TALKING POINT

Ontario Health Insurance Plan*

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The British North America Act of 1867 had vested responsibility for providing health care in Canada in the provincial governments.¹ During the 'fifties and 'sixties the Federal Government began to help the provincial governments to create health insurance schemes. Though they differed in each province the schemes followed Federal Government guidelines. The criteria were that the schemes should be universally available to all citizens without exception; should be easily accessible; should be run on a non-profit basis; and should be transferable between provinces.

At first the Federal Government shared costs almost equally with the provinces, funding the poorer ones more generously. The cost, expressed as a percentage of the gross national product, rose rapidly. One cause may have been "cost sharing," which certainly aggravated the inequalities, enabling the wealthier provinces to expand faster than the poorer ones. Now the costs seem to have stabilised and between 1971 and 1978 costs fell from 7.3% to 7.1% of GNP. From April 1977 the Federal Government changed to a "global budget" method of help with an annual increase related to the performance of the national economy and with reductions in federal taxation enabling the provinces to increase their own taxes. This system gives more flexibility and greater responsibility to the provinces.

Insurance cover and costs

Between 1959 and 1969 the Health Services Commission (HSC) in Ontario covered only hospital expenses. This led to an expansion, and expensive over-utilisation of hospital facilities. In 1969 the Ontario Health Services Plan (OHSIP) started to provide cover for outpatient services. In 1972 the HSC and the OHSIP were amalgamated into one organisation—the Ontario Health Insurance Plan (OHIP).² Outpatient services now covered by OHIP include doctors' fees, laboratory and radiological investigations, occupational therapy, physiotherapy, chiropody, optometry services, chiropractic, and osteopathy services up to \$125 per year, ambulance services, and some home nursing care. This is a drug benefit

scheme for pensioners and people receiving social security benefits. Dental care, glasses, false teeth, hearing aids, drugs, and services by some naturopaths are excluded.

About 75% of the population, who are not eligible for free drugs, are covered by either private insurance schemes or insurances negotiated as a fringe benefit from their employers. To reduce the cost of drugs Ontario has a generic drugs scheme, whereby a chemist, unless specifically requested by the doctor, must supply the generic drug from a list of about 1500 drugs in the *Drug Benefit Formulary*.³

Almost everyone participates in the Provincial Government Health Insurance Plan in Ontario. The plan is voluntary for the self-employed, or those in a firm with less than 15 employees. The subscription is \$19 per month or \$38 for family cover. People over 65 are exempt while others are partially or totally exempt, depending on income. About a quarter of the population receive free cover or partial assistance.

Organisation of the plan

There are 16 500 licensed doctors in Ontario, of whom 11 500 to 12 000 regularly submit their claims to OHIP. Six million claims are processed each month by 2000 clerical staff and administrative costs are about 5% of the \$1 billion paid out annually in claims. Each patient must have an OHIP number, which is allocated only to heads of households. Only when they reach 21 or marry do the children have their own instead of their father's number. Though it is possible to identify particular patients by birth date, sex, name, etc, the system does make research into health care and specific diseases difficult for the system was initially designed as a method of paying and surveying claims.

When a patient consults a doctor, a registered ancillary health worker, or a medical institution, a form is completed for each attendance. The form requires name, address, date of birth, and OHIP number, together with the doctor's name, number, and address. The date of the examination and the diagnosis, with the exact wording as laid down in the schedule of fees, are also noted. The type of service given to the patient is shown by ticking a box—that is, minor or major assessment; office, home, or hospital consultation. The doctor then has to insert his fee according to the schedule.

The Ontario Medical Association (OMA) renegotiates the fee schedule annually with the Ontario Ministry of Health.⁴ This year they failed to agree, so the Ministry produced its own schedule with increases of 6.25%, while the OMA has increased its fees by 36%.

In general, doctors must either accept the OHIP scale or opt out, negotiating fees directly with their patients. They have to complete a form on behalf of their patients. The scheme will reimburse the patient at the OHIP rate and he will pay the difference between the two fee scales. The doctors who opt out receive periodic computer printouts of reimbursements paid by OHIP to their patients.

Claim monitoring system

The Professional Services Monitoring Branch (PSMB), a unit of the Health Insurance Division of the Ontario Ministry of Health, monitors the claims sent to OHIP by doctors and other allied professions. A computer checks for accuracy, processes the claim, and arranges payment. It is programmed to produce a profile on each doctor relating his services to those of his colleagues in similar specialties, noting deviations, if any, from the profiles of his colleagues in the same locality, town, or province. The profile records referrals to other agencies such as laboratories, physiotherapy services, and other doctors. As only private laboratories and radiological units, together with hospital outpatient departments, submit claims to OHIP, referrals of patients for hospital inpatient care or for diagnostic procedures performed at provincial laboratories are not recorded, as their costs are refunded by the Ministry of Health in the form of global budgets. The profile also contains facts extracted from other computer files. These include the doctor's age, college licence number, status, graduation information, medical practice group affiliation, and specialty. It also records whether his licence to practise is current, cancelled, or suspended. The computer is programmed to detect those doctors who are apparently re-examining their patients too frequently, who have high work loads, or who are performing unusual patterns of practice.

Under the Health Insurance Act 1972⁵ the general manager of OHIP is empowered to authorise payments to doctors and other medical workers, provided that the insured services have been rendered; that they were medically necessary; that they have been provided in accordance with accepted professional standards and practice; and that the insured services were not misrepresented in the claim.

Each month 30 000 random payment verification letters are sent to patients who have used the medical services. These state: "Payments shown have been made on your behalf to the practitioner named. If you find any errors or have any comments concerning the services, please indicate below." (The letter is heavily franked with the phrase "This

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is not a bill, do not pay," as apparently some patients have mistaken these letters as bills from OHIP.) If there is any evidence that a doctor might be practising outside the accepted norms of practice or be in breach of the regulations a more specific letter is sent to some or all of that doctor's patients. From the accumulated evidence the general manager of OHIP can decide whether to refer the case to the Medical Review Committee for further investigation.

Investigation and disciplinary procedure

The Medical Review Committee (MRC) is an autonomous judicial committee empowered to investigate and adjudicate cases of apparent breaches of the Health Insurance Act Regulations. The eight-man committee includes two lay members and six doctors; the latter are selected by the Minister from a list of doctors nominated by the Ontario College of Physicians and Surgeons. The decisions of the MRC cannot be altered by the Government or by administrative interference, and its decisions are binding on the general manager of OHIP. The MRC decides whether a doctor should be investigated after considering the evidence from the monitoring branch. A warning letter is first sent outlining the committee's concern. An inspector, who is a practising doctor employed part time, then goes to interview the doctor. He receives \$250 per day plus expenses and usually practises in the same specialty as the doctor he interviews. If the committee is concerned about a specific type of treatment or procedure a doctor with a special interest or expertise in that type of procedure would be sent.

The inspector receives a memorandum on the case, the doctor's profile, and a printout of the OHIP records, including the patients' names and dates of treatment. The doctor is asked to complete a full profile of his education, experience, and practice activities; and the interview is tape-recorded. The inspector then goes through the printout with the doctor, explains why the committee was concerned, and invites his comments. The inspector sends his report—but no recommendation—to the MRC and a copy goes to the doctor, who has the right of reply. Should he refuse to meet the inspector, a warrant can be obtained under the Health Disciplines Act which enables an MRC inspector to enter the doctor's premises to remove all relevant medical and business papers. If the college believes the doctor to be physically or mentally incapable of practising it can temporarily suspend his licence to practise. A Justice of the Peace can also prevent him from practising under the Summary Conviction Act.

After considering the case the MRC can summon the doctor to a formal hearing: failure to attend would be considered a contempt of court. Specialists, nominated by the OMA, can either be co-opted to the committee, or be sent the written evidence and asked for their written opinion. The doctor may bring witnesses, friends, wife, or lawyers to the committee. Despite the long distances and the time a committee hearing takes the doctor cannot recover any expenses. The Canadian Protection Association does not cover OHIP proceedings, though the OMA will, if requested, send a representative to help the doctor at the committee meeting.

The decision of the MRC is binding on the

general manager of OHIP. It may exonerate the doctor, advise recovery or a reduction in the fees paid, or even recommend further proceedings. A doctor who has been overpaid by OHIP can negotiate for the repayment to be reimbursed by him over several months from his prospective payments.

About 100 to 125 doctors are referred to the MRC each year; 60% are summoned for interview. Four-fifths of those interviewed are found to be in breach of the regulations. OHIP has recovered about \$2m at an annual cost of approximately \$250 000. It is impossible, however, to calculate the savings made by the deterrent effect of the monitoring system.

Appeal mechanism

A doctor who is found in breach of the regulations may appeal to the Health Service Appeal Board. This is a tribunal, convened by the Ministry of Health, consisting of six lay people and two doctors. An appeal can then be referred to the Divisional Court of Appeal, where three judges review the relevant papers without a personal hearing. It is then possible to appeal to the Ontario Court of Appeal and finally to the Supreme Court of Canada.

The full appeal mechanism has not yet been tested by doctors.

Discussion

Complaints about our National Health Service are usually about administration, bureaucracy, paperwork, and financial problems. Canadian colleagues who invited me to their practices had the same criticisms of their own system. Standards of medical care in Canada are high but this has been achieved at great cost. Canadian health care costs 7.1% of the gross national product but excludes many services such as dental and optical care, and drugs for certain classes of patient. The NHS attempts universal care on only 5.7% of GNP, achieving eventually the same standards but without frills and often after great delay. Incomes of Canadian GPs are high; the average in 1977 was about \$46 000 net (£23 000) before tax.

The paperwork necessary in submitting fees for OHIP is onerous, probably amounting to one hour per day per doctor, excluding routine practice administration. The "fee for service" system is open to abuse not only by doctors but also by patients. Doctors with small lists or low incomes may be tempted to "play the system" by reviewing patients more frequently or overtreating them. As patients are not registered with a specific doctor there are no provisions or financial penalties to prevent a patient from shopping around. This can result in uncoordinated duplication of expensive, and in some cases potentially dangerous investigations. The doctors who disagree with the fee scale and opt out of the OHIP system can negotiate their fees with their patients. But they are not immune from the OHIP paperwork. Surprisingly, patients do not have to verify their treatment by countersigning the OHIP form.

The monitoring and disciplinary system is one of surveillance by computer. It could be argued that the Health Act lays down regula-

tions for payment for treatment and thus the provincial government has the right to check that the doctor gives value for money. The disciplinary system is strict but fair, with judgment by a committee of one's peers independent of bureaucratic interference. The system can probably identify the sick or the fraudulent doctor more quickly than is possible in the NHS.

There was fear that the government might be covertly introducing conformity into medical practice. Recently, monographs have been circulated describing schedules, which the ministry advised should be followed in the treatment of certain specific diseases. Some doctors believe that, in the future, if these are not followed, or if a computer profile shows deviation from the recommended treatment, payments may be withheld or the doctor investigated.

All OHIP employees are legally bound not to divulge information to a third party, except under certain specified provisions of the Health Act. These exceptions give greater access to medical information than would be allowed under English law, providing information to courts, patients, and their solicitors. A recent House of Lords ruling decreed that English hospital records must be made available to patients and their solicitors.⁶ Computerised information may make confidentiality difficult to maintain, though it could be argued that the OHIP computer only itemises specific services and not full clinical details of each consultation. But the Royal Canadian Mounted Police have recently admitted to the Royal Commission on Confidentiality that it has for years been receiving confidential information from the social security computer bank. This was despite several denials by government ministers that such actions had occurred. A private investigator also told the royal commission that the only medical information he regarded as confidential was information he was unable to obtain.

The BMA's Annual Representative Meeting this year decided that British doctors would not co-operate with the Government in the further use of computerised medical records, fearing that confidential information would not be safe.⁷ Computer printouts replacing often illegible and erratically filed medical records can only be obtained illegally with expert help. But once obtained they produce a concise and legible medical history which could easily be transmitted to unauthorised persons or other government agencies.

The OHIP numbering system has not only made research into health care more difficult, it has also on occasions unintentionally broken confidentiality. One example would be the teenage daughter receiving the contraceptive pill unknown to her parents. The information could be divulged unwittingly by the random payment verification letter which simply asks her parents whether or not "an examination" had been performed on a certain date. It is possible to prevent this breach of confidentiality if the doctor endorses the form with the words "no verification." Nowadays many teenage girls go either to private or to municipally run contraceptive clinics.

I doubt whether the full implication of a "fee-for-service system" has been adequately considered by doctors in the UK. If it were implemented here it would not result in a global increase in doctors' incomes to the level of those of our Canadian colleagues. But it could mean a redistribution of remuneration—an ideal that could be achieved by other

POWARs: Notes for guidance

These notes, prepared by the BMA, will be sent to place of work representatives (POWARs) who will initially be appointed in the hospital service (see leading article, p 1180). It is planned to produce audiovisual packs and to arrange training courses for POWARs.

(1) The following is a brief informal summary of the commitments involved in becoming a BMA place-of-work accredited representative (POWAR), for the information of those who may be interested in taking on this task. It is not an official statement of duties nor is it a statement of accreditation.

Man on the spot

(2) The POWAR will be the BMA "man" at the most local level—that is, the hospital or work place. He will need to be readily and regularly available to BMA members, to listen, sift, answer, or route their problems.

Part of the peripheral organisation

(3) The POWAR will be part of the BMA peripheral organisation. This includes provincial medical secretaries and regional officers and from 1979 will, as part of an expanded industrial relations service, include regional industrial relations officers, all of whom are permanent paid staff, available to give assistance as needed. The POWAR will also need to keep in close touch with the division honorary secretary and with other honorary officers.

Duties

(4) The POWAR's duties will vary in detail from place to place but will essentially fall into two categories:

(1) As the local BMA representative in the hospital work place, who will welcome and look after the interest of members and recruit new members to the BMA. In this he will work in close co-operation with the division honorary secretary.

(2) As the local representative of the BMA in a trade union capacity. This does not just mean if and when there is a major dispute,

giving rise to what is termed "industrial action," although if this were to happen the accredited union representative alone is protected in law if he acts on behalf of the union. It is much more a question of seeing that individual members of the BMA are aware of the terms and conditions of service they should enjoy and that they derive full benefit from the various protective measures which are embodied in recent employment legislation. For this, the POWAR will need to have an outline knowledge of the main aspects of this legislation, which he will gain with experience.

He may be able to sort out some of the members' problems on the spot but he will also need to be in close touch with, and able to contact quickly, those who by virtue of their job have a more detailed knowledge of these matters—the regional industrial relations officer and the provincial medical secretary, who in turn can call upon the staff of the operational branch at headquarters. Any POWAR who feels uneasy about embarking on a particular course of action should contact the regional industrial relations officer or provincial medical secretary.

Time off

(5) Much of this activity can best be conducted informally when off duty in a relaxed atmosphere—for example, in the hospital mess. However, it is worth noting that the ACAS Code of Practice 3, "Time off for Trade Union duties and activities," which came into effect in April 1978 (and which will be incorporated in a General Whitley Council agreement), provides, in para 13, that a trade union official is permitted to take reasonable paid time off during working hours for such purposes as:

(a) collective bargaining with the appropriate level of management;

(b) informing constituents about negotiations or consultations with management;

(c) meetings with other lay officials or with full-time union officers on matters which are concerned with industrial relations between his or her employer and any associated employer and their employees;

(d) interviews with and on behalf of constituents on grievance and discipline matters concerning them and their employer;

(e) appearing on behalf of constituents before an outside official body, such as an industrial tribunal, which is dealing with an industrial relations matter concerning the employer; and

(f) explanations to new employees whom he or she will represent of the role of the union in the work place industrial relations structure.

It does not follow that the BMA will necessarily want every POWAR to carry out all these duties, and in particular it is unlikely that he will be expected to appear before an industrial tribunal. Many of the duties listed will in practice be undertaken by either the industrial relations officer or the provincial medical secretary.

Facilities

(6) Early in 1976 the DHSS issued a circular (Advance letter (GC)2/76) on a General Whitley Council agreement on "Facilities for Staff Organisations." This will be superseded by the new agreement when it is issued. Meanwhile the ACAS Code 3 says: "Management should make available to officials the facilities necessary for them to perform their duties efficiently and to communicate effectively with members, fellow lay officials and full-time officers. Such facilities may include accommodation for meetings, access to a telephone, notice boards, and, where the volume of the official's work justifies it, the use of office facilities." (para 24).

Where a POWAR feels that he could usefully take advantage of this kind of facility, he should make arrangements with the employing authority directly.

Help with taxation

The BMA's accounts department has revised its series of taxation leaflets. There are five—(1) General principles; (2) Income tax—Schedule D; (3) Income tax—Schedule E; (4) Capital gains tax; and (5) Retirement annuity contracts. The leaflets are intended as a guide to doctors and are not meant to be used as a substitute for consulting accountants. The BMA plans to revise them every three years, with brief notes in the intervening period explaining the more important fiscal changes. BMA members who would like copies should apply to BMA House quoting their membership number.

Talking point—continued

financial adjustments. The "fee for service" method of payment, though initially attractive as it rewards actual effort, must be balanced against the level of controls, regulations, bureaucracy, and apparent reduced personal freedom which would follow from its implementation.

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References

- 1 Backley, W Alan, *The Health System in Ontario*, personal paper to King's Fund College Course, May 1978.
- 2 Gold, G, *Ontario Health Insurance Plan Bulletin*, December 1976.
- 3 *Ontario Drug Benefit Formulary*, 1978.
- 4 Ontario Medical Association, *Schedule of Fees*, 1977.
- 5 *The Government of Ontario Insurance Act 1972* (amended 1974).
- 6 *British Medical Journal*, 1978, 2, 135.
- 7 *British Medical Journal*, 1978, 2, 298.

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Correction

From the CCCM

We regret that in the report of the proceedings of the Central Committee for Community Medicine (7 October, p 1040) we said that Dr Anne Jepson represented the Association of Clinical Medical Officers. In fact Dr Jepson is a member of the Faculty of Community Medicine and of the Association of Specialists in Community Medicine (Child Health).