Ontario Health Insurance Plan*

K C HARVEY

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 (OHSP) was amalgamated into one organisation—the Ontario Health Insurance Plan (OHIP).

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.

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 boxes on the form, which is then sent to the doctor's name, number, and address. The form then is sent to the doctor according to the schedule.

The Ontario Medical Association (OMA) renegotiates the fee schedule annually with the Ontario Ministry of Health.1 This year they failed to agree, so the Ministry produced its own schedule with increases of 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 patient may opt out once every two years. The OMA and the Ministry have agreed to negotiate fees for doctors who choose to opt out.

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 Tractor. Under the Health Insurance Act 1972 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 30000 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

The author was a member of a King's Fund College multidisciplinary party which attended a course organised by the Department of Health Administration at the University of Toronto to study the organisation and delivery of health care in Canada.

Talgarth, Powys

K C HARVEY, MB, CGP, general practitioner
is not a bill, do not pay, 7 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, an investigation should be sent to the college of that doctor’s province. 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 presented a case is 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 people and two doctors. An appeal can then be referred to the Divisional Court of Appeal, where three judges review the relevant papers without being present. The appeal can then be sent 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 7½", of the gross national product but excludes many services such as dental and optical care, and personal drugs for out-patients. The NHS attempts universal care on only 5½", of GNP, achieving eventually the same standards but without fringe and often after great delay. Incomes of Canadian GPs are high; the average in 1977 was about $46,000 net (C$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 their 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 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 administrative interference. The system can probably identify the sick or the fraudulent doctor more quickly than is possible in the NHS.

The rights of 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 types of cases. 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 general practitioners a certain protection by allowing them to refer cases to the family doctor and not full or full-time secretarial staff to patients and their solicitors. A recent House of Lords ruling decreed that English courts may not disclose confidential information to patients and their solicitors.6 Computerised information may make confidentiality difficult to maintain, though it could be argued that the OHIP computer only itemsises specific facts and not full or full-time secretarial staff to patients or other government agencies.

The OHIP numbering system is not only made research into health care more difficult, it has also on occasions unintentionally broken confidentiality. One example would be the test-tube daughter recovering the contraceptive pills 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 medical inhospital than they would in a clinic.

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 result in a global increase in doctors’ income to the level of some 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 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 hospital, local ward—what 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 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 (a) collective bargaining or 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 officials 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.

References

1 Backley, W Alan, The Health System in Ontario, personal paper to King’s Fund College Course, May 1978.

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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).

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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