to these "liability reform" measures, won increases in the fees they can collect in malpractice cases. "Unfortunately the victims who will be harmed weren't in the room when the deal was cut," complained Harry Snyder, the regional director of the Consumers Union.  

Only the consumers were left at a disadvantage by the deal. For a six-year period, they lost any hope of increasing the amount of compensation for pain and suffering that they could receive from malpractice lawsuits.

Insurance companies are a third group that the California Medical Association continually battles. The California Medical Association has sought to defend doctors' interests from insurance companies and health plans that break their contracts by reducing their fees, failing to compensate physicians on a timely basis and practicing medicine without assuming responsibility for treatment denials. The CMA has won the right to arbitrate fees on behalf of all physicians in select lawsuits. It offers to review physicians' contracts before they enter into binding agreements with managed care companies. The medical association also seeks to limit the administrative costs that health plans can pass on to consumers.
7. Potential for the Group to Enter Into Coalitions.

Physicians enter into coalitions to gain more resources for turning their strategies into influence. They may need to modify some of their goals to work with other groups. Physicians' greater willingness to take part in coalitions today than three decades ago is indicative of their declining political strength. The Ontario Medical Association is less active in coalitions than the California Medical Association. In 1990, the OMA issued a joint statement with the Ontario Teachers' Federation and the Ontario Public Sector Employees' Union, although it is rare for the OMA to enter into coalitions with other groups. The organizations attacked Liberal Premier David Peterson for failing to live up to his commitment to improve health care and social services, two weeks after he announced that he was running for office again. The OMA was not willing to countenance another victory for Premier Peterson, since he began his term in office by alienating them more profoundly over the extra-billing issue than any other government had ever done.\(^ {238} \)

As will be discussed in more detail in chapter 4, the Ontario government, under the leadership of David Peterson, made it illegal for doctors to bill their patients in excess of the amount covered by public health insurance, and, in the process, infuriated many doctors to the point that they were willing to strike.

The Ontario Medical Association can bring significant influence to bear on the Canadian Medical Association because its members make up such a large proportion of that association. Dr. John O’Brien-Bell, former president of the Canadian Medical Association, recalled with displeasure that the OMA forced the Canadian Medical Association to dance to its tune by requiring the CMA to
discontinue its battle over the Canada Health Act, after it spent about half a million dollars to contest the legality of the Act. It seems the OMA was concerned that the CMA’s lawsuit over the Canada Health Act could interfere with the provincial medical association’s attempts to improve relations with the NDP government. In Dr. O’Brien-Bell’s opinion,

The reason for the discontinuation was that the OMA had a new lawyer of NDP persuasion who found the challenge ‘inappropriate.’

The Ontario Medical Association has cooperated in a variety of committees with representatives from government and other interest groups, which involved building coalitions over a longer period of time. For example, the OMA had a permanent seat on the Joint Management Committee with the Ministry of Health, as did the Professional Association of Internes and Residents of Ontario from 1991 until the JMC’s dissolution in 1993. The OMA also works on an ongoing basis with the Ontario Hospital Association and its Joint Policy and Planning Committee.

The California Medical Association was one of the founding members of Californians Allied for Patient Protection (CAPP). The participation of women’s groups and consumers’ groups on CAPP is crucial for its success, because physicians can then portray the MICRA issue as a battle to protect consumers from higher premiums instead of an economic conflict that is exclusively between doctors and trial lawyers. The California Medical Association also participates in coalitions when it seeks to promote or block individual propositions and pieces of legislation. For example, the CMA participated in the Coalition for a Healthy
California to prevent the passage of Proposition 188, the California Uniform Tobacco Control Act promoted by the tobacco industry in 1994. This initiative was aimed at replacing stringent local control of tobacco with lax statewide control. In 1998, the CMA was a leader in the Next Generation Tobacco Coalition. The CMA’s cooperation with the cancer and lung associations, many educational institutions and anti-tobacco coalitions strengthened its claim that it wanted to see tough anti-smoking laws enforced in California. As stated earlier, the medical association needed to rebuild its credibility, which had been undermined in 1995, when it had lined up against its traditional allies, the state chapters of the American Lung Association, American Heart Association and American Cancer Society to support the use of funds from Proposition 99 for indigent care rather than anti-tobacco education.

III. State Political Climate and Public Perceptions of Group Goals

8. Timing of the Changing Political Agenda.

The ability of the medical profession to advance its goals is partially dependent on whether they are compatible with the political agenda of the party in power. Theoretically, it would be more difficult for Ontario physicians to negotiate fee increases if the government ideologically favoured decreasing the province’s budget for health expenditures, although this has not always held true in practice. The OMA found that it was easier to negotiate union status with the New Democratic Party than with the Liberal Party that preceded it. It is not surprising that the NDP,
given its socialist leanings, was willing to extend the RAND status to the OMA and allow it to negotiate as the unified voice of medicine.

In California, the ability of the CMA to influence legislation can depend on the predisposition of the governor towards resolving managed care issues. Governor Wilson decided that it was too dangerous a minefield to step into. When he set up the Richter Task Force to study health care in California, he made it clear that he would allow no managed care legislation to pass until the Task Force's recommendations were submitted. Wilson slowed the pace of managed care reform by approximately two years\(^{242}\) by threatening to veto all managed care legislation, proposed by the California Medical Association or any other organization, regardless of its content.

9. **Partisan and Ideological Make-up of the Executive and Legislature.**

Ontario has had a history of one-party dominance. Prior to 1985, when the Liberals under David Peterson swept to power, the Progressive Conservatives ruled Ontario for 43 years. The New Democratic Party under the leadership of Bob Rae took power in 1990 until the Conservative Party, with Mike Harris as leader, replaced it in 1995. The OMA has sought, with varying degrees of success, to establish a good working relationship with government, regardless of the party in power. The low points in the OMA's relations with government came in 1986, when David Peterson was impervious to its demands to continue extra-billing, in 1993, when Bob Rae instituted the Social Contract, and in 1996, when Mike Harris introduced the Restructuring and Savings Act.
In 1986, the OMA staged a strike to protest the fact that the Peterson government was revoking physicians' right to extra-bill their patients. Though few Ontario physicians actually billed their patients in addition to submitting claims to OHIP, they placed a high symbolic value on retaining that freedom. It was not until 1990 that the OMA began to make peace overtures to the government. Bob Rae spoke with the OMA before he became premier and made promises to allow it to invoke the RAND formula and be recognized as the official voice of medicine in Ontario. The leadership moved quickly to hold Premier Rae to his promises. They persuaded the Canadian Medical Association to withdraw its legal challenge to the Canada Health Act in order to increase the New Democratic Party's goodwill. The OMA used the law firm as its representative that had previously employed Rae.

Premier Rae appeared to be as good as his word. In 1991, a Framework Agreement was reached that assured "fair treatment of doctors through a process of negotiation, mediation and binding arbitration" for the next six years.\(^{243}\) Within two years, the government violated the contract by instituting Bill 48, which gave it the right to unilaterally set fees for physicians.

Premier Mike Harris's government passed legislation that was just as threatening to physician autonomy as Bill 48. In January 1996, he introduced the Savings and Restructuring Act (Bill 26) that allowed the Minister of Health to "reduce or terminate funding to a hospital; direct hospitals to close, provide specified services or amalgamate; or make any other direction, if the Minister considers it in the public interest to do so."\(^{244}\) Under the legislation, hospitals could cancel contracts with any physician or medical staff with impunity and the OMA
lost the privilege of representing the profession as a whole in negotiations with government.

In 1997, the Harris government consented to once again accept the OMA as the negotiating partner for the profession and the OMA reinvoked the RAND formula. Although the OMA no longer has the status that it had when Bob Rae first became premier, the Harris government still recognizes it as an important bargaining partner. The OMA has a large operating budget, enormous expertise in the health field and members who can stage embargoes on taking new patients if the government does not honour its contracts.

In California, partisan politics are more volatile than in Ontario and political parties are weak even by American standards, making it difficult to pass legislation. The state government has been politically divided for 22 of the last 30 years. The Democrats held power from 1958 to 1966 under the leadership of Governor Pat Brown. His son, Jerry Brown, also a Democrat, was governor between 1975 and 1983. Democrat Gray Davis became governor in 1999. The Republicans were in power in the intervening years under Governors Reagan (1967-75), Deukmejian (1983-91) and Wilson (1991-99). The California Medical Association has shared its contributions fairly evenly between Republican and Democratic candidates in elections, favouring Democratic incumbents in the primary election and Republican incumbents in the general election. The CMA’s practice of giving almost equal support to the two parties is different from the American Medical Association’s practice of directing about 30 percent of its campaign contributions to Democrats and 70 percent to Republicans. Traditionally, the California Medical Association
has counted on the Republicans to protect MICRA, and the Democrats to take a larger role in expanding health insurance. Steve Thompson has commented that since the California Medical Association is bipartisan, change in the partisan control of the state Assembly does not affect it very much.246

Partisan politics in California have had the unintended effect of contributing to the decline in physician autonomy. Ronald Reagan rallied the public against a larger role for the state in the financing of health insurance. Using money from the American Medical Association, he recorded an album entitled "Ronald Reagan Speaks Out Against Socialized Medicine."247 His promotion of competition in the health marketplace left the medical profession less able to defend its autonomy against business interests than it would have been had the government played a larger role. The fact that Ronald Reagan won the electoral race against Pat Brown in 1966 meant that those in favour of expanding medical aid to the poor lost an important spokesman. One of Pat Brown's personal goals had been to raise funds for the mental health programs.248 He had given his strong support to setting up the first state Medicare program in the United States. Matthew Dallek argues that the 1966 election marked the decline of liberalism in California and the rise of the right in the decade that followed. According to his thesis, Reagan's decision to use the Berkeley and Watts riots to turn middle-aged white voters towards law and order issues and against Brown's more progressive social agenda reverberated through the years.249

Once in office, Reagan proceeded to try to bring Medi-Cal recipients into health maintenance organizations, but his efforts were partially unsuccessful and marked
by scandals and mismanagement.\textsuperscript{250} During the tenure of Democrat Edmund G. (Jerry) Brown, Jr., major Medi-Cal reforms took place (A.B. 799, A.B. 3480 and S.B. 2012).\textsuperscript{251} In the early 1980s, the state adopted a system of selective contracting, whereby the Medi-Cal program was authorized to contract with private insurers. These, in turn, could negotiate discounts with physicians and hospitals for the delivery of services. The Medi-Cal reform legislation, which was aimed at cutting health care costs, had the intended effect of forcing physicians and hospitals to reduce their rates by increasing the level of competition in the marketplace.

The reforms that governors have supported since then have been on a much more incremental basis. Pete Wilson was intent on avoiding managed care reform because the political stakes were too high. It was not until Gray Davis became governor that significant change became a real possibility. Davis outlined a plan of HMO reform legislation that he would be willing to accept. Legislators and advocates in both parties embraced it.\textsuperscript{252} The chief elements of the plan were that patients' rights would be increased in the area of external reviews. Patients could sue their health plans for certain punitive damages and a new state department would be set up to oversee health plans.\textsuperscript{253} The reforms, which were intended to be moderate and centrist, will help to address some of the concerns of patients and doctors. Thus, the governor's willingness to allow reforms to take place and the level of bipartisan support in the Assembly and Senate can help to determine whether any real progress will be made in passing legislation.

Interest groups are likely to influence government if they can show that they have the wide support of the public. One reason that the Ontario Medical Association’s strike was unsuccessful in 1986 was that the public was not clearly on side. People feared that physicians were sacrificing patients’ interests in favour of their own economic interests. Ontario doctors are more likely to win public support when they portray themselves as the victims of government bullying, a tactic which they often use, than when they focus on increasing their fees. Critics have suggested that the Ontario Medical Association does not reach out enough to the public unless it is in confrontation with the government.

The California Medical Association has been sensitive to the need to portray its defence of the MICRA cap as a public protection issue. Similarly, the CMA has been careful to frame its demands for improved regulation of the managed care industry as a call for better health care access for consumers. However, the medical association left itself open to criticism from anti-tobacco groups when it lined up with the tobacco industry to lobby for Proposition 99 funds to be used for indigent care rather than anti-tobacco education. Critics sometimes portray the CMA as a moneyed interest that tries to buy votes because it makes large campaign contributions to politicians.

The California Medical Association, like the OMA, tries to influence public opinion by issuing press releases and radio news tapes, encouraging physician-leaders to make public presentations and maintaining a website. Unfortunately, data from public opinion polls are not readily available that would show more
definitely the level of public support for the medical profession in Ontario and California.

IV. Long-term Group Relations with Public Officials


Doctors provide medical services that are absolutely vital to legislators and their constituents. Since they are front-line workers in the health system, their complaints and threats to withhold services can seriously undermine the credibility of the party in power. The Ministry of Health has benefited from the Ontario Medical Association's participation on joint committees such as the Joint Committee on Physician Compensation (1973-89), the Joint Management Committee (1991-95) and the Physician Services Committee (1997 to the present). They provide a forum for the OMA and government representatives to discuss proposed changes in the fee schedule that is constructive rather than adversarial. The government boosts its public image when it bargains in good faith, instead of imposing unilateral decisions. Organized medicine is then less likely to claim that it is being unjustly treated.

Ontario's highly disciplined and cohesive political parties are not nearly as dependent on interest groups for campaign contributions as are parties in California for a variety of reasons. Ontario's campaigns are much less costly and the government subsidizes them through tax credits. In California, politicians are virtually captive to special interests because they depend on them for their campaign contributions. The 1998 political campaigns in California cost an
estimated $500 million, with roughly half the money being spent on initiatives. The remainder was spent on the governor’s race and various other campaigns throughout the state.\textsuperscript{255} Most candidates needed the backing of special interests before they could think of launching their campaigns. Special interest money compensates legislators for their relatively low salaries. Lobbyists can help resolve disputes between legislators and help them sift through the vast quantities of information that they are expected to understand. Assembly members need to hear informed opinions because they must deal with about 4,000 bills a year. Of those, the California Medical Association might closely follow about 800 and take a position on 300.\textsuperscript{256}

One of the reasons that campaign laws are lax is that the courts struck down Proposition 208 in 1998, which had been designed to “severely restrict contributions and fundraising activities in all California races.”\textsuperscript{257} As Ron Unz observes, California is “one of the few states that places no restrictions on the size or source of contributions and huge cash payments from doubtful interests have become the norm.”\textsuperscript{258} Like Ontario, California has strong public disclosure laws so lobbyists’ contributions to politicians are public knowledge.

The extent to which money buys access to politicians in California is much greater than in most other jurisdictions in North America. Most donors know that their financial interests depend on the actions of the governor and Legislature.\textsuperscript{259} Donors are willing to make generous campaign contributions in the hopes that legislators will protect their financial interests. California politicians are dependent on individuals, corporations and political action committees to fund the costly
initiative process, which does not exist in most other states. Therefore, they are likely to pay close attention to the source of their campaign funds. Clive Thomas and Ronald Hrebenar have categorized California as one of the states where interest groups have alternated between being “dominant” and “complementary” over the last fifteen years. These authors use the term “dominant” to refer to states where “groups as a whole are the overwhelming and consistent influence on policy making.” They use the term “complementary” to refer to states where groups “tend to work in conjunction with or are constrained by other aspects of the political system.”

11. **Relations Between Lobbyist and Policy Makers.**

Relations between the Ontario Medical Association’s lobbyists and the government are occasionally confrontational but are usually conciliatory. The lobbyist’s personal image and connections do not matter as much in Ontario as they do in California, where legislative candidates are more dependent on interest group money to fund their campaigns. Since legislators are not as restricted by strict party discipline, there is a strong incentive for lobbyists to try to develop close relationships with them in the hopes that legislators will accept their advice regarding the content of the bills. Hap Hassard, Jay Michael, Steve Thompson, and John Lewin, to name just four, have worked diligently to raise the profile of the California Medical Association in the state legislature and in Washington.

Thus, the influence of physicians is a dynamic and multi-faceted concept. All of the twelve factors that Thomas and Hrebenar identify matter, but it is important to
distinguish which factors are most important for explaining physicians’ success in realizing their desired goals by using a theoretical framework. The framework that will be used in this thesis draws upon two streams of literature: historical institutionalism and policy networks.

THEORETICAL FRAMEWORK

Historical institutionalists reject the behaviouralist assumption that the observable behaviour of political actors accounts for politics. Behaviouralists tend to refer to the groups’ internal resources as the most important causal factor for explaining their policymaking influence. For example, resource mobilization theorists conceive “of social movements as collective and rational decision-makers that mobilize their followers and promote their causes with the best available strategies given limited cognitive and material resources.” Although most resource mobilizationists focus on the importance of internal variables of movement mobilization, some theorists, like Sidney Tarrow and Herbert Kitschelt, are sensitive to the ways in which “the strategic choices and societal impacts of movements [relate] to specific properties of the external political opportunity structures that movements face.”

The institutionalist literature suggests that the behaviour of groups should be understood in the context of institutions. By institutions, they mean the rules that structure individual and group behaviour. Institutions affect the capacities of governments to make policy changes. In some institutional contexts, it is relatively easy for the government to introduce comprehensive reform, but in other contexts, incremental reform is much more likely. Institutions influence not just who is involved in the policy networks and their
resources, but also their incentives to organize and the type of coalitions that are likely to result. Rather than trying to dissect the factors that cause events in a simple fashion, historical institutionalists trace political decisions to a highly complex combination of factors that "include both systematic features of political regimes and 'accidents of the struggle for power.'" Institutions "constrain policy and create policy opportunities," but they do not actually cause outcomes. Institutionalists do not necessarily completely overlook the importance of the internal variables of movement mobilization. For example, Professors Coleman and Skogstad draw attention to the ways in which policy networks influence policy outcomes. The variables that they use to distinguish between policy networks include state autonomy and coordinating capacity, meaning the ability of the state to concentrate its resources and expertise in making decisions, and the organizational development of sectoral interests, based on their logic of membership and logic of influence.

This thesis uses an institutionalist and policy network framework because they combine structural and agency explanations for change. A historical institutionalist approach to comparative politics emphasizes the importance of prior choices for future decisions. When the approach is used comparatively, it is useful for emphasizing the stable elements of the opportunities that the states provide for interest group influence, although it can also be used to show how structure and agency interconnect. A policy network approach shows how various constellations of actors can lead to different political outcomes. When a network analysis is applied at only one point in time, it emphasizes the stable patterns of linkages between interest groups and government, but has difficulty explaining changes in the networks. However, when a network analysis is applied at
different points in time, as it will be in this thesis, it can put "the politics back into policy-making," because it explores the dynamics of the contest that takes place between members of policy communities as interest groups and state actors pursue specific ends. Marian Döhler has given a succinct justification for uniting institutional and network approaches.

The strength of institutionalists is to elucidate the political impact of institutions, while they often lack an integrated perspective which allows one to grasp the single components of an institutional arrangement as interrelated and not as a more or less arbitrary set of institutions. Network analysts, on the other hand, have been strong in the detailed description of interaction systems but often are not able to link mappings of relations to underlying institutional frameworks.

There are various challenges involved in adopting a historical institutionalist approach. It is difficult to show precisely how the institutional constraints and opportunities of the polity alter the patterns of relations between the actors at the meso level. Fritz Scharpf has developed a model to explain how institutional arrangements affect policy choices. He suggests that policies are shaped by the "interaction effects between institutionalized boundary and decision rules on the one hand, and 'decision styles' on the other hand." The latter are "defined as cognitive and normative patterns that characterize the way in which interests are defined and issues framed and resolved under the applicable rules."

Historical institutionalists tend to emphasize the ways in which institutions are responsible for reinforcing ideas, rather than exploring an independent role for ideas in policy formation and implementation. Canadians are not considered inherently more favourably disposed towards public health insurance and Americans more disposed towards market-based health care. Instead, Canadians and Americans have become
conditioned to their national health care systems, which have evolved differently as a result of different institutional and political dynamics. For example, Antonia Maioni states,

The comparative historical analysis seems to show that political culture does not hold sufficient explanatory power in accounting for differences in the development of national health insurance in Canada and the United States. Rather, it seems to support the idea that political culture is 'embedded' in institutional phenomena, and like institutions, changes over time.277

Critics charge that many historical institutionalists do not give enough credit to ideas for the roles that they play in policymaking,278 whether they take the form of the underlying assumptions of the elite and public or their current preferences and policy prescriptions.279 The temptation is to restrict "political culture" to mean public opinion because that is the aspect that can be most easily quantified through polling data. It is difficult to make definitive judgements about the differences between the level of public support for universal health insurance in Ontario and California at particular points in time because the questions that were posed to the respondents were not directly comparable and were driven by the political agendas of the elites who asked them. John Campbell emphasizes that there are a number of different types of ideas, which have different effects on policymaking. I will allude to his framework in chapter 6 in order to elucidate the role of ideas as an independent variable, albeit a less important one than institutions and policy networks, for explaining the policymaking influence of the medical profession in Ontario and California. Campbell refers to the underlying elite assumptions as "paradigms," the underlying assumptions of the public as "public sentiments," the surface elite policy prescriptions as "programs" and "the normative concepts that elites use to legitimise these programs to the public" as "frames." A future research study of the health sector could
explore in more detail the ways in which ideas are influential insofar as actors can deploy them strategically in the public policy process.

While there is widely shared agreement in the literature that "institutions matter," what constitutes "institutions" is frequently debated. Historical institutionalists from the political science tradition may say that they subscribe to a broad definition of "institutions" that includes social and economic institutions, formal and informal ones; nevertheless their case studies tend to give primacy to formal political institutions. In conjunction with interests and ideas, institutions are expected to explain collective behaviour and policy outcomes. It can be difficult to formulate general hypotheses from the comparative case studies that are used to establish the links. Grant Jordan concludes his critique of "new" institutionalism with the opinion that "the argument is too ambiguous and preliminary for ready empirical application." Hence, in his view, "policy community realism" holds greater promise. However, as was shown above, institutionalist and policy network approaches are not mutually exclusive. An institutionalist approach can be used to show the conditions, when, where and how networks form and change and the policy network approach can specify the nature of the relations between state and societal groups at particular points in time.

The elements of historical institutionalist and policy network methodology are largely compatible. A historical institutionalist methodology is based on case study. It traces current situations to historical processes and understands actor behaviour in the context of institutional structures. It intertwines a narrative retelling of historical developments with an analytical interpretation of factors leading to outcomes. Paul Pierson's efforts to disaggregate the concept of institutions will serve as a useful model.
when exploring their effect on the policymaking influence of the medical profession in Ontario and California. He has attempted to design propositions about how historical institutionalism can be applied. He suggests that policies and institutions affect politics by providing material and psychological resources and incentives. These may spur interest groups to action by giving them access to decision makers at important points in their development. They may fuel the counter mobilization of interest groups. They may affect the administrative capacities of government. Or they may encourage the public to act in ways that "lock in a particular path of development." Pierson notes that past policies vary in terms of their visibility to the public and their traceability to government elites. He explores the role of particular sets of institutions, like federalism, on the development of Canadian and American social policy. He finds that they "influence the policy preferences, strategies, and influence of social actors; they create important new institutional actors; and they generate predictable policymaking dilemmas associated with shared decisionmaking."286

In health policy, the incentives for group formation are high because governments have been willing to grant self-regulating status to physicians and some allied health providers. Since health care is integral to the public's day-to-day lives, it is visible and its policy effects are highly traceable to government elites. The lock-in effects of health policy are lower in Ontario because the political structures and policy processes provide more opportunities for the federal and provincial governments to engage in coherent planned policy formulation, without interference from interest groups and political action committees than is the case in California. Hence, Premier Mike Harris has been able to challenge the collectivist tradition in Ontario and engage in restructuring of health services
without being deterred by left-wing opposition and protest, such as the “Days of Action”
marches in the early days of his government’s mandate.

In California, it is difficult for the government to accomplish major changes
because the state’s autonomy and coordinating capacity are weak. It is easier for the
medical profession to block changes in health policy than in Ontario. Even though some
presidents and governors have expressed strong support for universal health insurance, they
have not been able to enact it. The political system is so fragmented that a broad coalition,
including members of opposing political parties and special interests, would have to
support legislated health reform before it could be introduced. Since a broad enough
coalition does not exist, proposals for the universal public financing of health care keep
arising and being rejected at the federal and state level.

In this thesis, Pierson’s historical institutional propositions will be examined in
conjunction with the policy network approach, which involves determining the type of
relationship that has evolved between interests and institutions and then showing how the
patterns of influence affect the policy outcomes. The concept of networks is more
developed as a tool for comparative research than is historical institutionalism. There are
essentially two streams in the network literature. As Frans Van Waarden notes, the
political science literature uses a metaphorical conception of networks, in contrast to
“sociometric network analysis” in the organizational literature, which relies more heavily
on quantitative analysis. This thesis draws primarily on William Coleman and Grace
Skogstad’s conception of policy networks. They define policy networks as “the
properties that characterize the relationships among the particular set of actors that form
around an issue of importance to the policy community.”
A concertation network has developed in the health sector in Ontario, where the state's decisionmaking power is concentrated in the Cabinet and the Ministry of Health and Long Term Care, and relations between the medical profession and state are relatively stable. William Coleman and Grace Skogstad state that a concertation network exists when

- a single association represents a sector and participates with a corresponding state agency in the formulation and implementation of policy. The state agency has considerable capacity in its own right, being autonomous and able to concentrate power for coordinated decision-making. Sectoral interests match the state's strength by drawing on an inclusive, hierarchical associational system capable of engaging in longer term policy deliberations while maintaining member support.

In the California health sector, a pluralist policy network has developed. Coleman and Skogstad also provide a description of pluralist networks:

- [They] tend to arise in sectors where state authority is fragmented and the organized interests are at a low level of organizational development. This combination of dispersed state authority and a weak associational system unable to coordinate the multiple, narrow, specialized groups competing with one another, gives rise to a mode of group-state relations where groups approach the state independently, often competing for the ear of the state.

The policy network in the California health sector has become more open in the three decades, as more participants struggle to influence the decisionmaking process.

The theoretical framework has been used to generate hypotheses, which will be examined in each chapter in order to answer the research question:

Why have physicians retained more policymaking influence under the public health insurance model of Ontario than under the managed care approach of California?

I accept the contention that the institutional apparatus within which physicians are regulated and early policy choices account for the presence of a universal publicly financed health system in Ontario. As Antonia Maioni has shown, it was the nature of the Canadian federal and parliamentary institutions that facilitated the establishment of a mass-based
social party (CCF-NDP) and enabled it to play an important role in the introduction of a national health program. The federal government used its spending power to put pressure on the provinces to subscribe to the national plan. In the late 1960s, the provinces would have lost funding from the federal government had they refused to establish a system that met its specifications. With the enactment of the Canada Health Act in 1984, the federal government's principles for administering the health insurance programs became even more narrowly defined. While the provinces are theoretically autonomous enough that they could forego federal monies and allow extra-billing or user fees for medically necessary services, there has been continuous pressure on the first ministers to avoid penalties for failing to meet the national standards for health care.

In Ontario, a "robust" state that supports publicly financed health insurance has bolstered physicians' autonomy (corporate, clinical, most aspects of economic, and organizational). However, Ontario physicians have not gained as high a level of reimbursement as California physicians. It has been relatively easy for the provincial government to limit their fee increases since physicians negotiate with a single payer in the context of a global budget. Nevertheless, the Ontario Medical Association has been able to play an important role in policymaking and implementation because the state has provided organized medicine with access to key policy makers and encouraged the development of a concertation network. The medical profession has been able to preserve much of its autonomy in Ontario because it has employed a great deal of calculus in its relationship with the state. At times, the profession has been willing to make concessions in one area of autonomy in order to improve its overall bargaining position.
In California, a fragmented state has indirectly weakened physician autonomy and policymaking influence. The American Constitution was designed to limit the role of the government in the lives of individuals. Such devices as the separation of powers and federalism have made it difficult to establish a system of publicly funded health care. They provide many points, in the national and state institutions, for opponents of a compulsory system of universal health care to pressure government decisionmakers to veto single payer proposals. The fragmented state has contributed to the development of a pluralist policy network in the health sector. Medical doctors held sway over most of health care at the time that Medicare and Medi-Cal was adopted, but the system has gradually been reconfigured so that insurers are now the dominant force.

The existence of a pluralist network and the enactment of various policy decisions at the federal and state level have undermined most aspects of physicians' autonomy. California physicians continue to have a higher level of reimbursement than their Ontario counterparts. However, the difference is becoming narrower as managed care organizations and government administrators set stricter limits on physician expenditures. The ability of California physicians to maintain their dominance of the health system and their clinical autonomy in the treatment of patients has been undermined by the growth of capitation (partially as a result of the HMO legislation of 1973) and the dominance of a small number of big managed care institutions in the marketplace. Antitrust laws have prevented doctors from negotiating for contracts with managed care organizations on a level playing field. The Medi-Cal reforms of 1982 that introduced selective contracting have encouraged fierce competition among hospitals and doctors in the private sector. They have made it easier for purchasers to “call the shots” since the Medi-Cal “czar” can
confine their contracts to providers that offer their services at discounted rates. Thus, early decisions that reconfigured the political environment do much to account for providers' declining policymaking influence as compared to payers today.\textsuperscript{300}

\textbf{INFORMATION GATHERING}

I collected data from a variety of sources in order to trace the changes in the influence of the medical profession in Ontario and California. These included university libraries in Toronto, Berkeley, Los Angeles, Sacramento and San Francisco, provincial and federal archives, and medical association collections and websites. I depended on a document analysis technique supplemented by focused interviews, because I judged the historical issues to be too complex to be effectively studied through survey research, and too confidential to be studied by participant observation. I was not able to sit in on the general council meetings of the Ontario Medical Association because they are usually held in camera, much to the chagrin of the media.\textsuperscript{301} My request to shadow a medical association president for a day in California was denied because he was dealing with financial issues to which only a select few within the organization were privy. Parts of the medical association websites are now closed to the general public, although these were more accessible to non-members at the time that I began my research.

I attended public presentations by leaders of the Ontario Medical Association (Dr. Gerry Rowland, President and Chris Pattenden, CEO) and the Ontario Ministry of Health (Assistant Deputy Minister of Health John Oliver) organized by the Oakville Canadian Club. The Centre for Health Economics and Policy Analysis hosted a conference on the shifting involvements of the private and public sectors in Canadian health care in 1998 that
proved useful for my research purposes because I heard a broad range of stakeholders engaging in health policy-related discussion. The University of Toronto Joint Centre for Bioethics explored the problem of health care error in a conference held in January 2000. Merck Frosst made it possible for me to attend the Pulse '99 symposium that featured Dr. A. Gray Ellrodt of Cedars-Sinai Health System and visiting professor of medicine at UCLA School of Medicine. He discussed the value of using evidence-based decision making to prioritise, manage and evaluate health care programs. C. Michael Mitchell, a lawyer at Sack Goldblatt Mitchell, provided useful observations on the April 2000 OMA-government agreement in his presentation at the first annual health law day (October 27, 2000), which was co-sponsored by the Faculty of Law and the Centre for Innovation, Law and Policy at the University of Toronto.

In order to understand the context in which health care decisions were made in the 1960s, I reviewed the medical association papers and journals and read the interviews that were conducted by trained historians with Howard Hassard, legal counsel for the California Medical Association for forty years, and Dr. Roberta Fenlon, the president of the California Medical Association in 1970-71. I held confidential elite interviews with leading doctors, nurses, academics, lobbyists for medical and hospital associations and a public representative of a regulatory college who will not be identified, as promised. One of the lobbyists and one of the hospital administrators had extensive government experience. Although I prepared a set of standard questions prior to conducting my interviews, I tailored the questions to garner the information that I believed the person being interviewed would be willing and able to share. As is inevitably the case, some interviewees were more knowledgeable and candid than others. The interviews that were the most useful to me
were the ones that were set up by people that the interviewees knew and trusted as insiders. Three interviewees (an Ontario hospital administrator, a California lobbyist and a California county medical association president) consented to be interviewed twice. I used the interviews to help me piece together the story and gain a better understanding of the changes in the medical associations' goals and behaviour over time.

The American Association of Physicians of Indian Origin (AAPI) allowed me to attend their annual conference in Anaheim, California, in June 1999. I had the opportunity to listen to speeches by leaders of AAPI (President Kalpalatha Guntupalli and Dr. Mahesh Gupta), the California Medical Association (Dr. Marie Kuffner, President-Elect) and the American Medical Association (Dr. William Plested III, President-Elect). I also participated in an interactive forum with medical malpractice attorneys (John Bower and Ashish Desai) at the AAPI Conference. A University of Toronto School of Graduate Studies Travel Grant partially funded my field study in California on my fourth visit to that state during the course of my doctoral program.

I organized my research material by country (United States or Canada), level of jurisdiction (federal or sub-national) and aspect of autonomy. I then assembled lists of significant dates, relating to physician recruitment and training, quality assurance, malpractice and discipline, allied health professionals, unions, and the organization and allocation of health care resources, to help keep track of the order in which events took place. At each step of the way, from the thesis proposal to the final draft, I received significant input from the professors on my committee as well as other professors whom I contacted.
This chapter has reviewed the literature on professionalization and policymaking influence, described the evolution of the publicly funded model in Ontario and the managed care model in California, identified the major factors that affect the influence of interest groups, and provided a theoretical framework. The next four chapters will examine the relative success of the two medical associations in terms of realizing their goals of corporate autonomy (chapter 2), clinical autonomy (chapter 3), economic autonomy (chapter 4), and organizational autonomy and dominance (chapter 5). Each chapter will follow the same format. It will 1) define the type of autonomy under consideration; 2) discuss what medical associations are seeking with respect to autonomy; 3) describe the situation in each jurisdiction as measured against the definition of autonomy and the goals of doctors; and 4) assess the overall degree of success of the medical associations in realizing their desired goals. The cross-jurisdictional differences and outcomes will be explained using elements of historical institutionalism and policy network theory. The final chapter will draw conclusions about the usefulness of these approaches for explaining the policymaking influence of the medical associations in the two cases. It will reflect on the implications of my analysis for the two cases and will make suggestions for further research.
Ontario Medical Association, Brief Submitted to the Royal Commission on Health Services by the Ontario Medical Association, May 1962. The Ontario Medical Association stated that it was afraid of plans with government financing because 1) “political expediency dictates the allocation of money”; 2) “costs rise way beyond estimates and the easiest way to control costs is to limit facilities and services”; 3) “the loss of individual patient responsibility for his [sic] own care is a factor in increased costs.” The California Medical Association expected that there would be similar problems with socialized medicine: “1) Inadequate Physician Remuneration; 2) Decline of Professional Status and Subsequent Authority of Physicians; 3) Dominance of Political Decisions in Alloting Funds; 4) Bureaucracy of Federal Control; and 5) [From] The Patients’ Perspective: Impersonality of Care.” It regretted that with the passage of Medicare legislation “the physician’s ego has suffered from what might be interpreted as diminution of status and transfer of functional role to that of a government functionary or worse, a clerk. The physician, in the most extreme cases of federal control, is no longer even the master in the practice of his [sic.] own skills.” “Professional Problems in Federalized Health Care Abroad,” A Report of the Bureau of Research and Planning, California Medical Association, California Medicine, Vol.104, No.2, February 1966, pp.146-152. More recently, organized medicine in Canada has explicitly embraced two-tier medicine on occasion, as was the case in Halifax in 1996 when the Canadian Medical Association passed a resolution endorsing private alternatives to publicly financed health care. See Peter Holle, “The Root of our Health-Care Woes: Zero Price,” The Globe and Mail, September 9, 1996, p.A13. In 1998, OMA president William Orovan called for an open debate on the need to experiment with alternative delivery methods and payment options that are forbidden under the Canada Health Act. See Jane Coutts, “OMA Head Argues for 2-Tiered Health Care,” The Globe and Mail, November 3, 1998, p.A4.


3 The Ontario College of Family Physicians notes that the United States’ health system could more accurately be characterized as having many tiers than as a two-tier public/private system. There are uninsured, underinsured and fully insured Americans, with the majority falling into the underinsured category. See Two Tier or Multi-Layer Health System, The Ontario College of Family Physicians, 1999.

4 The contention that Canadian doctors have preserved a greater degree of clinical autonomy than American doctors is a common one in the political science literature. See Carolyn Tuohy, “National Studies in Comparative Perspective: An Organizing Framework Applied to the Canadian Case,” in Policy Studies in Canada: The State of the Art, eds. Laurent Dobuzinski, Michael Howlett and David Laycock (Toronto: University of Toronto Press, 1996), p.335; Tuohy, “Medicine and the State,” Canadian Journal of Political Science, Vol.21, June 1988, p.274. However, this opinion is open to challenge on the grounds that in Canada “government rationing,” by underfunding medical technology and research, presents a greater impediment to doctors’ autonomy than corporate medicine in the United States. Hence, medical associations on both sides of the border have viewed the emigration of Canadian doctors to the United States as evidence for an argument.
against “socialized medicine.” For a study that views the evidence of the doctors’ decline in the U.S. as contradictory, see Michael Moran and Bruce Wood, States, Regulation and the Medical Profession, (Philadelphia: Open University Press, 1993), pp.128-139.

3 There is a wealth of literature that seeks to explain differences between Canadian and American health policy. It emphasizes that these countries are basically similar: historically, economically, geographically, culturally, linguistically, demographically and politically. Nevertheless, their health care systems are fundamentally different. Canada has a single payer system in the form of a government monopsony. The United States has multiple payers, both public and private, that cover health care costs. See Joan Boase, “Institutions, Institutionalized Networks and Policy Choices: Health Policy in the U.S. and Canada,” Governance, Vol.9, No.3, July 1996, pp.45-68 and Carolyn Hughes Tuohy, Accidental Logics: The Dynamics of Change in the Health Care Arena in Britain, the United States and Canada, (Oxford University Press, 1999).

6 Carolyn Hughes Tuohy, Accidental Logics: The Dynamics of Change in the Health Care Arena in Britain, the United States and Canada, (Oxford University Press, 1999), pp.27-34.

7 In Canada, the provinces have the constitutional right to regulate health care, but the federal government offers fiscal resources to persuade them to uphold national health care goals. In the United States, the states are primarily responsible for regulating the health industry; they help finance and administer Medicaid; and they share with local governments responsibility for public health. The federal government retains primary responsibility for Medicare.

8 Carolyn Tuohy considered the 1960s to be a “critical juncture for both the U.S. and Canadian systems” because “the policies adopted in that era had implications for the structure of interests in the health care arena that would constrain subsequent policy choices at both national and subnational levels.” See “Variation in Health Care Policy in the American States: The Dog that Didn’t Bark,” Health Policy, Federalism, and the American States, edited by Robert Rich and William White, (Washington, D.C.: The Urban Institute Press, 1996), pp.211-212.


10 The American Medical Association defines managed care as “processes or techniques used by any entity that delivers, administers and/or assumes risk for health services in order to control or influence the quality, accessibility, utilization, costs and prices, or outcomes of such services provided to a defined population.” American Medical Association, Principles of Managed Care, 4th edition, 1999. Dr. Arif Bhimji of the health insurance company Liberty Canada has identified six aspects of managed care in Canada: “1. Management and administrative processes 2. Utilization management and review 3. Information systems 4. Quality assurance and evaluation 5. Risk management 6. Clinical care.” See T.M. Carmody, “Managed care looming over Canadian horizon,” Medical Post, November 5, 1996, p.17. In Canada, managed care is not nearly as developed as in the United States. See Peggy Leatt, George Pink, C. David Naylor, “Integrated Delivery Systems: Has their Time Come in Canada?” Canadian Medical Association Journal, Vol.154, No.6, March 15, 1996, pp.803-809. The Ontario Medical Association has slowed the implementation of
primary care reforms whereby patients would sign up with a roster of doctors and other health care professionals and physicians would be paid on a capitated basis. The provincial and federal government were in favour of speeding up the pace of the reforms. See Richard Macke, “Rock backs Ontario plan for health-care changes,” The Globe and Mail, January 15, 2000, p.A8.


“Allied health care professionals” is a term more commonly used in the United States than in Canada to refer to health care providers who practice complementary and alternative medicine.


25 Even individuals who have health insurance may not be adequately covered. For example, their coverage may exclude “already existing conditions.” See E. Richard Brown, Roberta Wyn and Rebecka Levan, The Uninsured in California: Causes, Consequences, and Solutions, Final Report to the California HealthCare Foundation, (Los Angeles: UCLA Center for Health Policy Research), December 1, 1997, p.vi.


27 The Canadian and American interest group literatures share common concerns about the determinants of the policymaking influence of interest groups. Typically, their policy success is perceived to vary with their organizational characteristics, the nature of their claim or their institutional context. The “resource mobilization” perspective has been more prevalent in the United States, focussing on the process of recruiting members. The Canadian literature has shown more concern with classifying the organizational development of interest groups or determining the influence of networks on policy outcomes. Some types of interest group literature only could have developed in the United States since the congressional system is so different from the parliamentary one. For example, it is not surprising that Canadian researchers have not engaged in lengthy debates about the effects of political action committees or the impact of lobbying on legislative votes. The Canadian system of strict party discipline means that it is more difficult for lobbyists to “buy” votes than in the United States.

28 See Rockwell Schulz and Stephen Harrison, “Physician Autonomy in the Federal Republic of Germany, Great Britain and the United States,” International Journal of Health Planning and Management, Vol.1, No.5, 1986, p.337 for their summary of Friedson’s definition of physician autonomy in Profession of Medicine, (New York: Dodd Mead, 1972). Four measure of professional dominance that Friedson cites are: “1) control over the content, terms and conditions of work; 2) control over other occupations within a particular division of labour; 3) control over clients; and 4) control over definitions and relations concerning all matters pertaining to a profession’s self-proclaimed sphere of influence.” See Eliot Friedson, Professional Dominance: The Social Structure of Medical Care (Chicago: Aldine, 1970) and Profession of Medicine, (New York: Dodd, Mead and Co., 1970).


35 Malcolm Taylor suggested that, "the medical profession as an interest group is a happy choice for examination, for not only does it provide insights into private government, and have a major influence on public policy, but it seems safe to state that in Canada, at least, no other private group is as deeply involved in public administration." "The Role of the Medical Profession in the Formulation and Execution of Public Policy," in *Canadian Journal of Economics and Political Science*, Vol.19, November 1953, pp.501-510.


38 Theda Skocpol has developed a state-centred approach that is more useful for identifying the contextual factors that affect policymaking than the traditional pluralist focus on interest groups. She draws attention to four kinds of processes involving state organizations, political parties and interest groups that explain policy outcomes. These include: "(1) the establishment and transformation of state and party organizations through which politicians pursue policy initiatives, (2) the effects of political institutions and procedures on the identities, goals, and capacities of social groups that become involved in the politics of social policymaking, (3) the “fit” – or lack thereof – between the goals and capacities of various politically active groups and the historically changing points of access and leverage allowed by a nation’s political institutions, and (4) the ways in which previously established social policies affect subsequent politics." See Theda Skocpol, "The Origins of Social Policy in the United States: A Policy-Centered Analysis," *The Dynamics of American Politics: Approaches and Interpretations*, edited by Lawrence C. Dodd and Calvin Jillson, (Boulder: Westview Press, Inc., 1994,) p.192. Thus, she is more concerned with the way that political institutions and former policies influence interest groups than the reverse. Researchers need to be sensitive to both aspects in order to have a more complete picture of reality. The behaviouralist focus on the activities of groups as determinate is incomplete without the institutionalists’ emphasis on the ways that institutional features
make some outcomes more likely than others and some groups more likely to be winners or losers. For a consideration of how researchers can move beyond “institutional determinism” without falling prey to the perils of behaviouralism, see Gary Mucciaroni, Reversals of Fortune: Public Policy and Private Interests, (Washington, D.C.: The Brookings Institution, 1995), pp.175-180.

39 For a discussion of the strengths and weaknesses of the interest group literature, see Clive S. Thomas and Ronald J. Hrebenar, A Reappraisal of Interest Group Power in the American States, American Political Science Association, Georgia, September 2-5, 1999.

40 NHS (UK) Research and Development Centre for Evidence-Based Medicine, Glossary of EBM Terms, 1999.

41 Scott Furlong suggests that interest groups can influence agency decisions by “providing comments to proposed rule makings, participating in regulatory negotiations, and having informed contact with agency personnel.” See “Political Influence on the Bureaucracy: The Bureaucracy Speaks,” Journal of Public Administration Research and Theory, January 1998.


44 In 1949, the Canadian Medical Association reversed its 1943 policy of endorsing public health insurance and opted instead for an extension of voluntary plans with the government covering the insurance costs of individuals who could not afford coverage. See Malcolm Taylor, Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System, (Montreal: McGill-Queen’s University Press, 1978), p.108.

45 In 1969, Premier Robarts disparaged the federal government for the coercive way that it pressured the provinces into accepting Medicare. He stated: “Medicare is a glowing example of a Machiavellian scheme that is in my humble opinion one of the greatest political frauds that has been perpetrated on the people of this country. The position is this: you are taxing our people in Ontario to the tune of $225 million a year to pay for a plan for which we get nothing because it has a low priority in our plans for Ontario.” See Malcolm Taylor, Health Insurance and Canadian Public Policy, (Montreal: McGill-Queen’s University Press, 1978), p.375.


48 Nizar Ladak and George Pink provide a description of the background of Ontario hospital funding in their discussion paper, Funding Ontario Hospitals in the Year 2000: Implications for the JPPC Hospital Funding Committee, Prepared for the JPPC Hospital Funding Committee, #DP3-4, December 19, 1997.
The basic tenets of the Canada Health Act are that the federal government will provide the ten provincial governments with a grant to partially fund their health care programs on the condition that their programs are “universal (covering all citizens), comprehensive, (covering all necessary hospital and medical care), accessible (no special limits or charges), portable (each province recognizes the others’ coverage), and publicly administered (under control of a public, nonprofit organization).” See Theodore Marmor, Jerry Mashaw and Philip Harvey, America’s Misunderstood Welfare State: Persistent Myths, Enduring Realities, (Basic Books, 1990), pp.203-209 for a concise description of the Canadian health system.


See Carolyn Tuohy, Accidental Logics: The Dynamics of Change in the Health Care Arena in Britain, the United States and Canada, (Oxford University Press, 1999).

The California Medical Association supported a compulsory health insurance bill in 1934. It proposed a voluntary, universally available health benefits program in 1970. In 1992, it promoted the Affordable Basic Care Initiative, which would have made it compulsory for all employees to provide a minimum level of health care to employees and their children. The employers would be responsible for 75 percent of the costs and the employees would be expected to cover the remainder. In 1994, the CMA initially took a neutral stance on Proposition 186, a single payer plan that was ultimately rejected by the voters. When the campaign intensified it eventually voted to "not support" the Proposition 186, although it did not actively join in the opposition coalition with the insurance companies. Proposition 186 was defeated in 1994 for some of the same reasons as Proposition 166 was defeated in 1993, namely, big money opposition from insurance companies, lack of positive media attention, and the difficulty of reaching the poor who were the most likely to benefit from the initiative but the least likely to vote. The CMA President Dr. Ralph Ocampo claimed that he was not opposed to a single payer system per se but to specific provisions in the proposition. For instance, too much power would be put into the hands of a single person who would control the system.


The National Health Program has provided a description of the governments' health care programs for poor Californians in State and Local Responsibility for Indigent Health Care, 1999.

According to the American Medical Association, "92 percent of [U.S.] physicians are in practices having at least one managed care contract. Among those physicians, nearly half (49 percent) of total practice revenues are derived from managed care sources." See American Medical Association, Center for Health Services Research, Socioeconomic Characteristics of Medical Practice, 1997/98, p.7.


Even though medical groups and independent practice associations are common in California, 32.3 percent of the state’s physicians continue to be self-employed in a solo practice. According to the American Medical Association, 31.7 percent of physicians are self-employed in a group practice, 3.4 percent work as independent contractors and 29 percent work as employees. See “Vital Statistics: Most Docs Still in Solo Practice,” California Medicine, December/January 1999-2000.


In the wake of the bankruptcy of FPA Medical Management Inc., a physician practice management company that was based in San Diego, thousands of Californian physicians...
have been denied payment amounting to millions of dollars for services that they had performed. The California Medical Association sued eight health plans in September 1999 for refusing to reimburse its physicians after FPA, the intermediary between the health plans and the doctors, filed for bankruptcy. The California Medical Association argued physicians and patients have suffered from the failure of the health plans to pay the doctors, as they are required by state law to do. The matter is currently before the courts. See Larry Casalino and Joan Trauner, Issue Brief: Physician Organizations Assuming Risk: Market and Policy Implications, No. 727, (Washington D.C.: National Health Policy Forum, November 9, 1998), p.6; and California Medical Association, The Coming Medical Group Failure Epidemic: Access to Medical Care for Millions of Californians is at Risk, September 2, 1999.


85 American College of Physicians – American Society of Internal Medicine, Physicians and Joint Negotiations, July 17, 1999.


87 Alain Enthoven and Sara Singer, the task force’s chairman and staff director, provide an assessment of its contribution in “The Managed Care Backlash and the Task Force in California,” Health Affairs, Vol. 17, No. 4, July/August 1998, pp.95-110.

88 California Medical Association, Solving the Puzzle of Managed Care: CMA’s Report to the State Task Force, November 1997.


91 In contrast, members of the California Medical Association make up approximately 11.6 percent of the American Medical Association’s members.


93 In Ontario, doctors are required to pay membership fees to the OMA in order to receive reimbursement from OHIP.


The state medical association that belonged to the AMA was originally named the Medical Society of the State of California. Its name was adopted in 1901. In 1923, the name of the Medical Society of the State of California was changed to the California Medical Association and the former name was used for an organization that provided malpractice coverage for doctors. See Fifty Years in Law and Medicine: Reminiscences: Howard Hassard: An Oral History, 1985, p.1.

These figures are derived from E. Ratcliffe Anderson Jr.'s speech to the AMA House of Delegates at the 53rd Interim Meeting, San Diego, California, December 5, 1999.

A. Melvin S. Schwarzwald, Major Factors to be Considered by the National Labor Relations Board in Determining Whether Physicians Are Employees of Managed Care Organizations With Which They Contract, (New York: The National Guild for Medical Providers, Office and Professional Employees International Union), 1997.


“LACMA Council Votes to Form Union,” LACMA Physician, April 1999, p.17.

Managed Care Information Center, New Bill Would Allow “Unionization” Among Physicians and Other Providers, June 1, 1999.


Medical Board of California, Guidebook to the Laws Governing the Practice of Medicine by Physicians and Surgeons, 5th edition, (Sacramento: Medical Board of California, Department of Consumer Affairs, 1996), p.13.

See Melinda Ann Goldner, Explaining the Success of the Alternative Health Care Movement: How Integrative Medicine Is Expanding Western Medicine, Ph.D. diss., (The Ohio State University, 1998).

Joan Boase identifies the steps that health care professionals tend to follow to try to achieve full status: "define an area of practice, expand the educational base, declare an exclusive scope of practice, develop specialties, and train assistants to perform the menial tasks." See *Shifting Sands: Government-Group Relationships in the Health Care Sector*, (Montreal: McGill-Queen’s University Press, 1994), pp.13-14.


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Boase, 1994, p.128.

See Patricia O’Reilly, *‘For a Word on a Page’: Ontario’s Health Practitioners*, Ph.D. diss., (University of Toronto, 1996).


Center for the Health Professions, *Critical Challenges: Revitalizing the Health Professions for the Twenty-First Century*, (San Francisco: Pew Health Professions Commission, 1995).


*Labor Party Press* November 1998 edition focuses on the subject of health care. It outlines the Labor Party’s proposals and includes interviews with Kit Costello, the president of the California Nurses Association and Kathleen Connors, the president of Canada’s National Federation of Nurses Unions, on health care reform.

Ivy Lynn Bourgeault notes that Ontario midwives’ “achievement of self-regulation (no matter how compromised), and an expanded scope of practice have no precedent in the midwifery experience elsewhere. See *Delivering Midwifery: An Examination of the Process and Outcome of the Incorporation of Midwifery in Ontario*, Ph.D. diss., (University of Toronto, Department of Community Health, 1996), p.282.


For a history of pharmacists’ struggle to increase their autonomy in Ontario, see Patricia O’Reilly, Health Care Practitioners: An Ontario Case Study in Policy Making, (Toronto: University of Toronto Press, 2000), pp.93-98.


Hans Baer, Cindy Jen, Lucia Tanassi, Christopher Tsia and Helen Wahbeh, “The Drive for Professionalization in Acupuncture: A Preliminary View From the San Francisco Bay Area,” Social Science and Medicine, Vol.46, Nos.4-5, 1998, pp.533-537.


Howard Hassard gives a first-hand account of the osteopathy controversy in California in Fifty Years in Law and Medicine, Reminiscences, Howard Hassard, An Oral History, (Hassard, Bonnington, Rogers & Huber, 1985), pp.82-90.

The number of first year students in osteopathic medicine has grown from 1724 in 1986-1987 to 2535 in 1996-1997, whereas the number of first year students in allopathic medicine has remained constant at about 17,000. See American College of Physicians, The Physician Workforce and Financing of Graduate Medical Education, 1998.

Catherine Lesley Biggs, No Bones About Chiropractic: The Quest For Legitimacy By the Chiropractic Profession, 1895 to 1985, Ph.D. diss., (University of Toronto, Department of Community Health, 1989), pp.37-47.

The California Chiropractic Association has posted CCA Tackles Legislation: A Chronological History on their website, 1999.


Ellen Immergut offers an institutionalist, rather than a behaviouralist, explanation for interest group influence. She suggests that the success of interest groups is not contingent so much on the characteristics or organization of the groups as the “opportunities proffered by institutional veto points for blocking or challenging government policy decisions.” See Health Politics: Interests and Institutions in Western Europe, (Cambridge: Cambridge University Press, 1992), p.30.


A Mercury News poll found that “84 percent of Latinos said the federal government should guarantee coverage. Among Americans overall, however, 65 percent think the government should provide such a guarantee.” See R.A. Dyer, “Widespread Support for Federal Health Care,” The Mercury News, October 14, 2000.


Joan Price Boase states that Premier Robarts opposed the federal government’s use of its spending power to force the provinces into accepting its terms for establishing health insurance because he believed the national plan was an example of “coercive federalism.” See Joan Price Boase, “Health Care Reform or Health Care Rationing? A Comparative Study,” Canadian-American Public Policy, No.26, May 1996, p.15. Premier Robarts’ criticism of the federal proposal is recorded in The Toronto Star, July 27, 1965.


It is not surprising that those individuals who do not have the right to vote are also less likely to have health insurance and have their health care needs met. J. Theodore Anagnoson notes that 39% of the uninsured in California are not eligible to vote. See Health Politics in the 1990’s After the Health Security Act: Can the Gaps Be Filled? American Political Science Association, 1998.


Sid Noel describes the operative norms of Ontario as “(1) the imperative pursuit of economic success; (2) the assumption of pre-eminence; (3) the requirement of managerial efficiency in government; (4) the expectation of reciprocity in political relationships; and (5) the balancing of interests,” p.53.


In 1998 underrepresented minorities constituted 14 percent of matriculants in UC medical schools and 11 percent in private California schools, down from a peak of 21 percent and 15 percent, respectively, in the 1992-1993 period.” Kevin Grumbach, Elizabeth Mertz and Janet Coffman, Underrepresented Minorities and Medical Education in California: Recent Trends in Declining Admissions, A Report by the Center for California Health Workforce Studies at the University of California, San Francisco, March 1999.


Jean Charbonneau suggested that “There is abundant evidence the OMA is being manipulated by the government at the expense of the right and freedoms of the Ontario doctors.” See Matt Borsellino, “‘Democratic Principles of OMA Are Being Violated,’” The Medical Post, November 3, 1992, p.57.


For a biography of Dr. Morgentaler, see Catherine Dunphy, Morgentaler: A Difficult Hero, (Toronto: Random House of Canada, 1996).
The Medical Post berated the OMA for failing to appear at the Martel inquiry when a provincial Cabinet Minister illegally revealed confidential details about an individual physician’s salary. The editorialist also felt that the OMA should have taken a public platform when Morgentaler’s abortion clinic was bombed. See “Is Circling the OMA Wagons Name of This Losing Game?” The Medical Post, June 2, June 23, July 21, 1992.

For an example of a rave review about CMA president Laurens White’s achievements, see “Dr. Laurens White: Top Doc Shakes Up Medical Group,” California Journal, February 1989, pp.89-91.

The California Medical Association was so pleased with Howard Hassard’s legal contribution that they conferred honorary membership to him and provided the resources for him to write a history of the Association. It was entitled Fifty Years in Law and Medicine, Reminiscences, Howard Hassard, An Oral History, (Hassard, Bonnington, Rogers and Huber, 1985).


Hobart Swan, California Medical Association and Davis Administration Put MedPartners Agreement Back on Track: Delayed Payments to Physicians To Resume, (Sacramento: California Medical Association, October 6, 1999).


The editorialist implies that the NDP government’s decision to allow the OMA to reinstate the RAND formula might be a product of its close ties with one of the OMA’s senior staff members, Brian Harling, who is also the party treasurer. The editorialist also draws attention to the OMA’s hiring of Sack Goldblatt and Mitchell, the legal firm that that employed Bob Rae. See “Is Circling OMA Wagons Name of This Losing Game (Part 3)?” The Medical Post, May 12, 1992.

A Council resolution at the OMA’s 1988 Annual Meeting stated that non-members should be required to help cover the organization’s costs since they share the benefits of its negotiating efforts. See “The Rand Formula: Protecting the Strength of Organized Medicine,” Ontario Medical Review, December 1989, p.1.


A Canadian-wide survey conducted by CMPA of its members showed that by a ratio of 10 to 1 they favoured providing protection to physicians who were under investigation by OHIP for overbilling. See Walter G. Morrow, "OMA Is Completely Out of Touch With Its Grassroots," The Medical Post, September 8, 1992, p.19.


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A recent Oakland City Council vote has made it possible for candidates to receive matching public funds in exchange for limiting their expenditure contributions, with the assistance amounting to between 5 percent and 15 percent of the expenditure ceiling. See Public Financing Wins in Oakland: Common Cause Victory in California, Common Cause, November 17, 1999.


Ontario Medical Association, About the OMA, (Toronto: Ontario Medical Association, 1998. Ontario Physicians' Alliance estimates that as many as 4,000 doctors are not OMA members, although they are required to pay OMA fees anyway under the RAND formula of mandatory deductions. Ontario Physicians' Alliance, Ontario Physicians' Alliance Newsletter, December 1998.

The "more than 30,000" estimate of the number of physicians in the California Medical Association was the number that the CMA provided for the Superior Court of California in 1999. See its lawsuit against Aetna U.S. Healthcare, Blue Cross of California, Blue Shield of California, Healthnet, Maxicare Health Plans Inc., Pacificare of California, Prudential Healthcare, United Health Care of California, Inc., and Does 1-100. On its website the California Medical Association estimates that it has 34,000 members.


See Kyriakos, May 9, 1995.

For example, see "One in 10 MDs Overbilling, Papers Show," *Toronto Star*, July 31, 2000 and Albert Schumacher's Letter to *Toronto Star*, August 1, 2000.

The Ontario Medical Association has taken a straightforward stance against tobacco products and in favour of making anti-tobacco drugs more available to the public over the counter.

An RJR inter-office correspondence from Gene Ainsworth to C.H. Long and P.C. Bergson with a copy to Larry Bewley dated April 9, 1987 identified the CMA as "the money machine for the Coalition's California tax proposal." The CMA withdrew financial support for the initiative after it qualified for the ballot.


See comments on RJR inter-office correspondence from Gene Ainsworth to C.H. Long and P.C. Bergson with a copy to Larry Bewley dated April 9, 1987 regarding the California tax proposal.


Jens Blom-Hansen shows how policy networks can be considered institutions, i.e., “rules constraining the actions of the participating actors” (p.669). He sees policy network analysis as lacking a model of “the actor,” which is strange since it understands groups as


Fritz Scharpf, 1989, p.149.


Mark Blyth, "‘Any More Bright Ideas?’ The Ideational Turn of Comparative Political Economy,” *Comparative Politics*, January 1997, p.229.


Pontusson levels this criticism against the authors of *Structuring Politics: Historical Institutionalism in Comparative Analysis*, although he admits that they are not the worst culprits. See p.129.

Professors William Coleman and Grace Skogstad outline the preferred methodology of institutionalists, which involves conducting archival research into the historical development of institutions and holding elite interviews. See Coleman and Skogstad, 1990, pp.3-4.


David Wilsford argues that systems “that are leveraged from the center or from the top (Germany, France, Britain), in combination with propitious conjunctural conditions (Germany, Britain), enjoy a greater likelihood of big reform than do weak, fragmented counterparts (the United States) requiring huge, unlikely conjunctures to accomplish big


295 Coleman and Skogstad, 1990, p.28. I am indebted to Professor Skogstad for noting that a concertation network has developed between the medical profession and the state in Ontario.

296 Coleman and Skogstad, p.27.


301 “Is Circling the OMA Wagons Name of This Losing Game? (5),” The Medical Post, June 23, 1992, p.8.
CHAPTER 2
CORPORATE AUTONOMY¹

The nineteen-fifties and sixties have been referred to by sociologists as the “Golden Era of doctoring,”² when the medical profession's control of the working conditions of its members was at its peak, having steadily increased since World War 1. Organized medicine spoke with a relatively unified voice in defense of such central tenets of the guild model as “free choice of doctor by patient, free choice of prescription by doctor, negotiated fees between doctor and patient, fee-for-service payment and solo or single-specialty small group practice.”³ Physicians signaled their adherence to this model by their participation in medical associations that used statements of policies and principles to articulate their shared objectives. Medicine had all the hallmarks of a profession, including a high degree of autonomy and self-regulation. The profession had greater freedom to control the number of physicians, their choice of specialty, and the location of their practices than it does today. Similarly, the profession’s freedom to establish standards through medical research, codes of ethics, licensing and accreditation, quality assurance, and discipline was virtually unchallenged. The medical associations defended physicians’ hospital rights and represented them in organized job actions when and if they saw fit.

Professionals construct myths about who they are and the meaning of their work.⁴ They use symbolic frameworks to maintain control over their membership and their environment. They draw upon their shared beliefs about their role in society and their goals with respect to autonomy when they lobby government for legislation to promote
their interests. This chapter 1) describes the multidimensional concept of professional autonomy at the corporate level; 2) summarizes the goals of the medical associations relating to corporate autonomy; 3) outlines the differences in the experiences of the Ontario Medical Association and the California Medical Association since the 1960s; and 4) combines elements of an institutionalist and policy network approach to explain their success in achieving their goals.

My hypothesis is that the medical profession in Ontario was able to retain more of its corporate autonomy than its California counterpart due to the existence of a stronger state and a concertation network between the medical profession and the provincial government. The leaders of the federal government had the will and capacity to establish a publicly financed universal health system and pass the Canada Health Act, which prevented the unrestricted development of business interests in the health sector. Business interests would have presented a challenge to medical providers and undermined their corporate autonomy, as happened in the United States, had the political system not been almost impervious to the demands of organized medicine and insurers that the health system should be privately run, and had it not been open to the proposals of a third party (CCF-NDP) to establish universal public health insurance.

The development of a concertation network between organized medicine and the state in Ontario means that they share a role in long-term planning and policymaking. It is in the interest of the state to support the dominance of the Ontario Medical Association over other associations in the health care sector, in order to ensure the continuation of the policy network. The state benefits from the concertation network because it allows the elite within organized medicine to act as mediators, helping to convince other physicians
of the value of the policies that political decisionmakers intend to pursue. The medical profession also acts as a buffer between the public and the state, absorbing some of the criticisms for resource allocation decisions. In return, the state offers medicine the right to self-regulate. The state gives the Ontario Medical Association the right to engage in collective bargaining, receive government-subsidized malpractice insurance on behalf of OMA members, and collect dues from all physicians.

A collectivist political culture has bolstered physicians' corporate autonomy making it easier for them to bargain collectively, since Ontario has not developed strict antitrust laws based on the premise that market competition should be encouraged, as is the case in California. Ontarians have been willing to accept an expanded role for the state in the financing of medical care, which has meant that physicians do not have to contend with as high a rate of malpractice lawsuits from patients who fear that their safety net is tenuous. A collectivist political culture has also made it easier for the state to cooperate with the medical profession in setting the terms for physician supply. On the surface, joint decisionmaking between the government and the profession on physician supply issues might seem to undermine corporate autonomy. It has actually had the effect of strengthening corporate autonomy because it means that the province is not flooded with more specialists than are needed, as is the case in California, where the oversupply of physicians diminishes their bargaining power with the five health plans that control nearly 90 percent of the market.5

In California, a weak state and a pluralist network between the medical profession and the state have led to a decline in the corporate autonomy of the medical profession. Legislators are heavily dependent on interest group contributions from insurance
companies. This makes it difficult for them to enact legislation that would strengthen physicians' corporate autonomy, such as 1) changes to the ERISA legislation that would make it more attractive for patients to sue health plans (and likely lower the rate of lawsuits against doctors) and 2) reform of the antitrust laws, which would allow physicians to engage in collective bargaining.

The pluralist policy network that exists means that interest groups compete for the state's attention and are more likely to advocate policies than participate in policymaking. The state in California is partially responsible for fragmenting physician interests because it has encouraged the expansion of health maintenance organizations and fierce competition between doctors and hospitals for Medi-Cal contracts. Since doctors hail from many different modes of practice, they are as likely to turn to unions, specialty organizations, or managed care organizations, as to their medical association to purchase malpractice insurance and seek improvements to their working conditions. When these groups lobby government, their legislative priorities may be different. The uncoordinated interest groups vie for the legislators' attention, thereby undercutting each other's strength. Consequently, physicians' corporate autonomy is diminished by the competing nature of different interest groups that claim to represent the medical profession and patients. Chapter 2 will show that the federal and state government, managed care plans and a strong consumer movement have diminished physicians' corporate autonomy in such areas as quality assurance, licensing, credentialing, accreditation and discipline. This chapter argues that the medical profession in California has lost more of its corporate autonomy, in the last three decades, than its counterpart in Ontario.
THE MEANING OF CORPORATE AUTONOMY

1. **Control of the number, mix and geographic distribution of physicians.**

   Physician supply is a matter that is plagued by controversy. What is the current physician-to-population ratio? Is there an oversupply or undersupply of physicians? What is an "ideal" physician-to-population ratio and how can it be achieved in the future? Would the "ideal" requirement of primary care and specialty care physicians be the same in Canada and the United States? Physician supply is complex because it is affected by so many different factors. These include population growth, changing health care technologies, the number and complexity of diseases, the entry and exit of physicians into the province or state, licensing practices, payment methods, physician productivity and the staffing ratios in health care organizations.

   Steps taken to correct an oversupply of doctors can create a shortage in the future. Conversely, steps taken to compensate for a lack of doctors can lead to an oversupply. It is in the interest of medical associations to try to ensure that there is not an undersupply of physicians, or their members will be overburdened and patients may have difficulty accessing health care in a timely manner. On the other hand, an oversupply can result in the unemployment and underemployment of physicians and wasted training resources. Moreover, physicians may not perform procedures often enough to keep their skills polished. An oversupply can also depress physician payment through market competition, or government decisions to institute individual and/or global caps.
Even though physician supply is so important to doctors, medical associations have few mechanisms at their disposal to try to influence it. They can publicize information about physician-to-population ratios, in order for students to make more informed choices about the desirability of medicine as a future career. They can also put pressure on government to dissuade officials from addressing physician supply issues in a strongly regulatory way. For example, physicians can lobby government officials to prevent them from pressuring medical schools to cut the number of their entry positions. Similarly, they can try to stop the passage of new laws, expanding the restricted acts that other health care providers can perform, that would reduce the number of physicians that are needed. In Ontario and California, the medical schools have the most direct control over recruitment and training. Their agendas do not always coincide with those of the medical associations. Medical schools often have expansionary tendencies, whereas the medical associations may believe that limiting the number of new recruits is more likely to increase their autonomy.¹²

Recruitment and training are two related processes that the medical profession seeks to control. Medical associations try to balance the ratio of family physicians and specialists because, if there is a gross imbalance, governments will be tempted to intervene. Patients will lack access to specialists if an insufficient number are trained and retained in a given locale. Health economists suspect that, if there are too many specialists, the number of expensive procedures performed on patients will increase, leading to a rise in health care costs. Provincial and state governments can increase the proportion of primary care physicians by
pressuring publicly funded medical schools to allocate more entry positions to primary care physicians if they make up less than half of the doctor population. Some researchers have suggested that managed care has aggravated the oversupply of specialists in the United States. Managed care reduces the number of specialists that are needed compared to a traditional indemnity model. Managed care organizations give primary care physicians incentives to act as gatekeepers, restricting patients' visits to specialists. They encourage physicians to meet preventive care targets in order to lower patients' need for acute care in the future.

Most members of medical associations think that physicians should voluntarily choose the location of their practices, even though an argument could be made that, since public money contributes to funding physician education they have a responsibility to go where they are needed. A trickle-down theory of physician supply suggests that underserved areas will eventually be adequately served if enough physicians are trained. However, empirical evidence has not proved this trust in the market to be warranted. California is a case in point. The geographic distribution of physicians is uneven, even though there is an oversupply of physicians, especially specialists, in that state. Therefore, the California Medical Association has encouraged payers to increase their incentives for physicians to practice in rural and remote areas, and poor inner city areas.

Governments have a whole arsenal of tools at their disposal for discouraging physicians from practicing in oversupplied areas, and encouraging them to practice in areas where they are needed. If health programs are publicly
funded, governments can use disincentives to dissuade physicians from practicing in oversupplied areas. For example, governments may be able to reduce physicians' income, if they practice in oversupplied areas, or deny them billing numbers. Alternatively, governments can offer doctors financial and training incentives to work in underserved areas. These might involve any combination of "differential fees, reduced on-call, defined hours of work, more backup and time for education leave, better access to specialty services, physician recruitment co-
ordinators, and free tuition in exchange for service guarantees."15

2. Control of medical research.

Professional autonomy in the area of medical research means that physicians have academic freedom to choose their focus of investigation, conduct research, draw conclusions, and disseminate and market their findings. Ideally, peer review committees make the decisions about awarding the research grants. Physicians use research studies to make decisions about their patients' diagnosis and treatment. Therefore, it is important that medical research be free from the perception of bias. The source of research funds is either public (i.e., government) or private (i.e., drug companies). Private funding is more likely to be given with strings attached, and be potentially threatening to the professional autonomy of physicians, than public money.

The process by which private interests sometimes, but do not always, bias medical research is a subtle one. Researchers and publications may aspire to the highest standards of unbiased research, but still break conflict-of-interest rules if they do not disclose the nature of their financial ties to industry.16
associations and journals argue that, as long as their ties are disclosed, they do not compromise the integrity of their medical research. When researchers do not inform their audience that they have a potential conflict of interest, their audience is left in the dark about what kind of bias to expect.\textsuperscript{17}

There are other ways that pharmaceutical companies can influence medical research (often legitimately) besides by making grants available to researchers. The Pharmaceutical Manufacturers Association of Canada has a code that covers eight different forms of promotion. They are:

- advertising and information dissemination (the provision of information about new products as well as the signing of promotional material by medical and scientific personnel),
- distribution of samples,
- sponsorship of continuing medical education (CME) events such as symposia and congresses, displays at conventions or clinical days,
- activities of pharmaceutical sales representatives,
- postmarketing clinical studies,
- service-oriented items (e.g., books and medical equipment) and “special promotions,” and
- marketing research used to identify and define marketing opportunities and problems.\textsuperscript{18}

The pharmaceutical industry, like the medical profession, is self-regulating. It has two codes of ethics, the Code of Marketing Practices of Canada’s Research-Based Pharmaceutical Companies (formerly the Pharmaceutical Manufacturers Association of Canada) and the Pharmaceutical Advertising Advisory Board’s Code of Advertising Acceptance. Dr. Joel Lexchin, an emergency physician in Toronto who has studied drug companies’ influence on doctors, has suggested that neither the pharmaceutical industry nor the Canadian Medical Association is vigorous enough in ensuring compliance with their codes.\textsuperscript{19}
3. **The existence of a professional code of ethics.**

One of the essential symbols of a profession is a code of ethics. Professionals are distinct from workers, according to the rhetoric of professionalism, since they work not for “pecuniary acknowledgement,” but for more noble objectives. They have traditionally been expected to forego their own self-interest in order to meet the needs of society. Doctors have appealed to the Hippocratic Oath as the basis for their fiduciary relationship with patients. Patients have traditionally been expected to obey their doctors’ orders because the doctors put the patients’ interests above their own. The Hippocratic Oath “refers to that ability of healing and that mastery over death which no profession save medicine can claim.” According to Gordon Horobin, “It does not matter whether or not that ability or mastery are real; at times of distress the public perceives and invokes them.” The enduring value of a code of ethics is that it protects the trust inherent in the physician/patient relationship that is the basis for physicians’ claim to professionalism. The existence of a standard, that all members of the medical associations implicitly accept, helps to unite the profession.

4. **Control of licensing, accreditation, credentialing, and quality assurance.**

The medical profession seeks to control the licensing and credentialing of physicians and the accreditation of hospitals and medical schools, since these are central aspects of their corporate autonomy. They are related but unique processes. Physicians must graduate from an accredited program before they can write a licensing exam. In order for hospitals and other medical facilities to meet
accreditation standards, there must be proper evidence of physician credentialing.

The American Medical Association defines credentialing in the following way:

the process by which the medical staff confirms and recommends to the institutions that physicians approved for clinical privileges are fully qualified to provide specific patient care services they have been approved to perform. Credentialing involves collecting and verifying information about a physician's education, training and experience in order to assess suitability for medical staff membership.\textsuperscript{24}

Two competing explanations are traditionally given to account for the importance that physicians' control over licensing holds for their professionalism. Both of these are too extreme to offer the "whole truth." The "orthodox theory" suggests that "the necessity for licensing arises from the complexity of the physician's calling, the innocence of the general public in matters medical, and the threat to health posed by unskilled practitioners."\textsuperscript{25} The more cynical view is that most regulations and licensing requirements are intended to "erect barriers against entry into the regulated industry or profession and thereby create a cartel, with all its attendant gains in income, power and prestige."\textsuperscript{26} In Ontario, the medical profession seeks to keep control over both the ethical and legal aspects of licensing. In contrast, the medical profession in California insists on looking after the ethical aspects of licensing, but most of the legal aspects have been ceded to the state. The Medical Board of California (MBC) is actually part of the Department of Consumer Affairs of the state of California. Thus, the MBC is not independent from government like the College of Physicians and Surgeons of Ontario.
These regulatory boards dictate the pathways to licensure for physicians, who only can practice legally in the provinces or states where they are licensed. Specialty boards also play a role in certifying physicians. In California, many more public and private sector accrediting bodies are involved in regulating physicians' practices and hospitals than in Ontario. Politicians have more influence over physician-licensure decisions in the United States. For instance, California politicians make the decisions about whether standards for licensing foreign medical graduates are the same as for graduates of schools accredited by the Liaison Committee on Medical Education; whether reciprocity agreements exist between states; and whether the scope of practice of health care professionals expands or contracts. Decisions about the scope of practice of health care professionals are more open to challenge in California because they are dealt with in the legislative forum. In contrast, in Ontario, the Health Professions Regulatory Advisory Council advises the Minister of Health on matters affecting the regulation of health care professionals.

The medical profession's control of quality assurance is a central aspect of physicians' corporate autonomy. In a narrow sense, quality assurance means efforts to assess, and if necessary improve, physicians' practices so that patients are not exposed to inappropriate risks or expenses in the course of their treatment. In its broadest sense, quality assurance can include a whole range of activities that are intended to make clinical outcomes more successful such as clinical practice guidelines, accreditation, continuing medical education, peer review and discipline. Since other sections of chapter 2 deal with peer review and discipline,
this section will focus primarily on the medical profession’s role in developing
clinical practice guidelines as a central component of quality assurance. Although
governments and medical associations have been collecting data about variations
in medical treatment for a long time, it is only recently that researchers have used
it to develop clinical guidelines, outcomes research and evidence-based medicine.
“Outcomes research” has been defined as “any research that attempts to link
either structure or process or both to the outcomes of medical care at the
community, system, institution or patient level.” 29 “Evidence-based medicine” is
a term that was coined at McMaster University in Hamilton, Ontario and has
almost the same meaning. It signifies clinical practices that have been recognized
as successful by an accumulation of evidence and rigorous analysis. 30

To understand the differences between quality assurance in Ontario and
California, it is useful to consider the models of accountability described by Drs.
Ezekiel and Linda Emanuel, as shown in Appendix B. In the professional model,
“the individual physician and patient participate in shared decision making and
are held accountable to professional colleagues and to patients.” 31 This describes
the Ontario case. Individual practitioners are assumed to be dedicated to their
patients’ wellbeing. Hence, neither the medical profession nor external bodies
insist that they modify their treatment decisions involuntarily to coincide with
clinical guidelines. The College of Physician and Surgeons of Ontario and the
Clinical Guidelines Committee of the Ontario Medical Association oversee the
process of designing clinical guidelines. Individual physicians have the
opportunity to exercise a great deal of discretion in applying them.
In California, the economic model is prevalent, “in which the market is brought to bear in health care and accountability is mediated through consumer choice of providers.” Ideally, in the economic model, if consumers are not satisfied with the level of service given to them by their providers, they can switch. However, the economic model does not operate perfectly in California because consumers’ ability to ascertain the quality of the health plans and individual physicians is limited by a lack of useful comparisons. Californians do not have a true option of switching plans or doctors when their employer-purchasers give them limited enrollment choices.

Corporate autonomy can be strengthened if physicians are entrusted with the task of measuring their peers’ performance. However, if external agencies impose change, physician autonomy and political influence are likely to decrease. In Ontario, medical associations and professional colleges have much greater autonomy to determine how quality assurance will affect the clinical decisions of individual doctors. Individual physicians maintain a great deal of clinical autonomy in deciding whether or not they will implement the guidelines. The situation is much different in California, where external entities (i.e., the state and private insurers) often achieve quality assurance by using economic incentives to coerce physicians to comply with guidelines.

5. Control of physician discipline and liability.

The state has delegated the right to self-regulate to the medical profession. It expects the profession to require physicians to conform to a code of ethics. The state is freed from the burden of disciplining errant doctors, by allowing the
profession to regulate itself. The state assumes that professionals are well equipped to judge each other’s performance through peer review. Conversely, it expects that non-professionals would have a more difficult time than physicians evaluating the performance of professionals, because they lack the requisite technical knowledge of medical work. The state expects the regulatory boards to impose serious enough penalties on doctors for contravening medical standards that patients’ interests are protected.  

Organized medicine has used a variety of mechanisms to scrutinize physicians’ conduct, such as medical society ethics committees, hospital credentials and utilization committees. If patients are not satisfied with the discipline meted out by the regulatory colleges, they have the option of appealing to a review board or seeking justice through the courts, usually under tort law. As well, they can choose a new physician, and in the case of California, a new health plan.


The hospital has traditionally been considered the “doctors’ workshop,” although doctors are not expected to invest their own money in setting up practices there. Doctors have exercised a great deal of control within hospitals for three primary reasons. First, they are not usually employees and therefore cannot be fired. Second, hospitals are partially dependent on the physicians for attracting patients, the source of their revenue. Third, physicians bill payers for their services independently from hospitals. Therefore, they are not considered a hospital expense like most non-physician workforce groups. Hospitals
historically have had an incentive to "overuse" physicians relative to nonphysicians and to shift costs to physicians.\textsuperscript{36}

Hospitals exercise power over physicians by virtue of the fact that physicians depend on access to hospitals to treat their patients, particularly if they are "hospitalists" or hospital-based physicians, as is common in California but not in Ontario. The medical associations have sought to ensure that the principles and structure of the self-governing medical staff are retained.\textsuperscript{37} They have feared that, if physicians became hospital employees, the dignity of the profession would be lowered and the standard of care for patients would suffer.\textsuperscript{38}

7. Representation rights.

The medical profession has traditionally scorned representation rights because they have envisioned themselves as independent entrepreneurs, not as employees needing to make a case to their employers to improve their working conditions. As Carolyn Tuohy observes,

Labour unions would seem to afford their members a considerably lesser degree of autonomy than do professional groups. Unions are involved in the negotiation of specific and explicit contracts with employers who are relatively knowledgeable about the value of their services.\textsuperscript{39}

Some doctors have argued that collective bargaining rights, rather than being an important component of professional autonomy, are actually incompatible with it. Many Ontario physicians regretted their status as pseudoemployees\textsuperscript{40} of the government when the Ontario Health Insurance Plan was introduced. Nevertheless, their right to bargain collectively through their medical associations and unions is now coveted by many American doctors.
In California, unionization has not been a traditional goal of doctors, but in a desperate attempt to retain the last vestiges of their clinical autonomy, medical associations at the county, state and national level are making the issue of collective bargaining rights a priority. Unionization promises physicians “a labor monopoly” so that they can negotiate on a more level playing field with health plans and insurers.

THE GOALS OF THE MEDICAL ASSOCIATIONS

Physicians’ goals have remained remarkably static given that changes in their environment, particularly in the United States, have been so great. The medical associations in Ontario and California share broad goals to maximize physicians’ collective control over resource planning (1) and standards of care (2-6). However, their goals for representation rights are different, which is not surprising since residents, interns and physicians have had dramatically different experiences of organized job actions within their different institutional contexts (7).

1. Control of the number, mix and geographic distribution of physicians.

The medical associations seek to establish a balance between the supply and demand for physicians. Ontario physicians are more likely than their California counterparts to think that organized medicine should be responsible for ensuring that the production of physicians meets the medical needs of the population. The Ontario and Canadian Medical Associations advise their respective governments about the appropriate number of family physicians and specialty physicians to hire, rather than expecting them to unilaterally make this
decision. However, many (43%) of the 1900 California physician respondents to a survey in 1985 indicated that they thought that supply/demand forces would balance themselves in the future without any outside intervention. The 49% of respondents who thought that supply/demand forces were inadequate held different opinions about which actor should intervene: 46.2% favoured organized medicine, 42.5% specialty societies, 39% graduate medical educators, 35.5% undergraduate medical educators, 18% state government and 17.3% federal government.42

The specific physician supply objectives of the medical associations have changed in the past three decades. Newspapers reported that the Ontario Medical Association’s 1987 document recommended that a physician-to-population ratio of 1:55043 would be appropriate.44 However, Dr. Adam Linton, the Chairman of the OMA Committee on Medical Manpower at the time, stressed that this ratio was only “a possible starting point in determining the right levels” in the absence of supporting data.45 Dr. Marjorie Keymer, chair of the OMA Physician Resources Advisory Committee to the Joint Management Committee and Dr. Tom Dickson, co-chair of the Joint Management Committee identified four general goals of physician resource planning in 1992:

First, organized medicine must always be involved in the planning, development and implementation of physician resource policies in the province. Second, government must understand that simple numbers, such as physician-to-population ratios, cannot begin to account for the diversity of practice patterns and service provision necessary to serve an increasingly heterogeneous population. Third, realization of adjustments in physician supply or geographic redistribution must respect the acquired interests of physicians in practice and those currently in training. Fourth, and most important, ensuring the availability of, and access to, high
quality health-care services must be the primary goals when developing physician resource policies.\textsuperscript{46}

One of the most controversial ways of controlling the number of physicians is by opening or closing the immigration gates to foreign doctors and restricting the opportunities for physicians to practice who are trained in other states or provinces of the country. The Ontario College of Family Physicians has made a number of recommendations to correct the current physician shortage. They are 1) “expand undergraduate class size to the numbers in place prior to 1991;” 2) “open the provincial borders to all Canadian-trained family physicians;” and 3) “accelerate the process of assessing graduates of medical schools in countries other than Canada and the United States.”\textsuperscript{47} The Task Force on Physician Supply of the Canadian Medical Forum\textsuperscript{48} has suggested that an ideal ratio would be in the range of 1.8 or 1.9 physicians per 1000 population.\textsuperscript{49} The Task Force would like to see the number of residency positions increased from 100 provincially funded postgraduate positions to 120 for each 100 medical graduates. Then, there would be more residency opportunities for international medical graduates, domestic medical students and family physicians, who want postgraduate specialty training. The Canadian Medical Forum rejects the option of lowering the standards through “limited licenses” and “temporary employment authorization” for international medical graduates. The Forum suggests, instead, that a formal process should be set up for health care providers and governments to make recommendations on an ongoing basis on the number of positions in Canada’s medical training programs.
In contrast to the Canadian Medical Association, which assumes that there is an undersupply of physicians, the American Medical Association suggests, "the United States is on the verge of a serious oversupply of physicians." The problem is particularly acute in urban areas of California. For example, a recent Dartmouth Medical School study found that San Francisco has the most doctors per capita in the nation "with 317 physicians per 100,000 residents versus 189 per 100,000 in the United States." The California Medical Association's views on the physician workforce are reflected in the consensus statement released by the American Medical Association and five other major interest groups in 1997. The statement called for a reduction in the number of medical school graduates through closing or merging medical schools and a limit on the number of funded residencies, with priority consideration being given to U.S. medical school graduates. The American Medical Association has also issued a statement on physician workforce planning, in conjunction with the Association of American Medical Colleges, that calls for the establishment of a national body organized outside existing government agencies to undertake long-term planning on the size and specialty mix of the physician workforce.

In 1962, the Ontario Medical Association was reluctant to identify either an ideal physician-to-population ratio, or an ideal ratio of general practitioners to specialists, because it had to take into account so many variables. The medical profession generally aims for a fifty-fifty split between family physicians and specialists, although it does not want this goal to be enforced by laypersons, governments or nonprofessional bodies. In 1999, the Canadian Medical
Association expressed its interest in ensuring that physicians have flexibility in their choice of specialty or primary care medicine. Much of the flexibility that had been in the system was lost when the "rotating" internship program was eliminated in 1992, and certification from the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons became "the required standard for licensure." The Canadian Medical Association made six recommendations to improve physicians' flexibility in making career choices that would have the added benefit of helping to relieve their growing debt burdens. It proposed:

1) a first year program that provides generalist training and facilitates streaming; 2) a resident-funding scheme; 3) national and regional pools of reentry positions; 4) a model career guidance program for students and residents; 5) a revised undergraduate curriculum to facilitate informed career choice; and 6) ways of influencing government to support a flexible post-MD system that meets societal needs.

In 1994, the U.S. Council on Graduate Medical Education embraced the goal of fifty percent of medical students becoming generalist physicians, as did President Clinton's failed health system reform package. More recently, the American Medical Association has been reluctant to set a specific target because there is insufficient information on which to base it, although the AMA does suggest that the absolute number and relative proportion of primary care physicians should be increased. The AMA recommends against "disincentives to students to enter primary care, such as the design of student loan programs, which force students to make career choices upon entry to their medical education programs." It opposes any expansion of the federal government's regulatory
authority in the area of postgraduate training. Although some federal government officials would like to regulate postgraduate training positions in return for funding training, the AMA fears that it would be the first step in limiting physicians' options.60

The medical profession hopes that free-market forces and voluntary decisions by physicians will result in an adequate distribution of physicians.61 The profession wants to strengthen the incentives for physicians to establish practices in rural and remote areas so that physicians will be willing to work in isolated areas. If an insufficient number of physicians voluntarily establish their practices in rural and remote areas, the medical profession thinks that incentives should be created to make work in isolated areas more attractive to physicians. Various medical interest groups have advanced their own proposals for correcting the problem of physician maldistribution in Ontario. The Ontario Medical Association has not wanted temporary billing restrictions or differential payment for physicians who set up practices in overserved areas. However, it has been more willing than the Professional Association of Internes and Residents of Ontario to compromise with the government on these issues. The Ontario College of Family Physicians recommends that the problem of maldistribution of physicians could be partially rectified by giving "a limited special education' license to second year family medicine residents to allow them to function in underserved communities or facilities under controlled circumstances as part of their elective time."62
The California Medical Association has had its own specific goals for alleviating distribution problems in rural areas. In 1969-70, these goals included conducting recruitment drives, analyzing the role of physician's assistant, researching the problem and developing recommendations for attracting more professionals and paraprofessionals to rural areas. Today, the California Medical Association's primary solution for encouraging physicians to provide services to Medi-Cal patients, who are grossly underserved, is to gain an increase in their level of fees through the legislature. In 1998, the CMA succeeded in obtaining the first increase in Medi-Cal payments for doctors in thirteen years, but the amount of money that would actually reach physicians, after it had been distributed to intermediaries like health plans, could be negligible. Hence, the CMA has made it a priority, in the year 2000, to gain a more substantial raise for the small percentage of physicians that provide health care to Medi-Cal patients, and make legislative changes to ensure that physicians will receive some of the money.

2. *Control of medical research.*

The Canadian Medical Association stresses the importance of physicians maintaining their professional autonomy when they collaborate in research activities with companies that manufacture pharmaceuticals, medical devices, infant formulas and health care products. The Canadian Medical Association encourages physicians to enjoy some of the benefits of cooperating with the companies, but cautions them against sacrificing their integrity. For example, while the Canadian Medical Association condones physicians accepting the
financial support of companies for their continuing medical education activities, it forbids physicians from engaging in peer selling (i.e., the event cannot focus exclusively on selling specific products). The Therapeutic Products Programs of Health Canada regulates clinical research in Canada. It has adopted Good Clinical Practice: Consolidated Guidelines in conjunction with the United States, the European Community and Japan.\textsuperscript{66} The three main research-funding councils in Canada have their own guidelines, Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans. The guidelines draw attention to the importance of research ethics boards, as one mechanism to enforce ethical standards in the research process. The research ethics boards are independent bodies that operate within research institutions to provide physicians with support in disseminating unbiased scientific information to the medical community. In the United States, private commercial ethics committees operate alongside public ones, reviewing their customers' clinical drug trials.

In the United States, as in Canada, the medical profession maintains its control over medical research by issuing guidelines about appropriate physician behaviour. The American Medical Association counsels physicians about the importance of resolving conflicts of interest in a way that benefits patients, but the AMA has no way of adequately enforcing its guidelines.\textsuperscript{67} Particular journals issue their own policies requiring that authors disclose potential conflicts of interest, and they use a system of peer review to monitor articles for their accuracy and originality.
3. **The existence of a professional code of ethics.**

The medical associations, at the national level, use their code of ethics to clarify the responsibilities of physicians to their patients and society. The Code of Ethics of the Canadian Medical Association applies to members of the Ontario Medical Association. Similarly, members of the California Medical Association implicitly accept the Code of Ethics of the American Medical Association, which is a much more detailed document. In the 1990s, medical associations have sought to design Charters for Physicians that identify their rights. The Canadian Medical Association unilaterally published its Charter in 1998, but the American Medical Association has been unsuccessful so far in its lobbying attempts to establish a charter for physicians involved in the Medicare program. The process of publishing a charter for physicians is much more complicated in the United States since the American Medical Association needs the approval of the legislature to make a charter become an enforceable law.

4. **Control of licensing, accreditation, credentialing, and quality assurance.**

The medical profession has maintained control over licensing and accreditation through a number of organizations. The College of Physicians and Surgeons of Ontario (CPSO) acts as the sole licensing power in the province, and has done so since 1869. The Royal College of Physicians and Surgeons of Canada (RCPSC), which is not a licensing body, extends accreditation to physicians in medical specialties. The College of Family Physicians of Canada accredits family medicine residency programs. The Canadian Medical Association acts as the coordinator for the Committee on Conjoint Accreditation,
which comprises 33 national professional organizations that work together to accredit 120 educational programs in ten health professions.\textsuperscript{69} Organized medicine seeks to make Canada self-sufficient in terms of its specialist supply. It only supports the hiring of offshore specialists as a last resort.

In California, as in Ontario, a single organization, the Medical Board of California, is responsible for licensing physicians.\textsuperscript{70} However, many more organizations are involved in the process of accreditation. The American Board of Medical Specialties has long accredited specialists, but it has not been able to keep as tight control over the process as its counterpart in Canada (RCPSC). In recent years, California physicians have gained permission to make known their affiliation with other boards such as the American Board of Facial Plastic and Reconstructive Surgery, the American Board of Pain Medicine and the American Board of Sleep Medicine. The American Medical Association plays an important role in accreditation through its sponsorship of the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, which is the accrediting body for all U.S. post-M.D. medical training programs, and the Accreditation Council for Continuing Medical Education. Since 1970, the California Medical Association has operated its own Certification Program to assess the adequacy of continuing medical education and certify physicians.

The California Medical Association resists changes in law that would make it mandatory for California physicians to take additional examinations for relicensure. The CMA seeks to ensure that only California-licensed physicians can practice medicine in the state. It does this in four ways. First, it tries to
prevent other types of health providers from expanding their turf. Second, it opposes the lack of accountability of health plan medical directors who second-guess the treating physician’s medical decisions. Third, it seeks to prevent an influx of American physicians from outside California by lobbying for tight reciprocity provisions between states. Fourth, it lobbies to increase the requirements for foreign medical graduates who wish to become licensed in the state. 

Reflecting the more competitive environment in the United States, the American Medical Association recommends that economic credentialing should be forbidden. The AMA has declared,

standards used in the accreditation of patient care and medical education, or the certification of specialized professional attainment should not be adopted or used as a means of economic regulation.

Economic credentialing is not an important concern in Ontario because its single payer system offers employment for all physicians. In contrast, in the United States, health plans hire some physicians and reject others. Health plans may be tempted to use economic rather than quality of care criteria to determine whether a physician should be granted medical staff membership or privileges. Therefore, credentialing has become a highly controversial issue. The American Medical Association has tried to corner the market for credentialing physicians by setting up the American Medical Accreditation Program in 1997. However, the AMA’s authority to credential physicians has been hotly contested by other physician associations such as the American College of Physicians and the American Board of Internal Medicine. These associations have called on the AMA to get out of
the credentialing business and leave it to a separate not-for-profit organization to set up standards for judging physicians to avoid the inherent conflicts of interests that exist when any constituency-based organization seeks to judge and accredit its own members.\textsuperscript{74}

Quality assurance is a highly contested area in Ontario, with a number of actors struggling to gain control of it. The College of Physicians and Surgeons of Ontario and its Clinical Quality Improvement Committee\textsuperscript{75} are responsible for assisting doctors with the development of clinical guidelines and carrying out quality assessments in Independent Health Facilities,\textsuperscript{76} that provide medical procedures traditionally performed in hospitals. Under the Regulated Health Professions Act, the regulatory colleges are required to “develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession.”\textsuperscript{77} The Ontario Medical Association has conceded that the CPSO has the legislative authority to set minimal standards for quality assurance but it insists that, as the primary representative of the profession, it should be responsible for determining optimal standards.\textsuperscript{78} In 1997, the Ministry of Health and the Ontario Medical Association set up a guideline advisory committee to evaluate guidelines as a means to improve the quality of medical services. The committee did not even give the College observer status.\textsuperscript{79} While the College, the Ministry of Health and the Ontario Medical Association have all been eager to assume a role in the development of guidelines, none of these organizations has been willing to dedicate a lot of resources for their implementation, out of fear of alienating individual practitioners.
The California Medical Association has sought to retain control over quality assurance by 1) taking innovative steps to assess medical activities; 2) lobbying to keep evidence of providers’ poor performance secret; and 3) resisting the government’s legislative initiatives in this area. Since 1972, the government has been involved in legislating quality assurance through its Professional Standards Review Organizations (PSROs) and their successors in 1982, Peer Review Organizations (PROs). These are physician-sponsored organizations that review the medical services that physicians provide to determine if they are medically necessary and meet quality standards. Even though these two types of organizations have operated in deference to the peer review principle that physicians are better able to judge each other’s performance than outsiders, the American Medical Association has claimed that PSROs and PROs were unnecessary. The very fact that these organizations were instituted by legislation has been interpreted as undercutting physicians’ authority.

5. **Control of physician discipline and liability.**

The Canadian Medical Association assumes that physicians should be willing to participate in peer review and undergo review by their peers, as outlined in the Code of Ethics. Physicians have the right to expect “procedural fairness with respect to policy, legal, contractual, administrative, and disciplinary decision-making concerning themselves,” and the opportunity to acquire “adequate and affordable medical liability protection.” The College of Physicians and Surgeons of Ontario has maintained substantial authority over physician
discipline. However, organized medicine, government and the legal community have expressed dissatisfaction with the tort system.

Dr. John Gray, former OMA President (1997-98) has indicated that he is ready to move toward tort reform in his new role as secretary-treasurer/chief executive officer of the Canadian Medical Protective Association (CMPA), the physician-owned and operated malpractice insurance company that covers more than 90 percent of Canadian physicians. CMPA held a conference in Toronto in November 1998 to consider the options. Colin McMillan, the representative for the Canadian Medical Association based his recommendations for liability and compensation reform on five principles: “equity and justice, beneficence, autonomy, accountability and cost effectiveness.” He read from a statement drafted by the CMA’s Division Presidents and Chief Executive Officers that endorsed

the principle of a universal, portable, occurrence-based, not-for-profit, independent and affordable liability assistance program such as is currently provided by the CMPA for all Canadian physicians.

At the same time, he embraced the reforms that Margaret Ross proposed in the 1997 discussion document she prepared for the Canadian Medical Protective Association. Ross drew attention to the need for a uniform statute of limitation that could be enforced nationwide. Currently, a patchwork system of statutes of limitation exists across the provinces. Judges are sometimes reluctant to impose them. Plaintiffs can accuse health care professionals of wrongdoing in cases where the primary defendants may be dead and much of the evidence lost. Colin McMillan regretted that more interest has not been shown in alternative dispute
resolution mechanisms, which allow the complainant and accused to participate in reaching a mutually acceptable and legally binding decision with the assistance of a trained mediator.

In 1969-70, the California Medical Association sought to resolve the problem of escalating malpractice insurance premiums in the state by supporting legislation that had four parts. It would 1) modify interpretations of the doctrine of ‘res ipsa loquitur,’ (the case stands on its own merit)\(^8\) and place a ceiling on malpractice damages, 2) limit the statute of limitations, 3) require the filing of a cost bond, \(^8\) and 4) “allow the introduction of evidence concerning ‘collateral payments’ (i.e., other sources of benefits to the plaintiff through social security and other insurance arrangements).”\(^8\) Some of the CMA’s demands were met in the Medical Injury Compensation Reform Act of 1975 (MICRA), otherwise known as A.B. 1. MICRA placed a $250,000 ceiling on compensation for pain and suffering in California. It offset collateral sources of plaintiff compensation, decreased incremental or sliding scale attorney contingency fees, and required periodic payments for awards over $50,000.

Since 1975, the California Medical Association has struggled to keep these reforms in place. In addition, the CMA opposes criminal charges against physicians for adverse clinical outcomes. It seeks to protect confidentiality regarding peer review reports and physician disciplinary actions. It lobbies to overturn the federal Employee Retirement Income Security Act (ERISA) of 1974, which diminishes managed care organizations’ exposure to lawsuits at the expense of physicians, by prohibiting states from regulating companies that self-
insure. The CMA opposes "hold harmless" clauses, which are common in managed care contracts. These clauses require physicians to accept the total risk of liability and relieve the managed care organization of responsibility in the event of a malpractice lawsuit.


The medical associations have sought to ensure that the profession retains its special privileges in hospitals. The Canadian Medical Association has insisted that physicians should not be required to work unreasonable hours. They suggest that one night in five should be sufficient for physicians' on-call duties. They further assert that decisions regarding physicians' appointments and terminations made in the hospital context should be fair. According to the CMA Charter, physicians need "assurance that appointment and reappointment procedures will include effective medical representation and an appeal process, and that decisions will be based primarily on required professional credentials, competence and performance." Furthermore, they need "to receive reasonable consideration and compensation when facilities and programs are discontinued, reduced, or transferred."87

In 1969-70, the California Medical Association's goals with respect to hospitals were to "promote continuing medical education in the hospital and participate in governing boards and administration liaison."88 The CMA has made it a goal to protect the confidentiality of physicians who participate in the peer review process. It has tried to prevent hospitals from entering into exclusive provider contracts with physicians or managed care organizations that would
interfere with the practices of physicians who already have privileges at the
hospitals. The CMA has insisted that treating physicians should not be forced to
participate in hospitalist programs, whereby in-hospital physicians become
responsible for directing their patients’ care regimes. According to the American
Medical Association, the medical staff should have the authority to make the
decisions about the services that may be provided by members of the emerging or
expanding health professions.89

7. **Representation rights.**

The medical profession in Canada has been deeply divided over the issue of
representation rights. As early as 1958, the Canadian Medical Association sought
collective bargaining rights through parliamentary legislation.90 In late 1965, the
CMA set up a “special committee on collective bargaining and arbitration.” The
latter is a means of reaching agreement between two disputing parties by having
an impartial third party render a decision. The Ontario Medical Association’s
goals, with respect to representation rights, have changed dramatically over the
past three decades. In 1968, the OMA sought permission from the provincial
secretary to act as bargaining agent for Ontario physicians, but its request was
denied at the time and not formally granted until Bill 94 in 1986.91 Susan Rappolt
notes that the Ontario Medical Association was opposed to binding arbitration
when Justice Emmett Hall recommended it in 1980, and when it was enshrined in
the Canada Health Act in 1984. Doctors rejected the idea of becoming part of a
union because they were afraid that they would have to relinquish their
professional status.92
The OMA’s goals changed after the strike of 1986, when physicians found that they were powerless to preserve their right to extra-bill. In 1990, the Ontario Medical Association revised its policies for relating to government. The OMA showed a new willingness to enter into a joint management relationship with government. In return for giving up physicians’ right to strike, it demanded representation rights from Premier Bob Rae’s New Democratic Party government, as outlined in the OMA’s paper “Towards A Partnership in the 1990s.” The Canadian Medical Association identified physicians’ representation “needs” in its Charter for Physicians, 1999:

[They need] to be free to associate for collective bargaining, and to be formally represented in negotiations on issues of health system reform, service delivery, payment, funding, and terms and conditions of work.

In 1970, the California Medical Association issued a statement indicating that it opposed strike activities by physicians because they threaten patient care. However, the California Medical Association has long been in favour of “union membership by interns and residents in California’s hospitals,” according to Dr. John Lewin, CMA Executive Vice President. The CMA’s support for collective bargaining rights for residents in private hospitals is so strong that it took an independent stance from the American Medical Association in 1997. Even though the American Medical Association withdrew its support of the Committee of Interns and Residents (CIR), the California Medical Association submitted an amicus curiae brief on the union’s behalf. The CIR won its legal challenge to the National Labor Relations Board’s 1976 decision – in a case originating at Cedars-Sinai Hospital in Los Angeles – which held
that residents in private-sector hospitals are primarily students, not employees entitled to collective bargaining rights.\textsuperscript{95}

The California Medical Association has also thrown its support behind physicians seeking collective bargaining rights from government. While the American Medical Association does not approve of strikes or workplace alliances with those that do not have a fiduciary relationship with the patients, the medical association does approve of some tools of collective action. According to the Current Opinions of the Council on Ethical and Judicial Affairs, which is one component of the American Medical Association’s Code of Ethics, “informational campaigns, non-disruptive public demonstrations, lobbying and publicity campaigns, and collective negotiation are among the options available which do not limit services to patients.”\textsuperscript{96}

THE ONTARIO CASE

1. \textit{Control of the number, mix and geographic distribution of physicians.}

   In the 1960s, governments in Ontario and California perceived that there was a critical shortage of physicians. In 1966, Ontario had one doctor for every 766 people.\textsuperscript{97} The federal government sought to rectify a shortage throughout Canada by setting up a Royal Commission on Health Services in 1964. The Royal Commission called for “crash programs to expand the education and training facilities,” in order to double the number of places for the study of medicine.\textsuperscript{98} Other organizations did their part to try to correct the problem of a physician shortage. The Canadian Medical Association formed a special
committee on Health Manpower Resources in 1966. In 1969, the College of Physicians and Surgeons of Ontario began accepting applicants from all of the institutions listed by the World Health Organization and removed a "basic science" examination requirement to make it easier for foreign physicians to become licensed.

The number of practicing physicians in Ontario increased at a much faster rate than population growth, in part, because population growth leveled off after the "baby boom" years.\(^9\) By 1975, the National Committee on Physicians in Canada concluded that there were enough students in domestic medical schools to satisfy future needs without hiring international medical graduates, who had received their undergraduate medical education outside of Canada. The Ministry of Health tried to completely ban graduates of foreign medical schools from setting up practices in Ontario, but the court overturned the regulation in 1984, forcing the Ministry to designate 24 residency positions for foreign medical graduates.\(^10\) Thus, the Ontario government's decision in 1975 was able to stop the rapid acceleration of the number of international medical school graduates.

By the 1980s, the federal and Ontario governments were in agreement that there was no longer a physician shortage. The second Hall Commission reported, in 1980, that the number of medical students should be reduced. The Ontario Council of Health's report on medical manpower, in 1983, determined that there was a balance between supply and demand, although the Council presciently predicted a shortage of doctors by the year 2001, due to the aging of the population. The members of the Federal-Provincial Advisory Committee on
Health Manpower of 1984 saw the need for reductions in medical students and post-graduate programs, but their recommendations were not implemented. In 1990, the medical authorities introduced regulations that prevented doctors who had trained in another province from obtaining licenses in Ontario.\textsuperscript{101}

In 1991, the government and health economists concurred that it was time to implement major reforms to reduce the number of physicians, who were viewed as "cost centres."\textsuperscript{102} Since physicians are thought to control between 70 and 85 percent of the health care spending, it was hoped that reducing the number of physicians would drive down health care costs. The Barer-Stoddart Report entitled "Toward Integrated Medical Policies in Canada" contained 53 recommendations on physician resource planning. Most importantly, the Report suggested that the number of medical students should be cut by 10 percent. At a conference in 1992, the ministers of health agreed to make across-the-board reductions in the number of positions open for training physicians. In an action plan entitled "Strategic Directions for Canadian Physician Resource Management," the ministers of health promised to reduce undergraduate medical enrolment by 10 percent in 1993, lower reliance on international medical graduates, cut the number of postgraduate trainees and maintain or decrease the physician-to-population ratio. Their plan reduced the number of doctors, but not the need for more money for the health care system.

The physician-to-population ratio in Ontario has changed from one doctor for every 766 people in 1966, to one for every 558 people in 1998, which still constitutes a shortage of physicians according to many observers. For instance,
Eva Ryten of the Association of Canadian Medical Colleges suggests that the cutbacks in the number of physicians graduating from medical school have led to a new era of physician deficit. The 1999 Task Force on Physician Workforce of the Canadian Medical Forum echoed her concerns that steps, such as increasing medical school enrolment, need to be taken to correct the current problem. The Task Force cited the recent increase in the recruitment of international medical graduates through temporary employment authorization, as evidence that governments and health authorities recognize that there is a physician shortage. In 1993, the government recruited 388 international medical graduates, but by 1997 that number had increased to 790.

In Ontario, the specialty mix is determined in negotiations between the medical schools, the provincial government and the medical associations. The fee schedule discourages specialists from providing care without a referral from a primary care physician. Ontario physicians have traditionally been divided evenly between generalists and specialists. However, Ontario has recently become the only province with a higher percentage of specialists than family physicians. (Appendix C reveals the difference between the number of general physicians per 100,000 people, and the ratio of specialists per 100,000 people for the years 1994 to 1998). The declining proportion of family physicians could be traced to the reduction in the size of medical school classes beginning in 1991, and the new requirement in 1992, that graduating physicians take a two-year family residency training program and pass the appropriate certification examinations to become licensed as family physicians.
Physician distribution in Ontario, as in California, is relatively unplanned. Nevertheless, a host of organizations make recommendations to correct the perennial problem of an insufficient number of physicians practicing in rural and remote areas. These include the Ontario Medical Association, the Canadian Medical Association, the Ontario Ministry of Health, the Association of Canadian Medical Colleges, the Professional Association of Internes and Residents of Ontario, the Society of Rural Physicians of Canada and the Provincial Coordinating Committee on Community and Academic Health Science Centre Relations. Physicians are often reluctant to move to underserviced areas because it means relocating their homes to communities where opportunities for educational advancement, cultural performances and jobs for their spouses are more restricted. Furthermore, physicians fear becoming “burned out” in underserved areas, since they are required to perform more on-call duties without a “critical mass” of colleagues for support.

The Ministry of Health has played an important role in preventing physician distribution from becoming more inequitable than it is, by operating an Underserviced Area Program since 1969. The Underserviced Area Program was originally intended to improve distribution in northern communities, but it was soon extended to encompass southern communities as well. In 1997, the program offered financial incentives to encourage general physicians to relocate ($40,000 to relocate in the north, $15,000 to relocate in the south). Specialists were given $20,000 to relocate in the north. Physicians in underserved areas were granted an exemption from the cap on OHIP billings to increase their
earning potential. The Underserviced Area Program also provided physicians in underserviced communities with practice supports (e.g., locum tenens, who would cover for their leaves of absence), outreach programs and recruitment support. The Ontario Medical Association has operated its own initiatives to improve recruitment and retention rates in underserviced areas, including a locum tenens program for physicians, a central registry, continuing medical education for physicians and a small group practice-based learning program. Physicians, who agree to work in emergency departments of 78 eligible community hospitals in underserviced areas, are now offered an hourly reimbursement for their on-call services. The 1995 Report of the Fact Finder on Small/Rural Hospital Emergency Department Physician Service (the Scott Report) recommended a $70 per hour on-call fee, but that amount has since been raised in some communities.107

The government of Ontario announced several heavyhanded measures to force physicians to practice in underserviced areas, when less onerous initiatives did not correct the problem. For instance, in 1993, the Ontario government threatened to cut the pay of newly certified physicians in some specialties by 75 percent, if they settled in areas that were designated as “oversupplied.” The amount, that was deducted from their pay for practicing in five restricted urban areas, was later reduced to 25 percent, when the Professional Association of Internes and Residents of Ontario protested that its members should not be held responsible for bearing the burden of cost-containment.108 The Ontario Medical Association and the provincial government agreed to restrict new billing numbers to graduates of Ontario medical schools and postgraduate training programs in
1993. The Omnibus Savings and Restructuring Act (Bill 26), which was introduced by Premier Mike Harris in January 1996, gave government the legislative authority to unilaterally withhold billing numbers, as a method of addressing supply concerns. The government’s decision to threaten to withhold billing numbers was part of its economic agenda to achieve fiscal savings. In April 1996, the billing number policy was replaced with a differential fees policy. The latest round of negotiations between the OMA and the government, in April 2000, eliminated the fee discounts for new physicians practicing in overserviced areas, and was hailed as a victory by the PAIRO.

The punitive measures alienated some members of the medical community, without correcting the maldistribution of physicians. The number of communities still listed as underserviced, as of October 1999, gives some indication of the extent of the problem. Ninety-nine communities in northern and southern Ontario have been designated as underserviced. These communities want to hire 534 physicians. A recent report by Dr. Robert McKendry suggests that a constructive approach to developing rural physicians would be to set up a new medical school in northern Ontario that is fully focused on preparing graduates for rural practice.

2. Control of medical research.

The pharmaceutical industry has increased its support of health services research over the past three decades, even as the proportion of government funds allocated to medical research and universities has declined in Ontario. Jonathan Lomas observed, “private for-profit (primarily the pharmaceutical industry)
The companies’ investments in clinical research have grown significantly since 1987, when legislation was implemented that favoured the protection of intellectual property in Canada. Drug companies now receive huge tax write-offs, which critics argue could be better spent on “supporting investigator- and patient-initiated randomised clinical trials (RCTs) that promote the health of Canadians.” Dr. David Sackett suggests that the problem with allowing private firms to set the nation’s research agenda is that “most pharmaceutically-funded research ignores the young and poor and seeks approval of ‘me-too’ drugs.”

Media reports provide anecdotal evidence that the increased role of pharmaceutical companies in funding clinical research is eroding the professional autonomy of physicians. Manufacturers have threatened researchers with legal action to prevent or postpone the dissemination of their findings. Pharmaceutical companies may try to withhold evidence that does not support the value of their products, as has been demonstrated recently in two Ontario cases. The media have closely followed the disputes between Dr. Anne Holbrook, who works at the Centre for the Evaluation of Medicines at St. Joseph’s Hospital in Hamilton, and AstraZeneca, and between Dr. Nancy Olivieri, a Senior Doctor at Toronto’s Hospital for Sick Children, and Apotex Inc. Dr. Holbrook chaired a panel of the Ministry of Health that developed guidelines for the treatment of heartburn, ulcers and related conditions in Ontario. The committee released a preliminary report that stated that there were no important differences between the proton pump inhibitor omeprazole, which AstraZeneca marketed with the trade
name Losec, and two less expensive drugs in the same class. In retaliation, AstraZeneca wrote a letter to Dr. Holbrook, threatening to instigate “appropriate legal proceedings” if she would not withdraw the guidelines. The company later apologized for sending the letter, drafted by a lawyer, directly to Dr. Holbrook instead of to the Ministry of Health. AstraZeneca also released a statement indicating that it was not pursuing, nor did it ever intend to pursue, any legal action. The case revealed some of the behind-the-scenes pressure that drug companies can put on physician-scientists to encourage them to draw conclusions that coincide with the company’s interests.

The dispute between Dr. Nancy Olivieri and Apotex Inc. showed that a drug company was putting too much pressure on physicians to prevent them from publishing negative research results about one of its drugs, in this case deferiprone, known as L1. Apotex gave Dr. Olivieri and her colleague, Dr. Gideon Koren, a contract to sign that contained a gag clause. The researchers were prohibited from disclosing information about L1 to a third party during the trial or for a year afterward, unless the company gave them explicit permission to do so. They both signed the contract without informing the Hospital for Sick Children or the University of Toronto, where they worked. When Dr. Olivieri went public with her findings that L1 had potentially harmful effects on her patients with thalassemia, it became obvious that Apotex could inflict significant damages on her and her employers. Apotex threatened Dr. Olivieri with legal action, if she breached the terms of the contract. The company terminated the trial at the Hospital for Sick Children. The hospital, in turn, demoted Dr.
Olivieri, as head of the hemoglobinopathy program. Dr. Olivieri paid a high price to defend her academic freedom. The affair tarnished the reputations of everyone involved, but it brought into the open some of the complex issues that can arise when physicians are dependent on private companies for research money.118

3. The existence of a professional code of ethics.

The Ontario Medical Association has adopted the Canadian Medical Association Code of Ethics, which, in 1868, was borrowed almost word-for-word from that of the American Medical Association, written in 1847.119 The most recent Code of Ethics of the Canadian Medical Association was approved on October 15, 1996, after four years of consultation. Dr. Doug Sawyer, the chair of the Canadian Medical Association’s Committee on Ethics, commented on the importance of the Code:

The updated code is a clear and explicit proclamation by the medical profession of what patients, society and colleagues can expect of physicians. At the same time, physicians and medical students will know their ethical duties and responsibilities to patients, society and their profession.120

Dr. Nuala Kenny of Dalhousie University pointed out that the new Code of Ethics leaves unexamined many of the more difficult questions about what it means to be a “good” doctor. For example, the Code does not provide physicians with a way of thinking about how to balance competing goals, or how to make difficult decisions regarding the allocation of health resources.121 Unlike the Code of Ethics of the American Medical Association, the CMA’s Code of Ethics does not inform doctors about the profession’s expectations of their duties to the patient if
they make a medical error,¹²² nor does the Code address controversial clinical issues like euthanasia.

4. **Control of licensing, accreditation, credentialing, and quality assurance.**

The licensure requirements of the medical profession in Ontario have become progressively stricter in the past three decades. In the 1970s, it was much easier for physicians to switch from a specialty program to general medicine than it is today. The standard process involved attending a medical school in Canada or the United States, “passing the first Medical Council of Canada Qualifying Examination (MCCQEI), completing a North American residency, passing the MCCQEII and finally the certification examinations.”¹²³ However, if physicians wanted to move out of specialty-training programs to become general physicians, they could obtain a license by participating in a one-year internship. As of 1992, they have been required to take a two-year family residency-training program and pass a certification examination to become family physicians. Since 1992, physicians, who have been barred for incompetence or misconduct in Canada or any other country, have lost the right to identify themselves as fellows of the Royal College.¹²⁴ In 1997, the Royal College of Physicians and Surgeons of Canada instituted a policy whereby residents would need to undertake their training in Canada in order to meet the certification requirements. Offshore training would no longer be accepted for RCPSC certification.¹²⁵

Now that there is a perceived lack of physicians in Ontario, there is a movement afoot to loosen licensing requirements. In July 1998, the College of Physicians and Surgeons of Ontario created a Special Committee on Restricted
Registration to consider the pros and cons of easing the licensing restrictions for four groups. These are fellows who are ineligible for Royal College certification, members who have failed the certification exam, residents who wish to engage in paid practice during their educational programs and fully-trained international physicians who cannot gain access to the certification process.126

Susan Rappolt has provided a brilliant analysis of the Ontario medical profession's control of the design and use of clinical practice guidelines, in her doctoral thesis, In the Name of Science: The Effects of the Clinical Guidelines Movement on the Autonomy of the Medical Profession in Ontario. She suggests that the guidelines movement in Ontario can be understood as part of a broader "trend toward the proletarianization of medical work, but physicians retain considerable levels of autonomy (Coburn, 1988), which serves to insulate the state from direct responsibility for health problems (Starr and Immergut, 1987).”127

Although private insurers considered compiling health care data prior to the introduction of Medicare, the Ministry of Health did not set up a central database until a single payer system was in place. A few initial efforts were made at publishing guidelines in the 1970s and 1980s. In 1977, the Ontario Council on Health published hypertension guidelines. In 1979, the Ministry of Health sponsored ongoing research to develop guidelines for preventive care. In 1984, the Ministry funded research that was used to develop caesarean section clinical guidelines. In 1987, the Ontario Medical Association resisted the cardiologists' demands that it lobby the government to cover the cost of tissue plasminogen
activator (t-PA) for coronary thrombolysis. The OMA leaders felt that there was insufficient proof that t-PA was more effective than less expensive drugs. The guidelines that the OMA produced for the use of thrombolytics allowed the individual practitioners to decide whether the use of t-PA was indicated.

In 1988, a broader, and more sustained, effort was put into developing guidelines, with the establishment of the Task Force on the Use and Provision of Medical Services (the Scott Task Force). Part of the impetus behind the introduction of clinical guidelines was cost containment. The Ministry of Health and the Ontario Medical Association wanted to eliminate the performance of unnecessary procedures, in order to stay within reduced health care budgets. The Scott Task Force issued guidelines on cholesterol and thyroid testing. In 1992, the Ministry of Health and the Ontario Association of Medical Laboratories agreed to economic disincentives that would discourage commercial labs from providing the four thyroid tests that the Scott Task Force considered of little value. Since the medical laboratories would not be reimbursed for the four thyroid tests, few physicians continued to request them for their patients. This was the government’s most draconian attempt to require physicians to implement guidelines.

More recent quality assurance initiatives have respected physicians’ right to self-regulation. The Canadian Medical Association has carved out a niche for itself in the area of guideline dissemination by maintaining an internal database of 900 clinical practice guidelines developed or endorsed in Canada. The CMA also publishes a handbook of “care maps” that “provide an efficient strategic plan
for how to do what should be done at each stage." Other organizations are involved in assessing variations in treatment and their outcomes. In 1992, the Joint Management Committee, consisting of representatives of the Ministry of Health and the Ontario Medical Association, set up the Institute of Clinical Evaluative Sciences (ICES), which was initially intended to help establish guidelines. The ICES publishes "practice atlases," showing provincial variations for specific medical services, an endeavour that is still considered suspect by some doctors. The Toronto Hospital has introduced an internal quality program that links the death rates, re-admission rates and infection rate to each department and doctor. In November 1999, the Ontario Hospital Association issued its first "system level" report card. The federal government indicated that outcomes research was high on its political agenda when it offered the provinces $1 billion in new funding, on the condition that they cooperate in developing a national system of measuring effectiveness, that would entail having an organization like the Canadian Institute for Health Information compile report cards.¹³⁰

5. **Control of physician discipline and liability.**

When a single payer health system was first introduced in Ontario, technological procedures for diagnosing and treating patients were relatively simple. Patients had limited expectations about their physicians' abilities to make diagnoses and cure them. Patients made few complaints to the CPSO about their physicians. Since they launched few malpractice cases, premiums for insurance were low.¹³¹ Technology has altered people's expectations about what their doctors can realistically be expected to achieve. As Jennifer Miller has observed,
"Many people feel that if the Pathfinder can travel across Mars, doctors should be able to cure their disease or repair their heart or improve their appearance to a standard of perfection."\textsuperscript{132}

Over the past three decades, the CPSO has gradually introduced more stringent oversight of physicians. The Ministry of Health tried to make inroads into the area of physician discipline when it created the Medical Review Committee (MRC). However, in 1978, the court ordered that only the CPSO could discipline doctors. Hence, the Medical Review Committee, which was set up to review cases of allegedly inappropriate billing practices, had to be reestablished as a committee of the CPSO. Nevertheless, the Minister of Health retained the right to appoint a majority of the members to the committee. The MRC remained accountable to the Minister, not the College.\textsuperscript{133} In 1980, the Health Disciplines Act gave the CPSO the authority to require physicians to open their records for review. That same year, the CPSO set up a Peer Assessment Program, which has reviewed the performance of more than 4,500 physicians, usually on a random basis and once they have reached a certain age. Physicians are told in advance why they have been selected and are given the opportunity to choose a date for their assessment that is convenient for them and their assessors. The peer assessors review the physicians' physical facilities, medical records and the quality of their patient care.\textsuperscript{134} In 1987, the CPSO, in collaboration with McMaster University, initiated the Physician Review Program (PREP), to evaluate physicians' strengths and weaknesses in order to develop individualized education programs to address their problems. If the Peer Assessment Program
indicates that there are significant concerns with the physicians’ performance, they can be referred to the PREP. No more than forty general physicians are selected each year to undergo the Physician Review Program, at an average cost of $2,300. A specialties assessment program reviews less than 100 specialists every year, at an average cost of $3,700.135

In November 1991, The Task Force on Sexual Abuse of Patients, an independent body commissioned by the CPSO issued its final report.136 Some of its recommendations were incorporated in the Regulated Health Professions Act (RHPA), which became law in January 1994. As the College proposed, the RHPA outlined three levels of abuse: sexual impropriety (i.e., sexually demeaning words and gestures), sexual transgression (i.e., sexual touching) and sexual violation (i.e., sexual intercourse). The Task Force proposed two levels and the government’s initial plan included one level of sexual offence, but both proposals were rejected.137 The RHPA declared that physicians had a mandatory duty to report suspected cases of sexual abuse involving another physician to the CPSO or they would be liable for a $35,000 fine.138 Consumer activists praised the CPSO’s “zero tolerance” policy for physicians’ accused of sexual intercourse with patients, as one of the toughest in North America. More recently, critics have called it “a lengthy, expensive, disappointing process” since the College rarely imposes severe penalties on physicians.139 The College’s disciplinary process is currently undergoing its first review by a private-sector consultant, Klynveld Peat Marwick Goerdeler.140
In 1992, an Alternative Dispute Resolution process was set up to allow the complainant and the accused to participate in reaching a mutually acceptable decision with a trained mediator. This process has advantages for the CPSO since it is less expensive than referring cases to a disciplinary committee. The process does not assign blame. Patients are required to sign gag agreements. In January 1999, the CPSO lobbied successfully for the passage of the Red Tape Act (Bill 25), which allows the College to unilaterally expedite the processing of complaints that it considers “frivolous, vexatious, made in bad faith or otherwise an abuse of process.” The CPSO estimates that between 10 percent and 30 percent of the approximately 1200 complaints it receives each year fall into this category. Complainants still have the right to appeal to the government’s Health Professions Board, which has a similar process of expediting complaints incorporated into its legislation.\(^{141}\)

6. **Physicians’ rights in hospitals.**

Physicians’ rights in Ontario hospitals remained relatively secure until the passage of Bill 26 in 1996 by Premier Harris’ Conservative government. Bill 26 gave the government the unprecedented power to decide which doctors can be tied to hospitals and revoke their privileges without legal recourse or compensation, [and] require hospitals to prepare a physician resource plan that would govern future doctor appointments, subject to health ministry approval.\(^{142}\)

The government passed this draconian legislation to facilitate hospital restructuring. However, even though this legislation is in place, lawyer Alan West argues that physicians still have the right to “procedural fairness,” which
may override the Savings and Restructuring Act.\textsuperscript{143} In practice, physicians' employment within the hospitals has been far more secure than any of the nonphysician workforce groups. Nevertheless, physicians have become less enthusiastic about providing hospital-based care as their workload increases. Physicians, who retain privileges, end up providing care for the growing number of “orphaned” patients whose family doctors no longer work in hospitals.\textsuperscript{144}

7. \textit{Representation rights.}

The Ontario Medical Association has had the right to negotiate payment and working conditions with the Ministry of Health since publicly funded health insurance was established in the province. In 1977, Dr. Lazarus Loeb, president of the Ontario Medical Association asked the government for fee arbitration. He was dissatisfied with the level of fee increase (6.5 percent) that was established by the Joint Committee on Physicians' Compensation, the forum that had been set up by the OMA and the provincial government, in 1974, for negotiations over fees, physician supply and related topics.\textsuperscript{145} However, in 1980, when Chief Justice Emmett Hall issued his report on the future of Medicare in Canada, the OMA reacted negatively to his proposal that binding arbitration should be used in contract disputes with the government. OMA delegates feared that they would lose their professional status and become de facto government employees. OMA President Dr. Robert MacMillan thought it was “naïve to expect the government to allow themselves to be ruled by binding arbitration.”\textsuperscript{146} The OMA threatened to examine unionization if the Hall proposals were enacted as law.\textsuperscript{147} After physicians realized that the 1986 strike did not help them meet their demands, the
OMA set up a committee on unionization. In 1988, the committee advised against unionization and in favour of seeking the right to binding arbitration as a method for settling disputes over fees and working conditions.

In 1991, the Ontario Medical Association sought, and was given, the following rights by Premier Bob Rae's government: "1) binding arbitration, 2) representational rights for all physicians regardless of payment mechanism, and 3) mandatory dues legislation i.e., the RAND formula." The Ontario Medical Association valued binding arbitration because it meant that the government could not use arbitrary power to unilaterally set fees. The OMA made the case that the RAND formula should be invoked since the entire membership should pay for its services of negotiating on their behalf. In January 1996, when Premier Harris enacted the Omnibus Savings and Restructuring Act, the OMA expressed its outrage by revoking the RAND formula. It recognized that the legislation stripped physicians of much of their bargaining power, by allowing the government to unilaterally set fees. The OMA reinstated the RAND formula in 1997, after the Ministry of Health again acknowledged the OMA's role as the representative of the profession for bargaining purposes. The OMA conducted a poll of its membership and found that 60 percent of voters favoured making membership dues compulsory. However, only 34 percent of eligible voters actually participated in the referendum. Some specialty groups hotly contest the right of the OMA to bargain on their behalf, on the grounds that the medical association does not properly represent their views. For example, in 1998, the 450-member Ontario Association of Radiologists sued the OMA and 15 of its
directors for $675 million in damages. The 300-member Ontario Association of Cardiologists voted to seek representation independent of the OMA.

Interns and residents in Ontario's teaching hospitals have fought their own battles over the last three decades, sometimes with the help of the wider medical profession. In 1980, they won the right to claim employee status and engage in binding arbitration with the Ontario Council of Administrators of Teaching Hospitals, following a protracted strike by 2,500 of PAIRO's members. In 1999, PAIRO and the Canadian Medical Association successfully opposed a $1,950 tuition fee for University of Toronto residents, on the grounds that they already make a significant contribution to the health care system and the university, through their teaching, research and clinical responsibilities. The Ontario government stepped in and offered to cover their fees.

THE CALIFORNIA CASE

1. Control of the number, mix and geographic distribution of physicians.

The California government, like the Ontario government, perceived a shortage of physicians in the late 1960s, when it first introduced its publicly financed insurance programs. In 1970, there were 114 physicians per 100,000 Americans. By 1996, California's supply of active federal and non-federal physicians rose to 247 per 100,000 people, which was much higher than the ratio in Ontario that year of 181 physicians per 100,000 people. Unlike in Canada, where the numbers of practicing international medical school graduates as a percentage of all physicians have declined since 1976, their numbers have
increased steadily in the United States.\textsuperscript{158} Whereas Ontario bemoans the migration of physicians to the United States, some U.S. politicians regret that they have not been able to stem the tide of physicians, trained outside the country, who want to practice in the U.S.\textsuperscript{159} Ontario faces a shortage of physicians, while California faces a surplus of specialists, partially because so many migrate to "the Golden State." Appendix D shows the steady rise in the number of active physicians per 100,000 civilians in California and the United States between 1975 and 1997.

The U.S. government made the Naturalization and Immigration Act more restrictive in 1976. Nevertheless, the number of international medical graduates continued to increase, as more U.S. citizens went abroad to receive their medical education, and then returned to the U.S. to set up practices. In 1997, the federal government introduced incentives that might be strong enough to help reduce the number of physicians. President Clinton's Balanced Budget Act included provisions to overhaul graduate medical education policy and discourage hospitals from training physicians. The Balanced Budget Act promised transition assistance to teaching hospitals that allocated fewer positions to residents. It reduced the support that the Medicare program gives to finance the indirect costs of graduate medical education, by lowering the indirect medical education adjustment percentage from 7.7 to 5.5 percent over a five-year period. The Act also set a limit on the number of residents that could be trained in hospitals, depending on their number of beds.\textsuperscript{160}
In the 1960s, in California, as in Ontario, medical graduates were almost evenly divided between those who pursued generalist, and those who pursued specialist, careers. While the ratio remained almost equal in Ontario over the next three decades, by the 1990s, three times as many medical graduates were choosing to become specialists, as generalists, in California. This resulted in a surplus of specialists of between 20 and 48 percent, depending on their specialty and location in the state. Appendix E reveals the differences between the number of primary care physicians and specialists per 100,000 people, in Ontario and California in 1996. Appendix F shows the differences between the number of primary care physicians and specialists per 100,000 people, in Canada and the United States between 1974 and 1994.

The growth in the number of California specialists could be attributed to a number of factors. Medical students chose to train as specialists because careers in surgery, radiology and cardiology offered higher payment, more leisure and control over one's time and the opportunity to use cutting edge technology and knowledge. The federal government's graduate medical education subsidies encouraged hospitals to train large number of residents. Teaching hospitals were paid about $170,000 per year per resident. Stephen Katz commented upon the absurdity of the program, which was introduced as part of the 1983 budget reconciliation act:

Within a year, hospital administrators were recruiting abroad for residents, because each one that they hired was a walking $170,000 check for the hospital! This is no way to create sensible residency programs. This monstrosity distorts the economics of hospital care, and teaching hospitals have stonewalled this issue for fourteen years. It is another example of
addiction to excessive cash flow and clearly needs re-evaluation and downsizing.  \(^{163}\)

At the same time, the market began to require fewer specialists because managed care organizations were becoming more pervasive.  \(^{164}\) Managed care organizations tend to tilt their hiring policies towards primary care physicians because they find it less expensive to use preventive care to treat patients in the early stages of their diseases, than to provide specialty care at a more acute stage.

In the 1990s, the federal and state governments adopted more stringent measures to encourage medical graduates to become primary care physicians. The resource-based relative value scale (RBRVS), which became effective in 1992, triggered a redistribution of Medicare funds away from medical specialists and toward generalists. (The resource-based relative value scale is a “coded listing of physicians services, which includes units that indicate the relative value of the various services they perform,” taking into account the time, skill and overhead cost required for each service.  \(^{165}\) It has been designed to give physicians an incentive to provide services where they are most needed). In 1992, Governor Pete Wilson vetoed Assembly Bill 3593, which would have required the University of California to allocate at least half of its positions to primary care residents, or face an $8 million reduction in government funding. The Clinton Administration’s Health Security Act, which was rejected in 1994, would have limited the number of physicians allowed to enter training programs, the number of training positions by medical specialty, and the number of international medical graduates allowed in American training programs.
At the state level, legislative efforts to reform the health care workplace have been sporadic, propelled by immediate consumer demands, instead of any long-term vision of societal needs. For example, in 1994, a bill was passed in the state assembly that allowed women to access obstetrician-gynecologists directly instead of waiting for referrals from primary care providers. This bill was an acknowledgement that many obstetrician-gynecologists could be better used as generalists than specialists. It was intended to compensate for a lack of planning, but significant public resources were expended on educating specialists in an area where many were not needed. Although state regulators and leaders of medical associations and medical schools have sought to shape physician workforce issues, California continues to be plagued by an oversupply of specialists and a poor distribution of physicians.

Unlike in Ontario, where there is an undersupply of physicians in urban areas and a much greater undersupply in rural areas, in California there is an oversupply in most urban areas and an undersupply in rural and impoverished inner city areas. Many initiatives have been set up at the federal and state levels to address the problem of the maldistribution of physicians. Even thirty years of overproducing physicians has not corrected the shortage in many areas. This leads Kevin Grumbach, Karen Vranizan and Andrew Bindman to conclude that, “a more geographically equitable distribution of physicians in urban areas is unlikely to compensate for an inegalitarian system of health insurance.”

In the early 1970s, “Critical Health Manpower Shortage Areas” were identified using a simple physician-to-population ratio. Congress began a
program to train physician assistants in the hopes that they would compensate for a lack of physicians. It established the National Health Services Corps to provide scholarships to medical students, who agreed to practice in underserviced areas upon completion of their training. The National Health Services Corps gave physicians the option of locating in designated underserviced areas instead of joining the military. In 1972, the California government set up the Area Health Education Center (AHEC) system to improve health care personnel distribution. The AHEC system comprised numerous health professions and medical schools, state agencies, and a Statewide Program Advisory Committee that cooperated with the aim of developing educational linkages between the academic health centers and the communities to motivate medical students to practice in underserviced areas.169

More recently, the Department of Health and Human Services’ criteria for identifying underserved areas have changed. Administrators have begun to designate “Medically Underserved Populations” and “Health Professional Shortage Areas” based on the economic, racial and linguistic characteristics of the communities, instead of focusing exclusively on physician-to-population ratios. Hence, metropolitan, and not just rural, areas have become designated as underserved.170 In 1999, the number of Californians, who lived in communities designated as Health Professional Shortage Areas, was more than 4 million, although researchers speculated that the number who lacked access to primary health care was probably far greater.171
In the 1990s, the resource-based relative value schedule was introduced, which was intended to encourage physicians to practice in underserviced areas. Physicians, who practiced in underserviced rural areas, received a bonus and a standard national fee that was higher than the traditional fee. The Balanced Budget Act of 1997 also provided new incentives for physicians to practice in underserved areas by giving direct payments to certain community clinics and rural health centers in the hopes that they would train residents in a rural community setting.\textsuperscript{172} The policy planners assumed that residents who were trained in underserved areas would be more likely to practice there.

State agency officials face daunting odds when they try to encourage physicians and health plans to move to underserved areas. Communities must meet the accessibility and financial viability requirements of licensure based on specific demographics before the Department of Managed Health Care will allow health plans to service the area.\textsuperscript{173} Rural health care providers sometimes cannot attract a sufficient number of consumers to make their practices viable, since the federal per capita rates paid to health maintenance organizations for treating beneficiaries of Medicare and Medicaid programs are so low.\textsuperscript{174} Even with the tax and grant subsidies that the federal and state governments provide, physicians do not always make enough money to cover the annual operating expenses of their practices.

Efforts to increase the number of physicians serving minorities through affirmative action initiatives in California are highly politicized. Some people claim that race-based quotas, which were first introduced in California in the late-
1960s, should be eliminated because they unfairly prevent whites from entering medical school. Those in favour of affirmative action point out that black and Hispanic physicians play a critical role in the health system because they are more likely to provide care to the underserved minority population than other California physicians. When Pete Wilson was Governor, some Democratic Assembly members supported bills that would make admission and graduation rates ethnically proportional in the state’s universities. Wilson vetoed the bills twice. In 1996, he supported Proposition 209, an initiative to ban affirmative action programs in the government and education system. Wilson’s opposition to racial preferences made him attractive to most Californian voters (54 percent of voters supported Proposition 209), but it meant that he had to reverse his earlier position in favour of affirmative action. The outcome of ending affirmative action programs has been a drop in the number of underrepresented minorities applying for medical school admission in California, due to the inhospitable atmosphere, and a drop in the number of Latinos willing to support the Republican Party.

2. Control of medical research.

Institutional Review Boards (IRBs) were set up by the National Institute of Health, in 1966, to ensure the ethical treatment of human subjects. These boards are set up within universities to examine physicians’ research proposals before studies are undertaken. They check that the proposals meet the guidelines established by the Food and Drug Administration and the National Institutes of Health, which protect the subjects from experiments where the risks of
participating outweigh the benefits. A landmark case by the California Supreme Court in 1990, Moore v. The Regents of the University of California, addressed the issue of full disclosure. The Court stated that,

[A] physician who treats a patient in whom he also has a research interest has potentially conflicting loyalties. This is because medical treatment decisions are made on the basis of proportionality – weighing the benefits to the patient against the risks to the patient....The possibility that an interest extraneous to the patient’s health has affected the physician’s judgment is something that a reasonable patient would want to know in deciding whether to consent to a proposed course of treatment.182

Recent reports on Institutional Review Boards have questioned whether these adequately protect human experimental subjects from abuse by investigators.183 The Inspector General’s Reports found that the workload of the Institutional Review Boards was far too heavy. There was evidence of a massive number of informed consent violations. Many “Independent” (For-Profit) Institutional Review Boards have been set up that are more exposed to conflict of interest problems than not-for-profit boards, since Independent IRBs, that provide negative reviews to the for-profit research companies that hire them, risk losing customers and future revenue.

On the positive side, research money from the public and private sector, and the close relationship between academics and pharmaceutical companies, has fueled the development of many new drugs and medicines in California. For example, six of the ten hottest selling drugs in the United States were born in the laboratories of the University of California – Berkeley,184 where government,
philanthropists, industry and university researchers work together closely to pursue the most promising projects.

3. The existence of a professional code of ethics.

The American Medical Association has put much more effort into developing their Code of Ethics than the Canadian Medical Association. There are four parts to the American Medical Association’s Code of Ethics: the Current Opinions of the Council on Ethical and Judicial Affairs, the Principles of Medical Ethics, the Fundamental Elements of the Patient-Physician Relationship, and the Reports of the Council on Ethical and Judicial Affairs. All of these are accessible to the public through the use of the Internet. The Principles were last revised in 1980. The American Medical Association has set up an Institute for Ethics and an Ethics Research Unit to develop innovative approaches for encouraging physicians to practice medicine ethically.

The government does not assume that the existence of a code means that physicians will necessarily assume a service orientation rather than an entrepreneurial orientation. Nor does it mean that the medical associations will necessarily enforce the code. Representative Pete Stark (California) introduced the Ethics in Patient Referrals Act of 1989, in Congress, to try to limit physicians’ conflicts of interest. Stephen J. O’Connor and Joyce A. Lanning note that,

Such legislation, which Congress folded into the Omnibus Budget Reconciliation Act of 1989, is designed to address perceived inadequacies in the profession’s own service orientation and ethical standards, further eroding the autonomy of the profession.185
4. **Control of licensing, accreditation, credentialing and quality assurance.**

Control over licensing is much stricter in Canada, where there are only 16 medical school “entry points,” than in the United States, where there are more than 120. In 1980, the Board of Medical Quality Assurance, which was the regulatory body that monitored doctors before being renamed the Medical Board of California in 1990, recognized eight different pathways to licensure, rather than imposing a standard route. However, licensing has become more restrictive in California over the past three decades. Prior to 1990, only one year of postgraduate training was required, along with the passage of the appropriate exams and a credentials review, before physicians could be licensed. Two years of postgraduate training are now required for licensure, much to the dismay of the California Medical Association and the interns and residents. The Medical Board of California allows residents to be regulated with a limited license, a policy that is now being considered in Ontario.

Since 1975, the California Medical Association has played a key role in the accreditation of hospitals, working alongside the Joint Commission on Accreditation of Hospitals (JCAH) and the Department of Health Services (DHS) to monitor the quality of hospitals using the Consolidated Accreditation and Licensure Survey. In 1996, the California Medical Association established an Institute for Medical Quality, which won the contract to judge health plans' compliance with Knox-Keene regulations for the California Department of Corporations. That same year, the CMA produced a standard credentialing application in cooperation with the Independent Physician Association of
California, the California Healthcare Association, the California Association of HMOs and the Medical Quality Commission. The purpose of the standard application was to streamline the credentialing process for physicians.

Robert L. Thomas, the Executive Director of the California Medical Association in 1973, boasted about his organization's achievements in the area of peer review. He asserted that the CMA "surpasses and has set a pattern for that of other states throughout the nation and other countries throughout the world."\(^{189}\)

The CMA's early initiatives included a Medical Staff Survey Program, begun in 1961, whereby CMA medical staff and local community physicians evaluated the care given in Californian hospitals. Only hospitals that passed the survey conducted by the CMA or the Joint Commission on Accreditation of Hospitals could participate in the Medi-Cal program. In 1969, success on the survey became a precondition for membership on the California Hospital Association.

The most intensive study that has been written examining quality-of-care problems was co-published by the California Medical Association and California Hospital Association, in 1977, in the wake of a malpractice insurance crisis.\(^{190}\)

The researchers analyzed hospital records in order to discover the extent of adverse reactions to medical treatment. The results showed that only a small fraction of iatrogenic injuries was reported or compensated.\(^{191}\)

In 1996, the California Medical Association formed an Institute for Medical Quality (IMQ) to consolidate accreditation, certification, and quality assurance functions into one body. That same year, the Department of Corporations awarded the IMQ a joint contract with the Joint Commission on the
Accreditation of Healthcare Organizations to evaluate up to 32 health maintenance plans in California.

At the federal level, the American Medical Association has been involved in cutting edge initiatives to improve the quality of health care. In 1997, the AMA co-sponsored the establishment of the National Patient Safety Foundation, a not-for-profit foundation to enhance the safety of the U.S. health care system. Since 1998, the American Medical Association has assisted the Agency for Health Care Policy Research and the American Association of Health Plans in making clinical practice guidelines more widely available through the National Guideline Clearinghouse on the Internet.

HMOs, employer groups and accrediting agencies expect physicians and medical groups to give them detailed quality data showing how well they compete on a variety of clinical and service quality measures, such as those developed by the National Committee for Quality Assurance. If physicians and medical groups do not consistently provide impressive data, they may have difficulty finding consumers and employers who are willing to purchase their services. The control of HMOs, employer-purchasers and accrediting agencies over the quality assurance process has diminished physicians' autonomy in the area of quality assurance. A drawback of directing a lot of time, energy and money towards manufacturing data is that physicians are left with fewer resources to direct towards improving patient access to quality care. Nevertheless, some doctors, like Alain Enthoven, professor of public and private management at Stanford Business School, who is on the payroll of Kaiser Permanente, argue that health
plans are likely to improve the quality of health care in the process of reducing costs.

5. **Control of physician discipline and liability.**

The regulatory board in California, the Board of Medical Examiners, was established in 1876. It had two main transformations that were signaled by changes to its name. In 1975, the same year that MICRA was enacted, the Board of Medical Examiners became the Board of Medical Quality Assurance. Democratic Governor Edmund G. "Jerry" Brown, Jr. encouraged members of the legislature to enact MICRA to rectify a malpractice crisis. Malpractice insurance rates skyrocketed so high that between 8 and 18 percent of physicians went "bare" (i.e., practiced without malpractice insurance) in 1976. Physicians in a low-risk premium class were faced with costs of $3,500 more than the previous year, while specialists in a high-risk class were expected to pay as much as $17,000 more.

The dramatic increases prompted many to withdraw their medical services in Los Angeles and San Francisco. More significantly, the malpractice crisis changed the face of the malpractice insurance industry. Large commercial companies like Argonaut, Travelers, Hartford and Pacific Indemnity chose to discontinue their services to California physicians, rather than cover the rising costs of lawsuits. Physicians set up their own carriers that grew to dominate the marketplace.

At the time that Medicare and Medicaid were instituted, allegations against doctors were rare because doctor-patient relationships were less transient and more hierarchical than they are today. The Board of Medical Examiners, as the regulatory body was then called, had only one public member. The Governor was
responsible for appointing the ten physicians who were members. With the massive reorganization in 1975, the composition of the Board of Medical Quality Assurance changed. Seven public members joined the twelve physicians on the Board. The new composition of the Board signaled that it was serious about seeking the interests of the public and not just the physicians. MICRA did not initially evoke as much enthusiasm from doctors as it does today. Linda McCready and Billie Harris of the Medical Board of California colourfully describe MICRA’s legacy:

MICRA did a great deal more than just rein in the explosion of malpractice litigation that sprang from the combination of the raveling of the patient-physician bond and the consumerism of the sixties and seventies. It told physicians they were no longer free to regulate themselves like a gentleman’s social club. It told consumers there were seats at the boardroom table. It told hospitals and insurance companies they could not just hustle their drunks, incompetents and larcenists out past the loading dock at midnight and pretend there wasn’t a problem.

In 1990, the year Senate Bill 2375 (Presley I) was enacted, the Board of Medical Quality Assurance was renamed the Medical Board of California. The Medical Judicial Improvement Act of 1990 (Presley I) incorporated most of the recommendations of a report by the Center for Public Interest Law entitled Physician Discipline in California: A Code Blue Emergency, which suggested overhauling the laws governing physician discipline. In 1993, Senate Bill 916 (Presley II) was enacted with provisions to increase disclosure of information on problem physicians, expedite disciplinary procedures and improve prosecutorial resources.
The California Medical Association and its parent body have fought vigorously to limit the disclosure of information regarding physician misconduct. The medical associations are concerned that disclosure could lead to the public humiliation of physicians in their communities. Disclosure could also jeopardize physicians’ future job opportunities and efforts to acquire malpractice insurance, regardless of the seriousness and merits of the disciplinary action. Nevertheless, through changes in legislation, computer technology and citizen empowerment, a great deal of information has become available.

In 1986, Congress passed the Health Care Quality Improvement Act, which established the National Practitioner Data Bank, to ensure that unethical or incompetent health care practitioners do not compromise health care quality. Hospitals, managed care organizations and health plans base their decisions to hire physicians partially on the information that they access from the National Practitioner Data Bank and many other publicly and privately-owned databases. As of 1990, the federal government has required malpractice insurers to report payments on behalf of physicians to the National Practitioner Data Bank.

California is the only state other than West Virginia that has strong penalties for failure to report adverse peer review reports to the appropriate authorities. A health care facility can be fined $10,000 for intentionally failing to transmit a report and the facility’s administrator can be charged $5,000. In 1993, the Senate passed Presley II, which required the Medical Board to make publicly available information on individual doctors, who have lost their licenses or lost a case where the jury or judge awarded $30,000 or more. The CMA successfully
sued the Medical Board to keep confidential the Attorney General's investigations of 350 doctors, who had not been formally charged. In 1996, the CMA failed to prevent the Medical Board from gaining access to peer review hospital records. In 1998, legislation was passed that required stricter reporting requirements and expanded public disclosure. The reporting threshold for professional liability judgments and arbitration awards was reduced from $30,000 to $0. In 1999, the AMA defeated a proposed regulation that would have expanded reporting to the National Practitioner Data Bank (NPDB). The proposed regulation would have required institutions to submit reports to the NPDB on payments made on behalf of the physician, who provided the medical care that was the subject of the claim or lawsuit, whether or not that physician was actually named as a defendant.

The California and American Medical Associations have lobbied to overturn the federal Employee Retirement Income Security Act (ERISA) of 1974, which diminishes physician autonomy in the area of malpractice liability. Congress originally ratified ERISA in order to encourage employers to offer their own benefit plans by making the standards uniform across the country. Although states normally bear the responsibility for regulating health care, ERISA preempts state law. That means the states cannot enforce legislation and regulations that relate to employee benefit plans. The federal law has left a "regulatory vacuum" preventing individuals from invoking tort law remedies in state court. While individuals can bring lawsuits against managed care organizations in federal court under ERISA's civil enforcement scheme, the amount of money that they can recover is much more limited than it would have been under state law.
Individuals, who sue in federal court to recover damages caused by wrongful 
denial of care by managed care organizations, can receive only the amount of the 
benefits that should have been provided plus incidentals. In a recent California 

case, the federal court ruled that ERISA protected a health maintenance 
organization from being sued for damages by the family of a woman who died of 
cancer before the company authorized a bone marrow transplant and high-dose 
chemotherapy. Thus, there is little that patients and their families can gain by 
suing managed care organizations for denying plan benefits. The patients’ only 
remedy is to sue physicians, even though utilization reviewers, who evaluate the 
appropriateness and quality of services delivered by health care providers, may 
have made the decision to deny care.

The California Medical Association’s reaction to ERISA is to support 
legislation that would make HMO medical directors liable for coverage decisions, 
rather than holding the organizations responsible. If the CMA supported HMO 
liability, it would inadvertently cede responsibility to HMOs for making clinical 
decisions. The CMA encourages physicians to protest (and keep records of the 
appeal) to managed care organizations that wrongfully deny care, because the 
physicians can be held liable for not seeking to have the utilization reviewers’ 
decisions overturned if their denial of care results in a bad outcome. The CMA 
successfully sponsored a law, Business and Professions Code 2056, which 
protects physicians from termination by managed care organizations for 
protesting bad utilization review decisions. It supported legislation (A.B. 55, 
Chapter 533, Statute 1999 – Migden) that establishes an independent review
system that health plan enrollees can use. Although the CMA has tried to limit physicians’ exposure to malpractice suits and the publication of information regarding disciplinary actions, California doctors continue to face a high risk of being sued and having their performance records made public. At the same time, self-insured health plans are virtually immune from malpractice suits under state law.

6. **Physicians’ rights in hospitals.**

In the 1970s, one of the most important perks of American Medical Association membership was that it enabled physicians to gain hospital privileges, from which they derived about half of their income. Now that many California hospitals are part of large chains of for-profit health systems, medical associations have lost the power to deny physicians the use of hospital facilities. Exclusive contracts between hospitals and medical groups, allowing only specialists from the group to have the right to practice particular specialties in the hospitals, have become increasingly popular. These contracts are open to abuse. Hospitals may be tempted to pressure physicians to pay more than market value for services provided by the hospital, or to accept less than the fair market value of goods and services that they provide to the hospital, even though it contravenes anti-kickback legislation and the bar against the corporate practice of medicine. The bar against the corporate practice of medicine prevents organizations comprised of laypersons from employing physicians and from making medical decisions. The California Medical Association must fight a perpetual battle to ensure that the bar is enforced.
The California Medical Association has vigorously defended the bar against the corporate practice of medicine and has argued, "by their very nature, arrangements between hospitals and hospital-based physicians raise concerns regarding physician autonomy in the practice of medicine." For example, the California Medical Association joined with the American Academy of Emergency Medicine and the California State Chapter of the American Academy of Emergency Medicine, in October 1999, to file an amicus curiae brief in a lawsuit, brought by Affiliated Catholic Healthcare Physicians against Emergency Physician Medical Group and Meriten Physician Management Company. The amici alleged that Meriton (a subsidiary of Catholic Healthcare West, a hospital system) was exercising inappropriate control over the way that the Emergency Physicians Medical Group practiced medicine by entering into a 30-year contract with them and treating health care as a business.

The California Medical Association welcomed the recent decision by the California Department of Health Services to reinterpret an 18-year-old law to mean that hospitals that participate in the Medi-Cal program are not allowed to sign exclusive contracts with physician groups except for pathology, radiology, anesthesiology and emergency services. Hospitals can still enter into exclusive contracts for other areas such as radiation oncology, cardiac surgery, thoracic surgery and neonatology.

7. Representation rights.

The state of California has been fertile territory for physician unionization, although the American Medical Association has had a history of vehemently
opposing it. The Union of American Physicians and Dentists (UAPD), which is based in Oakland, California, was founded in 1972. The UAPD has managed to survive until today, even though only one other of the 26 doctors’ unions in the United States that formed in the 1970s is still operating. The UAPD currently has about 6,000 Californian members.

In 1975, the single largest strike to date of U.S. private-practice physicians took place in California, as physicians protested the enormous rise in malpractice insurance rates throughout the state. Their complaints were heard. Governor Jerry Brown issued the MICRA legislation to address the issue. The California Medical Association and the American Medical Association did not actively support the strike, which was led by individual physicians. Instead, they took the position that withholding services did not constitute a strike, and could be viewed as a legitimate way to resolve disputes.

In the past decade, collective bargaining has risen to the top of the lobbying agenda for organized medicine in California. Collective bargaining rights have become attractive in a managed care environment, as more physicians become employees and recognize the need to level the playing field with health plans and insurers. 1999 was a banner year for unionization efforts in California and throughout the United States. In 1999, the California Medical Association filed an amicus curiae brief in support of the Committee of Interns and Residents’ (CIR) petition to the National Labor Relations Board, even when the AMA decided not to publicly declare its support. The CIR wanted the house staff at teaching hospitals to be given the right to bargain collectively. Hence, an earlier
ruling by the National Labor Relation Board in 1976, that they were not entitled to protection, had to be overturned. The CMA and the CIR formed an alliance in 1999, encouraging residents and interns to join both organizations. That same year, the Los Angeles County Medical Association took the initial steps to establish the Professional Union of Los Angeles County Physicians. That union is still in its formative stages, because federal antitrust laws are in the process of being changed to allow groups of independent-contracting physicians to bargain as single units.209

Instead of pursuing unionization, the American Medical Association set up Physicians for Responsible Negotiation (PRN), an organization to provide professional services for groups of physicians who need help negotiating with their employers. PRN also assists the 95,000 resident physicians who have been classified as employees by the National Labor Relations Board, and hence can negotiate collectively.210 The AMA has been seeking to build support for its contention that the court should consider some physicians to be “de facto employees” of health plans so that they can legally engage in collective bargaining. On March 30, 2000, the House Judiciary Committee approved H.R. 1305, “The Quality Health Care Coalition Act of 1999,” which was hailed as a “Big Win” for organized medicine. The bill, sponsored by Rep. Tom Campbell (R-Calif.), would allow physicians to engage in joint negotiations with health plans.211
ASSESSMENT AND EXPLANATION

1. **Control of the number, mix and geographic distribution of physicians.**

   As this historical overview shows, Ontario and California have taken different approaches to physician supply policy since the late 1960s. At that time, both jurisdictions struggled to increase the number of doctors providing medical services to their population, but were soon faced with a new problem – an oversupply of physicians. In Ontario, medical schools, the OMA and government have worked together to control physician supply. By restricting the number of residency training positions, the government and organized medicine reduced the number of physicians when they perceived an oversupply in the early 1990s.²¹² By the end of the decade, the perceived oversupply had been replaced by an undersupply of physicians. In contrast, physician supply policies have not been able to significantly alter the oversupply of California physicians. However, recent evidence suggests that states, with the highest rate of managed care penetration, are beginning to reduce the increases in physician-to-population ratios.²¹³

   What accounts for the divergence in the approaches to physician supply policies? This analysis explains the divergence by referring to the different ideas about the role that the state should play in health policy formation and implementation, physicians’ preferences, and incentives that the different institutional settings provide for political action. The Ontario government has played a proactive role in altering the incentives for training physicians to closely
reflect its goals. In California, there are many more constraints that limit the capacity of the state government to alter the number of physicians.

Ontarians are willing to tolerate a more interventionist role for the government than is the case in California. Although the government has the capacity to place tight restrictions on the number of new physicians, it is expected to negotiate with the medical profession to reach a mutually acceptable compromise. For example, even though the Harris government's Restructuring and Savings Act (Bill 26) originally contained a clause that would have given the government the authority to lock out new physicians, the clause was ultimately changed because it was vigorously opposed by the PAIRO and the OMA. The government was willing to make concessions to the medical profession in order to maintain good relations. The strength of the state and sectoral interests, and their ability to engage in long-term decision-making, are characteristics of a concertation network.

In Ontario, the medical profession has participated in policymaking as an insider, rather than advocating for change from outside the policy process as is the case in California. Robert Sullivan, Mamoru Watanabe, Michael Whitcomb and David Kindig observe:

Canadian provincial medical associations have been active participants, along with provincial health ministries, licensing bodies, regulatory authorities, and medical schools, in shaping policies that limit medical school enrollments, adjust the specialty training mix to accord better with needs, control immigration, and establish practice location incentives.214

When the Ontario government brought in global caps on fee-for-service payments, it gave the medical profession an incentive to try to reduce the number
of physicians by training fewer students. Now that a consensus has been reached that there is again an undersupply of physicians, the medical profession and government are working together to try to increase their numbers, as recommended in Dr. Robert McKendry Fact-finder's Report, commissioned by the Ministry of Health in 1999.

In California, physician supply has expanded with little oversight by the medical associations.\(^2\) The state legislature has tried to indirectly limit the size of classes by altering the level of funding that is allocated to the medical schools. Since only about 40 percent of medical schools are part of public institutions, the government does not have as much leverage as in Ontario, where all medical schools are public. Many physicians move to California from outside the state.\(^3\) No single government department has control over the number of international medical graduates that are trained in California. Instead, regulatory power is dispersed among many government departments that can grant exceptions to foreign medical students to allow them to set up practices in the state, even if there is little demand for them.

In California, a laissez faire system exists. Specialized groups compete with each other to have their interests heard by the many members of the state. Physician supply policy is studied exhaustively, but the outcome is rarely a coherent policy. The medical profession, research institutes and government agencies have produced numerous studies showing a physician surplus, but Californian policymakers have been reluctant or unable to act because
decisionmaking power is fragmented between so many stakeholders. Steve Schroeder describes the pluralist network that has developed in the health sector:

The United States, which departs from other nations in how it organizes and finances medical care, also differs in never having had a national policy on medical manpower. Instead we have delegated the production of physicians – that most crucial component of medical care – to a loosely connected confederation of voluntary agencies: the academic medical centers, the nation’s teaching hospitals, the American Board of Medical Specialties, and the Accreditation Committee for Graduate Medical Education (ACGME). The result of this arrangement has been the uncoordinated, de facto devolution of physician manpower planning to the clinical leaders of academic medicine.217

Thus, an irrational system has developed in California, whereby a surplus of physicians, particularly specialists, is trained at enormous cost to the state, but the uninsured still do not receive adequate access to health care.

In the 1990s, the surplus in the number of California physicians had the effect of reducing physician bargaining power with independent practice associations, medical groups and the health maintenance organizations with which they contract.218 Physicians have lost their clout in a state where five health plans dominate 90 percent of the market, instead of the many local, nonprofit HMOs that existed a decade ago.219 Physicians have felt compelled to accept contracts with managed care organizations, even if the terms are poor, because they need patients in order to bill for services and make their practices profitable. The surplus of physicians appears to have reduced their corporate autonomy in California and increased the influence of managed care organizations.

Ontario and California had close to the same proportion of primary care doctors and specialists when their government-financed health insurance
programs were set up in the late 1960s. The number of specialists has remained almost equal to the number of primary care doctors in Ontario, but in California a greater percentage of doctors have become specialists. Why is there a difference in the public policy approach for correcting workforce imbalance in the two jurisdictions?

The medical schools and the provincial government have had more leeway to negotiate the specialty mix and training of physicians in Ontario, due to the existence of a concertationist policy network. Dr. Harvey Barkun, Associate Dean (Professional Affairs) at the Faculty of Medicine, McGill University, gives three reasons for the significant difference in the ratio of specialists and primary care physicians on Canada and the United States. He suggests that in Canada family medicine is a more “satisfying discipline,” since physicians know that they can provide services to the poor and be paid for them under the universal comprehensive health care system. Canadian physicians are not as motivated to become specialists as their American counterparts, because they are not saddled with as high a level of student debt when they graduate and there is not as wide an income gap between most specialties and family medicine. The medical schools in Canada have departments of family medicine that have gained more respect from academic colleagues.220

Perverse incentives in the Medicare funding of Graduate Medical Education (GME) led to the training of more California specialists, and fewer primary care physicians, than were needed. Until 1997, hospitals were encouraged by the design of the Medicare program to try to recruit a large number
of residents because, by hiring many, they would augment their level of funding, even if the specialists that they were training were not needed in the marketplace. The institutional bias of the Medicare program and the traditional culture of academic medicine, that valued "departmental autonomy, a decentralized decision-making structure based on consensus and a commitment to the primacy of education and research," led to most specialists being trained in a hospital setting. Residents would have been better prepared to meet the needs of managed care patients if they had received more training in an ambulatory setting. The Council on Graduate Medical Education found, in 1992, that there were powerful disincentives in the Medicare GME policy that prevented managed care organizations from training physicians.22 The American policy of making specialty training more readily available in a hospital setting contrasts with the situation north of the border, as Harvey Barkun noted:

Once a resident in registered as a postgraduate student in a university-based accredited training program in Canada, the resident is paid regardless of the location of the training site. This policy has permitted programs to extend the educational experience outside the traditional teaching hospital wherever appropriate.23

Thus, the disjunction between Californians' needs and the mix and training of the workforce could be partially traced to the policies of institutions, which have remained in place long after they had outlived their usefulness, and the lack of a concertationist network between the government and the medical profession that might allow for the development of policies that are more receptive to the needs of physicians and patients.
The exponential growth in the number of specialists that resulted has reduced physicians' corporate autonomy. California specialists, who have often been trained outside the state, compete ferociously for managed care contracts. The few managed care organizations that dominate the market can virtually dictate the terms of the contracts because there is a surplus of specialists willing to accept them.

Ontario and California have consistently faced the problem that their physicians are poorly distributed. In Ontario, underserved populations are to be found mainly in rural and remote areas, but in California, many Latinos and blacks are underserved, even if they live in large cities. Why has the maldistribution of doctors been mainly a geographical problem in Ontario, whereas in California, it has taken on racial overtones as well?

In Ontario, medical services have been perceived as a universal right, offered to all citizens regardless of their age, race, place of employment and health status, yet there are significant geographic disparities in the medical care that patients receive. The provincial government has been strong and interventionist enough to influence some physicians to practice where they are needed, through its control of their fee schedule, and through its negotiations with key representatives in the Professional Associations of Internes and Residents of Ontario and the Ontario Medical Association. The government has successfully encouraged some physicians to practice in geographically remote areas, by offering to increase their level of reimbursement or by threatening to lower their pay if they locate in overserved metropolitan centres. The existence of a
concertationist network has provided the medical profession with opportunities to influence the distribution policy that the government pursues and the incentives that it offers physicians to practice in rural and remote areas. Nevertheless, the geographic maldistribution of Ontario physicians remains a significant problem because physicians ultimately have the freedom to set up practices where they choose, and many are attracted to the amenities that the cities offer.

In California, physicians have a financial disincentive to provide medical services to the uninsured and Medi-Cal patients, who are often ethnic minorities, because they will not be adequately reimbursed for their efforts. Since the risks of providing health care to the financially disadvantaged are not evenly shared across society, physicians may end up carrying a disproportionate share of the burden for providing medical care to patients, who lack sufficient means to purchase it on the market. Physicians know that they are more likely to make a profit from their medical practices in highly populated areas, catering to individuals and groups who are privately insured. Hence, it is difficult for the federal and state government to lure physicians and managed care organizations to set up practices in underserved areas.

Universal health insurance does not exist because many politically influential Californians consider medical care to be a consumer good that is primarily the responsibility of individuals and employers, and the state only in the case of the old, poor and disabled. The pluralist policy network that has developed has not encouraged members of the health policy community to engage in long-term planning and coordinate their efforts for the extension of health care
to the underserved. Instead, it has produced health policy that is reactive and the product of well-organized interest groups vying against each other to further their own self-interests.

2. Control of medical research.

Physicians' control over medical research has diminished since the 1960s, in Ontario and California, as academic physicians have become more dependent on the private sector as the source of funding for their research projects. The private sector has been able to play a growing role in research because the universities, hospitals, research centers and medical professors have welcomed the money to compensate for insufficient funding by the government. Although some medical journals, like the Canadian Medical Association Journal and the New England Journal of Medicine, have had policies in place to ban editorials that were biased towards drug manufacturers, they have had difficulty maintaining them because so many doctors have links to the companies.224

The rise of private sector funding for research has reduced physicians' ability to conduct the projects of their choice and disseminate their findings. This is particularly the case in California, where for-profit Institutional Review Boards face potential conflict of interest situations. For-profit IRBs risk losing business if they do not approve projects, even though the projects may compromise the safety of the research subjects.225

Thus, control over medical research has drifted away from physicians in Ontario and California as research ethics boards replace the medical profession as the decisionmakers on the matter of which research projects to approve, and
pharmaceutical companies replace or complement the government as the source of funds. The concertationist network between the medical profession and government in Ontario has not helped the profession maintain its earlier control over the ethics review of clinical drug trials, in recent decades, in the wake of "an international trend toward legislative or regulatory control over the conduct of medical research involving human subjects." 226

3. The existence of a professional code of ethics.

Both the Canadian Medical Association and the American Medical Association have longstanding policies of publishing professional codes of ethics. Codes of ethics outline the consensus within the associations about general principles that underlie their policies. However, neither the Canadian Medical Association, nor the American Medical Association, makes a practice of penalizing physicians for not honouring the code of ethics.

In Ontario, the key values and goals embodied in the code of ethics are better preserved than in California. Most Ontario doctors continue to be viewed by their patients as deserving of trust because they have a lot of clinical autonomy to provide medical treatment to their patients when they judge that it is warranted.

California doctors' values, decisions and competence are often treated as suspect, 227 since many face financial constraints that interfere with their ability to care for patients (see chapter 4). Utilization reviewers of managed care plans, who are sometimes physicians, have been known to deny medically necessary health care to patients without even examining them. 228 Medical associations do not often hold physicians accountable for contravening the code of ethics, when
physicians' allegiance to managed care plans leads them to make decisions that do not respect their patients' interests.

4. **Control of licensing, accreditation, credentialing, and quality assurance.**

In Ontario, which is closer to the ideal type of a profession-based health care system, the medical profession has retained much tighter control over licensing, accreditation and credentialing than in California, where many players have a role in these processes. The Ontario Medical Association and the College of Physicians and Surgeons of Ontario play a key role in overseeing health care quality assurance in the province. The expansion of the medical profession's corporate autonomy in the area of quality assurance has not come at the expense of physicians' clinical autonomy. Both have been preserved, since individual practitioners can exercise their own discretion in implementing the guidelines that the medical profession endorses.

In California, many public and private bodies are involved in accrediting health care programs and institutions and in credentialing physicians. The California Medical Association has had to struggle to try to ensure that decisions regarding accreditation and credentialing are made on the basis of quality of care and not just economics. If physicians provide few services to uninsured and low-income patients, who are disproportionately black and Hispanic, managed care organizations are more likely to rank their performance highly and retain them. Therefore, California physicians' lack of control over the credentialing process means that they have diminished autonomy with regards to choosing their patients and making decisions about the allocation of health care resources as well.
The state and federal governments and managed care organizations have diminished California physicians’ corporate and clinical autonomy in the area of quality assurance, as well. Many public and private sector organizations have taken a proactive role in developing clinical guidelines. Some like the Foundation for Accountability are geared towards consumers. Others, like the American Medical Group Association, view medical groups as their target audience. The merits of measurement are widely touted, but it remains to be seen if the effort put into generating comparative quantitative data on patients’ outcomes is well spent, or if it could be better spent directly on healing the patients. Harold Bursztajn and Richard Sobel of Harvard University have been critical of the growth of health care data banks, which are used to develop clinical guidelines and strengthen quality assurance, since they may threaten patient confidentiality. They write:

The proposed data collection and documentation subject patient care to nonconsensual and, at best, experimental influence and manipulation, because the usefulness of databases is unproven. For the government to impose what amounts to an experimental health care practice by assuming that care should be organized so that its outcomes are “measurable” is contrary to the goals of accountability, ethical concerns, and high-quality care.231

Ironically, the government has embraced evidence-based medicine with little empirical evidence that it improves quality and lowers costs. In the process of imposing their version of credentialing and quality assurance, purchasers have been known to interfere with physicians’ freedom to make decisions that are clinically appropriate for their patients. As David Barton Smith, the author of Health Care Divided: Race and Healing a Nation, eloquently observes:
Managed-care plans now impose requirements on medical practices and hospitals that the implementers of the Medicare program would never have dared to dream about. Purchasers, whether contracting for services for private employees or for public beneficiaries in the Medicare or Medicaid programs, now call the shots. They set the rules of the game that define the self-interest of the providers.  

5. Control of physician discipline and liability.

Physician autonomy in the area of discipline and liability has eroded over the past three decades in Ontario and California. However, it has been better preserved in Ontario, under a professional model of accountability, than in California, under an economic model. In Ontario, the CPSO has retained its independence from government and its role as the only regulatory body that can discipline doctors. In contrast, the medical profession’s regulatory body has been subsumed by the California state, thereby reducing physicians’ disciplinary control. The Medical Board of California is housed within the Department of Consumer Affairs of the State and Consumer Services Agency. The attorney general’s office makes the decision about whether to refer the case to the Division of Medical Quality for disciplinary action or to the local district attorney for criminal prosecution. The role of the public on the committees of the CPSO and the MBC has expanded, but in California, information about disciplinary actions against doctors is more readily accessible on the website.  

The managed care organizations, rather than the regulatory bodies, impose the heaviest penalties on physicians for incompetent or unethical conduct. The MCOs can refuse to hire physicians, and thereby limit their access to patients. The CMA has successfully sponsored legislation to protect physicians from
termination from managed care organizations for protesting utilization review decisions. Nevertheless, the California medical profession can never turn back the clock to the days when it was taken for granted that the regulatory board had the right to discipline physicians without a plethora of outside reviewers and public spectators watching over the process.

The California Medical Association has managed to preserve MICRA since 1975. The MICRA legislation has saved physicians millions of dollars that they would otherwise have had to pay in malpractice insurance premiums. While the preservation of MICRA has been one of the CMA’s most important achievements, the medical profession in California has still not retained as much control over physician discipline and liability as its Ontario counterpart because the rate of lawsuits for malpractice is much higher. Californian victims of iatrogenic injuries are dependent on gaining huge settlements to ensure that they can pay their living expenses, since they do not have access to a universal health system. California physicians are also more vulnerable to lawsuits than Ontario physicians because they are expected to practice at the same standard of care as fee-for-service physicians, even if they serve managed care organizations that limit their resources. As has been discussed, the courts have interpreted ERISA to mean that state suits on self-insured plans are not allowed and federal suits can only recover the cost of the denied services. In order for patients, covered by self-insured plans, to have any hopes of gaining a generous reward to compensate them for iatrogenic damages, they must sue their physician. Thus, California physicians have lost some of their control over discipline and liability under the
managed care model, because the judiciary has interpreted the ERISA law in a way that encourages victims of iatrogenic injuries to hold physicians responsible for negligent decisions, and lets managed care organizations hide behind the law.


Physicians’ rights in hospitals have declined in Ontario, but they have declined even more in California. In Ontario, Premier Harris used legislation in the form of “Bully Bill” 26 to deprive physicians of their right to damages if their hospital privileges were revoked, as the Health Services Restructuring Commission (1996-2000) overhauled the system with little input from doctors. Nevertheless, the HSRC was careful to solicit physicians’ goodwill, since the medical profession had been engaged in a longstanding concertationist relationship with the government. The HSRC set up a fact-finding team on physician human resources that was receptive to the OMA’s positions on physician workforce adjustment.236

In California, commercial exploitation has made it difficult for physicians to find a hospital where their work is properly valued and quality of care is preserved. In the turbulent marketplace, physician groups try to undercut each others’ bids in order to win exclusive contracts, even if it means that their performance is barely acceptable rather than of the highest quality.237 Hospitals are no longer seen as the physicians’ “temple of healing.”238 Instead, they are being held to a higher standard of evidence, as health-care purchasers require proof in the form of outcomes research that managed care is delivering a competitive product. Thus, California physicians’ hospital rights have declined as
the managed care organizations that contract with hospitals have forced physicians to accept suboptimal working conditions. Since there is an oversupply of California specialists, they have been eager to sign contracts under any conditions. The antitrust laws have prevented physicians from presenting a united front to resist unfair conditions imposed by managed care plans.

7. **Representation rights.**

Representation rights may be the aspect of professional autonomy that best shows that “the mighty have fallen.” Ontario physicians disdained binding arbitration rights when Justice Hall first suggested them. However, when physicians realized that they had limited strike power, binding arbitration appeared more attractive to them than the alternative of the government unilaterally imposing the terms of their work.

Three decades ago, most California physicians would have considered unions to be a threat to their dignity as professionals. Today, they hail it as a victory that they have almost won union status. Since an increasing number of physicians are subject to the control of managed care organizations and fewer remain in private practice, it is important for physicians to try to preserve their autonomy by advancing their claims as “workers,” as well as by asserting their rights as “professionals.” Medical associations do not want physicians to become subordinate to nonphysician organizational hierarchies because it means giving up decisionmaking powers. At the same time, union status promises some physicians more negotiating clout than they currently have.
This, then, is a comparison of corporate autonomy in Ontario and California since the late 1960s. The medical profession has lost some of its control over physician supply and distribution, research, accreditation, quality assurance and discipline in the two jurisdictions. Physicians' rights in hospitals and representations rights have also declined. Nevertheless, the Ontario medical profession has been better able to defend its interests than its California counterpart because the institutional apparatus within which physicians are regulated has locked in a system that has stunted the growth of the private insurance and business interests in the health sector. The Ontario government has not constrained the corporate autonomy of physicians to the extent that third-party payers have restricted corporate autonomy in California. Instead, a concertation policy network has developed between the government and the medical profession. Government officials and members of arm's-length bodies (e.g., the Health Professions Legislation Review and the Health Services Restructuring Commission) ask leaders of organized medicine for their advice on "physicians' issues;" however, their opinions on elements of health policy that more indirectly concern them no longer carry as much weight as they once did.

In California, the political and institutional setting provides few opportunities for major health reform. The institutions and interests are so fragmented that it is difficult to pass comprehensive health care proposals. In the absence of a universal publicly financed health system that minimizes the role of private insurers and business interests, third-party payers are drawn into the struggle to shape the health policies that affect physicians' corporate autonomy. In this pluralist free-for-all, it has been difficult for the medical profession to retain the remnants of its status as a self-regulating guild.
Consequently, its corporate autonomy is challenged on every side: by pharmaceutical companies, wanting to ensure that medical professors publish research studies that make positive references to their products; by consumers, eager to find doctors with untainted performance records; and by third-party payers, wanting to cut medical costs even if it means physicians' freedom to set their own standards is in jeopardy. The next chapter will compare physicians' struggle to maintain their clinical autonomy (i.e., keep other actors from interfering in the patient-physician relationship) in Ontario and California since the late 1960s.
"Corporate autonomy" is professional autonomy at the corporate level, as opposed to the individual physician level.


3 See Takagi, 1996, pp.74-77 for a discussion of the value of an institutional perspective for understanding the medical profession's quest for autonomy.


5 There are discrepancies in the medical manpower databases in Ontario. In 1996, the number of Ontario family physicians ranged from a low of 9,433 according to the Full-Time Equivalent Methodology to 10,926 using the Ministry of Health Method — a variance of 1,493 (14%). See The Ontario College of Family Physicians, Where Have Our Family Doctors Gone? #4 The Future is Now! 1999.

6 Michael Whitcomb has suggested that it is difficult to draw cross-national comparisons about whether or not the size of a country's physician workforce is adequate because we lack sufficient data about the effectiveness of health care systems. See "A Cross-National Comparison of Generalist Physician Workforce Data: Evidence for US Supply Adequacy," JAMA, Vol.274, No.9, September 6, 1995, pp.692-695.


8 In Ontario, the medical profession has been slower to acknowledge an oversupply of physicians and quicker to acknowledge an undersupply than prominent health economists. For example, Morris Barer and Greg Stoddart's report entitled Toward Integrated Medical Resource Policies for Canada prompted fierce resistance from the Canadian Medical Association. Physicians particularly disliked the recommendation that

Studies have found that it is difficult to establish a definite connection between an undersupply of physicians and a lack of access to care for patients. See Kathleen Lohr, Neal Vanselow, and Don Detmer, eds., The Nation's Physician Workforce: Options for Balancing Supply and Requirements, (Washington D.C.: Institute of Medicine, 1995), p.3. A lack of health insurance may be a more important reason that parts of the urban population in California are underserved, according to empirical evidence collected by Kevin Grumbach, Karen Vranizan and Andrew Bindman, "Physician Supply and Access to Care in Urban Communities," Health Affairs, Vol.16, No.1, January/February 1997, pp.71-86.


Ronald Hamowy, Canadian Medicine: A Study in Restricted Entry, (Vancouver: Fraser Institute, 1984).


Matt Borsellino, Medical Post, April 8, 1997.


A study in The New England Journal of Medicine demonstrated that physicians' financial relationships with the pharmaceutical industry pose potential conflicts of interest. In the case of authors who published articles on the safety of calcium-channel antagonists there was a strong association between their relationships with pharmaceutical manufacturers and their assessment. See Henry Thomas Stelfox, Grace Chua, Keith O'Rourke and Allan Detisky, "Conflict of Interest in the Debate Over Calcium-Channel Antagonists," The New England Journal of Medicine, Vol.338, No.2, January 8, 1998, pp.101-106.


In 1868, the Canadian Medical Association asserted that "A patient should, after his recovery, entertain a just and enduring sense of the value of the services rendered him by his physician; for these are of such a character that no mere pecuniary acknowledgement can repay or cancel them." Origin and Organization of the Canadian Medical Association with the Proceedings of the Meetings held in Quebec, October 1867, and Montreal.


23 Quality assurance could be examined under the rubric of professional autonomy or clinical autonomy because it impacts upon the collective and individual aspects of physician decisionmaking. Clinical guidelines can increase physicians’ collective autonomy since they represent a group of physicians’ consensus about treatment for a disease. Nevertheless, they can also undermine an individual physician’s autonomy if the guidelines are used as a substitute for the treating physician’s medical knowledge.


26 Ronald Hamowy, Canadian Medicine: A Study in Restricted Entry, (Vancouver, Fraser Institute, 1984), p.xii.


Under the Primary Care Practitioner Incentive Act, which was part of the Balanced Budget Act of 1997, Congress gave nurse practitioners and clinical nurse specialists the right to receive Medicare reimbursement directly. See Peter Jacobson, Louise Parker and Ian Coulter, "Nurse Practitioners and Physician Assistants as Primary Care Providers in Institutional Settings," Inquiry, Vol.35, No.4, Winter 1998/1999, pp.432-446.


Ontario physicians are "on the government payroll" but they generally do not have holiday and pension benefits through OHIP.


The 1998 physician-population ratio was 1:558. See The Ontario College of Family Physicians, Where Have Our Family Doctors Gone? #4 The Future is Now! 1999.


The Ontario College of Family Physicians, Where Have Our Family Doctors Gone? #2 Reversing the Trend, June 1999.

The Canadian Medical Forum makes recommendations on physician supply and health care organization. It is a coalition of the Association of Canadian Medical Colleges, the Association of Canadian Teaching Hospitals, the Canadian Association of Internes and Residents, the Canadian Federation of Medical Students, the Canadian Medical Association, the College of Family Physicians of Canada, the Federation of Medical Licensing Authorities of Canada, the Medical Council of Canada, and the Royal College of Physicians and Surgeons of Canada.


The contributors to the Consensus Statement on the Physician Workforce released in 1997 were American Association of Colleges of Osteopathic Medicine, American Medical Association, American Osteopathic Association, Association of Academic
Health Centers, Association of American Medical Colleges and National Medical Association.
64 A 1994 survey found that “Only 31% of physicians accept new Medi-Cal patients, compared to 77% who accept new patients with private insurance and 43% who accept new uninsured patients who were unable to pay full fees.” See California Medical Association, *Improving Access to Health Care for Medi-Cal Patients*, April 2000.
70 The Board of Medical Examiners in California was established in 1876. It was renamed the Board of Medical Quality Assurance by the Knox Keene Bill in 1975 and, in
1990, it became the Medical Board of California, which people thought was "a more dignified name than 'BUMQUA.'" See Linda A. McCready and Billie Harris, From Quackery to Quality Assurance: The First Twelve Decades of the Medical Board of California, (Sacramento: Medical Board of California, 1995), p.63.


74 "ACP, other groups ask AMA to get out of credentialing," ACP-ASIM Observer, 1998.
77 Daniel J. Kraftcheck, "Implementing the Quality Improvement Component of the College's Strategic Plan," (Toronto: College of Physicians and Surgeons of Ontario, April 1, 1998).
84 If "the case stands on its own merit," than the standard of evidence that is needed is lower than if it did not because it is not as necessary for the plaintiff to find an expert witness (i.e., doctor) willing to testify against the defendant who may also be a doctor.
86 Albert J. Lipson, Medical Malpractice: The Response of Physicians to Premium Increases in California, (Santa Monica, CA: Rand, November 1976), R-2026 Post-Secondary Education Commission, p.6.
94 Committee of Interns and Residents, CMA and CIR Sign Mutual Endorsement Pact, 1999.
95 Michael Myerson, A Brief CIR History, Housestaff Unions: Then and Now, Committee of Interns and Residents, 1999.
98 Ross Matthews, pp.649-653.
100 The Ontario College of Family Physicians, Where Have Our Family Doctors Gone? #1 A Brief History of the Family Physician Shortage in Ontario, 1999.
101 The Ontario College of Family Physicians, Where Have Our Family Doctors Gone? #4 The Future is Now! 1999.
105 The Ontario College of Family Physicians, Where Have Our Family Doctors Gone? #4 The Future is Now!
106 Morris Barer, Laura Wood and David Schneider provide a comprehensive discussion of Ontario programs designed to retain physicians in underserved communities. See Barer, Wood and Schneider, Toward Improved Access to Medical Services for Relatively Underserved Populations: Canadian Approaches, Foreign Lessons, (Vancouver: Centre


108 Carlos Martini, “Medical Workforce Planning and Medical Education: Attaining Consensus,” JAMA, Vol.270, No.9, September 1, 1993, pp.1101.


118 In September 1999, the media reported that the University of Toronto president Robert Prichard wrote a letter to several federal ministers requesting that the government give a 30-day extension to a review of drug-patent protection regulations. Apotex urged him to write the letter on behalf of the drug firm. They indicated that changes in the regulations jeopardized their ability to give $20 million to the University of Toronto for a new research centre in addition to $35-million worth of other donations. Krista Foss and
Nicola Luksic, "Lobbying for a Donor Drug Firm a Mistake, U of T Head Admits," 

118 Nuala P. Kenny, "The CMA Code of Ethics: More Room For Reflection," Canadian 

119 "Response from profession strengthens draft Code of Ethics," CMA News, Vol.6, 
No.7, 1996, p.3. See also Douglas M. Sawyer and John R. Williams, "After 4 Years' 
Work, Revised Code of Ethics Goes to General Council For Decision," Canadian 

1120 Nuala P. Kenny, "The CMA Code of Ethics: More Room For Reflection," Canadian 

1121 Although the Canadian Medical Association does not explicitly address the issue of 
whether physicians are expected to report their iatrogenic errors, the law is clear. 
"Unexpected deaths possibly relating to experiments must be reported within seven days. 
After that, the deaths, or other 'adverse events' are reported to ethics boards, which can 
change consent forms to include new information to help patients make more informed 
choices." See Natalie Southworth, "Toronto Death Raises Questions About Risks of 

1122 Gillian Wansbrough, "CPSO: Restricted licensure considered in Ontario," The 

1123 Alan Freeman, "Canadian College took years to strip doctor of credential," Globe and 

1124 The Royal College of Physicians and Surgeons of Canada, Invitational 
Workshop/Symposium: Specialized Physician Resources for Remote/Rural Regions and 

1125 Jim Maclean, Report on Council Meeting, June 17 and 18, 1999, (Toronto: College of 

1126 Susan Rappolt, In the Name of Science: The Effects of the Clinical Guidelines 
Movement on the Autonomy of the Medical Profession in Ontario, Ph.D. diss., 
University of Toronto, 1996, p.iii.

1127 Broadly-speaking, the medical profession and government are the two groups 
involved in designing clinical guidelines in Canada but there were actually about 40 
different groups comprising physicians, academics, and bureaucrats that contributed to 
the development of guidelines in 1994. See "Wait For It, Your New Guidelines to 

1128 Canadian Medical Association, "Care Maps Complement Clinical Judgement," CMA 

1129 See Daniel Leblanc and Edward Greenspon, "Provinces Dithering About Agreement 
Toronto professors, George Pink, Sandy Leggat and Michael Murray made scorecards on 
ten Toronto hospitals noting variations in management practices, hospitals' finances and 
patient satisfaction. See Lisa Priest, "We're Flying Blind Over Tests on MDs," The 

1130 Hugh Scully, who is currently the President of the Canadian Medical Association, 
notes that in 1980 physicians had a 1/53 chance of being named in litigation, whereas 
today the risk in 1/21. Malpractice fees have increased 881 percent over 13 years for


144 The Ontario College of Family Physicians, Where Have Our Family Doctors Gone? #3 Hospitals Without Family Physicians, 1999.


Southam Medical Database, Ontario. (Ottawa: Canadian Institute for Health Information, 1996-2000).
Pew Commission, California Needs Better Medicine: Physician Supply and Medical Education in California, (San Francisco: Center for the Health Professions, 1997). The Pew Commission recommended reducing the number of specialist residency positions by at least 25 percent and expanding opportunities for underrepresented minorities and for education in underserved areas.
The Physician Payment Reform Commission cautions against exaggerating the extent to which market forces have reduced the demand for physicians in the United States. They expect that it will take a long time before the effect of the growth of managed care alters the labor market for physicians. See “Competition Has Only Modest Impact on Physician Work Force,” PPRC Update, No.12, March 1997.
Center for Health Care Professions, California Needs Better Medicine: Physician Supply and Medical Education in California. (San Francisco: Center for Health Care Professions, 1997).


A white student successfully claimed in the Supreme Court in 1978 that he was unfairly discriminated because of the existence of race-based quotas at the University of California medical school. See “Minority Physicians Fill Critical Need in California,” *Nation's Health*, Vol.26, No.6, July 1996, p.8.


Kevin Grumbach, Elizabeth Mertz and Janet Coffman, Underrepresented Minorities and Medical Education in California: Recent Trends in Declining Admissions, A report by the Center for California Health Workforce Studies at the University of California, San Francisco, (San Francisco: University of California, March 1999).


The pathways to licensure as a California physician are 1) the National Board; 2) graduates of Medical Schools in the U.S., Canada, Puerto Rico, of the American University of Beirut who are not National Board Diplomates; 3) reciprocity; 4) special reciprocity; 5) United States citizens who are foreign medical graduates; 6) foreign medical graduates; 7) outstanding physicians holding academic positions on a temporary basis; and 8) other faculty positions held by physicians. See Board of Medical Quality Assurance, Department of Consumer Affairs, Division of Licensing, Pathways to Licensure As A Physician and Surgeon in California, March 1980.


Patricia Danzon summarized the conclusions that emerge from the CMA study:
"First, if the California experience is typical, the risk of injury due to negligent medical care is not trivially low: 1 per 126 hospital admissions in 1974. If this risk were uniform nationwide, it would imply a total of more than 260,000 negligent injuries per annum. Second, at most 1 in 10 incidents of malpractice resulted in a claim at the height of the malpractice crisis, and at most 1 in 25 received compensation." Medical Malpractice: Theory, Evidence and Public Policy, (Cambridge, Mass.: Harvard University Press, 1985), p.25.

Albert J. Lipson, Medical Malpractice: The Response of Physicians to Premium Increases in California, prepared for the California Post-Secondary Education Commission, R-2026, PSEC, (Santa Monica: RAND, November 1976), v.


Linda McCready and Billie Harris, From Quackery to Quality Assurance: The First Twelve Decades of the Medical Board of California, (Sacramento: Medical Board of California, 1995).
Cindy Pauline Evans, Disciplinary Actions By the California Medical and Psychology Boards: Comparable Treatment of Injustice for Mental Health Professionals? Ph.D. diss., (California School of Professional Psychology, Fresno Campus, 1997), p.85


Superior Court of the State of California for the City and County of San Francisco, Case No. C993954.


Maurice Penner, Managed Care in California, (Chicago: Health Administration Press, 1997), p.36.


The rate at which physicians are disciplined in California is now 20 percent over a 20-year career according to the California Medical Association or 4 percent according to the disciplinary actions listed on the Medical Board’s website. Tom Philp, “CMA’s Discipline Rate for Doctors: 20% - or 4%?” Sacramento Bee, May 28, 1999.

“Canadian physicians are only 20 percent as likely as their American counterparts to be sued for malpractice.” See Karen Capen, “Prevention Should Be the Preferred Insurance Program for all Physicians,” Canadian Medical Association Journal, Vol.154, No.9, May 1, 1996, pp.1385-1387.


CHAPTER 3

CLINICAL AUTONOMY

Clinical autonomy is a simpler concept than corporate autonomy, which was explored in chapter 2. In this chapter, I define clinical autonomy, compare the goals of the medical profession in Ontario and California, and describe the primary changes since the late 1960s. Then I combine a historical institutionalist and policy network approach to explain why clinical autonomy is less threatened in the context of the publicly funded system in Ontario, than in California’s managed care system.

As we saw in the last chapter, a strong state and a concertation network between the medical profession and the state have strengthened the professional autonomy of Ontario physicians by facilitating the development of universal health insurance. Clinical autonomy is better preserved in Ontario because the interests of physicians and patients are likely to more closely coincide under a single payer system, than under a system with multiple payers. In California, multiple payers have acted as a wedge in the physician-patient relationship. Primary care physicians, who are part of managed care organizations, have a dual and sometimes conflicting role: as gatekeepers to limit patients’ access to specialists and costly treatment options, and as patients’ advocates. In Ontario, organized medicine was unified enough to resist the use of clinical guidelines to reduce clinical autonomy by lobbying for individual practitioners to make the crucial decisions about how the guidelines would be implemented. In California, physicians’ interests were too fragmented to mount an effective opposition to the many strategies that managed care organizations employed for making physicians more cost-conscious.
including capitation, utilization review, clinical guidelines, and financial incentives, such as bonuses and withholds, and risk-sharing.

THE MEANING OF CLINICAL AUTONOMY

Some physicians consider clinical autonomy to be at the heart of physician autonomy. They believe that the sacredness of the patient-physician relationship is jeopardized if the clinical autonomy of physicians is not preserved. If insurers, governments and health plans assume the role of arbiters of the patients' fate, patients lose their ability to trust that physicians can effectively arbitrate on their behalf. When clinical autonomy is intact, physicians have the freedom to make decisions about the acceptance of patients, their diagnosis and treatment and the confidentiality of their records without interference from third parties.

Gloria Engel defined "autonomy on the individual level," which I refer to as clinical autonomy, as "the professional's self control over both his [sic] decisions and his [sic] work activities within a particular work setting, or his [sic] freedom to deal with his [sic] client." In 1968, she submitted a thesis at the University of California, Los Angeles in which she showed that "a moderately bureaucratic setting provides greater autonomy for the professional than either a highly bureaucratic or a non-bureaucratic setting." Physicians in a moderately bureaucratic setting had the benefit of sharing the costs of their physical facilities with other physicians, but were not subject to the same degree of hierarchic controls and rigid regulations as physicians in a highly bureaucratic setting. Engel found that physicians had the least autonomy in a highly bureaucratic setting, whereas they had a moderate level of autonomy in a non-bureaucratic setting or single
practitioner setting. She could not have anticipated the extent to which even physician-driven organizations, such as Kaiser Permanente Health Plan, would interfere with the clinical autonomy of California physicians over the next three decades.

1. **Control over the acceptance of patients.**

   The issue of physicians' control over the acceptance of patients is closely linked with the patients' right to choose physicians and with the patients' access to health care services. Theoretically, a physician may be able to accept any patient. However, a physician's ability to provide services to a patient will be limited if the patient is not covered by comprehensive health insurance, if the patient cannot afford necessary prescription drugs, or if there are long waiting lists for specialist referrals, surgical or hospital care, or diagnostic tests or procedures.

   Physicians contend that they should be free to decide which patients to accept and which to reject. Fee-for-service practitioners are better able to maintain continuity of care with their patients than doctors who work for health maintenance organizations. The latter usually renew their relationships with their patients on an annual basis. Since the health maintenance organizations do not want to risk losing money, they may be unwilling to hire or retain physicians with a history of catering to patients with chronic disabilities, whose treatment is costly (e.g. AIDS patients).

   The medical profession tries to limit the ability of HMOs to hire physicians selectively and terminate their contracts unilaterally. Physicians tend to support "any willing provider" legislation (that would require networks and organizations
to hire any physicians willing to accept their terms of employment), and legislation that prevents managed care organizations from terminating physicians without cause. If managed care organizations refuse to contract with some physicians, those physicians lose the opportunity of treating the patients associated with the plans, even if the patients would value their services. Another threat to physicians' ability to choose their own patients is the financial insolvency of health plans. If managed care plans face financial failure, physicians may be unable to retain their relationships with their patients.

Managed care organizations can pressure primary care physicians to treat patients for ailments that in a traditional health system would have been treated by specialists. In that situation, primary care physicians are forced to choose between refusing to treat the patients, and thereby risking that the directors of the health plan will be displeased with them, or treating the patients, and risking malpractice exposure for practicing beyond their skill level.

2. *Control over diagnosis and treatment by physicians.*

As part of their clinical autonomy, doctors seek to control the nature and volume of their tasks. They assert the right to communicate freely with patients and inform them of the full range of treatments available, not just the ones covered by their health plans. In a traditional model of health care, where clinical autonomy is preserved, physicians' relationships with their patients are direct and they can provide them with unconstrained referrals. In a managed care model, peer physician managers or other staff may review the treating physicians'
decisions about referrals and treatment patterns and discourage them from making referrals outside the organization.

The impact of utilization review on physician autonomy can be mixed. Mark Schlesinger, Bradford Gray and Krista Perreira have identified four ways in the literature that utilization review is thought to threaten physician autonomy: by presenting a direct challenge to their authority; intruding on their decisionmaking and increasing their paperwork; forcing them to standardize their treatment; and altering their professional ethics to make them more business-oriented and less scientific. These researchers determined that standardization presented the most pressing problem. Utilization review, conducted by licensed physicians, can also strengthen physician autonomy in ways that are often overlooked. It can help physicians to eliminate harmful practices and it can provide physicians with information that they can pass on to their patients, who can then make more informed decisions.  

Some physicians consider the option of using complementary medicine to be an essential part of their clinical autonomy. However, the medical profession may contest the right of individual practitioners to experiment with alternative medicine that is not sanctioned at the corporate level, because it seeks to standardize treatment protocols. Managed care organizations tend to favour the least expensive treatment option. Since allied health professionals provide services at a lower cost than doctors, they are more integrated into the delivery of services in managed care plans than in traditional indemnity insurance plans. Thus, the interests of physicians and managed care organizations may be very
different, with regards to the issue of diagnosing and treating patients, although there are invariably some areas of overlap.

3. **Ownership of patients' records.**

Physicians are expected to keep the details of their patients’ medical records confidential in order to maintain their trust. The Hippocratic Oath states that “Whatsoever I shall see or hear in the course of my profession . . . I will never divulge, holding such things to be holy secrets.” It was easier to preserve the confidentiality that is at the heart of the physician-patient relationship before a host of intermediaries became intent on gaining access to that information.

Physicians have traditionally assumed that they “own” patients’ records since they are the ones that produce and store them. Over the past three decades, their ownership of medical records has been challenged on every side. Patients have become more assertive about demanding to know the contents of their medical records and the courts have recognized their right to the information. Health plans have expected access to more and more “confidential” information so that they can be aware of consumers’ medical histories before providing them with insurance or treatment. Some employers improperly try to discover people’s medical histories before they make decisions about hiring or promoting them. Governments have required physicians to open their medical records so that they can audit them for fraud and abuse, which in California is referred to as the Medi-Cal program’s “billion-dollar” problem. The problem of fraud and abuse will be explored in chapter 4.
Advances in computer technology have made it possible for more people to have access to electronic records than have access to paper-based records. However, privacy features can be built into electronic medical records that make them safer than paper-based records and make it easier to identify who has read the records. If privacy regulations are not stringent enough, patients risk having intimate details of their lives released to interested parties, who may use them for discriminatory purposes. On the other hand, if privacy regulations are too stringent, medical researchers have difficulty gaining access to the information that they need to develop guidelines and determine the efficacy of case management methods.

THE GOALS OF THE MEDICAL ASSOCIATIONS

1. Control over the acceptance of patients.

The medical associations try to maximize physicians' freedom to accept or reject patients as they see fit. The Ontario Medical Association implicitly embraces the Charter for Physicians of the Canadian Medical Association. The Charter asserts that a physician needs "to be able to refuse to accept a patient, or to discontinue a professional relationship, except in emergency situations and consistent with the Canadian Medical Association's Code of Ethics."\(^{11}\)

California physicians can treat any patients, but they will not necessarily be reimbursed for their services. In order to be reimbursed under managed care, doctors must often obtain prior authorization from health plan reviewers. The California Medical Association defends physicians' right to treat any patients...
even undocumented ones, who were denied all except emergency medical care by Proposition 187 in 1994. The CMA opposes the right of health plans to terminate physicians without cause because this disrupts the relationship between the physician and the patient and can threaten patient confidentiality.

The American Medical Association makes several references to the issue of physician control over the acceptance of patients. The AMA states that any provider should have the right to appeal a managed care organization's decision that prevents them from participating in a plan. It opposes "any attempt to tie medical licensure to a physician's obligation to take part in any payment system or plan, including Medicare." 

2. Control over diagnosis and treatment by physicians.

The Canadian Medical Association asserts that physicians should have control over the diagnosis and treatment of their patients regardless of the changes that are made in the health care delivery system. According to the Canadian Medical Association Charter for Physicians, physicians need "to be free to inform patients of all appropriate options relevant to their care and to have clinical autonomy in recommending care."

Similarly, the California Medical Association states that patients should have freedom of choice for prescription drugs. It has lobbied to preserve physicians right to prescribe any drug, regardless of whether or not that drug is on the state's list of ones that are covered under public programs. The CMA suggests that physicians, not laypersons belonging to health plans, should be responsible for
utilization review. The American Medical Association identifies various aspects of clinical autonomy that it defends. It recommends that,

certain professional decisions critical to high quality patient care should always be the ultimate responsibility of the physician practicing in a health plan [including] when diagnostic tests are appropriate; when and to whom in-plan physician referral is indicated; when and to whom out-of-plan physician referral is indicated; when and with whom consultation is indicated; choice of in-plan service sites for specific services; frequency/length of office/outpatient visits or care; use of out-of-formulary medications; recommendations of patients for other treatment options, including non-covered care; [and] determination of the most appropriate treatment methodology.

3. Ownership of patients' records.

The medical profession in Ontario and California adamantly supports patients' rights to confidentiality, although it acknowledges that physicians have a duty to warn potential victims if patients threaten to kill or seriously harm a third party. The Canadian Medical Association has produced a Health Information Privacy Code, which it suggests should be the basis for legislation. In the Charter for Physicians, the Canadian Medical Association contends that physicians need "assurance that data generated by physicians in the context of clinical practice will not be compiled, sold, or otherwise used in a manner that compromises the privacy of patients or physicians, except as authorized by law." If physicians find themselves in a situation where they are legally required to reveal medical information because patients are at risk of harming themselves or others, the Canadian Medical Association advises them to disclose to their patients that their confidentiality will be breached.

The California and American Medical Association have assumed that the best way to ensure that physicians retain ownership of medical records is to lobby on
behalf of patient privacy and confidentiality. The American Medical Association supports the development of stringent regulations that would prevent medical records from being used for marketing practices. The proposed regulations would require law enforcement agencies to acquire court orders before gaining access to medical records that are not de-identified. “Whenever possible” even peer reviewers would have access to only de-identified medical records. The American Medical Association has also fought to prevent health plans from gaining the right of co-ownership of medical records that some of them, like Aetna, have coveted.

THE ONTARIO CASE

1. *Control over the acceptance of patients.*

   In Ontario, family physicians have a great deal of discretion over the patients they accept, relative to the California situation. However, quantitative data reveal that some Ontario specialists are dissatisfied with their level of control over patient admissions. Of 826 internal medicine respondents in Ontario, who were surveyed between 1992 and 1994, 26.1 percent indicated that they were satisfied with their control over patient admissions, but 41.8 percent indicated that they were dissatisfied. Their dissatisfaction may have been partially attributable to their concern about inappropriate referrals from family physicians or their inability to treat patients as quickly as they would like. There is currently a severe shortage of radiation oncologists, medical physicists and radiation therapists in Ontario, which makes it difficult for specialists to provide cancer patients with the
treatment that they need within the appropriate length of time. Only 38 percent of Ontario patients were seen within four weeks in September 1999. Approximately five hundred and thirty four cancer patients were sent to the U.S. for radiation treatment in 1999.

One way that Ontario physicians assert their clinical autonomy is by refusing to take new patients once they have reached the limit on their OHIP billings. Premier Harris has protested that this contravenes the spirit of the OMA agreement and physicians should lose their licenses for cutting back on services by refusing patients, but to date they have done this with impunity.

2. **Control over diagnosis and treatment by physicians.**

Physicians in Ontario have retained a great deal of control over the treatment of individual patients, even though the provincial government has taken some steps to constrain the utilization of medical services. The government has participated in the development of guidelines to decrease the inefficiencies presumed to accompany variations in service. However, as Susan Rappolt has argued, guidelines do not present a direct threat to clinical autonomy, because physicians still exercise discretion in the way that they implement them.

Government officials can influence the treatments that physicians offer by adjusting their schedule of benefits. Specialists may be forced to redefine the treatments that they offer or practice as family physicians if OHIP no longer covers their procedures. In order to stay within their budgets, government officials have refused to fund medical research and technology as generously as physicians
would like. This indirectly interferes with physicians’ control over their patients’ diagnosis and treatment.

Most Ontario physicians, who were surveyed by Richard Kravitz, Lawrence Linn and Martin Shapiro in 1987, were satisfied with their level of clinical autonomy. Only twelve percent of 635 respondents were “not very satisfied or very dissatisfied with their ability to meet the needs and demands of patients.” Seven percent were “dissatisfied with their ability to provide care of the highest quality.” Twenty-six percent were “dissatisfied with their ability to hospitalize patients when necessary and ten percent were dissatisfied with their ability to obtain clinically indicated diagnostic tests.” If a similar survey were conducted in 2000, Ontario physicians might be more dissatisfied with their control over patients’ diagnosis and treatment than they were in 1987. They lack the resources to provide patients with all of the services that they require, as Ontario’s population grows and ages, health care costs rise, and the federal government reduces its transfers to the provinces compared to what they would have been under earlier funding formulas such as the Established Programs Financing arrangements and the Canada Assistance Plan. Although a survey has not been conducted recently that would indicate Ontario physicians’ perceptions of their control over their patients’ diagnosis and treatment, the Commonwealth Fund has found evidence that Canadian generalist physicians (59% vs. 56%) and specialists (67% vs. 60%) are more likely than their American counterparts to think that their ability to provide quality care has worsened in the past five years. Canadian
specialists are also more likely to state that their nursing staff levels (66% vs. 64%) and emergency room facilities (62% vs. 26%) are “fair” or “poor.”

3. Ownership of patients’ records.

As early as 1977, a Royal Commission into the Confidentiality of Health Records was set up in Ontario, which gave startling information about the number of people, including police and insurers, which had easy access to them. It was estimated that on average 77 people in a hospital see a patient’s chart. Legislation was needed to protect the confidentiality of patients’ records, but which level of government should be primarily responsible? Many of the legal issues surrounding patients’ records have not been resolved in Canada, despite the efforts of both levels of government. Patient protection is lax and regulations are fragmented.

Two pieces of legislation exist that address the issue of the confidentiality of patients’ medical records in Ontario: the provincial Freedom of Information and Protection of Privacy Act, enacted in 1987, and the Municipal Freedom of Information and Protection of Privacy Act, which came into effect in January 1991. These are designed to protect personal information held by government organizations. However, they do not address the issue of health information privacy in the private sector.

Many people feared that the confidentiality of patients’ records was jeopardized, in 1996, when Bill 26 gave the Minister of Health new powers to inspect and disclose the medical records of any person in the province, in order to combat fraud. In 1996, Jim Wilson, the Conservative Minister of Health,
appeared committed to developing health information legislation for Ontario. His efforts never reached fruition. In December 1997, the Globe and Mail reported that Brett James, the special assistant for communications to the Minister of Health, Jim Wilson, disclosed that Dr. William Hughes, a Peterborough cardiologist, was one of the highest billers in the province. The Information and Privacy Commissioner submitted a special report to the legislature that concluded that it was impossible to know exactly what Brett James had said to the reporter. Nevertheless, it seemed that a disclosure had been made that violated the spirit of provincial legislation. The Ministry of Health's ability to protect confidential information was openly questioned and Wilson's medical confidentiality proposal was derailed.

The federal government introduced Bill C-54, the Personal Information and Electronic Documents Act, in 1998, to protect information in the private sector. The bill did not preclude the possibility that the provinces would introduce their own acts. Nor did it treat health care information as fundamentally different from other types of information that could more legitimately be used for commercial purposes.

The Canadian Medical Association has taken a proactive stance in trying to balance the competing issues at stake by participating in coalitions with the federal government and other organizations that study health privacy issues, like the Canadian Institute for Health Information. The CMA issued its own Health Information Privacy Code in 1996 that was more protective of patients' rights than the legislation that was currently in place.
The federal government has signaled its interest in health information networks by setting up a Canadian Population Health Initiative, following the National Forum on Health to operate as a national health surveillance network. In 1997, the federal government also set up the Advisory Council on Health Infrastructure to make suggestions about coordinating the health information systems across Canada. The Advisory Council estimated in its final report (1999) that the federal government would likely spend 1.5 billion on health information systems improvement. The Council recommended that legislation protecting personal health information should be standardized across the country. Federal Health Minister Allan Rock has indicated that he sees the value of electronic medical records but has no intention of coercing the provinces into adopting them. Until legislation is enacted and enforced that resembles the CMA's Health Information Privacy Code, patient privacy and the confidentiality of health records will not be adequately protected in Ontario.

THE CALIFORNIA CASE

1. Control over the acceptance of patients.

Physicians have had a more difficult time retaining their autonomy to accept patients in California than in Ontario in the 1990s. As Appendix G shows, the Robert Wood Johnson Foundation Surveys of Young Physicians in 1991 and 1996 found a substantial decline in the proportion of physicians who felt that they could afford to treat poor patients.

Only 67 percent of young California physicians in 1996 indicated that they had the freedom to care for patients who could not pay, and only 64 percent
indicated that they had the freedom to care for patients who required heavy time and resource commitment. These levels are down from 83 percent in 1991.\textsuperscript{35}

Governor Pete Wilson's policies were hostile to expanding health care services for illegal aliens. They reflected the animosity of many voters to providing social services to the poor.\textsuperscript{36} Proposition 187, which was passed in November 1994, would have denied illegal aliens the right to free health care and education even if they met the other criteria for the programs, if it had been put into practice and the federal court had not struck it down in 1998. The initiative would have required physicians to report illegal aliens to immigration authorities in order to cut down on public expenditures for state social services. Tal Ann Ziv and Bernard Lo observed that Proposition 187 could be expected to have a negative effect on clinical autonomy:

Doctors would relinquish their role as patient advocates. They would function as bureaucrats, employees, or government agents rather than as professionals with independent judgment and a code of ethics.\textsuperscript{37}

Proposition 187 was not implemented because lawsuits were immediately launched against it on constitutional grounds. Although the California Medical Association did not actually file any suits to the federal court, it did submit an amicus curiae brief in support of a suit. Governor Wilson retaliated by filing a nuisance suit against the CMA for questioning the constitutionality of Proposition 187.\textsuperscript{38} The State of California filed an appeal to stop the court from prohibiting the State Department of Health Services from interfering with the ability of undocumented women to receive publicly funded pregnancy care.\textsuperscript{39} The effect of Proposition 187 was that the number of immigrants seeking primary health care at
some clinics declined, apparently as a result of confusion over the status of the proposition,\textsuperscript{40} and the clinical autonomy of physicians to deliver care to patients was called into question.

In California, physicians' professionalism is also eroded by the managed care organizations' practice of making the final decision on whether or not a patient can see a particular specialist. Physicians risk losing their jobs if they spend what the health plans consider to be too much time treating the poor. Andrew Bindman found that "private doctors who take on the most charity cases are more likely to be shut out from HMOs than those who spend less time on the poor."\textsuperscript{41} A survey of young physicians conducted by the California Medical Association in 1995 found that of 1,141 respondents, more than one in four (27 percent) had been excluded from a physician panel at some time.\textsuperscript{42}

The California Medical Association has lobbied vigorously in support of "any willing provider" legislation that would force managed care plans to offer contracts to any physician meeting basic standards for participation. The CMA has also tried to prevent health plans from terminating physicians without cause. In 1990, the medical association successfully sponsored legislation that required health plans to give physicians explanations for their terminations, relating to quality of care. Nevertheless, some health plans continued to assert that their physicians were being terminated "without cause."\textsuperscript{43} In April 1997, a California appeals panel made the decision that doctors were entitled to a fair hearing when dropped by a health plan.\textsuperscript{44} Thus, managed care organizations have tried to limit physicians' ability to choose which patients to accept, but recent legislation has
begun to provide physicians with a more secure environment, where they can offer medical care.

2. **Control over diagnosis and treatment by physicians.**

   In California, the medical profession used to impose most of the restrictions on the clinical autonomy of individual practitioners in the hospital setting. The Joint Commission on Accreditation of Hospitals, an organization set up by doctors, evaluated the hospitals' quality of care practices, including the medical staff organization and committees that decided which procedures individual doctors were qualified to perform. The state licensure boards disciplined physicians, who failed to meet standards of competence in making diagnoses and treating patients. With the establishment of professional standards review organizations and peer review organizations, the locus of accountability shifted from professionals to government mandated review organizations, which were established by federal statute. Since 1983, hospitals have imposed controls on length of stay and utilization through peer review processes in order to comply with diagnosis-related group (DRG) incentives in the Medicare program. The hospitals are reimbursed according to the patients' demographic, diagnostic and therapeutic characteristics rather than their actual length of inpatient stay and amount of resources consumed. Consequently, the hospitals, like the health plans and physicians, try to minimize the amount of time that the patients are hospitalized.

   Under managed care, physician and non-physician reviewers and the pressures of capitation curb the treating doctors' clinical autonomy. Payers now impose
most of the restrictions on their treatment decisions. E.A. Kerr surveyed 94 large California physician groups that care for 2.9 million people to determine their utilization management methods. She found that all the groups used primary care gatekeeping and preauthorization, 79 percent used profiling of utilization patterns, 70 percent used guidelines, and 69 percent instituted some form of managed care education.\textsuperscript{47} Although she did not find that many requests for treatment were denied, she speculated that physicians would only submit requests that were likely to be deemed appropriate by the reviewers.

Quantitative data indicate that California physicians are profoundly aware of their lack of clinical autonomy. A Robert Wood Johnson Foundation Survey of Young Physicians, conducted in 1991 and again in 1996, found a significant decline in their perceived level of autonomy, as Appendix G shows:

In the 1996 age-matched sample, significantly fewer physicians reported that they had the freedom to spend sufficient time with their patients, hospitalize patients, carefully review histories and tests, care for patients unable to pay, order tests and procedures whenever they wanted to, and care for patients who required heavy use of time and resources. In most cases, the proportion of physicians indicating that they had autonomy fell by ten to twenty points.\textsuperscript{48}

The California Medical Association has complained that the Department of Corporation's oversight of health plans is inadequate to ensure that they do not improperly interfere with patient care. The CMA has lobbied to try to restore physicians' autonomy in the area of their control over their patients' treatment. For instance, it sponsored AB 1663, a bill that became law in 1996, making California the first state to establish an independent review process to which terminally ill patients could appeal if their health plan denied them coverage for
experimental treatment. The medical association has also supported the development of a “Patient Bill of Rights” that would give patients the right to access necessary medical services, appeal treatment denials and use experimental treatment.

In 1999, Gray Davis signed new legislation to improve the quality of care provided by health plans. It gave patients more opportunities to sue health plans for denying or delaying their doctors’ recommended treatment. The legislation required health plans to perform their internal reviews more quickly and made provisions for external reviews of disputed decisions in certain cases. It transferred responsibility for regulating health plans from the Department of Corporations to a new Department of Managed Care within the Business, Transportation and Housing Agency. Thus, physicians are beginning to recover from managed care plans some of their clinical autonomy in the area of their control over the diagnosis and treatment of their patients.

3. **Ownership of patients’ records.**

Physicians have traditionally kept medical records for their own use, to trigger their memories about the details of patients’ case histories, and to defend themselves if outside parties doubt that they have provided an adequate level of care. A growing list of entities is demanding access to the records including hospitals, medical groups, “health plans, employers, quality controllers, regulators, investigators, drugmakers, pharmaceutical benefits managers, disease management firms and empowered patients.” Although California has one of the most comprehensive laws in the country for protecting health information,
Janlori Goldman noted, in 1999, that confidential information could still be leaked once it had been reviewed by a health plan, or a claim had been processed in a pharmacy.\textsuperscript{54}

State law requires mandatory reporting of the names of people with AIDS but it does not require reporting of people with HIV infection. Physicians may notify the spouse of an HIV-positive individual but they are not required by law to take this action.\textsuperscript{55} The issue of mandatory HIV reporting has been a contentious one for the California Medical Association and typifies the difficulty of balancing accessibility and confidentiality.\textsuperscript{56} In 1996, the CMA reversed its longstanding policy of supporting mandatory HIV reporting, as a public protection measure, in favour of protecting people's privacy.\textsuperscript{57} At the 1997 Annual Session, the CMA again voted to support legislation that would make HIV a reportable disease for public health purposes, but people would still have the option of visiting anonymous test sites or testing themselves with home kits.\textsuperscript{58}

In 1999, Gray Davis signed into law new, more extensive, confidentiality protections for consumers that prohibited the unauthorized intentional selling of medical information and increased the penalties for violation. Health plans were required to submit to the state government a copy of their policies and procedures for medical record confidentiality on or before July 1, 2001.\textsuperscript{59} Public officials at the federal level are in the process of designing privacy provisions to make it more difficult for medical information to fall into the wrong hands once each individual is assigned a single numerical identifier for their records. Thus, confidentiality provisions are being put in place with the intent of making it more
difficult for individuals other than doctors to gain access to patients’ medical records. However, security provisions do not yet exist that can completely block interested parties from gaining access to the information that they want via the computer or from clinicians, that have access to the information once it is downloaded and/or printed out.

ASSESSMENT AND EXPLANATION

1. *Control over the acceptance of patients.*

As chapter 3 has shown, family physicians in Ontario have retained more control over deciding which patients to accept than primary care physicians in California. However, Ontario specialists lack the time and medical resources to treat many of the patients that need their services without resorting to lengthy waiting lists.

In California, physicians’ freedom to choose which patients to treat is restricted by employer-purchasers, which limit their employees’ choice of plans, and health maintenance organizations, which discourage patients from seeking treatment from providers outside the organization. Physicians have a difficult time accepting Medi-Cal patients and the uninsured because the level of reimbursement for their services is so low. However, California specialists can more readily provide specialized medical services for affluent and insured patients than Ontario specialists because California specialists are more numerous and have more medical equipment at their disposal.60
Why is it easier for Ontario physicians to accept patients with a broad range of socioeconomic characteristics than in California, but easier for California physicians to provide specialized services for insured patients? A historical institutionalist approach draws attention to the importance of political ideas, interests and institutions for explaining policy. Ontarians have traditionally viewed health care as a right and have tried to cultivate a reputation for social compassion. They have accepted a role for the state in financing health insurance in order to make health care available for all citizens, legal immigrants and refugees. They have treated the universal availability of health care as one of the primary characteristics that distinguishes Canada from the United States. However, Ontarians’ commitment to publicly financed health insurance became more tenuous in the 1990s, as the government abandoned other welfare state principles.

In California, where the political culture is arguably more individualistic and competitive, health care is viewed as a consumer product. Individuals are considered responsible for obtaining health insurance at their own expense or through their employment (with tax credits from government). The old are thought to have earned their access to Medicare by paying into it for many years. Only the “deserving” poor (legal immigrants and citizens) and the disabled are thought to have the right to expect the government to provide it.

Past choices, such as the Ontario government’s decision to adopt publicly funded hospital and medical insurance, at the prompting of the federal government, partially account for the ability of doctors to treat a full range of
patients today. The inability of Ontario physicians to provide a full range of services, without long waiting times for diagnostic tests and surgical and hospital care, could be traced to the federal government’s efforts to discourage the provinces from allowing the creation of a privately funded health care system, that would exist alongside a publicly funded system. A privately funded health care system would make it possible for the wealthy to use their money to bypass long waiting lines. Ontario specialists might be able to accept patients more easily, if there were fewer restrictions on the use of private money to fund medically necessary services, because more money would be available to purchase expensive medical equipment. However, the Canada Health Act prohibits the federal government from providing funding to provinces that do not comply with its five criteria (i.e., universality, comprehensiveness, accessibility, portability and non-profit public administration) and two conditions (i.e., the bans on extra-billing and user fees).

In California, organized medicine’s resistance to compulsory health insurance, in 1945, when Governor Earl Warren’s bill almost passed in the Legislative Assembly, was one in a series of events that prevented the development of a more comprehensive program today and led to the formation of a market-oriented health system. Governor Warren’s bill was only defeated by one vote in the state legislature, after the California Medical Association hired Whitaker & Baxter to conduct a public relations campaign denouncing “socialized medicine.” These events will be explored in more detail in chapter 5. The absence of a universal publicly funded health system left an opening for the rapid development of private
health care in California. Managed care became the dominant mode of health care delivery, as politicians and employer-purchasers sought new ways to reduce costs. California physicians have been eager to contract with managed care organizations, even though MCOs interfere with physicians' clinical autonomy, including their ability to choose their patients. Physicians have hoped that, by contracting with managed care organizations, they could gain access to patients, who would appreciate the fact that their premiums would be lower if they joined MCOs than if they joined fee-for-service health plans.

2. **Control over diagnosis and treatment by physicians.**

Why have Ontario physicians retained more autonomy than California physicians over the diagnosis and treatment of their patients? In Ontario, the medical profession has carved out for itself an important role in developing and disseminating clinical guidelines. Neither the government nor the medical profession has vigorously enforced the guidelines, out of fear of provoking physicians to retaliate. Physicians could protest against a government imposition of guidelines by engaging in job actions. If the leadership of the OMA cooperated too closely with the government in enforcing the guidelines, individual practitioners could voice their dissent by joining fringe medical associations and voicing their complaints to the media. Hence, individual physicians have managed to retain the freedom to exercise their own discretion about whether to adhere to the guidelines for the treatment of particular patients.

In California, externally based forces have taken control of medical effectiveness research and protocols, leaving individual physicians little choice
but to change the way they practice medicine to coincide with them. Physicians' clinical autonomy has declined as patients have lost their faith in the ability of doctors to manage their diseases effectively without adhering to clinical guidelines. Stephen J. O'Connor and Joyce A. Lanning observe,

The current fervor over quality of care and outcomes research, however, is a result of the growing realization that physicians often don't know what works and what doesn't, and that they vary widely in the way they apply what they do know. This evidence from the research on small area variations in practice patterns, coupled with a growing consumerism, threatens to undermine the patient's trust and dependency on the physician and further threatens professional autonomy.62

The California Medical Association has succeeded in gaining some legislative limits on the MCOs' ability to constrain physicians' and patients' treatment options, by drawing the attention of the public and politicians to the drawbacks of managed care. However, these limits are no substitute for the almost exclusive control of clinical decisionmaking that doctors once had, before they became subjugated to the demands of purchasers that they find a cost-effective way to deliver services, to stem the rapidly rising costs of medical care.

3. Ownership of patients' records.

When public medical insurance programs were first established in Ontario and California, patients took it for granted that their physicians could be trusted as the guardians of the medical records. Today, more people are interested in gaining access to medical records for such purposes as protocol adherence, audits, patient care reviews, and drug marketing. In Ontario, confidentiality laws need to be tightened to ensure that personal medical information is not leaked. Even with strict legislation, it is difficult to restrict access to medical records in California,
since managed care organizations have inserted themselves between the patients and their physicians. Government auditors want easy access to physicians' records to combat fraud, and purchasers distrust physicians’ willingness to make quality and cost-effective decisions without their intervention.

Why have Ontario physicians retained more of their control over the ownership of patients’ records than California physicians? The concentrated nature of political power in Ontario enabled the government to establish public health insurance and prevented the development of a plurality of interests in the health sector. Since there is universal health insurance in Ontario, patients with "pre-existing conditions" do not risk being denied employment and health insurance if their personal information is leaked, as is the case in California.

Ontario physicians are not exposed to the same level of close oversight from private insurers and business as California physicians. The latter have lost their clinical autonomy and some of their ability to keep patients’ records confidential because, in their quest for clients and an escape from burdensome paperwork, they have subordinated themselves to organizations that strongly influence their service decisions. Stephen O’Connor and Joyce Lanning refer to these as “administered autonomous” structures, where physicians have leadership responsibilities, or “heteronomous configurations” such as staff-model health maintenance organizations, where physicians become “subordinate to the hierarchy of the organization”:

In the heteronomous structure, physician relationships with patients, payors, and other physicians are characterized by substantial intervention on the part of the organization. The organization sets the standards and protocols of patient treatment, conducts negotiations with external third-party payors, and
strongly discourages or patently disallows referrals and consultations outside the organizations. Appendix H shows the implications of medical group practice structural alternatives. Physicians in heteronomous organizations (e.g., staff model HMOs) have much less clinical autonomy than physicians in organizations where there is administered autonomy (e.g., Mayo clinic), or in traditional private or small group practices.

Why have Ontario physicians retained their clinical autonomy to a greater extent than California physicians? Carolyn Tuohy argues that by participating in the public health insurance program, Canadian physicians have traded off a measure of their economic autonomy in order to retain their clinical autonomy. In the United States, organized medicine has tried to retain both, although it has been more successful at preserving physicians' entrepreneurial discretion than their clinical autonomy.

The existence of a strong state in Ontario has limited the interference of private insurers and employers in the patient-physician relationship, making it more difficult for them to restrict physicians' control over the acceptance, diagnosis and treatment of patients and ownership of the medical records. Therefore, corporate interests do not contest physicians' right to self-regulate in Ontario, to the same extent as in California.

In California, physicians' attempts to influence legislation have been counterbalanced by many interests, in an increasingly crowded policy environment, such as government, corporate purchasers and sellers, consumers, and other providers. These groups have been unwilling to countenance a high level of clinical autonomy for physicians because it would drive up costs and squeeze nonphysician providers out of the market. Physicians
have been unable to present a united front to defend their clinical autonomy because they work in so many different institutional settings that their interests do not always overlap, and because antitrust law forbids self-employed physicians from bargaining collectively with health plans (see chapter 1). Hence, countervailing forces have deprived doctors of their ability to manage their practices without external review. Recent provisions signed into law by Gray Davis to protect patients’ rights have only begun to swing the pendulum back in the other direction, so that health care may become more responsive to physicians’ and patients’ wishes in the future, rather than being primarily oriented toward making profits for managed care organizations.
Donald Light's continuum of professional control conceives of clinical autonomy as "the final frontier of the medical professions' ability to be the sole determinant of what goes on inside the surgery." He sees it as the most essential component on a continuum that includes fiscal autonomy, practice autonomy, organizational autonomy, organizational control and institutional control. "Countervailing Powers: A Framework for Professions in Transition," in Health Professions and the State in Europe, edited by Terry Johnson, Gerry Larkin and Mike Saks, (London: Routledge, 1995), pp.25-41. See also Jenny Lewis, Durability and Transformation in Health Policy Making, Paper prepared for "The role of ideas in policy making" workshop, European Consortium for Political Research, 26th Joint Sessions of Workshops, University of Warwick, UK, 23rd-28th March 1998.


In 1999 the CMA sponsored three bills to make California's medical groups more financially stable: "AB968 would have established financial reporting standards; AB691 would have prohibited inclusion of pharmacy risk in capitation rates, unless physicians designed the formularies and benefits; and AB918 would have required HMOs to base capitation rates on actuarial data." See Steve Thompson "CMA's 1999 Legislative Year," The Bulletin, March/April 2000.


44 Medical Economics, January 12, 1998.
51 California Department of Managed Care, 1999 Legislation Directly or Indirectly Impacting the Knox-Keene Health Care Services Plan Act, 1999.
52 Greg Borzo, "Whose Record Is It Anyway?" American Medical News, April 5, 1999.
53 In 1995, the California legislature passed a genetic anti-discriminatory bill to prevent companies from denying employment and health insurance to people who are prone to genetic disorders. See Arthur Allen, “Exposed,” The Washington Post, February 8, 1998.


59 California Department of Managed Care, *1999 Legislation Directly or Indirectly Impacting the Knox-Keene Health Care Services Plan Act*, SB 19 Chapter 526, Statutes 1999, Figueroa, 1999.


63 O’Connor and Lanning, 1992, p.70.

64 Carolyn Hughes Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in Britain, the United States and Canada*, (Don Mills: Oxford University Press, 1999), chapter 5.

CHAPTER 4
ECONOMIC AUTONOMY

Economic autonomy is a multidimensional concept that means the right of physicians, at the individual and collective level, to control their level of earnings and their method of payment. Economic autonomy also involves physicians’ right to be free from financial incentives that interfere with patient care; their right to accept gifts and make self-referrals; and their right to be accorded fraud and abuse protections under the documentation system. In chapter 4, I suggest that physicians’ level of income may not be the most important aspect of their economic autonomy.

In Ontario, physicians’ incomes are generally lower than in California, although the incomes of California physicians have been declining over the past five years. Ontario physicians have more control over the other four aspects of their economic autonomy. Because physicians collectively negotiate fees with the Ontario government, they are sheltered from market competition, which would fragment their interests and make it difficult for them to engage in long-term planning and a mutually beneficial concertation relationship with the state. Ontario physicians have the advantage that they can trade off different aspects of their autonomy in negotiations. Even if the provincial government finds it politically expedient to freeze or cap their salaries in one round of negotiations, doctors are not likely to leave the bargaining table empty-handed. The OMA can put pressure on policymakers to satisfy physicians’ demands by taking steps to strengthen their autonomy in another area. The medical association can also call for
concessions from the government to compensate physicians for sacrifices they may have made in an earlier round of negotiations to comply with the demands of policymakers.

In California, capitation rates have been driven untenably low as a result of competition between providers. The California Medical Association has begun to make dark predictions about an “imminent collapse of a key element in the state health care delivery system,” which threatens to include many of the medical groups and independent practice associations that contract with health maintenance organizations to provide care to “53 percent of the 19 million Californians enrolled in managed care.”

THE MEANING OF ECONOMIC AUTONOMY

1. Control over level of earnings.

Physicians have traditionally asserted their right to set their own fees, taking into consideration the fee schedules set by the medical associations and the ability of their patients to pay them. They have often supported the principle of balance billing, which allows them to charge their patients the amount that they consider fair irrespective of the arrangement between the patients and their insurers. Physicians have expected to be paid promptly and to be reimbursed for their services even if a health plan or intermediary with which they contract faces financial troubles. Control over physicians’ level of earnings and method of payment are intimately connected. Payers find it easier to cut costs when capitation and resource-based relative value schedules are in place, than when physicians are paid under a fee-for-service method based on a “customary, prevailing, and reasonable” fee schedule. These terms are explained below.
2. **Control over method of payment.**

The medical profession has traditionally considered fee-for-service to be the payment method of choice. Fee-for-service is the method for reimbursing doctors and hospitals for each service that they provide. The drawback is that fee-for-service gives physicians an incentive to overservice patients in order to boost their income. The other common payment methods are capitation and salary, which give no incentive for physicians to offer more than a minimum level of care. Capitation reimburses providers with periodic fixed payments, regardless of the actual cost of the services they provide. A drawback of the capitation method of compensation is that, if the financial stakes are high, it may place too much pressure on physicians to undertreat patients. Capitation also gives physicians an incentive to try to restrict their rosters to the healthiest patients, since it is less profitable for them to treat sick ones, a practice that is referred to as “cherry-picking.” As a result, sick patients may receive a poorer standard of care under capitation than under fee-for-service and their trust in their doctors may be undermined.

The medical profession has offered various reasons for its endorsement of fee-for-service over other methods. It claims that fee-for-service patients receive a higher quality of care because the incentives do not discourage physicians from providing service. Physicians retain their status as independent entrepreneurs under fee-for-service medicine, whereas if they are paid on a salaried basis, they are more likely to be viewed as employees subordinate to their employers.
The medical profession has suggested recently that individual practitioners have the right to make the decision about the type of remuneration that they will receive. Organized medicine, particularly in the United States, has had to adjust to the reality that many physicians are now paid on a capitated or salaried basis. It has softened its denunciation of capitation and salaries as methods of reimbursement, in order to retain members in the medical associations.

Organized medicine has provided some support for resource-based relative value scales, as long as physicians play a significant role in their development. The medical profession recognizes the value of updating fees according to a scientific method that takes into consideration the value of physicians' work, expenses, training, and malpractice exposure, rather than merely reflecting historical biases, like the "usual and customary or reasonable" method. A resource-based relative value scale is "a coded listing of physicians services, which includes units that indicate the relative value of the various services they provide."2 It is extremely difficult for physicians to cooperate in the process of designing resource-based relative value scales, even if they agree in principle, because some physicians will inevitably find that their services are no longer as highly valued as they were in the past.

3. **Freedom from financial considerations that interfere with patient care.**

Society gives physicians the right to self-regulate on the grounds that they are involved in a fiduciary relationship with their patients. That is, society expects physicians to put considerations of the health of their patients before their own personal desire for money or access to research subjects. Organized medicine
also asserts that physicians should make treatment decisions without being unduly influenced by financial incentives. Different institutional settings provide different incentives for conflicts of interest. Physicians who are paid on a capitated basis are given incentives to reduce the services they provide. They know that they will be paid a preset premium regardless of their expenses for providing the services, so it is in their personal interest to provide the least expensive services possible. Medical associations suggest that financial incentives should be small and should be spread across many doctors, in order to minimize the extent to which physicians take them into consideration when they make treatment decisions. Mark Hall and Robert Berenson note that there are at least six dimensions that influence the strength of the incentives:

1) the type of service covered, 2) the practice setting and base reimbursement method, 3) the size of the incentive, 4) the incentive’s immediacy, 5) the presence of various counterbalancing monitoring mechanisms, and 6) the relative generosity of the base reimbursement.  

Hall and Berenson suggest the interaction of these dimensions is so complex that ethics are at least as important as regulations for encouraging physicians to act in their patients’ interest. Rather than counselling policymakers on ways to tighten regulations, they offer suggestions to physicians on ways to maintain their sense of professionalism in a managed care environment.

4. *Freedom to accept gifts from industry and to make self-referrals.*

Organized medicine asserts that physicians should be able to engage in potential, but not real conflicts of interest. Physicians should have the right to accept small gifts from industry and make self-referrals if it is in their patients’ interest and does not jeopardize the integrity of the patient-physician relationship.
Pharmaceutical and medical device companies may offer physicians small gifts to attend conferences and find out about their products. In a best-case scenario, patients benefit when physicians accept gifts because physicians receive them in an educational forum where they gain knowledge about the most effective products to recommend to their patients. Similarly, patients can benefit when physicians make self-referrals to medical laboratories if the recommended services are medically necessary, no one else in the proximity is willing to provide the services, and the billing is not excessive. However, patients and payers are the losers when doctors engage in self-referrals and conflicts of interest, if they provide inappropriate medical service and pharmaceuticals or charge excessive fees.

Ideas about which authority should decide whether conflicts of interest are acceptable have shifted over time. It may be left to an individual physician’s conscience to rule on the ethics of self-referrals and conflicts of interest. Alternatively, medical associations may set guidelines and professional boards make regulations. Physicians’ autonomy is diminished when government makes the decisions about the legality of self-referrals and conflicts of interest rather than leaving it to the individual practitioner or the medical profession to rule on the ethical dimensions of these issues.

5. **Right to fraud and abuse protections under the documentation system.**

The medical profession opposes fraud and abuse, which destroy its reputation. Organized medicine takes some steps to correct physician behaviour, as do other state and non-state actors. Regulatory boards and health ministries
prescribe rules for billing practices. They may be in charge of tracking fraud, or those matters could be left to the police, other government departments, or insurance bureaus.

At the same time as the medical profession acknowledges that some physicians engage in corrupt practices, it does not want physicians to be presumed guilty of fraud and abuse, as may be the case when the government assigns patients the task of watching to ensure that physicians accurately submit their claims to insurers. The medical profession objects to government-supported initiatives, like telephone hotlines that have been set up for patients to report suspected fraud and abuse by physicians. It fears that such initiatives will undermine patients' ability to trust their doctors. In addition, the profession tries to ensure that the standards for documenting patients' visits are not absurd, and inadvertent billing mistakes are not treated as criminal offences. It argues that physicians should be able to submit documentation in stages and should be able to make financial amends for genuine billing mistakes.

THE GOALS OF THE MEDICAL ASSOCIATIONS

1. *Control over level of earnings.*

   The Canadian Medical Association defends the right of physicians to receive adequate compensation, even for services that are often undervalued by fee-for-service medicine. The Charter for Physicians declares that physicians need “to receive reasonable remuneration for the full spectrum of professional services including administration, teaching, research and committee work.”
The California Medical Association tries to ensure that physicians are fairly reimbursed for their services. The CMA is particularly concerned that Medi-Cal managed care capitation rates should be as high as fee-for-service Medi-Cal rates and cover physicians' expenses, since Medi-Cal rates were among the lowest in the country even before managed care became common.

2. Control over method of payment.

The Canadian Medical Association has traditionally favoured fee-for-service medicine. The CMA Policy Statement of 1955 asserted, "it is the view of the Canadian Medical Association that remuneration on a basis of fee for services rendered promotes high quality of care." More recently, the Ontario Medical Association has embraced the principle that all physicians have a right to choose their method of payment. The Primary Care Reform Physician Advisory Group, which is composed of OMA and PAIRO representatives, has taken a proactive role in trying to develop a new "reformed fee-for-service" model, which would operate alongside other modes of payment. This model combines elements of a fee-for-service system with current payment discounts and thresholds. Physicians bill using a fee-for-service method until the benchmark threshold is attained. Patients are rostered and are required to pay for non-emergency care obtained outside the family practice but within defined geographic limits. Although Mike Harris has indicated his enthusiasm for a system of primary care reform, whereby more patients would be rostered, the issue has divided the medical profession.

The American Medical Association still supports fee-for-service medicine, but suggests that physicians should have the right to choose their own preferred
method of payment. The AMA asserts that, in principle, it does not favour any specific payment methodology such as "usual and customary or reasonable." However, it has recently refused to endorse the Medicare RBRVS-based physician payment system because it opposes the reductions that have accompanied the introduction of the RBRVS.

3. **Freedom from financial considerations that interfere with patient care.**

   In Ontario, physicians are freer from financial incentives to deny care than in California. Although fee-for-service physicians might be tempted to provide too many services to their patients, in order to increase their level of reimbursement, health reforms in Ontario have oriented them toward cost reduction and the rationalization of their services.

   The American Medical Association has developed extensive guidelines on financial incentives and the practice of medicine, reflecting the importance of the subject in the American context. The AMA encourages physicians to sign only contracts with health plans that have incentives they can disclose to their patients without embarrassment. It suggests that incentives should not be large and should be spread across broad physician groups so individual physicians retain the freedom to make decisions that are in their patients' interest.

4. **Freedom to accept gifts from industry and to make self-referrals.**

   The Ontario Medical Association defends physicians' right to engage in potential conflicts of interest as long as they disclose them to their patients. Similarly, the American Medical Association defends physicians' rights to make self-referrals and own medical facilities if they do not provide direct care at the
facilities. Physicians must be able to demonstrate that the community needs the facilities and there is no alternative funding available to establish them. The AMA allows physicians to accept gifts from industry if they are not of substantial value and no strings are attached, whereas the Canadian Medical Association has a complete ban on personal gifts from the pharmaceutical industry.

5. **Right to fraud and abuse protections under the documentation system.**

The medical associations seek to retain the right to audit physicians' practices, rather than ceding it to the government authorities. The Ontario Medical Association has emphasized the need for patients to be held responsible for their use and abuse of health care services so that physicians are not the only ones who can be accused of health care fraud.

The California and American Medical Association have made it a priority to lobby the Health Care Financing Administration (HCFA) for fair and simplified documentation guidelines for evaluation and management (E&M) services. They suggest that Medicare could help fix the "fraud and abuse problem" by making the guidelines less burdensome. The medical associations oppose the use of criminal penalties for inadvertent errors. They assert that the HCFA should eliminate random audits of billing services and assign the task of reviewing the practices of statistical outliers to peer physicians. The California and American Medical Association also encourage physicians to establish compliance programs so that they can police themselves and minimize their coding errors.
THE ONTARIO CASE

1. **Control over level of earnings.**

   The history of fees in Ontario has involved the government seeking new ways to limit health expenditures, by gradually usurping physicians' autonomy to control their fees. Immediately before the government-funded single payer health system was set up in Ontario, physicians were reimbursed directly by their patients, or they were paid through one of 35 private insurance plans that later became amalgamated into the Ontario Health Insurance Plan. The Ontario Medical Association issued a fee schedule that all of the plans followed. In 1969, OHIP began to deduct 10 percent from the approved OMA Schedule of Fees to cover its administration costs. Under the public health insurance system, physicians no longer had to bear the risk that uninsured patients might not pay their bills. The drawback of public health insurance for physicians was that they were treated like public servants, in that they were paid directly by government, but they lacked many of the standard benefits, like maternity leaves and pensions.

   In 1974, the OMA and provincial government formed the Joint Committee on Physicians' Compensation to make decisions regarding doctors' salaries. A year later, the Anti-Inflation Board was established by the federal government, which restricted salary increases to $2,400. The wage and price controls remained in place until 1978, at which time doctors were eager to recover lost earnings. In 1978, the Conservative government removed the link between the OMA-approved fee schedule and the OHIP schedule, giving the government greater freedom to determine physicians' fees. Physicians were able to obtain a
slight redress in the balance of power, in 1979, when the government agreed that a neutral chairman of the Joint Committee on Physicians' Compensation could be designated as a fact-finder in the event of an impasse in negotiations.16

By 1982, many physicians were enraged that their salaries had failed to keep up with the rate of inflation in the years since 1971.17 The OMA resorted to job sanctions in the spring of 1982, at which time, the government agreed to a generous five-year contract. In 1984, the government reneged on its agreement, and unilaterally reduced from seven to five percent, the increase that it had promised to physicians.

Many physicians believe that, as entrepreneurs in a “free country,” they should have a right to bill their patients above the OHIP schedule, even though few Ontario physicians actually extra-billed their patients, before the practice was declared illegal by the Liberal government in 1986. The Liberals’ ban on extra-billing sparked a 25-day strike by Ontario physicians. However, the strike failed to convince the provincial government that it should reverse its decision to ban extra-billing, and physicians lost public support by refusing to provide services to patients. In 1988, physicians received yet another blow when the government decided to unilaterally impose a fee settlement of 1.75 percent, and it cancelled a 15-year-old agreement covering negotiations.18 The volume of services provided by physicians increased so dramatically after the 1988 fee settlement that the OHIP ended up paying an additional 9 percent.19

The NDP government, that replaced the Liberals, sought new ways to reduce health expenditures and curb the growth in utilization. In 1991, it
established a new framework agreement with physicians, which set up the Joint Management Committee structure, consisting of physicians and government representatives. The framework agreement created the Institute for Clinical Evaluative Services, an institution that studies utilization management. The agreement promised physicians that they would have the right to engage in binding arbitration on the price of their services. The government encouraged physicians to make their treatment decisions conform to guidelines. When the introduction of clinical guidelines failed to reduce costs, the Joint Management Committee instituted, first, soft caps, and then, hard caps. Soft caps are expenditure targets that allow physicians to share cost overruns with government in a prearranged fashion. For example, in 1991, payments to Ontario doctors were reduced by 33 percent after total billings exceeded $400,000 during a fiscal year, and by 67 percent after billings exceeded $450,000. Hard caps, which were introduced in 1993 for the Social Contract period, meant that physicians bore the full brunt of excess expenditures. The 1993 agreement between the NDP government and the OMA included a 3-year freeze on medical fees and the requirement that billings be reduced by $20 million through de-insurance (i.e., removing services from the list of those covered by OHIP so that patients could pay privately) within a set deadline.

In 1995, the Joint Management Committee was dissolved because physicians refused to participate in it. Physicians felt betrayed by the NDP government because Bob Rae did not carry out his promise to enact legislation allowing them to become incorporated. Some physicians in the Ontario Medical
Association were displeased that public education programs to slow utilization and fraud did not accompany the cuts to their salaries within a timeframe that they considered acceptable.\textsuperscript{22} Morris Barer, Jonathan Lomas and Claudia Sanmartin identify one of the key factors in the demise of the JMC as the "lack of prospective rules for dealing with cost overruns, particularly as they apply to the distribution of the pain across different groups of physicians."\textsuperscript{23}

In 1995, the new Conservative government did away with framework and economic agreements altogether. The government of Mike Harris initially took a hard line on payment issues, but gradually began to treat physicians more generously. In January 1996, the Harris administration declared that the government had the right to "unilaterally set fees for health care services, paying some doctors lower rates for the same services based on location or training." The Ontario government could retroactively require doctors to repay government for services that it deemed to be unnecessary.\textsuperscript{24} It imposed a 10 percent clawback on physicians, in 1996, which some physicians protested by refusing to take new patients.

By the end of 1996, the government tried to develop more conciliatory relations with physicians. It agreed to do away with wage clawbacks and increase funding for medical services by 1.5 percent each year for the next three years.\textsuperscript{25} That settlement boosted payments to doctors by about $1-billion so that these payments now amount to about $4.5 billion a year.\textsuperscript{26} In 1997, a new relationship structure was established. The Physician Services Committee (PSC), which was chaired by an outside Independent Facilitator, was a forum for key members of
the Ontario Ministry of Health and Ontario Medical Association to discuss utilization control proposals and payment issues. The Physician Services Committee has more credibility than its predecessor, the Joint Management Committee, since it is not seen as being dismissive of doctors' interests. The PSC suffered a loss of credibility, in 1998, when it failed to find an out-of-court resolution to the complaints of the Ontario Association of Radiologists. (This group of radiologists claimed that they were being unfairly asked to bear the brunt of $100 million in budget cuts).

Now, there are no legal limits on the government's power in its relations with physicians. The current agreement, reached in April 2000, could be overturned by unilateral government action, except for the formal clawbacks. Physicians' formal right to engage in fee negotiations with the government has been assaulted by the Harris government. This is not a huge loss for the profession. In the past three decades, the government has only paid lip service to most of its economic contracts with the medical profession. In the short term, the April 2000 contract promises physicians a 2 percent fee increase in each of three years, and soft commitments have been made in the budget to increase spending in such areas as primary and patient care, information systems, and alternate payment plans. The medical profession and the government appear to be satisfied with the new forum that has been established for quietly resolving their differences.
2. *Control over method of payment.*

Ontario physicians express some reservations about the fee-for-service system that most of them use. The fee schedule has not been subjected to any major revisions. It disproportionately rewards physicians for procedural interventions and does not adequately compensate them for their planning, teaching, counselling and research services. Nevertheless, statistics show that physicians continue to view the fee-for-service payment model as more acceptable than the alternatives. In 1998, an OMA survey found that 81 percent of physicians favoured fee-for-service as their payment method; 75 percent chose blended payment; 53 percent chose the reformed fee-for-service model; and 36 percent preferred capitation.

In Ontario, there are isolated instances where alternative payment methods have been adopted, such as salaries in community health centres (CHCs) and comprehensive health organizations (CHOs), and capitation in health service organizations (HSOs). Community health centres, comprehensive health organizations and health service organizations are non-profit, community-based organizations that use a multidisciplinary team of health care professionals to provide a broad range of programs to meet patients' health care needs including health promotion and disease prevention. The government funds comprehensive health organizations to purchase the health care services that its patients need from hospitals, physicians and pharmacists. In the case of health service organizations, the patients are rostered and the HSO only receives the full amount of funding available from the Ministry of Health if the patients do not make visits.
to outside providers of medical services. In 1994, Tina Kyriakos reported in *The Medical Post* that there were “about 200 non-fee-for-service CHCs, HSOs, hospital emergency departments and chronic-care centres.”\(^3\) Capitation has advanced very slowly in Ontario because the government’s attempts to promote it have been sporadic and the market has given it little impetus. The initial expense for government to promote capitation is high and the rewards are long-term and uncertain. There has been little definitive evidence that utilization and costs decrease with alternative payment methods in the Ontario setting.\(^3\)

The government and the Ontario Medical Association set up an independent resource-based relative value schedule commission in 1997. The commission has not met its final deadline by producing a schedule that can be embraced by all factions of the profession. Matt Borsellino has traced the cracks in the process to problems with “methodology, determining practice or overhead costs, taking into account opportunity costs incurred during specialty training and balancing knowledge and bias.”\(^4\) The Harris government has not been willing to risk the political fallout of unilaterally introducing a resource-based relative value schedule in Ontario, as the federal government did in the United States in 1992, with its Medicare program.

3. **Freedom from financial considerations that interfere with patient care.**

Ontario residents and citizens are entitled to “medically necessary” services under the Canada Health Act. There are few incentives to physicians to deny those services. However, physicians are not fully reimbursed for their services if individual thresholds, or hard or soft caps are in place, which limit their
annual salaries. As mentioned previously, many physicians have refused to take new patients if they are not adequately paid for treating them.

4. **Freedom to accept gifts from industry and to make self-referrals.**

"Gifts from industry" can take many forms in the Ontario context. For example, Toronto physicians have been known to accept lower rent from landlords in exchange for sending their patients to laboratories in the same building.\(^{35}\) Some drug companies give gifts to doctors who will accept them since, as studies have found, doctors tend to be more positive about the effectiveness of the drugs when they have close ties to the companies that make them.\(^{36}\) Similarly manufacturers have been known to make large grants to hospitals. Mead Johnson Canada, a baby formula company, reaped at least three benefits by providing a million dollar grant to Women’s College Hospital in Toronto in 1993. According to the *Financial Post Daily*, Mead Johnson Canada received "exclusive right to supply formula to the hospital; a professional endorsement of its product; and a probable entrée into the homes of new mothers."\(^{37}\) Critics of the grant wondered if new mothers would receive as much encouragement and assistance in breast-feeding once the money had changed hands.

The OHIP system has been susceptible to fraud by doctors, who refer accident victims to medical laboratories and rehabilitation clinics and, in return, receive cash payments, lowered rent, office improvements and equipment.\(^{38}\) Before Bill 59 (1997) was enacted to tighten some of the loopholes in Bill 164, insurers were required to pay out benefits within 14 days, regardless of whether or not they
intended to challenge the claims. Dr. Murray Waldman noted that the average cost per claim for accident-related rehabilitation took a substantial jump between 1989 and 1994 (from $2,108 to $25,305), and explained it by the fact that there was so much money to be made.\(^9\) The College of Physicians and Surgeons of Ontario tried to reduce conflict of interest problems by enacting a new set of regulations, in 1992, under the Medicine Act. The College does not officially ban self-referrals, but it has begun to place a greater emphasis on quality assurance in its oversight of Independent Health Facilities. The rationale, according to Dr. Geoffrey Bond, the head of the College’s committee on conflict of interest in 1996, is that if a procedure is medically necessary it should not matter who owns the facility whether it is “Donald Trump” or “Dr. Jones.”\(^10\)

5. **Right to fraud and abuse protections under the documentation system.**

Prior to the introduction of universal publicly financed health insurance in Ontario, it was easier for patients to detect if they were overcharged for services or charged for services that did not take place since they were handed the bills for the services directly. Once government began to finance medical services, physicians had more flexibility in deciding whether to claim that assessments were for minor, intermediate or major examinations, because their patients were unlikely to review the bills that their doctors submitted to OHIP. Researchers have found evidence that suggests upcoding may have cost the public health insurance system as much as $60 million a year. There was the same number of bills for minor and intermediate examinations in 1985, but by 1995, the number of bills for intermediate examinations was three times the number for minor
examinations. Alternatively, the increase in the number of bills for intermediate examinations may have been legitimate. Demographic explanations, like the aging of the population could account for the change in billing patterns, since seniors tend to require more extensive examinations and are the most expensive segment of the population to treat.

The government has usurped some of the profession's power to inspect physicians suspected of health fraud. The Medical Review Committee is technically a committee of the College of Physicians and Surgeons of Ontario, although the Minister of Health appoints its members. The Medical Review Committee has the authority to inspect physicians' records if the General Manager of OHIP notifies it of a concern. Premier Harris's Bill 26 greatly expanded the government's authority to conduct its own review process even without evidence of a prior concern or a defined scope to the inquiry. The College protested this assault on physician autonomy, but to no avail.

THE CALIFORNIA CASE

1. Control over level of earnings.

Fee indices were developed relatively early in California. In 1956, the California Relative Value Study was designed, which contained relative values based on the existing median charges of physicians. The California Medical Association assigned a coded value to physicians' services based on their median charges. The coded value multiplied by a conversion factor would equal the median charges. In 1962, the CMA Bureau of Research and Planning began to
conduct ongoing surveys, in order to compile a California Physician Fee Index based on random samples of physicians performing a few selected procedures. Critics questioned the legality of the California Medical Association's development of fee indices because, under antitrust law, self-employed physicians are prevented from collectively negotiating fee schedules through their medical associations. The Health Care Financing Administration could set the rates for the Medicare and Medicaid programs, but physicians were not allowed to agree collectively to set their own rates because such collaboration would threaten competition in the marketplace.

In 1965, Medicare adopted the "customary, prevailing, and reasonable" fee schedule, which allowed physicians to charge the going rates in the geographical areas for medical services. The federal government made this concession to doctors in order to gain their cooperation in implementing public health insurance. It soon became politically expedient to try to slow U.S. physician expenditures, which had grown from $5.3 billion in 1960 to $13.6 billion in 1970. In 1973, the federal government, with Reagan at its helm, instituted the Health Maintenance Organization Act, with the intent of encouraging physicians to move into capitated arrangements rather than fee-for-service, so that payments could more easily be controlled. The Act provided start-up funding for health maintenance organizations, required many employers to offer an HMO option, and removed state regulations blocking their development.
In 1982, under the leadership of Governor Jerry Brown, the California legislature passed the Medi-Cal reform legislation, known as A.B. 799 and A.B. 3480, which had the effect of lowering physician fees. The legislation made prices for physician and hospitals services more competitive and shifted responsibility for treating “medically indigent adults” from the state to the county level. The legislature was eager to make such sweeping reforms because California was in the midst of a severe fiscal crisis and the federal government, under President Reagan, was cutting back on social programs. The Constitution requires that the states produce balanced budgets. Enacting Medi-Cal reforms seemed one of the most promising ways to make cutbacks in healthcare costs. A state official, nicknamed a czar, was appointed, who had the power to virtually dictate to the hospitals the Medi-Cal rates they could charge for their services. Hospitals were suffering from low enrollment and, therefore, had an incentive to take contracts on whatever terms they were offered. However, many California doctors stopped seeing Medi-Cal patients because selective contracting did not pay them enough to cover their costs.

By 1983, the federal government was also looking for new methods to decrease the costs of paying physicians. Although it was not made public at the time, the American Medical Association signed a secret agreement with the Health Care Financing Administration, whereby the HCFA agreed to make exclusive use of the AMA’s “Current Procedural Terminology” Codebook. The AMA stood to benefit financially from this deal, since all physicians that were paid by HCFA needed access to a copy of the Codebook. In 1984, Congress froze
Medicare fee payments to physicians at their current rate and created the Physician Payment Review Commission to study the alternatives. The Commission recommended adopting a relative value scale for Medicare based on the resource costs of providing services rather than on the customary charges. Congress mandated the resource-based relative value schedule fee changes and the Health Care Financing Administration implemented them beginning in 1992, even though some physician groups were more vehement in their opposition than the American Medical Association. For instance, the American College of Surgeons refused to cooperate with the research team that developed the resource-based relative value scale, and the American College of Radiology and the American Society of Anesthesiology tried to design their own scales. The Association of American Physicians and Surgeons suggests that the AMA has developed such a close relationship with the Health Care Financing Administration that it has lost its ability to strongly oppose the government’s RBRVS.

In the 1990s, some large purchasers in the public and private sector played a key role in constricting physician salaries in California. For example, the Pacific Business Group on Health, which was composed of eleven participating firms, managed to reap $36.5 million in savings, in 1995, by negotiating collectively with health maintenance organizations. It had the purchasing power of $3 billion in annual health expenditures and was able to pressure health maintenance organizations to make improvements in the cost and quality of services provided to its members by publishing report cards on the preventive

The California Medical Association has lobbied to increase physicians' salaries. In 1998, the CMA convinced Governor Wilson to approve an increase in physician Medi-Cal reimbursements – the first since 1985. The increase amounted to $70 million to bolster the physician rate for preventive and primary care services. However, there were so many administrative levels between the Department of Health Services and the doctors that it was difficult to guarantee that any of the increase would reach the providers. In the two-plan Medi-Cal managed care model that is used in Los Angeles, the money had to flow from the Department of Health Services to either L.A. Care or Health Net (the two main plans). From there, it would be distributed to the HMOs that contract with the two main plans. The HMOs might, in turn, pass on some of the money to contracted independent practice associations, medical groups or individual physicians.

The California Medical Association has successfully made the case to legislators that Medicare bills should be paid promptly, with a minimum of bureaucratic hassles. The CMA has also suggested that health plans should be held liable for physician payment if their contracting agency declares bankruptcy and is unable to follow through on its contracts. For example, in 1998, the medical association represented physicians in court to try to recover lost payments from the FPA Medical Management's bankruptcy proceedings.
2. **Control over method of payment.**

Methods for compensating physicians are extremely complex in the public and private sector market that exists in California. Payment methods are designed to increase physicians' efficiency and have the effect of reducing their economic and clinical autonomy. Some of the payment methods take different forms than in Ontario and include capitation to medical groups or independent practice associations, discounted fee-for-service reimbursement and a vast array of fee schedules instead of one schedule agreed upon by the medical association and provincial government. The Governance Committee of the Advisory Board Company, which is a firm that produces research reports on progressive management and clinical practices in health care, has calculated that there are 461,760 possible combinations for compensating physicians in the United States based on variations in the base pay, maximum bonus size, level of performance measurement, criteria for bonus payout and stipend for leadership.

Physicians are paid differently, depending on whether they are primary care physicians or specialists, and whether their patients are enrolled with commercial health maintenance organizations, Medi-Cal managed care plans, or lack insurance. Health maintenance organizations in California report that they pay 86 percent of their primary care physicians by capitating their medical group or independent practice association. It is less common for HMOs to pay individual physicians (36%), or medical groups and independent practice associations (36%) on a fee-for-service basis. Only 21 percent of primary care physicians are paid on a salaried basis by their HMOs. Uninsured Californians, of
which there were 7 million, in 1997, comprising 24 percent of the state’s population, have three methods of paying physicians. They may qualify for government subsidized insurance, if they meet the eligibility criteria; they may purchase coverage on the individual health insurance market; or they may remain uninsured and pay out of pocket for all of their health care expenses. Even if workers are able to obtain insurance coverage at their place of employment, it does not necessarily cover all of their health care expenses. Physicians are not reimbursed for all of their services. On average, San Francisco physicians reported donating $52,300 worth of care a year between 1985 and 1989.

It is common for health maintenance organizations to base part of the physicians’ salaries on bonuses that reward productivity, cost containment, citizenship (i.e., attendance at meetings), quality of care and patient satisfaction. In California, the trend for the future is to base payments on effectiveness data and the level of patient satisfaction. For example, PacificCare has recently made 10 percent of the bonuses paid to eight of their senior executives dependent on the satisfaction of 80 percent of the California Public Employees’ Retirement System members with whom they have contracted. While some observers have praised PacificCare for signing this deal, others have considered it gimmicky, especially since the executives, whose salaries are partly at risk, are not the ones who actually deliver the care.
3. **Freedom from financial considerations that interfere with patient care.**

There is quantitative evidence that financial considerations sometimes interfere in patient care decisions in California. In 1998, the CMA young physician survey found that,

24 percent of respondents were very concerned that financial incentives drive medical decisions, and three-quarters said that they themselves sometimes (57%) or frequently (16%) make patient decisions that are influenced by reimbursement or capitation levels.

That same year, the California Medical Association successfully lobbied for a new law that made it obligatory for health plans, medical groups, independent practice associations, and participating physicians that use financial bonuses or incentives to give a clear written description of them to anyone who requests it. However, payment rates, trade secrets and other financial information may still be considered confidential under state law.68

4. **Freedom to accept gifts from industry and to make self-referrals.**

The American Medical Association's strategy for tackling problems of financial conflicts of interest has been to issue guidelines, beginning in 1986. Before the 1980s, the issue was not explicitly addressed. In 1991, the AMA Council on Ethical and Judicial Affairs reached a consensus that most physician self-referral should be avoided. However, the Council overturned this statement, in 1992, and substituted the opinion that self-referral is appropriate as long as it is disclosed.69 The American Medical Association has been reluctant to take any action against physicians who engage in conflict of interest activities, although it could theoretically expel members that do not respect its guidelines. The government also turned a blind eye toward conflict of interest problems, until
health care costs began to rise exponentially. By 1990, U.S. physician expenditures reached $148.3 billion, so the federal government made it a priority to hold the medical profession more accountable.

The federal government made a number of early efforts to prevent physicians’ conflicts of interest and fraud, but it was not until the 1990s that the real crackdown began. The first federal law to prohibit kickbacks in the Medicare program was enacted in 1972, and strengthened in 1977, 1980 and 1987. The California Medical Association successfully opposed A.B. 819, a state measure to ban self-referrals. Nevertheless, at the federal level, a self-referral law was enacted, in 1989, entitled the Original Ethics in Patient Referral Act (Stark law). The first Stark law banned referrals to labs, where the physicians were the owners or investors. In 1995, the second Stark legislation took effect, although the proposed regulations were not published for another two years. Stark II dramatically expands the prohibitions against referrals of Medicare and Medicaid patients for ten additional designated health services, where the physician or an immediate family member has a financial relationship. That year, the Department of Health and Human Services set up a Fraud and Abuse Hotline so that patients could inform officials running the Medicare and Medicaid programs of suspected instances of fraud and abuse by physicians. California was one of five states that was part of the Department of Health and Human Services’ demonstration project, Operation Restore Trust, which was aimed at eliminating fraud and abuse in the Medicare and Medicaid programs, most particularly in the areas of home health, nursing facilities, durable medical equipment and hospice care. Operation
Restore Trust coordinated the anti-fraud activities of 14 different federal and state agencies.72

5. **Right to fraud and abuse protections under the documentation system.**

The California health marketplace has been fertile ground for conflicts of interest and fraud. Billing codes are so complex that it is easy for physicians to make honest mistakes. It is tempting for physicians to deliberately manipulate the system to increase their remuneration because there are so many payers and there has been little cooperation between them to track fraud. As the American Health Lawyers Association notes:

> Congress and more than a dozen separate federal and state agencies are at work passing or amending fraud and abuse laws, regulating the healthcare industry, or enforcing the laws against healthcare fraud and abuse. Private purchasers of healthcare services are also setting up fraud investigation offices.73

In California, insurance fraud is estimated to cost between $3 and $5 billion annually.74 The following are examples of some of the more notorious recent California health care fraud cases involving doctors. Frank Aiello, who owned Lincoln Care Center, a nursing home in northern California, was paid almost $4 million for 7000 false claims that he submitted to Medicare.75 Dr. Michael Lightman, an owner of Amerimed Medical Corporation, netted millions of dollars in a statewide network of "illegal medical referrals, treatment incentive programs and billing practices through a string of medical clinics and law offices across California."76 One of his policies, before he was charged in 1995, was to bill the maximum amount, regardless of the nature of the patients' examinations and injuries. That same year, a San Diego ophthalmologist was charged for
falsely diagnosing Medicare patients with cataracts and eyelid problems and performing unnecessary surgery.77 A company that operated “rolling labs,” otherwise known as mobile medical labs, “was able to perpetuate a billion dollar fraudulent billing scheme that affected 1,400 insurance plans” over a ten-year period that began in 1981.78

In the 1990s, the Office of the Inspector General in the Department of Health and Human Services and the Department of Justice have vigorously attacked the problem of fraud and abuse, taking over the Health Care Financing Administration’s role as the industry’s primary regulator.79 In 1991, a National Health Care Anti-Fraud Association was set up to reduce the level of health care fraud in the private and public health care systems. In 1996, the AMA opposed the lower standard of evidence that would be required to penalize physicians for errors in Medicare claims, under the Health Insurance Portability and Accountability Act. California was one of nine states that shared $2.25 million in grants awarded by the Clinton administration for efforts to reduce fraud in the Medicare program. It helped the Health Care Financing Administration design a computer system at Los Alamos National Laboratories for detecting fraudulent claims. In 1997, the California Medical Association took a leading role in opposing the set of documentation guidelines for Medicare evaluation and management services developed by the Health Care Financing Administration. In conjunction with the American Medical Association, the CMA succeeded in delaying the implementation of the evaluation and management guidelines. In 1998, the American Medical Association began working with the Health Care
Financing Administration and the California Medical Association on a pilot project of evaluation and management code review methods that do not require numerical guidelines and focus on peer review of statistical outliers.

ASSESSMENT AND EXPLANATION

1. **Control over level of earnings.**

   As chapter 4 has shown, physicians in both jurisdictions have lost some of their control over their earnings. In Ontario, where doctors’ incomes are generally lower, it is politically expedient for the provincial government to engage in negotiations with the Ontario Medical Association. However, the government has acquired the legal authority to set fees. California physicians’ economic autonomy has gradually been diminished through the federal government’s cost-cutting initiatives, such as wage and price controls in the Medicare program (1971), direct limitations through the Omnibus Budget Reduction Acts of 1986, 1986, and 1989, and the imposition of the resource-based relative value scale, which has had the additional effect of threatening the cohesiveness of the profession, as Appendix J shows.

   A historical institutionalist and policy network approach can be used to develop a partial explanation for Ontario physicians’ relatively low level of reimbursements, but there are other important variables (i.e., public opinion, economics, and gender) that these approaches do not emphasize. The policy decision to establish a universal medical care system and the concertation network that has evolved between the Ontario Medical Association and the provincial
government have limited the autonomy of individual physicians to set their own fees. After the federal government introduced the Canada Health Act, the Ontario government stripped physicians of their right to extra-bill, because, although the issue held a lot of symbolic importance for physicians, the public was not willing to support the withdrawal of their services. Ontario has been able to impose across-the-board medical expenditure caps on physicians because joint management structures have been established between the government and medical association that share the task of controlling reimbursements. Leaders of organized medicine recognize that it may be necessary to concede some economic ground to the government, in order to maintain the stability of the negotiation structures.

A feminist interpretation for the decline in physicians’ economic autonomy would draw attention to changes in the workforce that transcend national boundaries, including the growing number of female physicians. Women in demanding professions, like medicine and law, often have different priorities than men. Female physicians may be willing to sacrifice a certain amount of their economic autonomy, in order to gain more control over their time and achieve other benefits, like maternity leaves.

In California, physicians’ autonomy to set their own fees is limited by governments’ decisions to control health care costs and market competition. The state government’s Medi-Cal reform has undermined physicians’ ability to establish fair market rates for their work, by forcing them into fierce competition with each other. Some physicians have developed a solid enough reputation to
restrict their practices to patients who have the insurance or wealth to pay them high fees. Most practitioners are not free to set their own rates because there is an oversupply of physicians. Purchasers are organized enough to drive down providers' practice revenues across the state. Managed care organizations employ allied health professionals to perform some of the tasks, previously undertaken by physicians, but at a lower cost.

Antitrust laws have placed physicians at a distinct disadvantage. These laws prevent physicians from negotiating as a united force, with the highly consolidated managed care organizations and purchasers. In contrast, insurance and managed care companies do have the freedom, under The McCarran-Ferguson Act of 1945, "to openly discuss among themselves what fees they are going to pay to physicians, and to formulate other strategies that allow them to control physicians." Thus, antitrust laws give managed care organizations an unfair advantage over physicians, which makes it easier for them to force down physicians' fees.81

2. **Control over method of payment.**

Many Ontario physicians are paid on the fee-for-service basis that physicians traditionally prefer. It is common for them to operate private practices and be reimbursed directly by OHIP for their services, without dealing with a host of intermediaries. Ontario physicians have not been forced to accept a resource-based relative value schedule, like physicians who provide services to Medicare patients in the United States.
In California, many different methods of payment are used. Physicians are less likely to function as independent entrepreneurs, and more likely to share their income with managed care organizations, which pressure physicians to meet cost-savings objectives. Why have Ontario physicians retained more control over their methods of payment than California physicians?

The Ontario Medical Association is in a strong position to influence physicians’ method of payment because it has a lot of credibility with the state. The OMA participates in a concertation policy network with the state, allowing it to pursue its long-term objectives, one of which is to preserve physicians’ right to freely choose their method of payment. The state could not force physicians to change their method of payment, without alienating doctors and a significant number of other voters.

In California, where pluralism and competition are important norms, the medical profession is highly fragmented. Physicians are less likely to be paid on a fee-for-service basis than in Ontario, as a result of early decisions, like the HMO Act (1973), which was Ronald Reagan’s policy instrument for encouraging the formation of health maintenance organizations as a cost-cutting initiative.

California physicians have been willing to contract with managed care plans, even if they are deprived of their preferred method of payment, because they practice in an environment where most physicians do not have the freedom to take concerted actions, such as discussing fees. Physicians have been afraid that they would suffer a financial loss, if they did not contract with managed care
organizations, which moved quickly in the 1990s to consolidate their market positions.

3. **Freedom from financial considerations that interfere with patient care.**

Why do Ontario physicians not have to contend with financial incentives that interfere with patient care to the same extent as in California? As we have seen, the historical institutional context has conditioned Ontarians to assume that the state should have a more important role than the private sector in financing health care. The Ontario government's efforts to control costs do not impinge as directly on physicians' clinical decisionmaking as in California, where managed care organizations relentlessly put pressure on physicians to drive down costs.

The recent enactment of California Medical Association-sponsored legislation, that requires managed care organizations and physicians to reveal their incentives, should make it more difficult for them to make treatment decisions purely on a financial basis. Nevertheless, the incentives of the health care system for the undertreatment of patients are so powerful that legislation alone will not protect patient care.

4. **Freedom to accept gifts from industry and to make self-referrals.**

The self-referral regulations in Ontario are lenient, which is not surprising since the College of Physicians and Surgeons of Ontario gave physicians the opportunity to express their preferences on their design. What led Congress to pass the strict Stark bans on self-referral in 1989 and 1993? Participants at a Public Interest Colloquium of the American Health Lawyers Association addressed that question. They suggested that the federal government took a
stringent approach to kickbacks and self-referrals in order to save the public money, since health care costs were so high.

A study by Health and Human Services' Office of Inspector General provided quantitative evidence that laboratory services were higher if physicians had relationships with the labs. Congressman Pete Stark, a Democrat from California, who was chairman for ten years of the House Ways and Means Committee's health subcommittee, used the OIG report as ammunition to show that health fraud was a major problem that needed to be addressed. Congressman Stark, who was no friend of the American Medical Association, wanted a complete ban on self-referral that would cover any physician-owned facility or services. The American Medical Association agreed that self-referral was unethical, but it argued that, if physicians disclosed their relationships with labs, conflict of interest problems would be corrected since patients would be able to make informed decisions when they were referred for tests at laboratories. The OIG report did not provide evidence that self-referral by physicians increased utilization of facilities other than clinical labs. Consequently, a compromise was reached, whereby the Stark legislation of 1989 would ban self-referrals to clinical labs, but not other services. The Stark legislation was extended, four years later, after eleven more studies found a correlation between financial incentives and the services ordered by physicians.

5. **Right to fraud and abuse protections under the documentation system.**

Health care fraud by physicians and patients has been treated as a relatively minor issue in Ontario, but in the United States, it has generated a high
level of political interest as the medical profession has protested the “unfair” prosecutions of doctors for inadvertent coding errors. Why is this? The Ministry of Health has played down the importance of fraud. Successive Ontario governments have been reluctant to make an issue of medical fraud because they do not want to antagonize doctors and make negotiations with them any more difficult than they already are. In 1995, senior members of Harris’ Conservative government, like Perry Martin, who was the Minister of Health Jim Wilson’s executive assistant and Peter Burgess, tried to create a “fraud squad.” Senior members of the Ministry of Health made it difficult for them to proceed by suppressing the background reports on fraud. The project was eventually downgraded. Peter Burgess, who would have been the head of the fraud squad, was declared surplus and he chose to move to the United States to prosecute health care fraud there.82 The Ontario Provincial Police, which has been gaining responsibility for handling health fraud investigations, uses a low-key approach, so the issue of health care fraud has been “depoliticized” in Ontario.

The Department of Health and Human Services’ Office of the Inspector General conducted 1600 criminal investigations against physicians between January 1996 and June 1998.83 What has led U.S. law enforcers to vigorously enforce fraud and abuse laws in the 1990s? Persecuting physicians for fraud has become a way for politicians to score political points and save bundles of money. President Clinton may have spearheaded a campaign to keep physicians from overutilizing the system, in order to divert attention from the failure of his health care reform in 1993. The Clinton administration boasts that Operation Restore
Trust reaps $23 in fines and penalties for every $1 spent on enforcement.\textsuperscript{84}

Physicians have lost economic autonomy under the anti-kickback law since its terms are so extensive. As one panelist at the American Health Lawyers Association’s Public Interest Colloquium remarked,

Everyone is against “raw fraud,” such as billing for services that are medically inappropriate simply to generate fees. But the anti-kickback law allows fraud charges to be brought in cases where the patient is not hurt and where there is no harm in terms of quality or cost to the government.\textsuperscript{85}

This examination of changes in physicians’ economic autonomy, in the last three decades, in Ontario and California, allows me to draw two conclusions. First, a lower level of income for physicians in Ontario may have been a small price to pay, considering they have retained more control than California physicians over their method of payment, more freedom from financial considerations that interfere with patient care, more freedom to accept gifts from industry and make self-referrals, and the right to be accorded more fraud and abuse protections under the documentation system.

Second, the medical profession in California has paid a high price in terms of its economic autonomy for resisting the introduction of a compulsory single payer universal health system at key points in time when it came close to being adopted (i.e., 1945 and 1994).\textsuperscript{86} Physicians have to face the daily reality that many of their patients cannot pay their bills. Many physician groups have had to claim bankruptcy, making it necessary for the California Medical Association to launch lawsuits to recover funds from health plans so that physicians can be reimbursed for their services.
51 The four alternatives for reforming physician payment under Medicare that were the most seriously considered by the Physician Payment Reform Commission were “refining the current payment system, making payments according to a fee schedule, creating a system of all-inclusive fees for defined packages of services, and increasing the use of capitation payments.” See Phillip R. Lee and Paul B. Ginsburg, “Building a Consensus for Physician Payment Reform in Medicare: The Physician Payment Review Commission,” Western Journal of Medicine, Vol.149, September 1988, pp.352-358.
59 In 1996, the CMA successfully lobbied for medical groups and independent practice associations to be required to pay claims to physicians within 30 days. In 1998, the CMA joined with Assemblyman Wally Knox to call for an audit to determine the extent of physician reimbursement problems. See "CMA Convinces State Legislature to Study Physician Reimbursement Problems," CMAAlert, No.1669, August 6, 1998.
64 California HealthCare Foundation and the Field Research Corporation, To Buy Or Not To Buy: A Profile of California's Non-Poor Uninsured, California HealthCare Foundation, 1999.


Unlike the American Medical Association, which has consistently opposed compulsory health insurance, the California Medical Association has taken a variety of positions depending on whether factions that supported or opposed compulsory health insurance were dominant within it at the time. The California Medical Association successfully opposed compulsory health insurance in 1917, 1945 and 1994. It unsuccessfully promoted compulsory health insurance proposals in 1934 and 1993. It unsuccessfully supported a proposal for a voluntary health insurance program in 1970. For a history of the vagaries of the California Medical Association’s positions on health insurance, see
Fifty Years in Law and Medicine: Reminiscences, Howard Hassard, An Oral History, (Hassard, Bonnington, Rogers & Huber, 1985). Hassard was a lawyer who represented the California Medical Association for over forty years.
CHAPTER 5
ORGANIZATIONAL AUTONOMY AND DOMINANCE

Physicians have tried to influence important aspects of the wider health system that affect the organization of their work and the day-to-day care of their patients. Chapter 5 will explore the physicians’ struggle for political influence with regards to the allocation and organization of health care resources (organizational autonomy) and vis-à-vis other health care professionals (organizational dominance). What do physicians understand by “organizational autonomy”? What are the specific goals of their associations in Ontario and California? Do they face similar challenges as they seek to have their reform proposals adopted? To what extent have their recommendations been transformed into policy?

A single payer universal health insurance system was introduced in Ontario despite the protests of physicians. Although it might have appeared at the time that physicians lost in the legislative arena, the presence of a single payer system has helped to bolster their organizational autonomy and dominance over the past three decades. In California, the medical profession successfully lobbied against a compulsory single payer system or remained neutral at key points in time when the proposals were being considered by political decisionmakers and the populace. While physicians “won,” on these occasions, in the sense they successfully resisted the enactment of single payer proposals that they did not support, they ultimately “lost,” because they failed to protect their organizational autonomy and dominance. Although there have been times when organized medicine in California lobbied for universal health care (usually using multiple
payers and a voluntary strategy), only incremental reforms have been enacted, such as comprehensive small-group market reforms in 1992, because these type of reforms have built on private market and managed care approaches that have been indigenous in California.¹

In Ontario, the state’s relationship with the medical profession could normally be characterized as concertationist, with two important exceptions. The provincial government has been strong and autonomous enough to make changes in the organization of health care resources and the regulation of health care professionals with limited input from the medical profession by using arm’s-length bodies (e.g., the Health Professions Legislation Review and the Health Services Restructuring Commission), when reforms could not be delayed any longer without seriously weakening the health care system. The medical profession initially criticized the reforms enacted by the HPLR and HSRC that somewhat diminished its organizational dominance and autonomy. Nevertheless, some moves to restructure hospitals and reform the health professions regulations were necessary to make a concertationist relationship between the state and the medical profession viable over the long-term, and improve the health care system. Even during the HPLR and HSRC processes, the government made important concessions to organized medicine to address some of physicians key concerns.

In California, the state has nurtured a pluralistic approach to the provision of health care through encouraging competition among health care providers to drive down costs.² Chapter 5 will show that physicians’ organizational autonomy and dominance is better protected by the state under the public health insurance model in Ontario than under the managed care approach of California.
THE MEANING OF ORGANIZATIONAL AUTONOMY AND DOMINANCE

Organizational autonomy and dominance are the physicians' freedoms to make decisions about the conditions of their work including the allocation of health care resources, the organization of the health care system and the scope of practice of other health care professionals without interference from third parties.

1. **Control over allocation of health care resources.**

   "The allocation of health care resources" is a phrase that conveys the flow of resources "from those who finance care to those who deliver it." It refers to the distribution of resources from the payers (patients, insurance companies, government) to doctors and hospitals for the services that they provide to patients.

   In the traditional guild model, physicians retain control over the allocation of health care resources. In fee-for-service medicine, they make treatment decisions based on patients' needs with little consideration of the financial cost to society. Medical associations may make private health insurance available to patients by setting up plans to allow them to prepay their medical costs. Individual physicians may subsidize the cost of providing insurance to the poor by extending "charity" care.

   If physicians are in control of rationing health care resources, they may base their decisions on their perceptions of the mental capacity, social class and likely benefit or risk to the patients. A drawback of giving physicians
responsibility for rationing decisions is that it tends to increase costs. If governments have the primary role in allocating medical resources, the criteria for making decisions are likely to be more explicit and decisions fairer, but physicians and citizens may feel that they have been deprived of the opportunity to make their own choices. If the market controls the allocation of health care resources, they will be distributed unevenly. Patients and physicians will need protections from cost-cutting measures that undermine the quality of care and the level of reimbursement for the sake of increasing profits for the health plans or other third-party payers. Alternatively, consumers could have control of deciding how health care funds should be allocated. They could be given medical savings accounts as the American Medical Association has recommended.\textsuperscript{5} Medical savings accounts are funds, which the government gives directly to individuals to finance their health care. The value of the account is based on the age and sex of the beneficiary.\textsuperscript{6} Proponents of medical savings accounts hope that they will increase access, lower costs, and empower patients relative to their doctors. However, individuals with medical savings accounts may deprive themselves of necessary care in order to save funds. There is no guarantee that there will be cost-saving benefits for government.

\section*{2. Control over organization of health care resources.}

In a traditional guild model, physicians practice as independent entrepreneurs in solo or small group settings, instead of as employees in large group settings. Hospitals operate as independent nonprofit facilities, rather than as part of for-profit multi-hospital chains or integrated delivery systems.
3. **Professional dominance over other health care professionals.**

Professor David Cobum of University of Toronto suggests that autonomy can be distinguished from professional dominance since autonomy, in its narrow sense means “freedom from” regulation by third parties, whereas dominance entails “authority over” other workers. However, in the sociological literature on professionalization, the two concepts are often conflated.

In a guild model, society acknowledges the primacy of medical knowledge. Physicians have a wide scope of practice, unlike other health professionals, whose scope of practice is limited. Physicians display their dominance when 1) they supervise other health care professionals on a day-to-day basis and 2) they successfully lobby government to make decisions that favour medical interests.

**THE GOALS OF THE MEDICAL ASSOCIATIONS**

1. **Control over allocation of health care resources.**

The Ontario Medical Association shares the goals of the Canadian Medical Association with respect to physician control over the allocation of health care resources. The Canadian Medical Association’s goals are articulated in the Charter for Physicians 1998. The Charter states that Canadian physicians need “sufficient resources to allow for the efficient, effective and professional delivery and management of medical care under reasonable and humane working conditions.” As well, Canadian physicians need “to be consulted and involved meaningfully in health care reform and policy planning” on issues related to the
funding of the health care system. The Canadian Medical Association suggests that only "core" services should be funded by OHIP. Patients, or their private insurers, should be held responsible for covering the costs of all other services. De-insurance has some of the same advantages for physicians as extra-billing. Both of these processes provide physicians with an opportunity to supplement the income that they receive under the Ontario Health Insurance Plan's fee schedule.

The Canadian Medical Association recommends that "core" services should meet these three criteria:

quality of care (e.g., effectiveness, appropriateness and efficiency of health care services), ethics (e.g., decisions that reflect fairness and acceptability to patients and physicians) and economics (e.g., measurement of service costs against economic benefits in a time of severe economic restraint).

The California Medical Association is committed to a universal health care system, where all citizens and residents have access to medically necessary services. The CMA generally prefers a pluralistic system, where individuals and groups can purchase their insurance from many different companies, to a government-controlled single payer system. However, the California Medical Association has historically been more positive than the American Medical Association, about the benefits of a single payer system. The California Medical Association sponsored a compulsory health insurance bill in 1935, but in 1936, the House of Delegates reversed its position and supported only voluntary approaches. The American Medical Association denounced single payer systems in 1998, concluding that they "are not in the best interest of the public, physicians or the health care of this nation and should be strenuously resisted."
2. **Control over organization of health care resources.**

The Ontario Medical Association aspires to have a joint role with government in planning and implementing any major reforms to the organization of health care resources. The OMA prefers a system where individuals have the freedom to choose their physicians and their hospitals,\(^{13}\) and there is incremental, rather than revolutionary, reform of the primary care system.\(^{14}\)

The California Medical Association's goals with respect to the organization of health care resources have changed over time.\(^{15}\) In the late nineteenth and early twentieth century, the CMA joined with the American Medical Association in declaring that free choice of physicians by patients was a priority. The CMA has gradually modified its opposition to contract-practice arrangements, whereby third parties like employers contract with physicians to give medical services to their employees. The California and American Medical Associations traditionally declared prepaid health plans unethical, on the grounds that these plans undermined physicians' professionalism by commercializing health care. Prepaid plans increase competition among physicians, which was considered undesirable because it threatened the unity of the profession.

Although the medical associations at the state and federal level publicly denounced closed-panel service arrangements, some of the county medical associations, in California, took a more moderate stance, in recognition of the local reality that there was a surplus of physicians and hospital services available to be used, albeit on a prepaid basis.
In a 1959 report, the American Medical Association first recognized patients' free choice of health plans or medical groups as an acceptable substitute for their free choice of physicians. The California and American Medical Associations now seek to change legislation to make it easier for physician-owned health plans to compete in the marketplace with their commercial-owned counterparts. The medical associations try to expand physician autonomy by opposing contracts that tie a physician’s membership in a managed care panel to participation in another managed care panel.

3. Professional dominance over other health care professionals.

The Ontario and Canadian Medical Associations support the work of other health care professionals, if it is carried out in collaboration with doctors or under the supervision of doctors. However, the medical associations have reservations about allowing allied health professionals to work independently.

The California and American Medical Associations similarly prefer that physicians retain the ultimate responsibility for providing care, and assert that any responsibilities delegated to allied health professionals should be at the discretion of the medical staff.

THE ONTARIO CASE

1. Control over allocation of health care resources.

Prior to the introduction of publicly financed health care, patients could purchase insurance from commercial companies or physician-owned companies, which were supported by the medical association. At its peak, about 90 percent of
Ontario doctors participated in Physicians' Services Inc., a private medical plan that the OMA established in 1948, so that individuals could prepay the major part of their medical costs. Most of these plans co-existed only for a short time with the Ontario Medical Services Insurance Plan, after it was established in 1966. That same year, the federal government introduced the Canada Assistance Plan, which was a cost-sharing arrangement for social assistance programs. The federal government agreed to fund health care on a fifty-fifty basis with the provinces, as long as they met the conditions for the funding. The federal government has gradually reduced its share of health care payments to Ontario, so that today it pays about 34 cents per dollar spent, according to the federal government,20 or 11 cents per dollar spent according to the Ontario government.21

In Ontario, physicians retain substantial control over the allocation of health care resources. The Canada Health Act requires them to provide "medically necessary" services, although the Act does not specify exactly which services should be insured or de-insured.21 The Ontario Ministry of Health, in consultation with the Ontario Medical Association, makes that decision. Cathy Charles, Jonathan Lomas, Mita Giacomini and colleagues have identified four definitions of "medical necessity," that were implicit in the government and stakeholder documents they reviewed. Namely, "what physicians and hospitals do," "the maximum we can afford," "what is scientifically justified," and "what is consistently publicly funded across provinces."22

Once physicians determine that patients are in need of medically necessary services, they may be placed in a queue to wait for their turn, if specialists and
medical equipment are not immediately available. Restrictions result from the sharing of scarce public resources, such as operating theatre time. Studies show that Canadians who lack financial resources are less likely to see specialists, because they may have difficulty arranging childcare, taking time off work, and advocating for their medical needs with primary care physicians.23

2. **Control over organization of health care resources.**

Most Ontario physicians continue to practice in small groups settings and most hospitals are still independent nonprofit facilities, as they were prior to the introduction of a national health insurance program. The Ontario Medical Association was in favour of maintaining the organization of health care services, as it existed before the enactment of the Medical Care Act in 1966. Nevertheless, the Ministry of Health introduced Health Service Organizations in 1973, in response to the Hastings Report of 1972. The Report had recommended “payment mechanisms alternative to the present form of fee-for-service; development by the provinces...of community health centers...in a fully integrated health services system; [and] funding of community health centers through global or block budgets given by the province to the district level.”24 Other organizational innovations that were introduced by the Ministry included the Community Health Centres, District Health Councils and Comprehensive Health Organizations.

Some of these were successful in their geographic area, but the programs have not grown to the extent that early reformers had hoped. In 1991, the provincial government froze the expansion of the health service organizations. In
1992, the government cancelled the HSO contracts and renegotiated a deal in order to reduce capitation payments and save $17 million annually. Brian Hutchison, Stephen Birch and J. Gillett identify many factors that have contributed to the Health Service Organizations program’s shortcomings. These include “lack of coherent policy direction, lack of support both politically and within the Ministry of Health, lack of resources, inadequate data/information systems, lack of evaluation, [and] lack of accountability mechanisms.”

Premier Harris’s election, in 1995, ushered in a new era of immense changes in the organization of health care services that included primary care reform, downloading provincial public health programs to Ontario municipalities, and hospital restructuring. The Ontario Medical Association has played an important role with the provincial government in developing a new vision of primary care reform to allow for a more rational distribution of resources and improve the quality of care. The Physician Advisory Group, under the leadership of Dr. Wendy Graham, presented a proposal to the government that has slowly been put in place. Over the past four years, pilot projects to test Primary Care Reform have been launched in seven communities, and have involved more than 150,000 patients. The pace of change has been much slower than is the case with hospital restructuring because physicians have been actively engaged in the process of primary care reform, an initiative that they view as central to their interests. The Ontario Medical Association has sought to ensure patient accountability, adequate capitation rates and careful evaluation of the projects.
Physicians have had less input into Harris's decisions to download provincial public health programs to municipalities and restructure hospitals. Bill 26, the Savings and Restructuring Act, which set up the Health Services Restructuring Commission (HSRC), was passed in 1996, with very little debate considering that it amended 44 statutes, created three new Acts and repealed two others. The Savings and Restructuring Act gave the health minister dictatorial authority to strip hospitals’ management and boards of trustees of their power and replace them with his/her own choice of supervisors. Opposition members staged a sit-in in order to force the government to hold public hearings, which lasted only three weeks.28

The Health Services Restructuring Commission, chaired by Dr. Duncan Sinclair, former dean of the faculty of medicine at Queen’s University, was given a mandate to lay the groundwork for an integrated health system. From 1996 to 1998, the HSRC concentrated on reviewing the functions and viability of the province’s hospitals.29 It made recommendations to close a number of hospitals including 11 of 44 in the Toronto area,30 and suggested reinvesting funds in home care, long term care, mental health, rehabilitation and sub-acute care. Critics note that the fast pace of the restructuring process is unfortunate because resources have not been put in place to support the individuals and families that are becoming the caregivers, as the institutional capacity of hospitals shrinks and patients are released “sicker and quicker” than used to be the case. They point out that there is no guarantee that hospital restructuring will save money, since it has already cost an estimated $2.3 billion.31 Nor is there any guarantee that the HSRC
will create a better health care system. Few would dispute that there were too many unused hospital beds prior to the hospital closings, but there were fewer in the flu season, at which time, the emergency wards would typically become overloaded. The Ontario government has had to partially reverse its earlier decisions of firing thousands of nurses, because it has found itself in the midst of a severe shortage. The government has had to establish 753 new hospital beds in Toronto to help compensate for the 5,700 acute care beds that have been closed across Ontario during Harris' tenure as premier.

The commissioners did little to involve physicians in the planning process at the beginning of their mandate. Nevertheless, they gradually developed a healthy respect for the influence that physicians have in forming public opinion on health care reform. In looking back at the process, they saw the value of physicians' opinions that change should be incremental, and advice from stakeholders and the public should be solicited. In 1997, the HSRC gave physician fact-finders the opportunity to make recommendations on the need for medical human resources during the transitional phase. The report indicated the principles that should be followed so that physicians would be fairly treated if the hospitals that they worked in were closed. The hospital closings may have made it more difficult for specialists to access hospital facilities.

3. **Professional dominance over other health care professionals.**

As was indicated in chapter 1, physicians remain the dominant group of health care professionals in Ontario, but they have gradually lost status relative to other health professionals, particularly since the state reconfigured its
relationships during the Health Professions Legislation Review of the 1980s. In the Health Disciplines Act of 1974, medicine was recognized as one of the five major professions along with nursing, optometry, pharmacy and dentistry. Another fifteen professions were considered for inclusion, but were ultimately excluded because they were not thought to be significant enough. In contrast, the Regulated Health Professions Act (RHPA) of 1991 made medicine one of 24 health care professions that met the nine criteria for self-regulation. The RHPA assumed that professional turf could be shared. It gave physicians the right to perform 12 of the 13 potentially dangerous acts (all but filling or dispensing dental appliances). Nurses could perform only three (undertaking a prescribed procedure, administering a substance by injection or inhalation, or putting an instrument, hand or finger beyond specified areas of the body). The College of Physicians and Surgeons of Ontario became one of 22 regulatory colleges with similar functions and authority. The Minister of Health won new powers to require the Councils of the Colleges to carry out certain acts.

Midwives and nurse practitioners made substantial legislative gains in the 1990s, as the Ontario government under the leadership of Premiers Bob Rae and Mike Harris sought new ways to contain costs, by making greater use of workers whose labour was less expensive than that of physicians. In 1991, midwifery became legal in Ontario and midwives gained the right to practice inside or outside of the hospital setting. In Ivy Lynn Bourgeault’s words, midwives achieved “self-regulation (no matter how compromised), and an expanded scope of practice [that] have no precedent in the midwifery experience elsewhere.”
Despite a rocky history, nurse practitioners gained the legal authority to diagnose and treat common diseases without doctor approval, as well as to order certain ultrasounds, basic lab tests and x-rays in 1998.\textsuperscript{38} These changes did not seriously undermine the dominance of medical interests in the Ontario health care system. The reforms showed that interest groups could significantly improve their relationship with the state, even if they lacked abundant internal resources, as long as they could frame their policy demands in ways that were compatible with the ideas of the political elites.\textsuperscript{39}

THE CALIFORNIA CASE

1. Control over allocation of health care resources.

In the past three decades, control over the allocation of health care resources in California has shifted from physicians to managed care organizations, even though physicians continue to bear most of the liability for adverse outcomes.\textsuperscript{40} In California, patients receive health care if they 1) have public, private or employment-based insurance that is comprehensive enough to cover the costs of their treatment, 2) are able to pay for it directly out-of-pocket, or 3) are indigent and sick enough to qualify for emergency care at their county’s or doctor’s expense. Appendix I shows the sources of physician practice revenue in California between 1994 and 1998.

Prior to 1965, when Congress introduced Medicare for the elderly and disabled and Medicaid for the poor, the California Medical Association opposed several plans for statewide compulsory health insurance. The California Medical
Association fought to defeat legislative measures introducing a statewide compulsory health insurance plan in 1918, 1946, and 1947. Only in 1934, in the midst of the Depression, did the CMA House of Delegates for a brief time support a compulsory health insurance bill.\textsuperscript{41} The medical association in California was the first in North America to support the formation of a physician-owned insurance company. In 1939, the CMA helped to set up the California Physicians' Service, a prepayment service company that was the forerunner of California Blue Shield.

Many Californians remained uninsured, even after Medicare and Medi-Cal were set up alongside the commercial and physician-owned insurance companies. In 1970, the California Medical Association developed a proposal for a "voluntary, universally available health benefits program."\textsuperscript{42} The CMA envisioned eliminating Medicare and other federal programs financing health care benefits and absorbing them into the new program that it was recommending. This was only one of a number of health insurance proposals that the CMA supported to make health care more universally accessible.

In the 1990s, the California Medical Association made significant efforts to try to reduce the number of uninsured Californians. The CMA promoted its Affordable Basic Care Initiative in 1992, which would have required all employers to provide care to employees and their children, in conjunction with Proposition 166. The proposed bills stalled in the Assembly (A.B. 2001, Brown) and in the Senate (S.B. 248, Maddy), and Proposition 166 was rejected by almost 70 percent of Californians that voted. Thus, the California Medical Association
proposals, which might have extended coverage to 4 million more Californians, were soundly defeated. Thomas Oliver and Emery Dowell explain their demise by pointing to the opposition of business groups and affluent, privately insured consumers to the initiative.43 The CMA proposals were not ambitious enough to interest the more socially liberal consumers, but were too ambitious for the conservative ones. The proposals were introduced at a time when the state of California was in the midst of a severe economic downturn. The state government had very little money left in its coffers to soften the effect on small business of requiring them to cover health insurance. At the time, it was possible that Clinton’s Health Security Act would be accepted. The American Medical Association was already preoccupied with promoting its own Health Access America plan to provide a basic level of health care for all citizens, and did not choose to give substantial funds to the Californian campaign. Hence, Californians were tempted to wait for the federal government to take the lead on reform.

Even though many California doctors were in favour of supporting Proposition 186, the state’s single payer initiative of 1994, the California Medical Association decided to “not support” the initiative. Proposition 186 was defeated at the polls by a margin of 73.4 to 26.6 percent.44

In the 1990s, the California government introduced a complex patchwork quilt of programs to extend health care coverage to specific segments of the uninsured population. The California Medical Association put little effort into setting up the Access for Infants and Mothers Programs, established in 1992, and the Health Insurance Plan of California, established in 1993, because it was
preoccupied with trying to introduce more comprehensive reform through an employer mandate. The Health Insurance Plan of California was designed to act as a purchasing agent for small employers. In 1997, a Healthy Families program was launched to provide coverage for children of low-income families. In 1998, the Clinton administration approved California’s Children’s Health Insurance program. As was noted in chapter 3, the California Medical Association fought in court to ensure that undocumented residents could receive prenatal services, even though voters supported Proposition 187, which aimed to deny non-citizens care that was provided at the taxpayers’ expense.

Despite the best efforts of the California Medical Association and the state government, more and more Californians are falling into the ranks of the uninsured, and they are much less likely to seek needed health care or receive preventive care than the more affluent insured. Financing for indigent health care, like its delivery, remains highly uncoordinated. Money is drawn from a combination of realignment funds, tobacco taxes, Medi-Cal Disproportionate Share Hospital dollars, and local property taxes. Through cost-shifting “large companies providing benefits have subsidized the health expenses of the uninsured, of other companies, and of the government,” although they are becoming much less willing to do so. This is an inefficient way of financing health services for California’s many uninsured. The indigent uninsured often wait until they need emergency services before they seek health care. Then, health services are provided at a much higher cost in human and financial terms than would have been required if patients had received care at a less acute stage.
2. *Control over organization of health care resources.*

California has a long history of using innovative forms of health care delivery. Kaiser Permanente was set up in the 1940s and grew to the point that it enrolled 36 percent of the California HMO market in the 1990s. One factor that has enabled managed care to grow to be the dominant form of health care in California that it is today is the favourable reputation that Kaiser Permanente has built among many of its patients. Other explanations for its growth are that managed care organizations have offered Californians lower insurance premiums than most solo fee-for-service physicians have been able to offer. The many physicians that have located in that state have made it a hospitable environment for health maintenance organizations to flourish. Federal legislation introduced in 1973 encouraged their rapid growth through financial incentives for employers.

State legislation has influenced the type of health care delivery systems that have developed in California, with more than 80 percent of beneficiaries enrolled in health maintenance organizations and preferred provider organizations by the 1990s. As we have seen, the passage of A.B.799 and 3480, in 1982, made it legal for health insurance plans to establish preferred provider organizations to vie for Medi-Cal contracts. Physicians and hospitals that participated in preferred provider organizations agreed to accept discounted fees as payment for their services.

The existence of corporate laws that prohibit physicians from working on salary for anyone but other physicians has encouraged the growth of large
managed care-oriented group practices in California. Legislation that bans corporate ownership of physicians' practices makes it illegal for hospitals to own medical groups. Staff-model health maintenance organizations are forbidden. Consequently, powerful group-model HMOs have emerged to control the market and drive down costs. Independent practice associations have become common in the California marketplace because they provide a way, which does not contravene the antitrust laws, for physicians to band together to negotiate contracts. The particular types of physician-system integration that have developed have placed many physicians at risk. Physicians' salaries are often partially contingent on the profits of the health plans through fee withholds. Potentially even more devastating to their income is the risk that they bear of having to provide medical services at their own expense if the health plans that they contract with claim bankruptcy. The California Medical Association has lobbied the legislature to try to limit physicians' liability in this regard.

Between 1990 and 1997, eighty-nine bills were passed in the California legislature to try to reform failings in the managed care system. Phil Isenberg, a former assemblyman who represented Sacramento for 14 years, referred to them as "tinker-at-the-edge bills," while the CMA called them "body part" legislation. Governor Pete Wilson appeared to take a more systemic approach by setting up the Managed Health Care Improvement Task Force of 1997. It made more than 100 recommendations to improve managed care, very few of which were implemented by Wilson. Critics suggested that he used the Task
Force as an instrument to stall reform since he refused to pass managed care bills while the problems were being studied. Once the report was issued, he shelved it.

Pete Wilson’s successor, Gray Davis, has implemented some of the report’s recommendations such as creating a new regulatory body to oversee HMOs, within the California Department of Corporations. The CMA had argued that a new regulatory body was needed, but recommended that it be housed within the Health and Welfare Agency, as did the California State Auditor, since the Department of Corporations is the general business regulatory agency and has no particular expertise in the area of health care.

3. **Professional dominance over other health care providers.**

The California Medical Association has consistently opposed the expansion of the allied health professionals’ scope of practice. The CMA has launched turf battles in the Assembly, Senate and courts to prevent the expansion of their role. Nevertheless, allied health professionals have made inroads into physicians’ territory. Podiatrists won the “battle of the ankle” against orthopedic surgeons in 1983. Acupuncturists’ status as physicians was established in 1988. In 1998, the role of pharmacists was expanded to allow them to initiate prescriptions or patient consultations outside pharmacy premises and provide refills without authorization.

Perhaps even more significant changes have been made for nurse practitioners and clinical nurse specialists at the federal level. Congress enacted the Primary Care Practitioner Incentive Act as part of the Balanced Budget Act of 1997, which enabled them to bill directly for Medicare reimbursement regardless
of the setting in which the service is performed.\textsuperscript{59} Formerly, only physicians had the right to bill Medicare directly, so this change represents an important expansion in nurse practitioners' and clinical nurse specialists' autonomy and may lead to an increase in their numbers.

The scope of practice of allied health professionals depends not only on the legislation that is in place, but also on the incentives of the institutional settings. Studies have found that nurse practitioners and physicians assistants have acquired a lot more autonomy and a wider scope of practice in institutions with large managed care populations in the West, as part of their efforts to contain costs and increase productivity.\textsuperscript{60} Health maintenance organizations have curbed physician autonomy by directing allied professionals to review their treatment decisions. As one Californian doctor observed,

\begin{quote}
HMOs dictate and direct social workers, pharmacies, paramedics, ambulance drivers, insurance inspection teams, any Tom, Dick, and Harry, to inspect, dictate, limit, and tell the physician what to do. Their jobs and business contracts will be terminated if the HMOs are not followed. The physician has no say and has to do what everyone else says, or else his/her practice is in jeopardy.\textsuperscript{61}
\end{quote}

Thus, one reason that California physicians have lost more of their organizational autonomy and dominance than Ontario physicians is that allied health professionals in California have achieved significant gains in their level of autonomy.
ASSESSMENT AND EXPLANATION

I. Control over allocation of health care resources.

Why do Ontario physicians have more control over the allocation of health care resources than California physicians, although they are frustrated with limited health care dollars and long waiting lists? Why has California not developed universal health care insurance, despite many attempts by interest groups to achieve a more equitable distribution of health care resources? To understand the differences in the policy outcomes, it is necessary to examine the content and context of the debate over health insurance in Ontario and California.

Ideas, interests and institutions have facilitated some actions and constrained others. In Ontario, some elites in political parties, unions, the medical profession, the business community, and the academic community have promoted the idea that health care is a right and that a single payer system is the most efficient way to provide care. Their support for universal health insurance has resonated well with the public, which has treated it as a symbol of what makes Canada different from the United States. Many Ontarians have glorified publicly financed health insurance as the jewel of their social policy.

Supporters of publicly financed health insurance have had sufficient institutional access to transport their ideas into the policymaking arena in Ontario, as was discussed in chapter 1. Insurance associations, which have played an important role in promoting market forces in the health care sector in the United States, have had limited influence in Canada, since the Medical Care Act was enacted in 1966, and government assumed their role as the third-party purchaser.
of medical services. The state in Ontario has been strong enough to foster concertationist relations with the medical profession and gain its cooperation in implementing universal health insurance, even though many doctors would have preferred a voluntary system. Joan Boase observes,

It is apparent that if governments are to withstand the negative reactions of organized societal interests to a redistributive public good such as universal health insurance, the state must be proactive, autonomous, interventionist and strong. The institutions of such a state will have the capacity to preclude effective pluralist policy networks, fostering instead cooperative and accommodating or corporatist intermediation. Furthermore, the strong state’s ability to determine which groups may participate in the policy process circumscribes and controls membership in the policy community.64

Opponents of universal health insurance in California have traditionally labeled it “socialized medicine.” They have suggested it is a precursor to a socialist state and represents an assault on the American values of individualism and competition. This argument was particularly compelling around the time of World War Two. The California Medical Association waged a successful campaign against Governor Earl Warren’s compulsory health insurance bill in 1945 at a cost of approximately $3 million.65 They hired Whitaker & Baxter, a public relations firm, and ran advertisements in every newspaper in California that fanned public sentiments that government-run health insurance could not solve the state’s problems. Thus, the California Medical Association framed universal health insurance as “socialized medicine” to delegitimize a compulsory health insurance program and legitimize a voluntary one. Even though Governor Warren was a popular leader, he did not have the institutional capacity to push the
legislation through the Assembly and Senate without the support of the medical profession.

With the passing decades, it has become more difficult to enact universal health insurance in California because the interests of the medical/industrial complex have backed the early decisions to pursue market principles in health policy. Insurers would lose a large part of their raison d’être if government replaced them as the primary purchaser of medical services, as is the case in Canada. It is not obvious to the medical profession that their economic autonomy would be better protected in a universal health care system run by government, given that Medicare and Medicaid reimbursement rates are much lower than those negotiated by private payers, and physicians’ salaries in Canada are generally lower than in the United States.

2. *Control over organization of health care resources.*

Why is the organization of health care resources in Ontario almost the same today as it was in the 1960s? Why has the California health system been radically transformed from “a cottage industry structure” to “a corporate industry structure” over the past three decades? The Ontario Medical Association drew upon the widespread acceptance of the biomedical paradigm to justify physicians’ control over the organization of health care resources. Only in 1996, when Premier Harris stripped the OMA of their right to act as the representative for all Ontario physicians and set up the Health Services Restructuring Commission to transform the health care delivery system, did their influence significantly decline in this regard.
The biomedical model\textsuperscript{68} has traditionally been the dominant paradigm throughout North America. It emphasizes the importance of providing care to individuals, often in an institutional setting, once they become ill, rather than trying to prevent the societal causes of disease in a community context, as the public health paradigm recommends. According to the biomedical paradigm, physicians play a critical role in curing patients. The public health model, which was first popularized in Canada in the Lalonde Report of the 1970s, puts the onus on communities to participate in health care. Premier Harris’s government drew upon fiscal conservative ideology and public health rhetoric (rather than referring to the biomedical model) to justify its decision to launch the Health Services Restructuring Commission. The Commission was the policy instrument of choice because it allowed the politicians and bureaucrats to distance themselves from the public criticisms that would inevitably arise when hospitals were closed. The Commission solicited little input from doctors and other members of the health policy community so that it could proceed very quickly with fundamental changes.

The relatively timid efforts of the OMA, the opposition and the public to alter Harris’s hospital restructuring agenda could be traced to the fact that they were given little warning that Bill 26 was about to become law. The Ontario Federation of Labour notes, “most members of the opposition were still in the budget lock-up\textsuperscript{69} when Bill 26 was rammed through with little public debate. The OMA was recovering from the effects of fiscal restraint in the early 1990s, when physicians had been made to bear the indignities of “caps,” or limits on
their earnings, and reduced enrolment in medical schools. Therefore, the medical association's input to the restructuring process was rooted in a relatively narrow vision of physicians' interests.

Hospital restructuring was central to the Common Sense Revolution, since health expenditures represent a large percentage of the provincial budget. Harris was able to proceed with hospital restructuring, because he was a relentless leader and had the powers of a parliamentary government at his disposal (e.g., a disciplined party). This enabled him to enact Bill 26 and establish the HSRC, a decisionmaking body that was relatively isolated from interest group lobbying and receptive to his vision of reform. The HSRC destabilized the health system, making change possible with relatively little input from the medical profession.

In a similar way, the Ontario government had shifted the difficult task of rewriting the regulatory legislation governing the various health disciplines to a review coordinator in the 1980s, to temporarily reduce the influence of the major health professions, although in the earlier case, a private consulting firm was selected to make the difficult political decisions instead of a commission. Each time the government sets up a process to make major changes in the health system with little input from organized medicine and the public, it sets a precedent that makes it easier for the state to impose top-down solutions in the future. Recently, the Harris government has negotiated generous agreements with the Ontario Medical Association, which may reduce the acrimony of the HSRC process for doctors.

As Janet Lum observes,

The imposition of "caps" led the profession to retaliate with a series of job actions. In 1997, the government was forced to back down. It removed
the caps on physicians’ incomes and guaranteed that total physician payments would increase to an estimated $4.17 billion by 1997-98, $4.29 billion by 1998-99 and $4.35 billion by 1999-2000. In California, the reorganization of the health care delivery system could be traced to decisions by government and managed care organizations to contain costs. The California government, which has not historically been as “proactive, autonomous, interventionist and strong” as the Ontario government, catered to medical interests in the 1960s. However, the private and public purchasers of health care became frustrated with the rising costs of health care associated with fee-for-service medicine, and they have found new ways to rein them in, such as fixed prepayment and integrated health systems, that have undermined physicians’ power. Third-party payers have emphasized the importance of non-institutional, preventive care. It is less expensive for payers to direct services to consumers who are healthy, than to ones with chronic or serious illnesses. The sicker patients may face daunting obstacles when they try to obtain care from managed care organizations.

3. **Professional dominance over other health care providers.**

Why have Ontario physicians retained more of their authority over allied health professionals than California physicians? Ontario physicians have experienced a decline in their dominance, particularly since the enactment of the Regulated Health Professions Act, which assumed that they could share the authority to perform dangerous medical acts with allied health professionals. The decline has not been nearly as severe as physicians in the California HMO market have experienced. As mentioned in chapter 1, Ontario physicians benefit from a
close working relationship with the provincial government, that allied health professionals do not have. The existence of the Physician Services Committee provides the Ontario Medical Association and the Ministry of Health with an ongoing dispute mechanism where they can air their concerns. The Ontario Medical Association’s services and resources are vital to public officials because physicians are an articulate, well-educated group that can stage job actions and make critical comments in the press if they feel they are treated unfairly.

Although nurse practitioners, midwives and other nurses can use similar tactics, there are differences in their gender, professional status and educational level that make it less likely that their demands will be taken seriously by the provincial government. 73

In California, health maintenance organizations have made extensive use of nurse practitioners and physician assistants, as substitutes for primary care doctors, in order to save money, or more precisely in order to transfer money “from doctors, nurses, hospitals, and other providers to executive management teams and investors.” 74 Peter Jackson, Louise Parker and Ian Coulter have noted that health maintenance organizations may not need as many primary care doctors because their patients are not as sick as those in other settings. Health maintenance organizations have many tactics for excluding sicker subscribers. Steffe Woolhandler and David Himmelstein have observed that they place sign-up offices on upper floors of buildings with malfunctioning elevators; refuse contracts to providers in neighborhoods with high rates of HIV infection (an example of medical redlining); structure salary scales to assure a high turnover among physicians (the longer they are in practice, the more sick patients they accumulate); provide luxurious services (even
exercise club memberships) for the well, and shabby inconvenience for those with expensive chronic illnesses.\textsuperscript{73}

Health maintenance organizations have been able to consolidate their market strength and gain political power that rivals physicians' by driving deep discounts with physicians and other health care providers. In the process, they have deprived physicians and allied health professionals of some of their autonomy.

Chapter 5 has shown that Ontario physicians have retained more organizational autonomy and dominance than California physicians, even though physicians in both jurisdictions expected that a government-financed system posed the ultimate threat to their autonomy. As Steven Wartman of the Albert Einstein College of Medicine in New York City observed:

Doctors in the U.S. were so singlemindedly guarding the gates against socialism that they were blindsided by something far more powerful – capitalism.\textsuperscript{76}

The existence of a single payer system in Ontario, as a result of early policy decisions and a stronger state, made it possible for the Ontario Medical Association to negotiate with the government as a cohesive unit. In contrast, the emergence of managed care in California, partially as a result of a more competitive policy environment and a weaker state, led to a situation where physicians have widely different interests depending on the nature of their practice and the companies that they serve. Thus, institutions, political culture, and historical decisions have contributed to the type of policy networks that have developed – concertation in Ontario and pluralist in California – and this, in turn, has influenced the level of autonomy and policymaking influence of physicians and allied health professionals in the two jurisdictions.
6 See the Fraser Institute’s plan for a medical savings account experiment in Canada, posted at www.fraserinstitute.ca, 1998.
15 Peter Newbanks Grant, The Struggle for Control of California’s Health Care Marketplace, Ph.D. diss., The Department of History, Harvard University.
29 Health Services Restructuring Commission, Change and Transition: Planning Guidelines and Implementation Strategies for Home Care, Long Term Care, Mental Health, Rehabilitation, and Sub-acute Care, (Toronto: Health Services Restructuring Commission, April 1998), p.5.
35 The health profession might be considered qualified for self-regulation if its members operated under the jurisdiction of the Minister of Health; they were insufficiently supervised and were not regulated under an alternative regulatory mechanism; patients risked being harmed by its members; the profession drew upon a distinctive body of
knowledge; there were high education requirements for entry to practice; the leadership favoured the public interest over the profession's self-interest; members would comply and were sufficiently numerous to staff the committees. See Patricia O'Reilly, *Health Care Practitioners: An Ontario Case Study in Policy Making*, (Toronto: University of Toronto Press, 2000), pp.359-360.


49 Kaiser Permanente was ranked as the leader among the 765 HMOs in the United States, with 12 percent of the total membership over a five-year period in the early 1990s. See *Kaiser Permanente: Not-for-Profit or "Not for Patients?"* California Nurses Association, 1997.
Michael Johnson observes that HMO premiums for families average almost $900 a year less than fee-for-service premiums in California. See “Forces Behind HMO Regulation,” Sacramento Bee, November 7, 1997.


Alain Enthoven and Sara Singer, “The Managed Care Backlash and the Task Force in California,” Health Affairs, Vol.17, No.4, pp.95-110.


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CHAPTER 6
CONCLUSIONS

This dissertation has tackled the broad research question: Why have physicians retained more policymaking influence under the public health insurance model than under the managed care approach of California? I defined policymaking influence in the case of the medical profession to mean corporate, clinical and economic autonomy, and organizational autonomy and dominance. I attempted to answer the question by looking at the meaning of the various aspects of physician autonomy and dominance, the goals of the medical associations, and the policy outcomes in Ontario and California. Then, I identified the most relevant factors in the comparison. I showed how the political articulation of the medical profession's demands changed over time and was shaped by the presence of very different political institutions, patterns of interaction between interest groups and the state, and early policy decisions that have locked in subsequent paths of development and political processes.

1. DISCUSSION OF THE FINDINGS

The foremost task of the dissertation was to explain differences in the policymaking influence of the medical profession in the two jurisdictions. An investigation of why universal publicly funded medical insurance was adopted in Ontario but not in California was considered beyond the scope of this thesis because it would have involved investigating broad federal issues that dated back well before the period of time under consideration (1969-2000). Nevertheless, those early policy choices, and not
just formal institutions, have framed “the choices of political actors both by creating resources and incentives and by influencing the efforts of individuals to interpret the social world,” as Paul Pierson notes is often the case.¹ The Ontario medical profession has retained more of its autonomy and dominance despite the fact that it was not able to prevent the enactment of a single payer universal health care system in the province.

In contrast, the California medical profession has lost much of its autonomy and dominance because organized medicine in the United States resisted the enactment of a single payer system at key points in time, when it came closest to being introduced. Physicians feared that an expansion of the government’s role in financing health insurance would undermine their autonomy, but, ironically, they have lost political influence even though they appeared to be “successful” in opposing governmental health insurance programs. Third-party payers, in the form of insurers and employer-purchasers, have proven to be more of a threat to physicians’ autonomy than government alone would likely be. The pluralist network that developed has helped to “lock-in” the “non-decision” regarding universal public health insurance in the United States.² Organized medicine in the U.S. has softened its opposition, and in some cases actually embraced, proposals for universal health insurance in the 1990s, as physicians’ perceptions about how a national health program would affect their autonomy have changed. Physicians would likely receive a higher level of reimbursement if they could provide more services to the 17 percent of Americans who are currently uninsured.

In the Ontario case, the existence of a parliamentary government has meant that the state can act as a cohesive unit. It is relatively rare for individual members of the government, particularly ministers, to take different stances on party policy in the
legislature. Hence, the executive effectively controls the legislature and can introduce comprehensive policy changes. The presence of a parliamentary government has reinforced the centralizing tendencies of federalism and encouraged the formation of a third party (CCF-NDP) that influenced the policy agenda of the prime minister at the time that a single payer system was adopted. The federal structure of the state enabled Saskatchewan to take the lead in experimenting with universal health insurance and showed that the public financing of hospital and medical insurance was a workable solution to the problem of uneven access to health care, at least at the provincial level. Prime Minister Pearson used the federal spending power to pressure the provincial governments to design health programs that met the criteria set out by the federal government. The collectivist ideology of citizens at the time that universal health insurance was adopted meant that they were generally receptive to the idea of sharing the costs of health care together, even though organized medicine and the insurance industry initially resisted the introduction of a single tier system.

The Canada Health Act (CHA) of 1984 had the effect of locking in the earlier policy decisions that hospital and medical insurance would be publicly financed in each of the provinces. The Act slowed the growth of a parallel private health care system by prohibiting extra-billing and requiring all essential medical and hospital services to be delivered exclusively by public money, although the terms of the CHA have not always been vigorously enforced. The institutional configuration that developed in Ontario served to privilege medical interests. The strong state encouraged the Ontario Medical Association to dominate the associational system in the health sector, and act as an important partner in long-term planning and policymaking.
concertation policy network gave representatives of the medical profession many opportunities to discuss proposed changes to physician compensation and the health system in such forums as the Joint Committee on Physician Compensation (1973-89), the Joint Management Committee (1991-95) and the Physician Services Committee (1997 to the present).

In the United States, it has been difficult to introduce coherent policies like comprehensive health reform because presidents and governors cannot guarantee the passage of government's programs. The congressional system divides political power between the executive and the legislature, providing many opportunities for interest groups to put pressure on political leaders to veto legislation. Many legislative leaders need to be convinced to vote for policy proposals before they can be passed because there is a low level of party discipline in both houses. A more activist judiciary than exists in Canada has interpreted the federal Employee Retirement and Income Security Act of 1974 to mean that individual states do not have the authority to require employers to provide health insurance to their workers. The inability of the states to make regulations that apply to self-insured plans makes it difficult for legislators to introduce a universal system of health insurance at the state level. In California, specific initiatives have also impeded the enactment of universal health insurance proposals. The passage of Proposition 13 in 1978, and Proposition 4 in 1979, restricted the ability of the states to allocate funds to health care by capping future increases in property taxes and limiting per capita increases in state spending. Proposition 140, which shortened the term limits in California in 1990, made it difficult for interest groups to establish a strong rapport with assembly members and senators to encourage them to embrace their preferred bills.
Thus, early policy decisions and a fragmented state have reinforced the decentralizing tendencies of federalism by preventing the introduction of universal state financed health insurance. A weak state has exacerbated the fissiparous tendencies within the medical profession. It has fostered a pluralist network in the health policy community and exposed the medical profession to a high level of competition in the marketplace. As a result of government policy that encouraged the rise of health maintenance organizations and market competition, California doctors have organized themselves into different interest groups, depending partially on their choice of specialty and whether they participate in solo (32.3%) or group practice (31.7%), or work as independent contractors (3.4%) or employees (29%). Physicians find it difficult to present a united front in negotiating with health plans because antitrust laws prevent those who are self-employed from engaging in collective bargaining.

The difference in the number of payers in the Ontario and California health systems has important implications for the way that physicians express their discontentment. As Robert Evans has observed, in the Canadian single payer system, it is easy for physicians to identify the source of “their collective frustration and anger.” They blame “the government” for being “so irresponsible and short-sighted as to fail to meet professional demands.” In contrast,

The American practitioner must defend to the payer her decisions and intentions with respect to an individual patient; the intrusion is thus much more personal and direct. But the corresponding frustration and anger are more difficult to focus. The constraints that are in Canada a political problem for the profession, are in the United States a personal problem for each physician.

It is difficult for California physicians to agree upon a common target for their dissent since the reasons for their declining autonomy are so complex.
The California Medical Association, as one pluralist interest group among many, has no special status. Unlike the Ontario Medical Association, the state has not treated it as the official voice of medicine. The California Medical Association has had to resist encroachments by powerful business interests, consumers, other self-regulating health groups and the state, which have challenged physicians' autonomy in such areas as workforce planning, discipline, quality assurance, payment and conflicts of interest. California physicians have retained a higher level of reimbursement than Ontario physicians, but they lost some of their credibility as health expenditures skyrocketed. Physicians were perceived as part of the problem, rather than the solution, when inflation escalated wildly in the U.S. health care industry\textsuperscript{15} because, under a fee-for-service system of payment, their salaries rose when they provided more services. In order to make physicians more accountable, business interests, consumers and the state sought the right to closely monitor the cost and quality of their services. Thus, the institutional configuration in California with a weak state and fragmented interests has made it difficult for the medical profession to promote its policy preferences and retain its autonomy and status.

My analysis of corporate autonomy in the second chapter showed that the medical profession in Ontario has had more opportunities to influence physician supply because it participates jointly with the provincial health ministry and medical schools in the policymaking process. In California, a laissez faire system determines physician supply with little input from the medical profession or the state. The oversupply of primary care physicians and specialists may have encouraged managed care firms to locate in California because many providers have been willing to compete for contracts. Partially
as a result of the high degree of managed care penetration and selective contracting in the hospital markets, the rate of increase in costs and the physician-to-population ratios have slowed. In Ontario, the medical profession has had more opportunities to contribute to setting the standards for medical research, ethics, licensing, quality assurance, and discipline in hospital and ambulatory settings because it, along with state actors, occupies a position of influence, unlike in California, where entrepreneurs responding to shareholders dominate the market. The judiciary in the United States has taken a more activist role in the policy process than is the case in Canada, and has made key decisions that have reduced physician autonomy. The courts in the United States have interpreted the federal Employee Retirement Income Security Act (ERISA) to mean that the state cannot regulate managed care plans offered by self-insured employers. This has had the effect of protecting managed care organizations from lawsuits and increasing physicians' vulnerability. As Peter Jacobson and Scott Pomfret explain:

ERISA preemption has indirectly caused courts to favor MCOs’ cost containment initiatives over traditional notions of physician autonomy. The treatment a physician recommends is vulnerable to a managed care utilization management process largely unconstrained by state regulation or liability law, inevitably resulting in reduced physician autonomy.

In Ontario, physicians have also retained more of their corporate autonomy since they have the right to bargain collectively. In California, physicians and independent practice associations lack the resources and legal right to negotiate with health maintenance organizations on a level playing field.

Chapter 3 showed that individual practitioners have a great deal of clinical autonomy to make decisions about their patients’ diagnosis and treatment in Ontario, but the many California physicians that participate in medical practices with managed care
contracts are given strong incentives to undertreat their patients. Ontario physicians have more control over their method of payment because they can run their practices on a fee-for-service basis, without facing stiff competition from health maintenance organizations like their counterparts in California, as we saw in chapter 4. They have historically been paid less than California physicians, because the private market has not standardized costs to the same extent as government. However, managed care has pushed physician reimbursements to new lows since 1995. According to a PricewaterhouseCoopers report, California family physicians now earn as little as $75,000 U.S. per year, which is 44 percent less than the national average of $134,000.\textsuperscript{20}

Chapter 5 showed that Ontario physicians have been able to maintain more control over the allocation of health care resources because the Canada Health Act has removed financial access barriers (like extra-billing and user fees), that might interfere with their ability to deliver comprehensive medically necessary care. In California, “direct financial copayment/deductible or means-test access barriers”\textsuperscript{21} make it difficult for physicians to provide comprehensive medical services to all those who need them, as a result of wide variations in their patients’ insurance status and plans. Physicians in Ontario have maintained more control over the organization of health care resources, since they can negotiate with government to modify its reform proposals. California physicians have witnessed turbulent changes in the marketplace that are outside of their control and have proceeded with little oversight by government. The Ontario medical profession experienced a loss of influence with regards to other health care professionals, when the Regulated Health Professions Act was introduced in 1991, and when the Long Term Care Act was enacted in 1994, leading to more service substitution. Nevertheless,
the Ontario Medical Association and the College of Physicians and Surgeons of Ontario have been able to maintain a "position of consultation" with the Ministry of Health and Long Term Care\textsuperscript{22} that is coveted by other groups of health care professionals. In California, nonphysician providers have seriously undermined physicians' organizational dominance. They have won legislative battles to expand their scope of practice and are often hired by managed care organizations to perform, at a lower cost, some of the tasks that were previously undertaken by physicians.

I cannot draw upon survey data over the last thirty years to definitively support my hypothesis that physicians have retained more autonomy under the public health insurance model in Ontario than under the managed care approach of California because surveys were conducted on an intermittent basis and were not performed simultaneously in both jurisdictions. The surveys more often addressed the question of professional satisfaction than professional autonomy, although these two concepts are quite closely related.\textsuperscript{23} In 1984, Malcolm Taylor, H. Michael Stevenson and A. Paul Williams conducted a province-by-province survey of Canadian physicians to explore their attitudes to policies and problems of the medical care insurance program. The researchers found that their subjects' views were mixed. Eighty-six percent of Ontario physicians agreed or strongly agreed that MDs were "losing ground" economically relative to other occupational groups and 39 percent indicated that, "the Medicare system should be returned to voluntary and commercial control." Nevertheless, only 27 percent of Ontario physicians noted that they were "dissatisfied" or "very dissatisfied" with the practice of medicine.\textsuperscript{24} In 1987, three Californian researchers, Richard Kravitz, Lawrence Linn and Martin Shapiro, conducted a survey to determine the level of
professional satisfaction experienced by Ontario physicians. They found that the majority of Ontario doctors were at least moderately satisfied with most aspects of their work. However, the high number of physicians who leave Ontario indicates that many feel that other countries offer them better education and/or employment opportunities. Between 1995 and 1999, an average number of 242 Ontario physicians moved abroad each year and 90 returned from abroad.25

In the California case, there is evidence that physicians perceive a significant decline in their autonomy and are becoming less satisfied with their careers.26 In 1998, 34 percent of young physicians said that they would not choose medicine if they were making their career decision over again, as compared to 27 percent in 1991. Seventy percent of physicians reported being “very or somewhat dissatisfied” with their relationships with managed care organizations and 66 percent were “very or somewhat dissatisfied” with their reimbursement levels.

There is a lack of survey data recording physicians’ views of their neighbouring health system, but in my interviews with California physicians I found that they were fairly perceptive about the strengths and weaknesses of the Canadian health system. They rarely identified the single payer system in Canada as a worst-case scenario of “socialized medicine.” Some characterized it more mildly as a system that would not be transferable to California because patients would find the long waits and restrictions on access to advanced technology intolerable.27 Others, like Dr. Gerard Burrow, Vice Chancellor for Health Sciences and Dean at the University of California, San Diego, who practiced in academic internal medicine in Canada for 12 years, saw no reason why a Canadian health system could not work in the United States.28 However, Dr. Burrow
doubted that a Canadian system would ever be implemented in the United States due to the high level of cooperation that would be required among government, physicians and insurance companies to set it up.

There is some national-level data on American physicians’ perceptions of their levels of autonomy that indicates a decline in their clinical freedom in a managed care environment. A recent Commonwealth Fund survey reported that Canadian physicians were much less likely than American physicians to complain about external review of their clinical decisions. The percentages were 13 percent and 10 percent of Canadian general physicians and specialists respectively, as opposed to 36 percent and 42 percent of American general physicians and specialists respectively.29

2. USEFULNESS OF THEORETICAL APPROACHES

The strength of an institutionalist and network framework is that it can provide a nuanced explanation for the ways in which ideas, interests, and institutions (including previous policies) influence policy decisions and affect the level of physician autonomy in different health systems. The combined approaches can be used to draw attention to the importance of incentives and policy legacies for explaining interest group strategies and policy success, rather than focusing purely on the groups’ organizational resources, which cannot always account for policy change. A policy network approach does not overlook the importance of interest groups’ internal resources. Rather, this approach draws attention to the ways in which the organizational development of sectoral interests, based on their logic of membership and logic of influence, affect, and are affected by, the state’s autonomy and coordinating capacity.
This dissertation has linked two levels of analysis: relations between the interest
groups and the state and the underlying rules of the game that structure human
interaction. Historical institutionalism has explained the stable elements of political
opportunity, like the strong/weak state tradition, the patterns of linkage between interest
groups and government, and the underlying assumptions of many of the political leaders
– in Ontario, that a collective response is needed to the public’s health needs, and in
California, that free market principles should dominate the health care sector.30
Historical institutionalism has been less useful for explaining the more volatile aspects of
political opportunity that have the potential to result in policy changes and that, in turn,
create new political forces.31 Sidney Tarrow provides a valuable explanation of the ways
in which changes in the structure of political opportunities spur the development of
collective action. He argues that “it is when divisions open up among elites, influential
allies emerge, political alignments become unstable, and access to power is improved that
the external environment offers incentives for collective action, and that ordinary people
will mobilize collectively.”32

Another way to explain the more volatile aspects of political opportunity is to
refer to the ideas that are temporarily in vogue such as elite policy prescriptions (or
programs) and “the normative concepts that [particular] elites use to legitimize these
programs to the public” or “frames.”33 To understand the absence of compulsory health
insurance in California, it is necessary to refer to the early shifts in the California Medical
Association’s position on the relative merits of compulsory and voluntary health care
reform that mirrored shifts in the power of factions within the organization. In 1935,
Howard Hassard, who was legal counsel for the CMA, and personally opposed to
compulsory health insurance, was asked to draft a proposal for it by the CMA’s Committee of Six. Not surprisingly, the bill did not pass since there was little support for the proposal within the rank and file and almost no support outside of the CMA, where it was perceived to be a special-interest bill for doctors.34 A decade later, the CMA played a crucial role in defeating Governor Earl Warren’s compulsory health insurance bill by launching a mass advertising campaign led by Whitaker & Baxter that portrayed the bill as a proposal for “socialized medicine.” Hassard realized that Warren’s chief consultant was a veterinarian. He used that piece of information to make a laughingstock out of the Warren’s chief consultant, before the Assembly Committee on Public Health.35 At Hassard’s instigation, a Democrat named Evans exclaimed, “you’re not a real doctor, you’re a horse doctor!” depriving the “expert” of his credibility. Thus, compulsory health insurance did not gain a following in the legislature or with the public, partly because of the way it was framed by the CMA and its legal counsel at specific points in time. This example shows that, if ideas are strongly enough presented and have enough appeal with the electorate and political decisionmakers, they can be used to prevent policy change.

Conversely, ideas can be used to induce change, if they are skillfully framed in a way that will shake the foundations of political institutions and realign policy networks. An interest group is more likely to have policymaking influence if it fits "with the ideas in good repute with the policy makers."36 Patricia O’Reilly describes how midwives and nurse practitioners have succeeded in gaining professional autonomy in Ontario, even though they are small in number. Their leadership has astutely convinced government leaders of the compatibility of their goals, which include promoting preventive health
care and reducing the number of hospital beds needed (and therefore costs). Thus, when using institutionalist and network approaches, it is important not to completely overlook the ways in which groups use their "ideational resources" to further their goals. In a future research study, it would be interesting to explore in greater detail the role of ideas as strategic resources that actors can use to influence the formation and implementation of health policies.

A drawback of an explanation that focuses on lock-in effects and policy legacies is that it can be used to account for dramatically different policy outcomes. For example, a historical institutionalist explanation emphasizing the importance of policy legacies could be used to explain the absence of a system of universal health care in California, or, if it ever happened, its enactment. In the first case, policies might be seen to have encouraged the creation of a network that locked in a particular path of development for groups and made the enactment of compulsory health insurance unlikely. In the highly improbable second case, one could argue that political decisionmakers had chosen to support a different path of policy development because the original policy of selectively providing publicly financed care to citizens based on their age and socioeconomic status had consistently failed to make comprehensive health care accessible to all individuals. Hence, Californians would have engaged in a process that Paul Pierson calls "negative learning." As Ellen Immergut notes, "it is difficult to see how such historical narratives can ever be proved wrong." However, if the social scientist is using institutionalist and network approaches effectively, he/she will do more than just provide a historical narrative. He/she will use them to direct the reader's attention to the variables that are most important for explaining the policy outcome (ideas, interests and institutions,
including public policies) and will explore the mechanics of how the variables influence the outcome. The theoretical reflections will provide signposts for analysts to draw useful lessons for other cases.

Thus, the value of this dissertation is not simply the detailed description of the cases, but more importantly, the analysis of the complex interplay between interests, institutions and power. To summarize, this dissertation has demonstrated the importance of the institutional legacies of past policies. Government decisions have clearly exerted a great deal of influence on the political life of physicians in Ontario and California. Early policies, such as the decision to introduce a single payer health system, have affected the policymaking influence of the Ontario medical profession by providing incentives for the Ontario Medical Association to engage in a concertation relationship with the state (e.g., access to key politicians in joint decisionmaking forums). The medical profession has been able to turn many of its preferences into government policy because it has normally maintained accommodative relations with a strong state. In California, the presence of a multiple payer health system has created opportunities for insurers and employer-purchasers to compete with providers to shape government policies. As a result, the legislation that has been enacted has put self-employed physicians at a disadvantage relative to the payers by denying them the right to bargain collectively, and has contributed to the fragmentation of the medical profession by encouraging competition between providers (e.g., Medi-Cal reform of 1982).
3. PUBLIC POLICY IMPLICATIONS

I will examine some of the broader public policy lessons that arise out of this dissertation related to the issues of interest group-state activity and the prospects for health care reform in Ontario and California. In Ontario, an expanding policy agenda is challenging the existing concertation network, as non-medical actors must increasingly be accommodated. In California, the participants in the health care market have had difficulty in forming coalitions that can help to establish comprehensive health care reforms like universal coverage. It is likely that the reforms that will be enacted in the near future will continue to be incremental in nature. They may include initiatives to protect patients in a turbulent managed care environment (e.g., a patient bill of rights and a bill to protect the confidentiality of medical records).

THE ONTARIO CASE

Lesson 1: Public disclosure is important when the government and medical profession engage in a concertation policy network.

Although pressure pluralist networks appear to have evolved in many policy sectors in Ontario (e.g., day care, agriculture, trade and fisheries), a concertation network has developed in the health sector between the state and the medical profession. This type of network existed in Ontario before the introduction of a publicly financed medical system, and may continue well into the future. The concertation network is so resilient, partly because the leaders of organized medicine have shown themselves to be adept at making limited concessions to accommodate the interests of other health care
professionals and citizens, in order to maintain physicians' role as key actors in long-term planning and policymaking.

Economic agreements, struck in secret between the government and medical profession, may jeopardize the broad welfare of the public. When physicians reach agreements that involve generous fee increases and other benefits, the government is left with fewer resources to distribute to other areas of the health system, which may need it more.

Lesson 2: The federal, provincial and territorial governments need to work with stakeholders to improve the collection and assessment of health care data.

The discussion of quality assurance in chapter 2 on corporate autonomy drew attention to the differences between the implementation of clinical guidelines in Ontario and California. In chapter 3, it was argued that Ontario physicians have been better able to maintain their clinical autonomy because they can exercise their discretion about whether they use guidelines in the treatment of particular patients. In order for Ontario physicians to maintain their autonomy in the future, it will be necessary for them to show that they are committed to improving accountability mechanisms such as performance measures in the health system. The medical profession should continue to take a leading role in designing clinical practice guidelines and should encourage individual practitioners to implement them diligently.

If standard treatment protocols are followed, it will be easier for researchers to develop outcomes literature. Health services researchers may also benefit from the development of electronic patient records. The federal government has recently promised to invest $500 million in an independent corporation to accelerate the development of
information technology such as electronic patient records. When physicians make the transition from paper-based to electronic-based medical records, more standardized information will become available for academics undertaking epidemiological research. It will then become possible for them to more accurately identify the treatments that are most beneficial and cost-effective and to provide advice about which types of providers can safely administer them.

**Lesson 3: The federal, provincial and territorial governments need to establish a long-term plan for improving the working conditions of health care professionals.**

The working conditions for health professionals in Ontario are stressful in the aftermath of the Health Services Restructuring Commission. Demands for health care services are growing as the population ages. At the same time, Ontario faces a shortage of physicians and nurses that is partially government-induced.

Physician supply policies were discussed in chapter 2 on corporate autonomy. It was observed that the provincial government decreased the number of physicians by encouraging the universities to cut the number of entry spaces that they made available in their medical programs in the 1990s. In response to the federal government’s reduction in cash transfers, the Ontario government laid off nurses. Political decisionmakers did not anticipate the extent to which health care professionals would migrate to the United States, leave the profession in search of better employment opportunities or retire.

To turn the situation around, it will be necessary for representatives of the federal, provincial and territorial governments to make a significant financial investment in improving the employment conditions of doctors and nurses. They will need to listen to
the various stakeholders and formulate “a long-term integrated human resource plan for all health care providers,” that accommodates their diverse aspirations.

Lesson 4: The federal government needs to work with stakeholders to introduce a national approach to home care.46

Chapter 5 described the organization of the health system in Canada, which has remained almost unchanged since the single payer system was established. The lack of a national vision for delivering home care in Canada has become a cause for concern. As Peter Coyte and Patricia McKeever observe, “the availability of, access to and quality of home care varies considerably across the country,” since the Canada Health Act does not protect patients who receive health services in a community setting. Canadians must pay out-of-pocket expenses for services and pharmaceuticals that a decade ago would have been delivered in a hospital, and covered by their provincial health insurance plans. Activists and home care workers are worried that the home care services that are currently available are woefully inadequate to meet the needs of patients, who are being discharged earlier from hospitals.

In its efforts to adopt a more integrated approach to the delivery of health services, the Ontario government has set up 43 Community Care Access Centres (CCACs) since 1996. These are reminiscent of the managed competition model that has been adopted in the health sector in California. Therefore, the effects of the managed competition model in California should be studied carefully before Ontario proceeds further with its experiment. Alain Enthoven lobbied for the adoption of managed competition in the private sector in order to “break up the medical guild,” whereby managers would choose
between competing providers on behalf of individuals. His plan was adopted despite the opposition of doctors.\textsuperscript{48}

The CCACs in Ontario oversee a competitive bidding process among health providers, who try to win service contracts to provide care to patients who are old, chronically disabled or are making the transition from hospital to home after an acute episode. Critics fear that there are unintended consequences of the managed competition model’s focus on costs, which threaten the effectiveness of the home care system. For example, the Ontario Community Support Association has suggested that managed competition may jeopardize the therapeutic relationship and lead to the degradation of the health providers’ working conditions.\textsuperscript{49}

Since the Ontario government appears to be committed to the policy of moving health care services outside the hospital, it should make a greater effort to ensure that caregivers, who work in the community, are adequately trained and compensated for their services. The federal government should introduce national standards for home care as soon as possible, and discourage for-profit companies from establishing a strong presence in the field that may compromise the quality, universality and comprehensiveness of the Canadian health system. If the government continues to contract out its functions, it will jeopardize its ability to develop the expertise it needs to implement complex health policy in the future.\textsuperscript{50} The contracting out of services will mean that stakeholders with broader interests than medical elites or traditional allied health professionals will demand a more open policy network in the health sector and will lobby to influence government policy.
THE CALIFORNIA CASE

Lesson 1: Managed care organizations, hospitals and physicians would benefit from presenting a more united front as they lobby for policy changes.

Physicians have often criticized managed care organizations for inadequately reimbursing them and choosing to direct too much money towards administrative expenses and profits. They have blamed MCOs for forcing them into competition with each other for contracts that have left them exposed to too much risk. Managed care organizations have been critical of hospitals and physicians for being inefficient. These health care players have focused on bargaining against each other instead of on creatively solving health care problems.

Pluralist policy networks have proliferated in the United States, where the state has not assumed a strong and autonomous role in shaping the associational system. The various interest groups have missed important opportunities to cooperate in lobbying government for more comprehensive health insurance coverage and money in the system. Steven Epstein, a health law attorney in Washington, suggests that all parties would have benefited from pressing the government for changes to the Balanced Budget Act of 1997, "which appears to be the underlying reason for the record number of managed care companies pulling the plug on their managed Medicare programs, while leaving hospitals high and dry."

The price of cutthroat competition in the California health system is that 75 to 95 percent of California’s medical groups and independent practice associations are “in serious financial trouble.” The number of uninsured is high and rising. Even the HMOs are not making significant profits (54 percent of California HMOs suffered a loss
in 1997). All parties would benefit from more stability in the system. The policy process is so conflictual and slow and the health system is so turbulent that by the time legislation is passed, it tends to address the problems of the past and be replete with unforeseen consequences. In the absence of a more interventionist government, the health policies that are enacted will continue to be "ad hoc, uncoordinated with previous decisions, and oriented almost entirely to the short term." Incremental policies are a poor response to California's problems of uneven health insurance. Organized medicine has reversed its earlier decisions to oppose universal health insurance, since it perceives that physician autonomy could be boosted if all Americans were insured. Nevertheless, there are daunting institutional obstacles that make the enactment of universal health care unlikely.

**Lesson 2: A weak state will continue to make the enactment and enforcement of legislation difficult in the United States.**

The weakness and fragmentation of the federal and state agencies fosters a pluralist policy network in the health sector and reactive policy. In the absence of a government that can make proactive policy decisions, the private sector assumes a broad role in financing and delivering health care services, causing the government's capacity to shrink. When governments contract out their functions, they forego the opportunity to expand their administrative capacity and their ability to play an important role in health care delivery in the future. The inadequacy of the federal government's enforcement capacity became painfully obvious when the Health Insurance Portability and Accountability Act was passed in 1996. The Health Care Financing Administration expected the states' legislatures to enact implementing legislation, but California's failed to do so. As a result, HCFA was forced to establish a regulatory framework in
California’s individual market, even though it did not have sufficient staff or financial resources to enable it to undertake the task. The process took over a year and involved coordinating with two state agencies – the Department of Insurance, which regulates insurance carriers and the Department of Corporations, which at the time regulated managed care plans. It showed that the federal and state governments lacked the capacity and/or authority to take a broad role in shaping the health care delivery system.

The state’s ability to regulate the activities of health plans is still restricted, despite the creation of the California Department of Managed Health Care in 1999. This Department was located within the Business, Transportation, and Housing Agency and given the mandate of undertaking the tasks formerly performed by the Department of Corporations, such as overseeing HMO finances, collecting patient satisfaction and performance data, and deciding where HMOs can operate. In addition, Daniel Zingale, the first director of the California Department of Managed Health Care, intends to set up an independent review system, "implement new internal grievance standards for HMOs, issue new HMO report cards and enact financial solvency standards for doctor organizations." The Department of Managed Health Care’s scope of authority is limited by legislation, which means managed care organizations still do not need to be overly concerned about its oversight. Under the Knox-Keene Health Care Service Plan Act of 1975, the Department of Managed Health Care does not have the authority to regulate the following relationships:

- Individual physician versus individual physician
- Medical group versus medical group
- Provider versus entity regulated by the California Department of Insurance
• Plan versus provider.\(^{59}\)

Thus, state enforcement capacity needs to be expanded, if it is to take a more active role in shaping the health care delivery system. The Department of Managed Health Care needs to have its jurisdiction extended, if it is to take a more active role in resolving the disputes that arise between health care actors.

**Lesson 3: A form of managed care that incorporates consumers’ demands for freedom is likely to become more prevalent in the United States.**

Political institutions in Sacramento and Washington are likely to remain paralyzed on the question of sweeping health insurance reform because many political elites, who cater to diverse business, insurance and medical interests, would be required to support it before changes could be made.\(^{60}\) Nevertheless, some modifications will be made to the managed care system to accommodate physicians’ and consumers’ interests. Managed care organizations will offer consumers more flexibility in choosing providers.\(^{61}\) Legislators will adopt more patient protection legislation at the federal and state levels. I expect that managed care will become even more prevalent in California and the other states in the next decade because it provides a proven way to keep health care costs lower than in fee-for-service medicine in a system with multiple payers.

Managed care has the potential to improve the quality of care if effective use is made of the data culled from the HMO patient records.\(^{62}\)

## 4. SUGGESTIONS FOR FURTHER RESEARCH

There were enormous differences in the social and historical environments of the medical associations in this study of their policymaking influence in Ontario and
California. Future research comparing the policymaking influence of medical associations in the same country (e.g., Ontario and British Columbia; California and New York; a medical association at the sub-national and national level) would be useful because the policy paradigms, interests and institutional context would not be so diverse.

A comparative analysis of accountability mechanisms in Ontario and California would be timely, since stakeholders in both jurisdictions are setting up new systems for monitoring health outcomes and assessing the performance of health care providers. Differences in policy networks and the historical legacies of political institutions could be shown to partially account for variations in the development of accountability mechanisms in the two jurisdictions. In the Ontario case, a concertation policy network in the health sector between the medical profession and a strong state have protected physicians' professional, clinical and organizational autonomy and slowed the development of intrusive mechanisms that threaten to invade patients' privacy and erode their trust in their physicians. In the California case, where medical interests are fragmented and the state is relatively weak, managed care organizations have taken a leading role in gathering health care data and implementing outcomes measures, in order to reduce the costs of the health care plans that they offer to employers and individuals. Independent accreditation and standard-setting organizations have been established to verify the quality of health plans. A strong consumer movement has successfully lobbied for the publication of data that reveal the performance level of physicians and hospitals, and increase the pressure on these providers to improve the quality of patient care.
More research is needed on the autonomy and policymaking influence of other groups of health professionals besides doctors to determine why some have been more successful than others at reaching their goal of improving their professional status. The framework that has been developed for this thesis on the medical profession could be adapted for other cases.

This thesis did not trace physicians' collective contribution to the public dialogue on such complex issues as euthanasia, genetic engineering, or the AIDS crisis in developing countries. These issues need attention from activists and policy analysts alike. They are likely to become even more politicized in the future as new technologies and drugs become available.

The comparative political science literature would benefit from further exploration of the ways in which political institutions and policy legacies influence the formation of different types of policies in Canada and the United States. For instance, it would be interesting to explore why the government has maintained a health insurance policy in Canada that is significantly more comprehensive than in the United States, but why there is much less divergence between the two countries in another policy area (e.g., environmental policy).63


The California Medical Association defines solo-practice as "an independent single physician or a one-physician business entity billing under a single taxpayer identification or physician identification number (PIN). This could include physicians who share space that practice independently. A solo practice is a private practice. Solo practitioners may be paid on a fee-for-service or capitation basis." See California Medical Association, Glossary, 2000.

A group practice is a multiple physician business entity.

In California, hospitals and medical groups are legally required to hire physicians as independent contractors instead of as employees due to the ban on the corporate practice of medicine. See Joanne Todd, "Medical Apartheid," California Medicine, April/May 1999.

Joanne Todd has noted that there are exceptions to the California law banning the corporate practice of medicine that allow physicians to be considered "employees." These have been "established for professional corporations, Knox-Keene-licensed healthcare service plans and federally qualified HMOs." See "Medical Apartheid, California Medicine, April/May 1999.


17 For a discussion of the logic of health systems, see Carolyn Tuohy, Accidental Logics: The Dynamics of Change in the Health Care Arena in Britain, the USA and Canada, (Don Mills: Oxford University Press, 1999).
25 Southam Medical Database, Canadian Institute for Health Information, Table 6: Physicians Who Moved Abroad and Returned From Abroad, By Province/Territory, Canada, 1995 to 1999, August 9, 2000.


35 Howard Hassard, 1985, p.44.


44 The Health Action Lobby notes, "Since the early 1990s, the number of nurses emigrating to the U.S. has increased nearly four-fold." See Health, Productivity and Prosperity for Canadians: HEAL Pre-Budget Submission 2000/2001, (Ottawa: The Health Action Lobby, September 1999), p.12.


46 The Institute for Research on Public Policy Task Force on Health Policy has made a number of important recommendations for the reform of the Canadian health system. For example, it calls for a national approach to pharmacare. To read its justification, see


52 For a discussion of the differences between the traditional “positional” approach to lobbying and the more cooperative “interest-based” approach, see Elizabeth Carlton, “The ABCs of Interest-based Bargaining,” Hospital Perspectives, (Toronto: Ontario Hospital Association, 2000).

53 The Managed Care Information Centre, MCOs Should Have Helped Row the Boat, Before They Jumped Ship, September 19, 2000.


55 For example, patient protection legislation in a number of states including California has made it difficult for physician-owned health plans to stay in business.


57 See Karen Pollitz, Nicole Tapay, Elizabeth Hadley and Jalen Specht, “Early Experience With ‘New Federalism’ In Health Insurance Regulation,” Health Affairs, July/August 2000, pp.7-23.


61 The Managed Care Information Center, MCOs Should Have Helped Row the Boat, Before They Jumped Ship, September 19, 2000.
GLOSSARY

Academic Medical Center (AMC) is "a group of related institutions including a teaching hospital or hospitals, a medical school and its affiliated faculty practice plan, and other health professional schools."\(^1\)

Access is the set of factors that affect the ability of an individual or group to acquire health care services.

Access for Infants and Mothers (AIM) Program was established in California in 1992. It provides low cost health insurance to pregnant women and their infants who are not eligible for Medi-Cal health insurance. Its parent agency is Managed Risk Medical Insurance Board (MRBIB).

Accreditation is a process of evaluation to determine whether an institution or residency program meets the standards of an accrediting body.

Accreditation Council for Graduate Medical Education (ACGME) is the accrediting body for all U.S. post-M.D. medical training programs. It operates in concert with the residency committees for the 24 medical specialties. Its five "parent bodies" included the AMA, American Hospital Association, American Board of Specialties, the Association of American Medical Colleges, and the Council of Medical Specialty Societies.\(^2\)

Affordable Basic Care Initiative (ABC Initiative), also known as Proposition 166, would have required all Californian employers to provide care to employees and their children, had it been adopted. The California Medical Association promoted the ABC Initiative in 1992.

Aid to Families with Dependent Children (AFDC) was an individual income assistance program, established in 1935, that the federal government provided until it was transformed into a block grant program for states under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. The states determined which individuals received AFDC.

Allied health professionals are individuals who are licensed, when necessary, to work in the health care field and are not doctors. They are sometimes referred to as nonphysician clinicians.

Allopathic medicine is the type that is most commonly practiced in Canada and the United States, using drugs, medical devices and surgery to manage diseases.


\(^2\) For a useful list of acronyms and definition of terms in the Californian context, see California Medical Association’s Glossary, 2000 on its website.
Alternate Payment Program (APP) was introduced in Ontario in the late 1960s to fund health care providers for medical services, which were seen as not being adequately addressed by fee-for-service payment. In 1991 it was determined that any conversion of funds from the OHIP budget to the APP would require the approval of the OMA. The Alternate Payment Unit of the Health Human Resources Planning Division administers the APP.

Alternative dispute resolution (ADR) mechanisms allow all interested parties (i.e. the complainant and accused) to participate in reaching a mutually acceptable and legally binding decision with the assistance of a trained mediator.

Ambulatory care is “medical services provided on an outpatient (non-hospitalized) basis. Services may include diagnosis, treatment, surgery and rehabilitation.”

American Medical Association (AMA) is a national medical association with 271,000 members that represents physicians and produces scientific, medical and political information.

American Medical Association Program (AMAP) was set up in 1997 by the AMA to certify physicians.

Amicus curiae brief is a “friend of the court” document written to support the plaintiff or defendant in court. The California Medical Association files amicus curiae briefs and lawsuits on behalf of physicians.

Antitrust laws are currently interpreted by the U.S. Federal Trade Commission and Department of Justice Statements of Antitrust Enforcement Policy to require that physicians be clinically and functionally integrated in order to bargain collectively with a health plan.

Arbitration is a means of reaching agreement between two disputing parties by having an impartial third party render a decision that may or may not be binding.

Area Health Education Center (AHEC) is “an organization or organized system of health and educational institutions whose purpose is to improve the supply, distribution, quality, use and efficiency of health manpower in specific medically underserved areas.”

Balance billing is also known as extra-billing. It is the practice of billing the patient in excess of the amount covered by health insurance. In Canada, it was banned in

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4 Anne Sawyer, Dana Hughes, Maureen Finan, Tenzing Donyo, Christy Beaudin and Ann Monroe, Guide to California Health Data Sources, (Woodland Hills, California: Blue Cross of California), February 1996, B-1
1984. In the United States, it is subject to a limit. In Medicare, a balance bill cannot exceed 15 percent of the allowed charge for nonparticipating physicians.5

Blended funding mechanism is a method of payment “comprised of a base salary, overhead costs, and both volume and non-volume modifiers.”6 The Ontario’s College of Family Physicians proposed blended funding in 1992.

Board of Medical Quality Assurance (BMQA) was set up to monitor Californian doctors. Before 1975 it was known as the Board of Medical Examiners (BME). In 1990 the BMQA was renamed the Medical Board of California (MBC).

Bundling is the practice of grouping several procedures together for the purpose of paying for them as a package.7

California Advantage was a doctor-owned health plan with approximately 7,600 shareholders that operated between 1995 and 1998.

California Area Health Education (AHEC) System was established in 1972 to rectify the maldistribution of health care personnel.

California Cooperative HEDIS Reporting Initiative (CCHRI) holds HMOs accountable for their provision of preventative care using measures developed by the National Committee for Quality Assurance.

California Information Exchange (CALINX) includes the California Medical Association, the Pacific Business Group on Health, California Association of Health Plans, California Healthcare Association, the American Medical Group Association and the National IPA Coalition. It aims to set standards for sharing health information.

California Medical Association (CMA) is part of the American Medical Association and is composed of 38,000 members. It was established in 1856 as the Medical Society of the State of California.

California Medical Political Action Committee (CALPAC) is the political arm of the California Medical Association formed in the early 1970s.

California Public Employees’ Retirement System (CalPERS) purchases health insurance for public employees. In 1997 it represented over one million Californian workers.

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Californians Allied for Patient Protection (CAPP) is an interest group that was founded by former CMA lobbyist, Jay Michael, in 1991 to keep MICRA in place.

Canada Assistance Plan (CAP) was established in 1966 as a cost-sharing agreement between the federal government and the provinces and territories whereby the federal government shared half of the costs for the provision of welfare and health-related services to individuals who meet the needs-based criteria.

Canada Health Act (CHA) was enacted in 1984. It sets out the five criteria and two conditions that the provincial health plans must meet in order to receive full funding under the Canadian Health and Social Transfer. It requires health plans in Canada to be publicly administered, comprehensive, universal, portable and accessible. The two conditions are that the provinces must provide the information that the Ministry of Health requires and must give appropriate recognition to the CHST relating to insured health services and extended health care services.

Canadian Health and Social Transfer (CHST) is block funding from the federal government to the provinces that replaced CAP and EPF in 1996. The federal government no longer requires that provinces provide financial assistance to everyone in need.

Canadian Medical Association is the national voice of Canadian physicians. It was founded in 1867 to promote health care. It consists of 45,000 medical students, residents and practicing physicians that are members of its 12 provincial and territorial divisions. It has 42 affiliated medical organizations.

Canadian Medical Protective Association (CMPA) is a physician-owned and operated mutual-defence organization.

Capitation is a payment method that reimburses providers with periodic fixed payments regardless of the volume of services they provide.

Certification is the process by which a physician is approved by a board recognized by the regulatory body in the jurisdiction. In California board-certified most often indicates that the American Board of Medical Specialties has certified the physician.

Chiropractic is medicine that focuses on the proper alignment of the spine as the key to human health.

The Civilian Health and Medical Program of the Uniformed Services (TRICARE/CHAMPUS) is the federal government’s health insurance program for all seven of the uniformed services. TRICARE was set up in 1995.

“Cherry picking” is the practice of allowing only healthy people to enrol in health care plans.

The Children’s Health Insurance Program (CHIP) was created by the Balanced Budget Act of 1997. The Clinton administration allocated about $20 billion over five years to help the states insure children. It was approved in California in 1998 with the Medicaid portion of the plan accelerating teen coverage.
Claims-made insurance policies are designed to protect physicians from claims that “arise out of services performed after a specified date, commonly referred to as the ‘retroactive date,’ and asserted prior to a policy’s expiration date.”

Clinical autonomy is “the ability of physicians to make medical judgments based on their training, experience and specialty without outside interference.”

Clinical practice guideline (CPG) is a “systematically developed statement designed to assist practitioner and patient to make decisions about appropriate health care for specific clinical circumstances.” The CMA has assembled a database of CPGs.

Coinsurance is “a type of cost-sharing where the insured party and insurer share payment of the approved charge for covered services in a specified ratio after payment of the deductible by the insured. For example, for Medicare physicians’ services, the beneficiary pays coinsurance of 20 percent of allowed charges.”

Collective bargaining is the negotiating process between union representatives and employers to formulate and implement a labour contract.

College of Physicians and Surgeons of Ontario (CPSO) is the professional standards body for the medical profession in Ontario.

Commercial IPA/Network HMO is a type of health maintenance organization that contracts with many doctors, individually, in groups and in independent practice associations.

Commercial Staff/Group HMO is a type of health maintenance organization that employs physicians on staff or contracts exclusively with one group of providers.

Community Health Centres (CHCs) are non-profit, community-based organizations that provide a broad range of programs to meet patients’ health care needs, including health promotion and disease prevention. They use multidisciplinary teams of health providers that are paid by salary. There are at least 300 across Canada.

Comprehensive Health Organizations (CHOs) provide a wide range of health services to a rostered population in Ontario.

Conflict of interest in a medical context is a discrepancy between patient welfare and the economic interests of the physicians, hospitals, purchasers of health care services or managed care organizations.

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9 See California Medical Association’s Glossary, 1999, on its website.
10 NHS (UK) Research and Development Centre for Evidence-Based Medicine, Glossary of EBM Terms, 1999.
Cost containment is “a collection of strategies -- including cost-sharing approaches, benefit designs, provider contracts, volume of services to be provided, discounts or set charges, and benefit and payment incentives and disincentives -- used to control the total cost of health care services. Costs are generally considered to be contained when the price and utilization of health care services do not increase more rapidly than the pace of other consumer services, taking into account the increase in the number of consumers and scope of health problems.”¹²

Cost shifting is a financial management strategy in which the costs of care are not fully paid by the beneficiaries. Instead they are allocated in higher charges to another group of patients that can better afford to pay them.

County Organized Health Systems (COHS) model of Medi-Cal Managed Care was developed between 1983 and 1996. It is “a county organized and controlled plan serving the full Medi-Cal population in a designated region through a capitated contract with DHS.”¹³

Customary, Prevailing and Reasonable (CPR) was “the method of paying physicians under Medicare from 1965 until the implementation of the Medicare Fee Schedule in January 1992. Payment for a service was limited to the lowest of 1) the physician’s billed charge for the service 2) the physician’s customary charge for the service or 3) the prevailing charge for that service in the community.”¹⁴

Defensive medicine is a physician’s performance of medical procedures for the purposes of reducing the risk of a liability claim. A common example is undertaking diagnostic tests of marginal value.

Department of Health Services (DHS) is a California agency that is responsible for a broad range of health-related divisions and activities, including the division of Licensing and Certification.¹⁵

Department of Corporations (DOC) included the Health Plan Division, which regulated health maintenance organizations, until the California Department of Managed Health Care was created in 1999.

Department of Insurance (DOI) regulates indemnity plans.

Department of Managed Health Care is located within the Business, Transportation and Housing Agency. It was created in 1999 to undertake the tasks formerly performed by the Department of Corporations, which involved regulating health plans.

Diagnosis-Related Group (DRG) specifications were introduced by Congress in 1983 as part of a new Medicare hospital prospective payment system. The patients’ length

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¹³ California Medical Association, Back to the Future: Medi-Cal Managed Care Reform in the ’90s and CMA’s Legislative Recommendations, April 1995, p.9.
of inpatient stay and amount of resources consumed was determined by their demographic, diagnostic and therapeutic characteristics.

Direct Medical Education (DME) payments are funding by the Medicare program for the direct costs of graduate medical education.

Disproportionate share hospital (DSH) expenditures are given to hospitals under Medicare's PPS or under Medicaid to compensate them for receiving a greater than average number of low income patients.

Economic autonomy of physicians is their ability to determine their level and mode of payment without outside interference.

Economic credentialing is “the use of economic criteria that do not relate to quality to determine a physician’s qualification for the granting or renewal of medical staff membership or privileges.”

Electronic medical records (EMRs) are also known as computer-based patient records and are replacing paper documents.

Employee Retirement and Income Security Act (ERISA) of 1974 is a federal law that has the effect of prohibiting states from regulating or taxing companies that self-insure.

Established Programs Financing (EPF) was introduced in 1977. “The federal government provided the provinces with 13.5 personal income tax and 1 corporate income tax equalized tax points, plus a cash transfer. The value of tax points would grow as economies expanded, and the cash transfer was escalated by GNP per capita growth. Entitlements were distributed equal per capita.” The funds were used for post-secondary education and health care. EPF was replaced by CHST in 1995.

Evaluation and management (E&M) guidelines are AMA and HCFA approved Medicare documentation guidelines. Carriers auditing physicians use the guidelines to determine what documentation should be in their medical files to justify their choice of billing codes.

Evidence-based medicine (EBM) is “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.”

Exclusive contracting is an agreement between a physician or physician group and a hospital that the physician or group will be solely responsible for providing defined services.

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18 NHS (UK) Research and Development Centre for Evidence-Based Medicine, Glossary of EBM Terms, 1999.
Exclusive provider organization (EPO) is "a fee-for-service plan with a closed panel of physicians."\(^\text{19}\)

Federation of State Medical Boards (FSMB) is composed of 69 member boards that regulate physician activity at the state level.

Fee-for-service (FFS) is the traditional method for reimbursing doctors and hospitals for each service that they provide. It is also referred to as "indemnity."

Fiduciary duties are the legal requirements for physicians or health plans to act solely in the interest of their patients. The federal Employee Retirement Income Security Act of 1974 imposes a fiduciary duty on those who make decisions on behalf of the employee benefit plan to act in the interests of the health plan’s beneficiaries.\(^\text{20}\)

Geographic managed care is a model that is available only in San Diego and Sacramento where Medi-Cal enrollees choose from commercial health plans but do not have the option of choosing county organized plans.

Global budget is a comprehensive plan for financing a health program over a set period of time.

Hard cap or expenditure cap is a fixed limit on total expenditures for a given year.

Health and Human Services (HHS) is a national department formed from the Department of Health, Education and Welfare in 1980. It is responsible for the Public Health Service, HCFA, the Office of Human Development Services and the Social Security Administration.

Health Care Financing Administration (HCFA) is the federal agency within the Department of Health and Human Services that is responsible for administering Medicare and Medicaid. It also enforces the minimum standards established by HIPAA if the state does not enact enabling legislation.

Health Disciplines Act gives the CPSO the statutory obligation to develop standards of knowledge and qualification for the Ontario medical profession.

Health Insurance Plan of California (HIPC) was established in 1992 to act as a purchasing agent for small firms with 2 to 50 employees.

Health Insurance Portability and Accountability Act (HIPAA) of 1996 was formerly known as the Kennedy-Kassebaum bill. It contained provisions to expand individual and small employer health insurance and gave federal agencies the authority to keep the money they recovered from fraud investigations.


Health maintenance organization (HMO) offers a comprehensive set of health services to enrollees but supplies almost no coverage for services not provided by the HMO.

Health Plan and Employer Data and Information Set (HEDIS) is designed by the National Committee on Quality Assurance as the industry standard for measuring the quality of care given to members of health maintenance organizations.

Health Professional Shortage Area (HPSA) is an area that the U.S. Department of Health and Human Services designates as underserved by providers. HPSAs may include “1) an urban or rural geographic area, 2) a population group for which access barriers can be demonstrated to prevent members of the group from using local providers, or 3) medium-and maximum-security correctional institutions and public or non-profit private residential facilities.”

Health Professions Legislation Review (HPLR) was established in Ontario in 1983 with the mandate of deciding which of the designated controlled acts each health profession would be legislated to perform.

Health Service Organization (HSO) program was established in Ontario in 1973 and there are now 77 HSOs in existence. An HSO receives a set amount of Ministry of Health funding for each patient that is rostered. If a patient goes outside the HSO for health care services, the HSO does not receive the full amount of funding.

Health Services Restructuring Commission (HSRC) is an independent body of health experts that was chosen by the Ontario government to make decisions about services needed in a restructured health system. It was established in 1996 and had a four-year mandate.

Healthy Families program was launched in 1998 to provide coverage for children of low-income families who are not eligible for Medi-Cal. It provides Medicaid for children aged 14-18 with family incomes up to 100 percent of the poverty line and creates a non-Medicaid program for children of families whose income is up to 200 percent of the poverty line. The Managed Risk Medical Insurance Board administers the Healthy Families Program.

Historical institutionalism is a theory that draws attention to the ways that previous policy decisions and the organization and character of political institutions affect policy outcomes.

"Hold harmless" clauses in managed care contracts require physicians to accept the total risk of liability and relieve the managed care organization of responsibility in the event of a malpractice lawsuit.

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21 Sawyer, Hughes, Finan, Donyo, Beaudin and Monroe, Guide to California Health Data Sources, (Woodland Hills, California: Blue Cross of California, February 1996), B-5.
Horizontal integration refers to "the coordination or consolidation of activities, units or services that are at the same stage in the patient care production process, for example the consolidation of hospitals into multi-hospital systems."\(^{22}\)

Iatrogenic harm refers to injuries caused by physicians or other health care professionals in the course of a patient's medical treatment.

Independent Health Facilities Act (IHFA) specifies the licensing, funding, and quality assurance requirements of facilities providing medical procedures traditionally performed in public hospitals. It was established in Ontario in 1990.

Independent Practice Associations (IPAs) are groups of physicians that share risk and contract with health plans.

Indirect Medical Education (IME) payments are part of the support that the Medicare program gives to finance the indirect costs of graduate medical education. The Balanced Budget Act of 1997 reduced IME payments from 7.7 to 5.5 percent over a five-year period in the first major overhaul of graduate medical education policy since the early 1980s.

Initiatives are direct democracy devices that allow registered voters to draft ballot measures, if they can provide the required number of signatures. The initiative process has become a primary means of making policy in California.\(^{23}\)

Institute for Medical Quality was set up in 1996 as a subsidiary of the California Medical Association. The California Department of Corporations gave the IMQ a joint contract with JCAHO to evaluate HMOs in that state.

Institute of Clinical Evaluative Sciences is funded by the Ministry of Health to conduct research that contributes to the effectiveness, quality and efficiency of health care providers in Ontario. It is affiliated with MOH, OMA, University of Toronto's Faculty of Medicine and Sunnybrook Health Sciences Centre. It was established by the JMC in 1992.

Institutional Review Boards (IRBs) are administrative bodies that have been established in the United States to ensure that researchers meet federal guidelines and obtain the informed consent of their subjects. IRBs have been set up in organizations that conduct research, such as universities, private foundations, corporations, and in the medical setting, to review proposed research protocols.

Integrated academic health system (IAHS) is an integrated health system that emphasizes research and teaching and is organized around one or more academic


\(^{23}\) See Ken DeBow and John Syer, Power and Politics in California, 5th ed., (Boston: Allyn and Bacon, 1997), p.124. These two professors at California State University suggest, "It is probably no exaggeration to state that the initiative process has replaced the legislature as the state's primary policy arena."
institutions. The HSRC's vision of a newly organized health system includes five IAHSs.

Integrated or organized delivery system (IDS or ODS) is "a network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and the health status of the population served."24

Integrated health system (IHS) is a group of health care providers who join together to take responsibility for providing or purchasing all the services needed for a defined and rostered population.

International medical school graduates (IMGs) are defined in the United States as individuals who received their undergraduate medical education outside the U.S. or Canada. In Canada even individuals who received their undergraduate medical education in the United States are considered to be IMGs.

Joint Commission on Accreditation of Hospitals (JCAHO) was established in 1952. Its members included the American College of Surgeons, the American College of Physicians, the American Hospital Association, the American Medical Association and the Canadian Medical Association.

Joint Committee on Physicians' Compensation (JCPC) was established by the OMA and the provincial government in 1974 as a forum for negotiations over fees, physician supply and related topics.

Joint Management Committee (JMC) of the Ministry of Health and the Ontario Medical Association operated from 1991 to 1995. In 1997, the Physician Services Committee was established to replace the JMC and provide a forum for the OMA and government representatives to discuss proposed fee changes and health system reforms.

Knox-Keene Health Care Service Plan Act of 1975 is designed to ensure a minimum standard of quality for the Californian health care plans.

Locum tenens program provides replacements for physicians so that they can temporarily be relieved of their duties. The Ontario Ministry of Health operates a locum tenens program under the auspices of the Under-serviced Area Program, which includes primary care physicians, specialists and in some cases nurses.

Maintenance of competence (MOCOM) is the Royal College of Physicians and Surgeons of Canada (RCPSC) voluntary pilot program to assess the competence of practitioners.

Managed care is a system used by third parties, their agents, health plans and physician organizations to control physicians' decisions about their patients' access to health care services.

Managed care organization (MCO) is an umbrella term that encompasses many different types of mechanisms including HMOs, PPOs, POSs, and EPOs.

Managed competition requires large employers and purchasing groups to choose between managed care plans on the consumers' behalf. "Features of managed competition include competing health plans, standardized benefits, open enrolment, consumer awareness of premium differences, continuous quality measurement and a limit on the tax deductability of health plan premiums." 25

Managed Risk Medical Insurance Board (MRMIB) is a California agency that was established to expand health insurance for individuals and employees of small firms. It administers CalPERS and AIM. It administered HIPC until it was privatized and put under the control of the PBGH in 1998.

Management service organizations (MSOs) are affiliations between physicians and hospitals for the purpose of sharing management expertise. They do not require physicians to sell their practices to an outside firm.

Medi-Cal – Medicaid in California

Medi-Cal reform legislation – AB 799 and AB 3480 -- were passed in 1982 to make prices for physician and hospital services more competitive and to shift responsibility for treating “medically indigent adults” from the state to the county level.

Medicaid is funded partially by the federal government but operated and administered by the state. It provides medical benefits to certain low-income people in need of health care benefits such as those who can be covered under the welfare cash payment program and members of families with dependent children in which one parent is absent, incapacitated or unemployed.

Medical Board of California (MBC) is the regulatory body charged with disciplining doctors. It is one of 38 boards and bureaus within the California Department of Consumer Affairs.

Medical Injury Compensation Reform Act of 1975 (MICRA), otherwise known as AB 1, placed a $250,000 ceiling on compensation for pain and suffering in California. It offset collateral sources of plaintiff compensation and decreased incremental or sliding scale attorney contingency fees. It required periodic payments for awards over $50,000.

Medical malpractice is considered actionable in court when a physician fails to properly treat a medical condition and the negligent failure is the cause of additional injury to the patient. It is also referred to as medical negligence. The American Medical Association prefers the more legally accurate term “physician liability.”

Medical savings accounts (MSAs) are funds that the consumers receive from their employers to invest in medical expenses at their own discretion to allow them greater freedom to control their medical care.

"Medically indigent" referred to low-income pregnant women, children under the age of 21, and certain low-income individuals in long-term facilities under the Medi-Cal program prior to Welfare Reform.

"Medically needy," under the Medi-Cal program prior to Welfare Reform referred to the low-income people whose income was too high to qualify them to receive AFDC or SSI cash assistance, but still allowed them to receive subsidized medical services.

Medicare in the United States is a nationwide health insurance program for people aged 65 and over, those eligible for social security disability payments for at least two years and certain workers and their dependents, who need kidney transplantation or dialysis. Medicare is also the term that is used to refer to the public health system in Canada. For the purposes of this thesis, the term will be used exclusively to refer to the program in the United States to avoid confusion.

Medicare+Choice is “a program created by the Balanced Budget Act of 1997 to replace the existing system of Medicare risk and cost contracts. Beneficiaries will have the choice during an open season each year to enrol in a Medicare+Choice plan or to remain in traditional Medicare. Medicare+Choice plans may include coordinated care plans (HMOs, PPOS, or plans offered by provider-sponsored organizations), private FFS plans, or plans with MSAs.”

Medigap insurance is “privately purchased individual or group health insurance policies designed to supplement Medicare coverage. Benefits may include payment of Medicare deductibles, coinsurance and balance bills, as well as services not covered by Medicare. Medigap insurance must conform to one of ten federally standardized benefit packages.”

Ministry of Health (MOH) is the provincial ministry in Ontario that oversees health services. It includes integrated services for children, health system management and integrated policy and planning.

Mixed model HMOs include staff or group and IPA/network arrangements with physicians.

Modalities of care refer to different types of care including home care, long term care, mental health, rehabilitation, sub-acute care and preventive care.

Multi-payer system refers to a multiplicity of payers, often public and private, that cover the costs of health care.

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National Committee for Quality Assurance (NCQA) has developed standards to evaluate the medical and quality management systems of managed care organizations.

National Health Service Corps (NHSC) program was created in 1970. It was amended in 1987 to encourage medical students to serve in needy areas by forgiving part of their education loans. More than 21,000 health professionals have served with the NHSC in the United States since its inception.

National Patient Safety Foundation (NPSF) was established in 1998 by the American Medical Association to improve measurably patient safety in the delivery of health care.

National Practitioner Data Bank (NPDB) was established in accordance with the Health Care Quality Improvement Act of 1986 to ensure that unethical or incompetent physicians, dentists and other types of health care practitioners do not compromise health care quality. NPDB makes information regarding practitioners available to registered entities but not to the public.

Nonphysician clinicians (NPCs) include traditional and alternative healthcare providers that substitute for physicians and/or work under their supervision. They include nurse practitioners, certified nurse midwives, certified nurse anesthetists, physician assistants, chiropractors and acupuncturists and other allied professionals.²⁸

Nurse practitioners (NPs) are registered nurses, with at least one additional year of training, who are licensed in primary health care.

Occurrence-based malpractice insurance provides physicians with coverage that lasts long after their policies expire.

Ontario Health Insurance Plan (OHIP) pays at specified rates for insured services provided to Ontario residents by physicians and other health care providers, commercial laboratories, and diagnostic and therapeutic facilities.

Ontario Medical Association (OMA) is a voluntary organization that represents 24,000 physicians.

Organizational autonomy is the influence of physicians on the allocation and organization of health care resources and their dominance over other health professionals.

Osteopathic medicine provides comprehensive medical treatment and focuses on the joints, bones, muscles and nerves.

Outcomes research is "any research that attempts to link either structure or process or both to the outcomes of medical care at the community, system, institution or patient level."²⁹

Pacific Business Group on Health (PBGH) is a negotiating alliance that represented 20 large employers in 1997.

Physician autonomy is used in this thesis as an umbrella term to refer to professional, clinical and economic autonomy and the ability of physicians to influence the allocation and organization of health care resources.

Physician-driven organizations are structures where physicians have leadership responsibilities in the organization and review the treatment patterns of their peers.

Physician Payment Review Commission (PPRC) was established by the Consolidated Omnibus Budget Reconciliation Act of 1985 to advise Congress on physician payment policies.

Peer review organizations (PROs) replaced professional standards review organizations in 1982. It is a physician-sponsored organization that reviews the medical services that physicians have provided in order to determine if they are medically necessary and meet standards of care.

Physician-hospital organization (PHO) is "1) a structure in which a hospital and physicians both in individual and group practices negotiate as an entity directly with insurers 2) an organization that contracts with payers on behalf of one or more hospitals and affiliated physicians. The PHO may also undertake utilization review, credentialing and quality assurance. Physicians retain ownership of their own practices, maintain significant business outside the PHO and typically continue in their traditional style of practice."³⁰

Physician practice management organizations (PPMs) are publicly traded companies that manage the business side of physician practices.

Physician Review Program (PREP) was established by McMaster University in conjunction with CPSO to evaluate physicians' strengths and weaknesses in order to develop individualized education programs to address their problems.

Physician Services Committee (PSC) was established in 1997 to replace the Joint Management Committee as a negotiating forum for appointed members of the OMA and MOH.

Point-of-service (POS) plan is a type of managed care plan that allows enrollees more choice of providers than a health maintenance organization but not as much as a preferred provider organization. It uses economic incentives to induce enrollees to use network providers.

³⁰ University of Washington, Glossary, 1999 citing PPRC, 1996.
Policy community is “all actors or potential actors with a direct or indirect interest in a policy area or function who share a common ‘policy focus,’ and who, with varying degrees of influence shape policy outcomes over the long run.”31

Policy network is “the properties that characterize the relationships among the particular sets of actors that form around an issue of importance to the policy community.”32

Preferred provider organization (PPO) is a discounted fee-for-service plan that offers financial incentives to induce enrollees to obtain health services from a preset list of physicians and hospitals. Enrollees pay a higher proportion of the costs for services obtained from out-of-network providers, although the PPO still covers some services obtained from out-of-network providers.

Primary care provider (PCP) acts as a gatekeeper to specialists and other services.

Primary Care Reform (PCR) is intended to be an improvement in the delivery of basic health care services.

Professional Association of Internes and Residents of Ontario (PAIRO) is the provincial union for medical students and residents.

Professional autonomy is the ability of the profession to control central aspects of its existence. A profession has the regulatory authority to decide the type of knowledge that is necessary to become a professional, who can join the profession, and the number entitled to practice. It can also collectively set the standards of appropriate behaviour and the penalties for deviating from it.

Professional standards review organizations (PSROs) were established in 1972 to monitor the quality of care given to beneficiaries of federal health programs.

Proposition 4, otherwise known as the Gann Initiative, was passed in 1979 to limit per capita increases in state spending.

Proposition 13 established a rollback and a strict limit on future property tax rate increases, which has had the effect of restricting the funds available for health care and other public services. It was passed in 1978.

Proposition 22 effectively merged the California Osteopathic Association with the California Medical Association in 1961. It gave osteopaths the opportunity to buy medical degrees.

Proposition 99 provided a 25-cent increase in tobacco tax to fund care for the uninsured. It was passed in 1988. Physicians who provide uncompensated medical services can apply to California Healthcare for Indigents Program and Rural Health Services Program can apply for reimbursement using these funds.

Proposition 140, which was passed in 1990, limited legislative service in the Assembly to six years and the Senate to eight years.

Proposition 166 was the California Medical Association’s Affordable Basic Care proposal for health reform which was rejected by voters in 1993.

Proposition 186 was a single-payer initiative that Californian voters overwhelmingly rejected in 1994. It would have enabled providers to be paid by the state rather than by insurance companies.

Proposition 187 would have prohibited the provision of publicly funded services, including non-emergency medical care, to illegal and undocumented immigrants. It was accepted by voters but struck down in court.

Proposition 188 was the California Uniform Tobacco Control Act, which was unsuccessfully promoted by the tobacco industry in 1994.

Proposition 208 was designed to restrict campaign contributions and fundraising activities in California political races, but it was struck down by the courts in 1998.

Proposition 209 prohibited preferential treatment towards individuals or groups by the California state or local governments, universities, colleges, and schools as of 1996. It reduced the number of minorities entering medical education.

Proposition 214 was a consumer protection initiative that would have prohibited health care companies from “gagging” health care professionals to discourage them from recommending treatments. It was intended to ban financial incentives for withholding medically necessary services. The California Medical Association voted to take a neutral stance on it and it was rejected in 1996.

Proposition 215 was the 1996 California medical marijuana initiative, approved by 56 percent of the voters, which was intended to allow physicians to prescribe marijuana to seriously and terminally ill patients.

Proposition 216 was a consumer protection initiative similar to Proposition 214. The California Medical Association voted to take a neutral stance on Proposition 216 and it was rejected in 1996.

Prospective Payment System (PPS) is “Medicare’s method of paying acute care hospitals for inpatient care. Prospective per case payment rates are set at a level intended to cover operating costs for treating a typical inpatient in a given DRG. Payments for each hospital are adjusted for differences in area wages, teaching activity, care to the poor, and other factors. Hospitals may also receive additional
payments to cover extra costs associated with atypical patients (outliers) in each DRG.  

Providers are individual physicians, physician groups and hospitals, but not insurers.

Public Citizen's Health Research Group (PCHRG) is a public interest group led by Sidney Wolfe that is highly critical of the limited role for consumers in health care decision making.

Quality is "the degree to which health services for individuals and populations increase the likelihood of desirable health outcomes and are consistent with current professional knowledge."

Quality assurance involves "techniques to assess and improve the quality of care delivered by health care practitioners and provider organizations."

RAND formula is being used to require doctors to pay OMA dues even if they do not voluntarily become members of the Association because it reaches collective agreements with government on their behalf.

Reformed fee-for-service (FFS) was proposed by the Ontario Primary Care Reform Physician Advisory Group in 1998. This model combines elements of a fee-for-service system with current payment discounts and thresholds. Physicians bill using a fee-for-service method until the benchmark threshold is attained. Patients are rostered and are required to pay for non-emergency care obtained outside the family practice but within defined geographic limits. The OMA envisions combining reformed FFS with other modes of payment.

Res ipsa loquitur ("the case stands on its own merit") means that the case speaks for itself. It lowers the standard of proof so that it is easier to trace iatrogenic harm to mistakes made by health care professionals.

Resource-based relative value scale (RBRVS) is a "coded listing of physician services, which includes units that indicate the relative value of the various services they perform. The RBRVS takes into account the time, skill and overhead cost required for each service ... When used with conversion factors, medical procedures can be priced or payment rates determined."

Savings and Restructuring Act (Bill 26) was enacted in Ontario in 1995. It created or amended 50 pieces of legislation.

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35 Joint Commission on Accreditation of Healthcare Organizations, Quality Assurance in Managed Care Organizations, (Chicago, Ill.: Joint Commission on Accreditation of Healthcare Organizations, 1989).
Selective contracting is the process by which managed care organizations contract with physicians. Through the California State's Selective Provider Contracting Program the federal and state governments negotiate contracts to pay for hospital care at discounted rates.

Single-payer system is a system with a single dominant payer, most commonly the government. Individuals or their private insurers continue to pay for procedures that are not deemed medically necessary, such as cosmetic surgery.

Soft cap, otherwise known as an expenditure target, is a spending goal for a program that is not binding like a hard cap. Cost overruns may be absorbed by doctors and insurers in a predetermined way.

Soft money "is any contribution not regulated by federal election laws, such as money donated to state and local party organizations or money contributed to the national parties but specifically earmarked for their local affiliates. Soft money may only be used to support state and/or local activities or activities that jointly support state/local and federal candidates."37 There is no limit on the amount of soft money that can be donated by individuals or interest groups.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) is "legislation that established target rate of increase limits on reimbursements for inpatient operating costs per Medicare discharge. A facility’s target amount is derived from costs in a base year updated to the current year by the annual allowable rate of increase. Medicare payments for operating costs generally may not exceed the facility’s target amount. The provisions still apply to hospitals and units excluded from PPS."38

Third-party payer refers to insurers and others who are responsible for covering the cost of health care services when the individual (or employer) is registered with their company and pays them premiums.

Tort reform is a change in the laws governing medical malpractice lawsuits.

Two-plan model is a Californian managed care model permits only two Medi-Cal HMOs to operate in 12 approved counties, one is a mainstream (or private sector) plan and the other is a government-run plan.

Underserviced Area Program of the Ontario Ministry of Health was set up in 1969 to encourage physicians to practice in under-serviced areas. Under-serviced areas can be identified by the physician-population ratios or unmet medical needs of the communities.

Utilization review (UR) is "the review of services delivered by a health care provider to evaluate the appropriateness and quality of the prescribed services. The review can be performed on a prospective, concurrent or retrospective basis."\(^{39}\)

Vertical integration involves "organizing the 'production' of patient care so that the successive stages in the process of providing and distributing care are carried out by a single organization."\(^{40}\)

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### Key Health Care Facts in California and the U.S.

<table>
<thead>
<tr>
<th></th>
<th>California</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage uninsured (non-elderly) (1996)</td>
<td>24.4%</td>
<td>18.3%</td>
</tr>
<tr>
<td>Percentage of children uninsured (1996)</td>
<td>20.8%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Percentage of non-elderly enrolled in Medicaid:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1998</td>
<td>11.1%</td>
<td>8.4%</td>
</tr>
<tr>
<td>1994</td>
<td>14.3%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Percentage of employers that offer health insurance (1999)</td>
<td>48%</td>
<td>61%</td>
</tr>
<tr>
<td>Percentage of workers with access to coverage for &quot;non-traditional&quot; partners (1999)</td>
<td>31%</td>
<td>18%</td>
</tr>
<tr>
<td>Average monthly HMO premium for family coverage (1999)</td>
<td>$405</td>
<td>$445</td>
</tr>
<tr>
<td>Percentage of premium paid by covered workers (1999):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single coverage</td>
<td>11%</td>
<td>16%</td>
</tr>
<tr>
<td>Family coverage</td>
<td>24%</td>
<td>32%</td>
</tr>
<tr>
<td>Percentage of workers enrolled in HMOs (1999)</td>
<td>53%</td>
<td>28%</td>
</tr>
<tr>
<td>Percentage of health care dollars spent on (1993):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals</td>
<td>37%</td>
<td>41%</td>
</tr>
<tr>
<td>Nursing home care</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>Physician services</td>
<td>31%</td>
<td>24%</td>
</tr>
<tr>
<td>Physicians' mean net income (1997)</td>
<td>$172,400</td>
<td>$199,600</td>
</tr>
<tr>
<td>Average spent per Medicaid beneficiary (1997)</td>
<td>$2,418</td>
<td>$3,582</td>
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<tr>
<td>Health of Californians (1998):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall percentage saying they're in fair to poor health</td>
<td>15%</td>
<td>13%</td>
</tr>
<tr>
<td>Percentage of Hispanics saying they're in fair to poor health</td>
<td>23.8%</td>
<td>14.8%</td>
</tr>
<tr>
<td>Percentage of the population living in poverty (1998)</td>
<td>15.4%</td>
<td>12.7%</td>
</tr>
</tbody>
</table>

© 2000, KFF. Copied with permission from The Kaiser Family Foundation, Health Care Trends and Indicators in California and the United States.
<table>
<thead>
<tr>
<th>Variable</th>
<th>Professional Model</th>
<th>Economic Model</th>
<th>Political Model</th>
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<tr>
<td>Conceptual model</td>
<td>Professional dedicated to patient well-being</td>
<td>Consumer of health care</td>
<td>Citizen-member deciding over public good</td>
</tr>
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<td>Consumer of health care</td>
<td>Citizen-member deciding over public good</td>
</tr>
</tbody>
</table>

## Ontario

### Southam Medical Database (SMDB)

<table>
<thead>
<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Total Physicians</strong></td>
<td>20,469</td>
<td>20,202</td>
<td>20,216</td>
<td>20,447</td>
<td>20,581</td>
</tr>
<tr>
<td><strong>Physicians Per 100,000 Population</strong></td>
<td>178</td>
<td>178</td>
<td>181</td>
<td>185</td>
<td>189</td>
</tr>
<tr>
<td><strong>Total GPs/FPs</strong></td>
<td>9,802</td>
<td>9,773</td>
<td>9,903</td>
<td>10,230</td>
<td>10,359</td>
</tr>
<tr>
<td><strong>GPs/FPs Per 100,000 Population</strong></td>
<td>85</td>
<td>86</td>
<td>89</td>
<td>93</td>
<td>95</td>
</tr>
<tr>
<td><strong>Total Specialists</strong></td>
<td>10,667</td>
<td>10,429</td>
<td>10,313</td>
<td>10,217</td>
<td>10,222</td>
</tr>
<tr>
<td><strong>Specialists Per 100,000 Population</strong></td>
<td>93</td>
<td>92</td>
<td>92</td>
<td>93</td>
<td>94</td>
</tr>
</tbody>
</table>

© 2000, CIHI. Copied with permission from the Canadian Institute for Health Information, Ottawa, Canada.
Non-Federal Physicians per 100,000 Civilian Population, California and the United States, 1975-1997

Non-federal physicians per 100,000 population was calculated using population data from the U.S. Census Bureau.

© 2000, KFF. Copied with permission from The Kaiser Family Foundation, Health Care Trends and Indicators in California and the United States, p.70.
Chart of Active Physicians in Ontario and California Per 100K Pop, 1996

Per 100K Pop

<table>
<thead>
<tr>
<th></th>
<th>TOTAL</th>
<th>PCP</th>
<th>NON-PCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontario</td>
<td>181</td>
<td>89</td>
<td>92</td>
</tr>
<tr>
<td>California</td>
<td>247.4</td>
<td>82.9</td>
<td>164.5</td>
</tr>
</tbody>
</table>

PCP, Primary Care Physicians
NON-PCP, Non-Primary Care Physicians

Source: Active Civilian Physicians (Ontario), Southam Medical Database, Copyright 2000, Canadian Institute for Health Information

Figure 1.- Primary care and specialist physicians per 100,000 population in Canada and the United States from 1974 to 1994. These figures exclude residents, interns, fellows, and, for the primary care categories, primary care subspecialties. The data prior to 1983 are estimated from later data.

From: Sullivan: JAMA, September 4, 1996, 276;704-09, Figure 1, ©1996, American Medical Association.
## EXHIBIT 2
Perceived Autonomy Among Young Physicians In 1991 And In The 1996 Age-Matched And Cohort-Matched Samples

<table>
<thead>
<tr>
<th>Sample size</th>
<th>Response rate of cohort-matched sample</th>
<th>Response rate of cohort-matched sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians who say they have the freedom to</td>
<td>1996</td>
<td>1996</td>
</tr>
<tr>
<td>Spend sufficient time with patients</td>
<td>492</td>
<td>92</td>
</tr>
<tr>
<td>Hospitalize patients who, in their opinion, require it</td>
<td>420</td>
<td>79</td>
</tr>
<tr>
<td>Keep patients in the hospital for the length of time they think is appropriate</td>
<td>405</td>
<td>74</td>
</tr>
<tr>
<td>Carefully review patients' medical histories and test results</td>
<td>487</td>
<td>92</td>
</tr>
<tr>
<td>Care for patients even when they are unable to pay the fees and changes</td>
<td>479</td>
<td>87</td>
</tr>
<tr>
<td>Order tests and procedures whenever they want to</td>
<td>493</td>
<td>86</td>
</tr>
<tr>
<td>Control their own work schedule</td>
<td>495</td>
<td>93</td>
</tr>
<tr>
<td>Care for patients who require heavy use of time and resources</td>
<td>419</td>
<td>61</td>
</tr>
</tbody>
</table>

### SOURCES
- * 1996 significantly different from 1991, p < .01, chi-square test.
- ** Question was not asked of radiologists, anesthesiologists, and pathologists.

## TABLE 1
**IMPLICATIONS OF MEDICAL GROUP PRACTICE STRUCTURAL ALTERNATIVES**

<table>
<thead>
<tr>
<th>Administrative style and accountability</th>
<th>Individual autonomy</th>
<th>Administered autonomy (external control)</th>
<th>Heteronomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative style and accountability</td>
<td>Autonomy of individual physician protected as is autonomy of the group.</td>
<td>The physician organization is sovereign, but individual physicians subordinate to centrally controlled negotiated policy.</td>
<td>The physician organization is subsidiary to some other entity; physicians are subordinate to the organization. Executive command.</td>
</tr>
<tr>
<td>Examples</td>
<td>Traditional private practice or group with fewer than 25 physicians and few managed care payments.</td>
<td>Physician-driven organizations: HMOs, EMOs, and MCOs.</td>
<td>Staff model HMO; military hospital.</td>
</tr>
<tr>
<td>Physician relationship to:</td>
<td>Patient</td>
<td>Direct; no intervening parties except payment constraints like pre-certification.</td>
<td>Mediated/collaborative. Adheres to jointly negotiated protocols.</td>
</tr>
<tr>
<td>Client agents</td>
<td>Payors deal directly with each individual physician for constraints on payment.</td>
<td>Payors deal with organization that may negotiate discounts.</td>
<td>Must consider global resources. Organization negotiates with payors; guarantees adherence.</td>
</tr>
<tr>
<td>Other physicians</td>
<td>Free access to consults.</td>
<td>Consults, referrals, and treatment patterns reviewed by peer physician managers.</td>
<td>Consults and referrals out of group discouraged by organization.</td>
</tr>
<tr>
<td>Physician organization</td>
<td>Owner-operated with rule by consensus.</td>
<td>Owner-operated or employee; professional staff hierarchy for negotiation and oversight.</td>
<td>Employee subordinate to organizational hierarchy.</td>
</tr>
</tbody>
</table>

### Aspects of the profession: Who

| Selection | Attracts self-directed entrepreneur; many applicants. | Collaborators, willing to take financial risks. | Fewer risk-takers, less income-oriented, more women, caretakers. |
| Training | Research-oriented; individual decision making stressed. | Managerial, research skills; protocol development. | More emphasis on computer expert systems, decision support. May be some pressure to license alternative systems or providers. |
| Licensure | Physician-directed; control must allied health professions, too. | Pressure to allow other health professionals own licenses. | May increase with development of union-type professional organizations. |
| Cohesion | Few threats, except RBRVS fee schedule and income differentials. | Distance between manager and managed, specialty income gaps may decrease cohesion. | Innovation only if cost-savings required for competitiveness. Strict adherence to cost/quality procedures. |

### What

| Knowledge | Innovators to innovate and use new technology. | Pressure to evaluate medical theory before widespread use. | Lack of autonomy may obscure any service orientation of the employed physicians. |
| Standards | Widely varied in practice, development, and use. | Greater use of guidelines; possibly selling protocols to others. | Any capitalized arrangement will be required to guard against underinsurance. |
| Why | Continuing disputes over fees and propriety facility ownership raise questions. | Time to research and care of underinsured could improve service image. | Ability to influence social policy altered by “union” status. |
| Service | Entrepreneurs may assume as conflicting with professional ethics. | Arrive-length transactions with patient may limit conflict of interest. | |
| Ethics | “Fewer friends” in D.C. | Greater impact if service role seen to outweigh proprietary. | |

---

*HMO, health maintenance organization.
*RBRVS, Resource-Based Relative Value Scale.

Mean Physician Net Income, California and the United States, 1994-1997

Net income data for the years 1994-1997 was derived from the 1995-1998 American Medical Association's Socioeconomic Monitoring System (SMES) surveys.

<table>
<thead>
<tr>
<th>Event</th>
<th>Description</th>
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<tbody>
<tr>
<td>Relief and regulation economic autonomy in public policy</td>
<td>Direct effect through hospital-based specialties</td>
</tr>
<tr>
<td>Federal Government implemented clinical autonomy—cannot interfere in practice of medicine</td>
<td>Indirect effect linked to specific specialties</td>
</tr>
<tr>
<td>Negotiable direct impact on physicians; sanctions imposed through hospital denial</td>
<td>Indirect effect linked to specific specialties</td>
</tr>
<tr>
<td>Direct effect, incentives created to limit fee-for-service practice</td>
<td>Indirect effect linked to specific specialties</td>
</tr>
<tr>
<td>Direct limitation through establishment of price maximums through &quot;maximum allowable actual charge&quot; fees on non-participating physicians</td>
<td>Indirect effect linked to specific specialties</td>
</tr>
<tr>
<td>Reduction in prevailing charge for observation procedures</td>
<td>Indirect effect linked to specific specialties</td>
</tr>
<tr>
<td>Direct limitation through 5-year implementation of the schedule; based on relative values for clinical work of physicians</td>
<td>Indirect effect linked to specific specialties</td>
</tr>
<tr>
<td>Excludes physician's performance standard</td>
<td>Indirect effect linked to specific specialties</td>
</tr>
</tbody>
</table>