

The Boundaries of Medicare: Tensions in the Dual Role of Ontario's Physician Services Review Committee

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1. Introduction

How do we decide what health care services are publicly funded? On what basis are such decisions made? Much has been written on the experiences of various jurisdictions, including Oregon, the Netherlands, and New Zealand. These accounts describe the outcomes of panels charged with deciding what will and will not be publicly funded.¹ However, remarkably little is known about the complicated layers of decision-making that cumulatively determine what services Canadian patients receive from Medicare. In this research, we describe and analyse the Physician Services Committee (PSC) in Ontario, focussing on its role in determining what physician services are publicly funded and what services are “de-listed” (i.e. no longer eligible for public funding). We explain how the PSC's role in determining the boundaries of Medicare is in tension with its role as a medium for labour relations between the government and the medical profession. We suggest that while the values of privacy, secrecy and a lack of transparency may enhance the PSC's fulfilment of its labour relations mandate, they impede the Committee's successful fulfilment of its health policy mandate. The remainder of this paper is dedicated to a detailed investigation of the PSC's process of determining candidate services for de-listing, and the principles upon which it bases its decisions. Particular attention is paid to the principles of open participation, transparency, accountability, and the degree to which these principles are incorporated into the PSC's decision-making.

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¹ See generally Chris Ham & Glenn Robert, eds., *Reasonable Rationing: International Experience of Priority Setting in Health Care* (Maidenhead: Open University Press, 2003); see also Office of Medical Assistance Programs, Oregon Department of Human Services, *The Oregon Health Plan: It May be for You* (Oregon: Oregon Department of Human Services, 2001); Oregon Health Services Commission, *Oregon Health Services Commission Report: Prioritized List of Packages for OHP Standard*. (Salem: Office of Oregon Health Policy and Research, 2001); Wendy Edgar, “Rationing Health Care in New Zealand — How the Public Has a Say” in Angela Coulter & Chris Ham eds., *The Global Challenge of Health Care Rationing* (Philadelphia: Open University Press, 2000) 175; Kieke Okma, *Health Care, Health Policies and Health Care Reforms in the Netherlands* (The Hague: Ministry of Health, Welfare and Sport, 2001); and Raisa Deber, *Delivering Health Care Services: Public, Not-for-profit, or Private: Discussion Paper 17* (submission to Commission of the Future of Health Care in Canada) (Saskatoon: Commission on the Future of Health Care in Canada, 2002).

2. The Divided Mandate of the PSC

The *Canada Health Act* (CHA)² requires all Canadian provinces to publicly fund “medically necessary” hospital services and “medically required” physician services. However, the concept of medical necessity is not defined in the CHA or provincial legislation. The Ontario Ministry of Health and Long-Term Care (Ministry) has historically consulted and negotiated with the Ontario Medical Association (OMA), representatives of the medical profession in Ontario, regarding the “tariffs” or fees paid to physicians for the provision of publicly-funded services. It is this process that indirectly determines what services are deemed “medically necessary” and thus publicly funded.³ As a result, the phrase “medically necessary” does not derive from an explicit application of principle. Rather, it is a label applied *ex post* to the list of physician services negotiated between the Ministry and the OMA.⁴ The critical decision-making about what is in and out of the publicly funded basket of services is thus intimately bound up with questions of physician remuneration.

To better understand the nature of these negotiations and the impetus for the establishment of the PSC, a brief review of the political context may be of assistance. Prior to the election of the Ontario Progressive Conservative Party in 1995, negotiations between the Ministry and the OMA were conducted through “Framework Agreements.”⁵ The newly-elected Conservative Government concluded that physician behaviour was driving a rapid increase in medical service utilization.⁶ In other words, it was believed that physicians were supplying at least some patients

² *Canada Health Act*, R.S.C. 1985, c. C-6 [CHA].

³ Pursuant to ss. 3(1) and 3(2) of the *Health Care Accessibility Act*, (*Health Care Accessibility Act*, R.S.O. 1990, c. H.3), the Minister may enter into agreements with the OMA “to provide for methods of negotiating and determining the amounts payable under the [Ontario Health Insurance] Plan in respect of the rendering of insured services to insured persons.”

⁴ Medical necessity is incorporated into the CHA through the comprehensiveness criterion of section 7. Section 9 requires that for the criterion to be satisfied, a province must insure all “insured health services”. Section 2 defines “insured health services” as hospital services, physician services and surgical-dental services. In turn, “hospital services”, “physician services” and “surgical-dental services” are also defined in section 2: “hospital services” is defined as any of a list of services provided to in-patients and out-patients at a hospital “if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability”; “physician services” is defined as “any medically required services rendered by medical practitioners”; and “surgical-dental services” is defined as “any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures.” See Cathy Charles *et al.*, “Medical Necessity in Canadian Health Policy: Four Meanings and ... a Funeral?” (1997) 75:3 *The Milbank Quarterly* 365.

⁵ Framework agreement is a generic term for a commercial contract or agreement with suppliers, the purpose of which is to establish the terms governing contracts to be awarded during a given period, in particular with regard to price and quantity. In other words, a framework agreement is a general term for agreements with suppliers, which set out terms and conditions under which specific purchases (call-offs) can be made throughout the term of the agreement. In this case, the framework agreement sets the conditions for negotiating payments to physicians for their services under the OHIP scheme.

⁶ Mark E. Geiger, “Mutual Gains Bargaining” (Paper presented at the Human Resources Professional Association — Ontario (HRPAO) Annual Conference, 18 February 1999), online: <http://www.blaney.com/pubs_articles_labour.html> [Geiger].

with services that were of questionable or marginal benefit. The Government passed Bill 26, the *Savings and Restructuring Act*,⁷ an omnibus piece of legislation that nullified pre-existing framework agreements, and allowed the Ministry to bypass the OMA and directly negotiate with physician groups either on a specialty-specific or interest basis. The new negotiation scheme did not prove successful. When the Ministry did not respond effectively or quickly enough, the newly established groups threatened to withdraw or reduce services. The Government was thus forced to return to negotiating with the OMA. It was against this backdrop of threats and claw backs that the OMA and the Ministry negotiated a new framework agreement in 1997,⁸ pursuant to which the PSC was created.

The 1997 Physicians' Services Agreement (*1997 Agreement*)⁹ was intended to address both the improvement of labour relations between the Ministry and the OMA, and the disconcerting increase in utilization. The focus of the *1997 Agreement* remained unchanged when it was renewed on April 1, 2000 for a 4-year period ending March 31, 2004 (*2000 Agreement*).¹⁰ Established in the *1997 Agreement* and reaffirmed in the *2000 Agreement*, the PSC was the central mechanism through which the parties sought to address these concerns. This is evident in the Committee's mandate, which can broadly be divided into two central roles.

First, the PSC acts as a medium for labour negotiations between the Ministry and the OMA. The Committee was designed to "build and sustain a strong positive working relationship between the Government of Ontario and the medical profession."¹¹ The PSC advises the Ministry and the OMA about the changing role of physicians, including improved models of service delivery and compensation. The Committee also develops recommendations for the enhancement of the quality and effectiveness of medical care in Ontario, and works to identify efficiencies, thereby maximizing returns on the funding provided for medical services. Finally, the PSC reviews any disagreement arising out of the Framework Agreement and recommends possible resolutions to the Ministry and the OMA.

Second, the PSC assumes a public service role by monitoring and evaluating physician service use in Ontario. Under the *1997 Agreement*, the Ministry and the OMA recognized that while "[c]hanges are necessary in order to meet the demands and needs of a changing Ontario population requiring health care services," the Government is under "substantial fiscal constraints ... in all areas, including health

⁷ *Savings and Restructuring Act*, R.S.O. 1996, c. 1.

⁸ *Geiger*, *supra* note 6.

⁹ *OMA-MOHLTC Comprehensive Agreement 1997 — 2000*. Ontario Medical Association and Ontario Ministry of Health and Long Term Care (December 1996), online:

<<http://www.oma.org/member/negotiat/agreement/agree.htm>> [*1997 Agreement*].

¹⁰ *OMA-MOHLTC 2000-2004 Agreement*. Ontario Medical Association and Ontario Ministry of Health and Long Term Care, online: <<http://www.srpc.ca/librarydocs/omaagmt.htm>> [*2000 Agreement*]. Negotiations to establish the next Physician Services Agreement was to have begun no later than January 10, 2004.

¹¹ *Ibid.* at App. A; *1997 Agreement*, *supra* note 9 at App. A.

care.”¹² The Ministry and the OMA therefore “agreed to various initiatives for the purpose of, *inter alia*, lessening the impact of utilization growth.”¹³ Hence, the PSC reviews the utilization of services and ultimately recommends changes to the Schedules of Benefits. The Ministry only funds those medically necessary services that are rendered by a physician to eligible Ontario residents and contained in the Schedule of Benefits of Physician Services (SOB-PS).¹⁴ The SOB-PS lists approximately 4,800 insured physician services. It includes a description of the service, a billing code, the amount payable and any applicable conditions or restrictions.¹⁵ The PSC thus plays a central role in the determination of the boundaries of publicly-funded Medicare.

The PSC does not act alone in reviewing the utilization of services. Rather, the Committee relies on the contributions of related subcommittees, namely the Physician Human Resources Committee,¹⁶ the Guideline Advisory Committee,¹⁷ and the System Management Committee.¹⁸ Each committee works with recommendations developed by Expert Panels appointed by the PSC, and advises the PSC in relation to its specialty. The Schedule of Benefits Working Group (SOBWG) most centrally facilitates the PSC’s role in reviewing utilization of services. The SOBWG is composed of Ministry and OMA representatives and is required to ensure that the SOB-PS adequately reflects the current and best medical practices.

Our research concentrates on the PSC as a mechanism for determining the boundaries of publicly funded services. However, it is important to recognize that the PSC’s restricted membership, which is limited to representatives of the Ministry and the OMA,¹⁹ and its private decision-making process, which invites minimal

¹² *Ibid.* at s.1.03.

¹³ *Ibid.* at s.2.04.

¹⁴ General, R.R.O. 1990, Reg. 552, s. 37.1(1). (Enabling statute: *Health Insurance Act*, R.S.O. 1990, c. H.6.).

¹⁵ When the *Health Insurance Act* was adopted in 1972, there was no SOB-PS. Rather, the government paid physicians a discounted fee based on the OMA schedule of fees. The Ministry published the SOB-PS in 1978, and has subsequently modified it over the years.

¹⁶ *1997 Agreement*, *supra* note 9 at s. 5.02; *2000 Agreement*, *supra* note 10 at 11.1.

¹⁷ *1997 Agreement*, *supra* note 9 at s. 10.01; *2000 Agreement*, *supra* note 10 at 18.1. This Committee consists of three members appointed by the OMA, three persons appointed by the Ministry and a chair selected by the parties. The GAC is aided in its work by the appointment of ex-officio member from the Institute for Clinical Evaluative Sciences. According to its website (www.ices.on.ca), the Institute for Clinical Evaluative Sciences (ICES) is “an independent, non-profit organization, whose core business is to conduct research that contributes to the effectiveness, quality, equity and efficiency of health care and health services in the province of Ontario”. The Institute seeks “to use research methodologies in innovative, creative ways to probe the interface of clinical practice, health services research and health policy, in order to create a blueprint for a better health care system in Ontario”.

¹⁸ *2000 Agreement*, *supra* note 10 at 8.2. The System Management Committee is designed to manage the growth in the cost of the physician services system caused by factors such as an aging and increasing population, the addition of new physicians to the system, new technology and physician and patient behaviour.

¹⁹ Representatives from the Ministry and the OMA wholly constitute the PSC. The Ministry and the OMA

input from other stakeholders, is partly a function of its intended operation as a labour relations improvement mechanism. Significant levels of trust and close contact between the medical profession and the Ministry are necessary for the success of a “mutual gains bargaining” approach.²⁰

The PSC’s role as a medium for labour relations is in tension with its function of determining value-laden decisions concerning the boundaries of publicly-funded Medicare. In the *1997 Agreement*, the PSC was to provide “an *open* and structured process for regular liaison and communication between the MOH [the Ministry] and the Medical Profession”²¹ (emphasis added). In the *2000 Agreement*, this description of the PSC was amended. The PSC was to “continue to provide a *broad* and structured process for regular liaison and communication between the MOHLTC [the Ministry] and the medical profession”²² (emphasis added). The change of wording presumably signals a lesser commitment to openness and transparency in the PSC’s decision-making process. We suggest that while the values of privacy, secrecy and a lack of transparency may enhance the PSC’s fulfilment of its labour relations mandate, they impede the Committee’s successful fulfilment of its public service mandate. The remainder of this paper is thus dedicated to a detailed investigation of the PSC’s role in determining what physician services are publicly funded and what services are “de-listed” (i.e. no longer eligible for public funding). Particular attention is paid to the principles of open participation, transparency and accountability, and the degree to which these principles are incorporated into the PSC’s decision-making process.

First, we describe the requirement in both the *1997 Agreement* and *2000 Agreement* that the PSC identify changes in the existing SOB-PS resulting in specified annual savings. Second, we examine the basis upon which the PSC

each appoint five members to serve on the PSC, and all members are expected to remain on the Committee for a minimum of two years. In 1997, the original composition of the PSC was: (OMA) Dr. Elliot Halparin, Dr. David Mendelsohn, Dr. Bill Orovan, Dr. Wayne Parsons and Mr. Mark Geiger; (MOHLTC) Dr. Reuben Devlin, Dr. Cheryl Levitt, lawyer Mr. Harvey Beresford and Assistant Deputy Ministers Ms. Mary Catherine Lindberg and Ms. Judith Wright of the Ministry of Health. As of November 2002, the PSC comprised: (OMA) Dr. Wayne Tanner, Dr. Chris McKibbon, Dr. Stewart Kennedy, Dr. Garnet Maley and Mr. Mark Geiger. Dr. Tanner is chair of the OMA Section on Vascular Surgery. He was a member of OMA negotiating team during 1999-2000 round of bargaining with government. Dr. Kennedy was appointed in May 2002 from the General and Family Practice Assembly. He also served as a member of the OMA negotiating team during the 1999-2000 round of bargaining. The OMA representatives are recruited through a province-wide campaign via the OMA Fax Network, a communication tool used by the OMA to send notices and bulletins to its members, and selected by the OMA Board of Directors. The government membership is selected from the Provider Services Branch of the Ministry. Under the agreements, the parties choose a professional facilitator to chair the PSC.

²⁰For further discussion of the PSC as a labour relations tool, see Tom Archibald & Colleen M. Flood “The Physician Services Committee: The Relationship Between the Ontario Medical Association and the Ontario Ministry of Health and Long-Term Care” CHSRF-OMHLTC Research Project “Defining the Medicare Basket” (RC2-0861-06, Working Paper No. 3), online: <<http://www.law.utoronto.ca/healthlaw/basket/index.html>>.

²¹ *1997 Agreement*, *supra* note 9 at s. 4.01.

²² *2000 Agreement supra* note 10 at s. 2.1.

identifies services to be de-listed from the SOB-PS. According to what principles and process does the PSC identify services for de-listing? To what extent does the PSC weigh the relative costs and benefits of particular treatments vis-à-vis all other possibilities (cost-effectiveness analysis)? Last, we explore the degree to which the PSC is publicly accountable for its decisions. To what extent is the public permitted to participate in the decision-making process? To what extent are public values otherwise incorporated into its decisions?

3. A Mandate to De-List

Under both Framework Agreements, the Ministry and the OMA agreed to modify the existing SOB-PS to create annual savings of at least \$50 million dollars.²³ By January 1998, the Ministry had cut \$50 million of OHIP services resulting in 39 restrictions to OHIP coverage. In the *2000 Agreement*, the “parties agree[d] that by December 31, 2000 they shall identify changes in the existing Schedule of Benefits which will result in annual savings of at least \$50 million.”²⁴ The first set of recommendations, projected to save \$20 million annually, was implemented on August 13, 2001. The remaining \$30 million in savings measures was targeted for implementation in the following fiscal year.²⁵

The “de-listing” of services from OHIP coverage pursuant to the *1997 Agreement* was not the first time that the Ministry and the OMA engaged in such a process. In a 1991 Agreement between the OMA and the then NDP provincial government, \$20 million in savings was realized through the elimination of 19 insured services identified as “not medically necessary.” The list of candidate services for de-listing originated with the OMA, but was subsequently referred to an OMA-Ministry Joint Management Committee (JMC) for evaluation. This committee was comprised of physician, ministry and consumer representatives.²⁶

It is noteworthy that in addition to de-listing public funded services from the SOB-PS, both the *1997 Agreement* and the *2000 Agreement* increased the fees payable to physicians for services remaining on the SOB-PS. The *1997 Agreement* provides for an annual 1.5% increase in the pool of funds available for medical services, confirms that the 2.9% claw-back on physician billings would expire on February 28, 1998, and asserts that no new claw-backs from payments would be introduced during the term of the Agreement.²⁷ The revised *2000 Agreement* increases physician fees for all publicly funded services (except technical fees for

²³ *1997 Agreement*, *supra* note 9 at s. 6.01; *2000 Agreement*, *supra* note 10 at 13.1.

²⁴ *Ibid.*

²⁵ Health Canada, “Provincial submission to the Canada Health Act Annual Report — 2001-2002”, online: <<http://www.hc-sc.gc.ca/medicare/ont-n-all.htm>>

²⁶ Steve Wharry “Delisting health services not for the faint of heart” *eCMAJ* (14 January 2002), online: <http://www.cmaj.ca/news/14_01_02.shtml> [Wharry].

²⁷ *1997 Agreement*, *supra* note 9 at ss. 2.03, 2.04 and 2.06.

diagnostic services) by 1.95% in the first year and by an annual increase of 2% thereafter for the duration of the Agreement.²⁸

4. The Process and Principles of Decision-Making

While the Framework Agreements clearly stipulated what the PSC was to accomplish, they provided little clarity on the principles and process by which de-listing decisions were to be made. In 2002, Dorothy Pringle, the former Chair of the JMC, noted that:

[d]e-listing [of insured health services] should — and does — go on all the time, ... [h]owever, the process should be open and done in full view of the public, which is not necessarily the case now. ... [t]he biggest issue, which we never established, was deciding what is medically necessary. You need the wisdom of Solomon to do that.²⁹

Both the *1997 Agreement* and *2000 Agreement* stipulate that savings are to be achieved through a mix of “tightening” and “modernization.”³⁰ Neither of the Agreements defines these terms, but supporting documents aid in the clarification of their meaning. Apart from these principles, however, there is no evidence of a systematic approach to the de-listing process. Moreover, the *1997 Agreement* and *2000 Agreement* differ dramatically with respect to the processes that must be followed in deciding what services to de-list from the SOB-PS. Whereas the *1997 Agreement* establishes a vague, but identifiable methodology, the *2000 Agreement* provides no guidance at all.

(a) PSC Decision-Making Process — 1997 Agreement

According to the *1997 Agreement*, the parties agreed that “at least \$25 million [worth of changes to the SOPB-PS] will be in the nature of tightening and at least \$25 million will be in the nature of modernization.”³¹ A report released by the Schedule of Benefits Working Group (SOB WG) defines these terms by reference to the PSC’s mandate.³² In order to ensure that the “OHIP Schedule of Benefits adequately reflects current standards in the practice of medicine,” the Committee’s review of services is designed to provide “value for money by removing services that are outdated or not medically necessary, so that they are no longer funded from the public purse.”³³ The term ‘modernization’ thus refers to the removal of outdated treatments and technologies, or those that have been surpassed by better and more

²⁸ *2000 Agreement*, *supra* note 10 at s. 3.1.

²⁹ *Wharry*, *supra* note 26.

³⁰ *1997 Agreement*, *supra* note 9 at s. 6.01; *2000 Agreement*, *supra* note 10 at s.13.

³¹ *Ibid.*

³² Ontario, Ministry of Health and Long Term Care, Schedule of Benefits Working Group, (Toronto: 1998) “Summary of 1998 Updates and Definitions for the OHIP Schedule of Benefits to February 24, 1998.”

³³ *Ibid.*

efficient techniques. The term ‘tightening’ refers to the removal or conditioning of services that are not medically necessary. For example, cosmetic services deemed “not medically necessary for the diagnosis, prevention or treatment of illness.”³⁴

Changes to the SOB-PS were divided into three categories under the 1997 “tightening” and “modernization” schema. The first category consisted of “procedures/services considered outdated or unproven.”³⁵ In some cases, these services were superseded in clinical practice by more efficacious and professionally accepted techniques and were thus no longer considered the best treatment in the opinion of the profession.³⁶ Examples of these services include the removal of warts, benign male mastectomy, insertion of testicular implant, and xanthomata. The second category consisted of services classified as cosmetic, and therefore not medically necessary. Aligning itself with other provinces, “Ontario [was] moving to de-insure any services or procedures intended solely to satisfy cosmetic concerns.”³⁷ The third category dealt with clarification of physician billings. These “items needed up-to-date descriptions of when and how to bill OHIP for various new/changing services.”³⁸

Appendix B of the *1997 Agreement* established the process by which outdated or unproven services, medically unnecessary services, and services requiring clarification of physician billing were identified.³⁹ First, the SOB-PS identified recommendations for “tightening” and “modernization” in consultation with experts in each area of medical specialization and reported findings in medical literature. For example, the OMA’s Central Tariff Committee is required to keep physician service fees under review and to make recommendations with respect to such revisions as might be warranted.⁴⁰ The Committee often considers recommendations of the OMA Committee on Economics, and forwards these recommendations to the SOB-PS regarding possible services for de-listing. Second, the SOB-PS submitted its recommendations to an Expert Panel composed of Ministry staff, physicians, a nurse, and outside health care experts. This Panel considered the various ramifications flowing from the SOB-PS’s recommendations, and whether the identified services are publicly funded in other provinces. If the Expert Panel approved of the recommendation, it endorsed the recommendation and submitted it to the PSC. If the Expert Panel did not support a recommendation, it indicated the basis of its decision and referred the recommendation back to the

³⁴ *Ibid.*

³⁵ *Ibid.* Examples of these services include: Eustachian tube catheterization, opening of dura, posturography, and caloric testing.

³⁶ “Some treatments, which had been used in limited settings, were removed from the SOB-PS because there was still no convincing evidence of their effectiveness. Finally, in some cases the procedure was removed because in the opinion of the profession it was no longer an appropriate practice.” *Ibid.*

³⁷ *Ibid.*

³⁸ *Ibid.*

³⁹ *1997 Agreement*, *supra* note 9 at App. B.

⁴⁰ Ontario Medical Association Central Tariff Committee, By-law 12:6 *CTC Orientation Manual*, (November 2000). Mandate of the CTC is being reviewed — OMA Report to Council, November 2000.

SOBWG.⁴¹ Finally, the PSC considered the recommendations supported by the Expert Panel. If the Committee was in agreement and the recommended changes were balanced in value, equal amounts of tightening and modernization, the recommendations were forwarded to the Minister for consideration.

Beginning in 1997 and culminating with a major report released in the March 1998 edition of the *Ontario Medical Review*,⁴² the PSC tracked the increasing rate of medical service utilization in Ontario. The data indicated that the utilization rates exceeded the targets set in the *1997 Agreement*. As a result, the PSC issued reports to the OMA Clinical Sections describing those services that had experienced the most substantial rate of growth, and sought responses from the relevant Sections. This research undoubtedly factored into the PSC's ongoing decision-making process.

Members of some Clinical Sections claimed that the PSC did not sufficiently analyse the causes of increased utilization. Rather, it opted to simply pursue clawbacks directed at selected specialities.⁴³ For example, the Ontario Association of Radiologists argued that the "decisions made to recommend cutbacks were arbitrary and taken without any substantial degree of consultation with the sections of the OMA."⁴⁴

(b) PSC Decision-Making Process — 2000 Agreement

Under the *2000 Agreement*, the parties similarly agreed to accomplish changes to the SOB-PS through a mix of tightening and modernization. However, no required balance for the mix was cited.⁴⁵ Furthermore, the process for identifying and making changes was to be "agreed upon by the parties."⁴⁶ A provides the only procedural consideration. It states that "[t]he PSC is committed to giving appropriate opportunity to affected parties to provide timely input to the PSC before making recommendations to the MOHLTC [the Ministry] and the OMA."⁴⁷

⁴¹ The SOBWG is still operational under the *2000 Agreement*, although it is not explicitly referred to in the text of the agreement. *The Provincial Submission to the Canada Health Act Annual Report for 2001-2002* stated that "a Schedule of Benefits Working Group, composed of Ministry and Ontario Medical Association representatives, was given the mandate in the agreement to identify changes in the existing Schedule of Benefits that will result in annual savings of at least \$50 million. Health Canada, "Provincial submission to the Canada Health Act Annual Report — 2001-2002", online: <<http://www.hc-sc.gc.ca/medicare/ont-n-all.htm>>.

⁴² See Bris Kralj, "Examining Trends in Medical Service Utilization" (1998) 65:3 *Ontario Medical Review* 17.

⁴³ C. Ian Doris, "Ontario Association of Radiologists launches legal action against the Ontario Medical Association" (1998) 42(4):1 *CAR FORUM* 6.

⁴⁴ *Ibid.*

⁴⁵ *2000 Agreement*, *supra* note 10 at s. 13.1.

⁴⁶ *Ibid.*

⁴⁷ *Ibid.* at App. A.

Various groups have challenged the openness of the PSC decision-making process, most notably, the Ontario Association of Speech-Language Pathologists and Audiologists' (OSLA).⁴⁸ OSLA's concerns arose from a PSC decision to de-list hearing aid evaluation and restrict coverage of diagnostic hearing tests. As of August 13, 2001, hearing tests performed by audiologists are publicly funded only when performed by an audiologist acting under a physician's direct supervision (employed in a physician's office).⁴⁹ The Report of the Schedule of Benefits Working Group III (SOBWG III), dated April 25, 2001, was instrumental in this de-listing decision. Dr. Michael Hawke, an otolaryngologist who employs audiologists and also acts as the Chair of Otolaryngology Section of the OMA, co-chaired the SOBWG III. The Report of the SOBWG III recommended that an estimated \$7.72 million would be saved annually through the de-listing of services provided by independent audiologists.⁵⁰ The report also noted, however, that the recommendations would "restrict the provision of services and may result in reduced access to DHTs (longer waiting lists) and end existing arrangements between physician and audiologists."⁵¹ On June 8, 2001, PSC co-chairs Mary Catherine Lindberg and Dr. Chris McKibbin sent a letter to Minister Clement and OMA President Dr. Kenneth Sky endorsing the SOBWG III's recommendations, but making no mention of the predicted impact on access to services for the hearing-impaired.⁵²

OSLA's account of PSC decision-making is troubling. Membership in the PSC is restricted to representatives from the Ministry and the OMA. Under the *2000 Agreement*, the agenda of the PSC is determined by the facilitator in consultation with the co-chairpersons appointed by the Ministry and the OMA.⁵³ Participation from other interested stakeholders is limited to invitation by either the Ministry or the OMA. The membership of subcommittees formed by the PSC is no more diverse than the PSC itself. For example, the inclusion of an otolaryngologist in the SOBWG III, whose profession directly benefited from the restriction on services provided by audiologists, presented a clear conflict of interest. The Ministry defends the PSC's decision-making process and the constitution of its subcommittees on the basis of the required expertise possessed by medical specialists and physicians.⁵⁴ This very same expertise, however, can result in conflicts of interest.

⁴⁸ Ontario Association of Speech-Language Pathologists and Audiologists (OSLA), "Unheeded Advice: Consumers Pay the Price" (February 2002), online: Ontario Association of Speech-Language Pathologists and Audiologists (OSLA), <<http://www.osla.on.ca/pdf/Unheeded%20Advice%20Feb%202002%20re%20PSC%20RecommendationsPDF.pdf>>.

⁴⁹ Ministry of Health and Long Term Care, Bulletin #4369, "Changes to the Ministry of Health and Long-Term Care Schedule of Benefits for Physician Services Effective July 1, 2001" (22 June 2001), online: <<http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bul4369.html>>.

⁵⁰ As reported by OSLA in "Unheeded Advice", *supra* note 48.

⁵¹ *Ibid.*

⁵² *Ibid.*

⁵³ *2000 Agreement*, *supra* note 10 at App. A.

⁵⁴ Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, 54A (22 October 2001).

A spokesperson for Health Minister Tony Clement is reported to have said that discussions regarding Medicare coverage should remain behind closed doors. In reference to patient groups that lobby to protect coverage of particular items, he stated: "Let's be frank, there will always be somebody saying, 'Don't do that.'"⁵⁵ The sentiment thus expressed is that the more public involvement in decisions about priority setting and rationing, the harder it is to control costs through the rationing of services.⁵⁶ The closed nature of the relationship between the OMA and the Ministry, which legitimately serves the function of improving labour relations, is also a convenient cloaking for controversial and difficult decisions about what services ought to remain publicly funded, and what services should be shifted into the private sector.

In an effort to disentangle the PSC's decision-making about the boundaries of publicly funded services from questions of physician remuneration, the Resource Based Value Schedule Commission (RBRVSC) was established. It determines the relative value of services provided by physicians on a revenue neutral basis. The budget neutral schedule was designed to replace the current SOB-PS, and to thereby lessen the possibility of pecuniary conflicts of interest in the decision-making process. On July 24, 2002, the RBRVSC released its report to the Ministry and the OMA for review. Since its release, little has been heard of the report thereby giving rise to the concern that it has been "buried." If implemented, the RBRVSC would fundamentally change the nature of the review and de-listing process of OHIP services.⁵⁷ Such a change would of course upset existing entitlements and expectations, and thus may be fiercely resisted.

5. A Demand for Reasons and Public Accountability

Given the closed nature of the PSC's membership and decision-making process, what alternative measures are available to hold the Ministry and the OMA accountable for their de-listing decisions? Are these parties required to provide timely and public reasons for their decisions? Can their decisions be legally challenged?

The OMA notifies only its physicians about services de-listed from the SOB-PS via an update service sent by facsimile. Physicians are also able to access this information by referring to OHIP Bulletins located on the Ministry website.⁵⁸ These

⁵⁵ Vanessa Lu "More Cuts Coming to Medical Procedures" *The Toronto Star* (2 February 2002), H4.

⁵⁶ Discussion about setting substantial limits on Medicare's benefit package could actually increase costs because legislators and health ministers are placed in the position of confronting public pressures. See Jonathon Oberlander, Theodore Marmor & Lawrence Jacobs, "Rationing medical care: rhetoric and reality in the Oregon Health Plan" (2001) 164:11 CMAJ 1583.

⁵⁷ The report was previously available online: <<http://www.rbrvs.on.ca/c.reports/c.reports.html>>. However, the website is now defunct, and it is unclear if the report remains publicly available.

⁵⁸ See The Ministry of Health and Long Term Care, "OHIP Bulletins", online: The Ministry of Health and Long Term Care <http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/bulletin_mn.html>.

bulletins, while publicly accessible, clearly indicate that the information provided “requires knowledgeable interpretation and is intended primarily for members of the professional health care community.”⁵⁹ As a result, there is no mechanism by which members of the general public are advised of de-listing decisions.

Numerous medical providers have issued complaints respecting the lack of warning of benefit deletions. For example, on June 22, 2001, the Ministry released changes to the SOB-PS regarding various physical therapy and related procedures, as well as, hearing aid evaluation and re-evaluations.⁶⁰ These changes were to become effective as of July 1, 2001, a mere eight days following notification of the change. Only in response to criticism did the Ministry release a second bulletin indicating that the effective date for the changes had been extended to August 13, 2001.⁶¹

The notices also fail to provide detailed reasons for the de-listing. In the case of de-listed hearing aid evaluations, the notice simply states that the services were “de-listed as ... [they] fall within the discipline of audiology and it is not necessary for a physician to provide or supervise these services.” The bulletin explains that “[t]hese changes permit more effective allocation of physician resources by redirecting care that does not require the assessment or intervention of a physician.”⁶²

Furthermore, the Ministry is intent on keeping the proceedings and deliberations of the PSC confidential, as evidenced by a recent appeal filed through the Ontario Privacy Commission.⁶³ The appeal involved a request for all information held by the Ministry, including OHIP offices and any associated advisory panels and working groups, related to the PSC’s creation, mandate, membership, financial support and the processes that led up to its decision to recommend the de-listing of travel medicine services. The Ministry resisted the applicant’s request arguing lack of jurisdiction, cabinet-records, solicitor client privilege, advice or recommendation, third-party information, economics and other interests. Tom Mitchinson, the Assistant Commissioner, upheld many of the Ministry’s defences on the basis of solicitor-client privilege, but refused to recognize others.

⁵⁹ *Ibid.*

⁶⁰ Ontario Ministry of Health and Long Term Care, Bulletin # 4369, “Changes to the Ministry of Health and Long-Term Care Schedule of Benefits for Physician Services Effective July 1, 2001” (22 June 2001), online: The Ministry of Health and Long Term Care <<http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bul4369.html>> [*Bulletin #4369*].

⁶¹ Ontario Ministry of Health and Long Term Care, Bulletin #4370, “July 1, 2001 Effective Date for Changes to the Schedule of Benefits for Physician Services Extended to August 13, 2001” (9 July 2001), online: The Ministry of Health and Long Term Care <<http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bul4370.html>>

⁶² *Bulletin # 4369, supra* note 60.

⁶³ Ontario Information and Privacy Commissioner, Order PO-1721, Appeal PA-980309-1 (October 18, 1999), online: <http://www.ipc.on.ca/scripts/index_.asp?action=31&N_ID=1&P_ID=4003>.

The private nature of the PSC's decision-making process, and its failure to communicate reasons for its decisions, has contributed to the recent commencement of multiple legal actions challenging the Ministry's decisions to de-list services from the SOB-PS.

On November 27, 2001, the College of Audiologists and Speech Language Pathologists of Ontario (CASLPO) and the Ministry presented arguments before the Ontario Superior Court of Justice in *Shulman v. College of Audiologists and Speech Language Pathologists of Ontario*.⁶⁴ The applicants challenged the decision to de-list audiology services, and argued that the principle of "medical necessity" did not justify the restriction of public funding to services provided under the supervision of a physician. They also claimed that the Ministry's decision disenfranchised audiologists from their right to practice independently under the *Regulated Health Professions Act*⁶⁵ and *The Audiology and Speech-Language Pathology Act*.⁶⁶ The College further argued that the decision entrenched a public funding gatekeeper function for a much smaller group of physicians. Finally, the College argued that the Ministry's decisions violated section 15(1) of the *Canadian Charter of Rights and Freedoms*.⁶⁷

The hearing impaired depend upon public coverage for services, and the loss of funding will adversely affect their health and well-being. The Ministry responded that the Court's intervention in de-listing decisions would unduly restrict the government's ability to properly administer OHIP and to control costs for all persons receiving care under OHIP. The Court found in favour of the Ministry. Despite the delisting decision, the court found that:

OHIP continues to insure hearing impaired persons for medically necessary physician services. Hearing impaired persons are not excluded from the benefits of OHIP in the same way as the claimants were denied access to human rights legislation in *Vriend v. Alberta*.⁶⁸

The Court also held that the government's concern about paying for medically unnecessary diagnostic hearing tests was legitimate, and noted that "[r]equiring physicians to assess medical necessity is one means whereby the long term financial sustainability of the publicly funded health insurance plan can be maintained".⁶⁹ Reflecting a general tendency on the part of the courts to defer to governmental decision-making in health policy matters, the Court concluded that the

⁶⁴ *Shulman v. College of Audiologists and Speech Language Pathologists of Ontario*, [2001] O.J. No. 5057 (Sup. Ct.) [*Shulman*].

⁶⁵ *Regulated Health Professions Act*, S.O. 1991, c. 18.

⁶⁶ *The Audiology and Speech-Language Pathology Act*, S.O. 1991, c. 19.

⁶⁷ Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11.

⁶⁸ *Shulman*, *supra* note 64 at para. 40.

⁶⁹ *Ibid.* at para. 42.

healthcare system is vast and complex. A court should be cautious about characterizing structural changes to OHIP which do not shut out vulnerable persons as discriminatory, given the institutional impediments to design of a healthcare system by the judiciary.⁷⁰

Although the Ministry was successful in defending the PSC decision-making in *Schulman*, other challenges are underway. On October 1, 1998, the Ontario government de-listed sex reassignment surgery.⁷¹ The transgender community challenged the decision, claiming that it was based on discriminatory views that regarded the health of transgendered people as insignificant or unimportant. On December 6, 2002,⁷² the *Toronto Star* reported that an Ontario Human Rights Commission investigation found the government's decision to cancel OHIP coverage for sex-change surgeries discriminatory. On September 26, 2003, the Ontario Human Rights Tribunal conducted a hearing to determine whether the Ontario government's decision violated the *Ontario Human Rights Code*.⁷³ The hearing was stalled for a number of months as the Ontario government engaged in extensive settlement negotiations. Current health minister George Smitherman was reportedly working for months to restore OHIP coverage for sex reassignment surgery in certain cases.⁷⁴ In May 2004, however, the reinstatement of reassignment surgery was absent from the Liberal party's provincial budget.⁷⁵ The Human Rights Tribunal has thus resumed its hearing.

6. Conclusion

Our modest research goal was to explain the role played by the PSC in the determination of what services should continue to receive public funding, and what existing services should be de-listed. Little is known about the complicated layers of decision-making that collectively determine the boundaries of Medicare. The PSC is one piece of the puzzle.

⁷⁰ *Ibid.* at para. 43.

⁷¹ Ontario Ministry of Health and Long-Term Care, OHIP Bulletin #4330, "Changes to Regulation 552 under the Health Insurance Act" (24 December 1998), online: Ontario Ministry of Health and Long Term Care <<http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bul4330.html>>. A clause in the new regulation did allow coverage for all people who had completed the program at the Gender Identity Clinic at the Clarke Institute of Psychiatry and had been recommended for surgery as of October 1, 1998.

⁷² Karen Palmer "Sex-change delisting 'prejudiced' — Probe finds OHIP bias against transsexuals Tribunal to decide on issue of coverage" *Toronto Star* (7 December 2002), A8.

⁷³ "De-Listing of Sex Reassignment Surgery (SRS) an Injury to Public Health: Access to SRS by Transsexuals is Crucial to Ensuring Full Dignity and Participation" *Egale Canada* (26 September 2003), online: Egale Canada <<http://www.egale.ca/index.asp?lang=E&menu=34&item=427>>; *Human Rights Code*, R.S.O. 1990, c. H. 19.

⁷⁴ "Ont. Won't pay for sex-change surgery" *Canadian Press* (27 May 2004), online: CTV.ca <http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/1085676420292_81085620/?hub=Health>.

⁷⁵ *Ibid.*

The PSC operates in a cloistered and private world with minimal input from other parties. The PSC, its various subcommittees and related working groups are almost entirely populated by representatives from the Ministry and the OMA. As a consequence, concerns regarding conflicts of interest necessarily arise when decisions are made to de-list services that are not provided by physicians. A committee populated by physician representatives clearly has a strong incentive to identifying savings that do not affect the remuneration of their own colleagues. Moreover, the PSC engages in a closed decision-making process with no means by which the interests of other stakeholders are explicitly incorporated. There is little opportunity for any form of public participation. Rather, the public must rely on the Ministry to represent the larger public interest in its funding negotiations with the OMA.

The closed nature of the PSC is in part a function of its role as a labour relations improvement mechanism. While restricted membership, secrecy and a lack of transparency may be necessary attributes for the fulfilment of this labour relations role, they do not serve the larger public interest in determining the boundaries of publicly funded Medicare.

First, the rationing of decisions in the health care context is not merely a function of clinical expertise and government spending. Public values are particularly implicated in decisions about publicly funded services. As a consequence, some consideration should be given to mechanisms by which greater public participation can be accommodated in the PSC's decision-making process.

Second, the PSC's decision-making process is not governed by any meaningful principles or standards. Concepts such as "tightening" and "modernization" are ill defined. If decision-making is to remain closed within the world of labour negotiations, decision-makers must articulate and account to the general public for the principles upon which their decisions rest. In defence of the secrecy of its process and the reasons for its decisions, the Ministry relies on the assumption that greater transparency in the decision-making process renders it more difficult to ration or to make cutbacks. This is mere speculation as there is no evidence to support the Ministry's position. Transparency protects against arbitrary decision-making, and guarantees that de-listed services are not simply those that engender little political backlash. If the public is to accept difficult decisions, the PSC must demonstrate that candidate services for de-listing were chosen rationally and fairly, according to cost-effectiveness analyses and with due respect for public values. This lack of transparency coupled with the absence of any internal mechanism by which to challenge de-listing decisions, including an opportunity to revise a decision in light of further evidence or arguments, will likely result in continued legal challenges.

We acknowledge that in evaluating the PSC and its decision-making process against the principles of open participation, transparency and accountability, we are applying values that have only come to prominence in the health policy context after the creation of the PSC. Moreover, we would be remiss to undervalue the contribution that the PSC has made to labour peace between the Ministry and the

OMA. The purpose of our research, however, is to emphasize that the PSC also performs a very public role in the determination of the boundaries of public-funded Medicare. It is a role that cannot remain buried or subsumed within a labour relations context. Rather, it is a role that requires the Committee to assume a very different character; one that is precisely marked by the features of open participation, and transparency. Only by exhibiting these qualities can the PSC engage in informed, principled and accountable decision-making. Our task moving forward is thus to determine how and whether the PSC can assume both roles, each perfectly suited to its respective context.