

**Working Paper No. 1 – Defining the Medicare Basket**  
**CHSRF-OMHLTC Research Project “Defining the Medicare Basket” (RC2-0861-06)**

**2 March 2004**

# **The Boundaries of Medicare: The Role of Ontario’s Physician Services Review Committee**

**By Colleen M. Flood\* and Joanna Erdman\*\***

**\*Canada Research Chair in Health Law and Policy, Associate Professor, Faculty of Law, University of Toronto**

**\*\* JD candidate, Faculty of Law, University of Toronto**

**Please do not quote or cite without the authors’ express permission. We welcome comments and feedback at**  
**[colleen.flood@utoronto.ca](mailto:colleen.flood@utoronto.ca)**

**Copyright: Joanna Erdman & Colleen M. Flood, 2004.**

Research and editing assistance from Kajal Khanna and Greig Hinds.

## **Table of Contents**

1. Introduction
2. Legal Authority of the PSC: OMA-MOHLTC Agreements
3. PSC: Composition and Operation
4. PSC: Mandate and Subcommittees
  - a. Mandate
  - b. Subcommittees
5. Nature of the PSC Decision-Making Process
  - a. PSC Decision-Making Process - 1997 Agreement
  - b. PSC Decision-Making Process - 2000 Agreement
  - c. Additional Considerations
6. Decisions: Record, Communication and Reasons
7. Legal Challenges
8. Assumptions, Effects and Proposals
9. Conclusions

## 1. Introduction:

Who should decide and on what basis which health care services are publicly funded? For many years, industrialized countries have dealt with the complexity of health care services rationing. They have adopted methods varying from the drafting of a specific list of services with public involvement (Oregon), to decision-making by national committees with some (United States, United Kingdom and Australia) or little (Singapore) public input, to the use of guidelines (New Zealand).<sup>1</sup> Much has been written on their experiences. In Canada, as required by the *Canada Health Act*, (the “CHA”)<sup>2</sup> provinces ensure public funding for “medically necessary” hospital services and “medically required” physician services. The concept of medical necessity, however, is not defined in the CHA, nor is it defined operationally in provincial legislation. Rather, provincial governments and medical associations negotiate which services are to be publicly funded in the process of determining the fees that physicians will receive in exchange for providing services.<sup>3</sup> As a consequence, through these negotiations, provincial governments similarly engage with questions of public health care funding. Unlike other jurisdictions, however, remarkably little is known about the complicated layers of decision-making that cumulatively determine what services Canadian patients receive from Medicare.

In an effort to minimize the informational deficiency in Canada, this research paper describes the role of the Ontario “Physician Services Committee” in determining what physician services should and should not (i.e. “de-listed”) be funded under the provincial health insurance plan. The paper examines the extent to which the Committee’s decisions are open and transparent, and the degree to which its process allows for public participation. This inquiry identifies both the underlying assumptions that shape and the effects produced by the current decision-making structure and process.

## 2. Legal Authority of the PSC: OMA-MOHLTC Agreements

In 1991, the Ontario Medical Association (“OMA”) was designated the exclusive bargaining agent for the medical profession in Ontario.<sup>4</sup> Although ostensibly a “voluntary” organization, the *OMA Dues Act*<sup>5</sup> requires that all members of the medical profession in Ontario pay dues and assessments to the

---

<sup>1</sup> Commission on the Future of Health Care in Canada, *A Framework for Determining the Extent of Public Financing of Programs and Services: Discussion Paper No. 16* by Cynthia Ramsay (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at 12.

<sup>2</sup> Canada Department of National Health and Welfare. 1985. *Canada Health Act*. R.S.C. 1985, c. C-6.

<sup>3</sup> Commission on the Future of Health Care in Canada, *Strengthening the Foundations: Modernizing the Canada Health Act: Discussion Paper No. 13* by Colleen M. Flood & Sujit Choudhry (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at 8.

<sup>4</sup> *Health Care Accessibility Act* R.S.O. 1990 Chapter H.3 s. 3(1) and 3(2) and *Health Insurance Act*, R.S.O. 1990, c. 1, Sched. H, s. 19 s. 27. *Physicians Services Delivery Management Act 1996* S.O 1996, Chapter 1

<sup>5</sup> S.O 1991 c. 51

OMA. In light of its recognition of the OMA as the exclusive bargaining agent for physicians, the Ontario Ministry of Health and Long-Term Care (MOHLTC) has historically consulted and negotiated with the OMA regarding the “tariffs” or fees to be paid to physicians for the provision of publicly funded services. This process indirectly determines what physician services are “medically necessary,” and thus publicly funded.<sup>6</sup>

To understand the nature of these negotiations, it is important to appreciate the context in which they occurred. Prior to the election of the Ontario Progressive Conservative Party in 1995, the relationship between the OMA and the MOHLTC was negotiated through “Framework Agreements”.<sup>7</sup> Two framework agreements had been successfully negotiated, the first covering the period of 1991-1994, and the second covering the period of 1994-1997. Concerned by evidence that the rate of medical service utilization was increasing by double digits and concluding that this increase was driven by physician behaviour,<sup>8</sup> the newly elected Conservative Government passed Bill 26, the *Savings and Restructuring Act*,<sup>9</sup> an omnibus piece of legislation that nullified the existing 1994 Framework Agreement. The OMA counter-argued that increased utilization was not attributable to physician behaviour. Rather, it was primarily due to demographic change, population growth, new medical programs and expanded use of medical technology.<sup>10</sup> Notwithstanding these arguments, the Conservative government stopped negotiations with the OMA. Instead, it chose to deal directly with groups of physicians on a specialty-specific or interest basis. When the MOHLTC did not respond effectively or quickly enough, however, the newly established groups threatened to withdraw or reduce services. These threats effectively forced the Government to negotiate with the OMA. It was thus against the backdrop of threats and claw backs that the OMA and the MOHLTC negotiated a new agreement in 1997.<sup>11</sup>

---

<sup>6</sup> Pursuant to s. 3.1 of the *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."

<sup>7</sup> “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.

<sup>8</sup> Mark E. Geiger, *Mutual Gains Bargaining*. (18 February 1999) Presented at the Human Resources Professional Association - Ontario (HRPAO) Annual Conference. Online: <[http://www.blaney.com/pubs\\_articles\\_labour.html](http://www.blaney.com/pubs_articles_labour.html)> (date accessed: 27 February 2004).

<sup>9</sup> 1995, S.O. 1996, c. 1

<sup>10</sup> The PSC has subsequently acknowledged that data used to attribute increased utilization rates to physician referrals were not of high quality and speculative at best -- C. I. Doris. “Ontario Association of Radiologists launches legal action against the Ontario Medical Association” *Forum*, CAR FORUM 1998; 42(4):1 (August 1998).

<sup>11</sup> *Geiger, supra* note 8.

On May 14, 1997, the OMA Governing Council ratified the Physicians' Services Agreement (the "1997 Agreement").<sup>12</sup> The *1997 Agreement* constructed a joint OMA-MOHLTC model of voluntary primary care reform. Under s. 1.03, the parties acknowledged that "[c]hanges are necessary in order to meet the demands and needs of a changing Ontario population requiring health care services."<sup>13</sup> The parties also recognized that the Government is under "substantial fiscal constraints ... [and thus] changes must be attained within appropriate budgets established by the Government for the MOHLTC."<sup>14</sup> Furthermore, under s. 2.04, both parties acknowledged, "growth in utilization, and its corresponding impact on the cost of physician services, can occur for a number of reasons. Accordingly, the parties have agreed to various initiatives for the purpose of, *inter alia*, lessening the impact of utilization growth."<sup>15</sup> The agreement provided for an annual 1.5% increase in the pool of funds available for medical services,<sup>16</sup> and confirmed that the 2.9% Social Contract claw-back on physician billings would expire on February 28, 1998.<sup>17</sup>

The *1997 Agreement* was renegotiated on April 1, 2000 for a 4-year period effective from April 1, 2000 to March 31, 2004. The renewed Physicians' Services Agreement (the "*2000 Agreement*")<sup>18</sup> provides for 1.95% increase in all fees listed in the schedule of benefits (except technical fees for diagnostic services) as of April 2000 and for the duration of the Agreement an annual increase of 2% for all fees.<sup>19</sup> The *2000 Agreement* also included a re-opener provision<sup>20</sup> that provides for certain re-negotiations during the final year of agreement. In April 2003, the MOHLTC and the OMA negotiated a *Memorandum of Agreement for Fiscal 2003-2004* (the "*2003-2004 Re-Opener Agreement*"),<sup>21</sup> which among other features, established Family Health Groups (FHG), and enhanced the Hospital On-Call Coverage Program and the Medical Review Committee process. The *2000 Agreement* states that

---

<sup>12</sup> OMA-MOHLTC Comprehensive Agreement 1997 – 2000 (December 1996) online: <<http://www.oma.org/member/negotiat/agreemnt/agree.htm>> (date accessed: 4 March 2003) [hereinafter *1997 Agreement*].

<sup>13</sup> *Ibid.* at s. 1.03.

<sup>14</sup> *Ibid.*

<sup>15</sup> *Ibid.* at s.2.04.

<sup>16</sup> *Ibid.*

<sup>17</sup> *Ibid.* at s.2.03

<sup>18</sup> OMA-MOHLTC 2000-2004 Agreement, online: <<http://www.srpc.ca/librarydocs/omaagrmt.htm>> (date accessed: 4 March 2003) [hereinafter *2000 Agreement*].

<sup>19</sup> *Ibid.* at s. 3.1.

<sup>20</sup> Re-opener clauses allow the parties to an agreement to re-negotiate at certain time periods during the term of the agreement, certain topics or clauses, even though the agreement does not expire until a future date. The rationale for re-openers is to provide the parties with an opportunity to negotiate over important issues that may arise during the life of the agreement, but which could not have reasonably been anticipated at the time the contract was negotiated.

<sup>21</sup> The *2003-2004 Re-Opener Agreement* was posted on OMA WebLink on April 16, 2003 and subsequently published in the April 2003 edition of the *Ontario Medical Review*. See "Memorandum of Agreement" *Ontario Medical Review* 70:4 (April 2003).

"[n]egotiations to establish the next Physician Services Agreement will begin no later than January 10, 2004."<sup>22</sup>

The Physician Services Committee (PSC) was established under the *1997 Agreement*. It was specifically designed to make recommendations to the Minister of Health and Long-Term Care regarding utilization. According to s. 4.01, the PSC was to provide "an *open* and structured process for regular liaison and communication between the Ministry and the Medical Profession"<sup>23</sup> The *2000 Agreement* altered the committee's mandate. According to s. 2.01, the PSC was to provide a "*broad* and structured process for regular liaison and communication between the Ministry and the Medical Profession"<sup>24</sup> (emphasis added). The change of wording may suggest a lesser commitment to openness and transparency in the decision-making process, although any commitment in this regard was already circumscribed to dialogue between the MOHLTC and the medical profession.

### 3. PSC: Composition and Operation

Under the 1997 and 2000 agreements, the PSC consists of five members appointed by the OMA and five members appointed by the MOHLTC. All members are expected to remain on the Committee for a minimum of two years. The OMA Board of Directors appoints the OMA representatives.<sup>25</sup> The OMA Board of Directors initiates a province-wide recruitment campaign through the OMA Fax Network<sup>26</sup> and appoints its representatives from applications received.<sup>27</sup>

The government membership of the PSC is selected from the Provider Services Branch of the MOHLTC.<sup>28</sup> Under the agreements a professional facilitator, chosen by the parties, facilitates the PSC.<sup>29</sup> Each party funds its own members, and the MOHLTC funds the administration costs of the Committee and the cost of the facilitator. In 1997, the agenda of the PSC was to be determined by the chair. Under the *2000 Agreement*, the agenda is determined by the facilitator in consultation with the co-chairpersons

---

<sup>22</sup> *2000 Agreement, supra* note 18 at s. 21.1.

<sup>23</sup> *1997 Agreement, supra* note 12 at s. 4.01.

<sup>24</sup> *2000 Agreement, supra* note 18 at s. 2.01.

<sup>25</sup> As of March 4, 2003, the OMA membership of the PSC consists of Drs. Christopher McKibbon (co-chair), Garnet Maley, Stewart Kennedy and Wayne Tanner. Mark Geiger serves as legal counsel.

<sup>26</sup> The OMA Fax Network is a communication tool used by the OMA to send notices and bulletins to its members.

<sup>27</sup> In 1997, the original composition of the PSC was: (OMA) Dr. Elliot Halparin, Dr. David Mendelssohn, 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.

<sup>28</sup> As of March 4, 2003, the government membership of the PSC consists of Drs. David McCutcheon (co-chair), Rueben Devlin and Lynn Wilson and Mary Kardos-Burton. Harvey Beresford is the province's lawyer.

<sup>29</sup> As of March 4, 2003, Mort Mitchnick serves as facilitator.

appointed respectively by the MOHLTC and the OMA. According to the *2000 Agreement*, the PSC must meet at least twice per month.<sup>30</sup> This usually consists of two full day meetings, plus one evening teleconference. The PSC may also be intermittently involved with ad hoc and co-committee work. The dates and times of upcoming meetings for the following 4-6 months are published monthly in the *Ontario Medical Review*, the official publication of the OMA.

#### **4. PSC: Mandate and Subcommittees**

The PSC's mandate consists of five roles.<sup>31</sup> First, the PSC receives and considers reports and recommendations as provided for in the agreements. Second, the PSC advises both the MOHLTC and the OMA in connection with the changing role of physicians, including possible improved models of delivery of and compensation for services. Third, the PSC develops and delivers recommendations to the Minister of Health leading to the enhancement of the quality and effectiveness of medical care in Ontario. Fourth, the PSC works towards identifying efficiencies and maximizing return on the funding provided for medical services. Finally, and most importantly for the purposes of this paper, the PSC reviews the utilization of services and ultimately makes recommendations regarding changes to the Schedule of Benefits. The Schedule of Benefits is a list of medical services that eligible Ontario residents will be publicly-insured for. Under subsection 37.1(1) of Regulation 552 of the *Health Insurance Act*, a service rendered by a physician in Ontario is an insured service if it is medically necessary, and is contained in the Schedule of Benefits of Physician Services (SOB-PS). The SOB-PS lists approximately 4,800 insured physician services. It contains a description of the service, a billing code, the amount payable and any applicable conditions or restrictions.<sup>32</sup>

Under both the 1997 and 2000 agreements, the MOHLTC and the OMA contracted to identify changes in the existing Schedule of Benefits that would result in annual savings of at least \$50 million dollars. By January 1998, the MOHLTC had cut \$50 million of OHIP services resulting in 39 restrictions to OHIP coverage. In the *2000 Agreement*, the "parties agreed 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."<sup>33</sup> The first set of recommendations, projected to save \$20 million annually, was implemented

---

<sup>30</sup> *2000 Agreement*, *supra* note 18 at appendix A

<sup>31</sup> *Ibid.*

<sup>32</sup> 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.

<sup>33</sup> *2000 Agreement*, *supra* note 18 at s. 13.1

on August 13, 2001. The remaining \$30 million in savings measures was targeted for implementation in the following fiscal year.<sup>34</sup>

It is important to note that the “de-listing” of services from OHIP coverage pursuant to the *1997 Agreement* was not the first time that de-listing was used as a strategy to reduce health care costs. In a 1991 Agreement between the OMA and the then NDP Government, \$20 million in savings was realized through the elimination of 19 insured services identified as “not medically necessary.” Under this former system, the list of candidate services to be de-insured originated with the OMA, but was referred to an OMA-MOHLTC Joint Management Committee (JMC) for evaluation. In 1993, Dorothy Pringle chaired this joint committee, which included physician, MOHLTC, academic and consumer representatives.<sup>35</sup> Originally, the MOHLTC considered de-insuring psychotherapy, psychoanalysis, and in vitro fertilization, but a powerful psychiatry lobby effectively removed the mental health interventions from consideration.<sup>36</sup> It was thus decided that the candidates for de-insurance be chosen and the process driven by the umbrella concept of medical necessity. Although it was traditionally thought that the *private sector* would not provide *medically unnecessary* services because there would be no demand for such services, the Committee recognized that while services may not be beneficial enough to warrant public funding, patients might still sufficiently benefit from the services to privately fund them. The Committee thus used an existent or potential private market to flag candidate services for de-listing.<sup>37</sup> It is noted, however, that such a consideration presents “potential conflicts of interest for physicians who work in both the public and private systems and, who, at least in the absence of sophisticated regulation, would have a financial incentive to shift patients into a privately financed system for their services.”<sup>38</sup> The same financial incentive may have motivated physicians on the JMC to de-list services. In general, de-listed services were chosen according to principles that were not well articulated or publicized.<sup>39</sup> Pringle herself described the final assembly of services as “bizarre”<sup>40</sup> and speculated that the commission would have probably de-insured an entirely different set of services had they been given a wider range of choice. In 2002, Pringle commented that “[d]e-listing [of insured health services] should ... be open and done in full

---

<sup>34</sup> 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>> (date accessed: 27 February 2004).

<sup>35</sup> 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](http://www.cmaj.ca/news/14_01_02.shtml)> (date accessed: 27 February 2004).

<sup>36</sup> Dorothy Pringle, “Deinsuring Medical Services: Practical or Perverse?” (1995) Presentation to the Annual Meeting of the Canadian Health Economics Research Association (25 August 1995).

<sup>37</sup> Mita K. Giacomini, “The *Which-Hunt*: Assembling Health Technologies for Assessment and Rationing.” *Journal of Health Politics, Policy and Law* 24.4 (1999) 715 at 730.

<sup>38</sup> Flood, *supra* note 3 at 9.

<sup>39</sup> Giacomini, *supra* note 37.

<sup>40</sup> Pringle, *supra* note 36.



view of the public, which is not necessarily the case now. The biggest issue, which we never established, was deciding what is medically necessary. You need the wisdom of Solomon to do that.”<sup>41</sup>

The question raised then is whether the OMA and MOHLTC have designed the PSC to function differently from its predecessor, i.e. according to a rational set of principles? According to which principles does the PSC decide what is “medically unnecessary”, and consequently, what should be de-listed? The *1997 Agreement* and *2000 Agreement* differ dramatically in their provisions of the processes to be followed in the determination of service de-listing. As elaborated below, whereas the *1997 Agreement* established a vague, but identifiable methodology, the *2000 Agreement* provides no guidance at all.

#### (b) Subcommittees

In order to facilitate the fulfilment of the PSC’s mandates, a number of sub-committees were created under the 1997 and 2000 Agreements. There are three subcommittees relevant to the PSC’s role in monitoring and reducing utilisation: the Physician Human Resources Committee<sup>42</sup>; the Guideline Advisory Committee<sup>43</sup>; and the System Management Committee.<sup>44</sup> Each committee advises and provides recommendations to the PSC on its area of specialty. Additionally, the Committees work with recommendations developed by Expert Panels appointed by the PSC. The Schedule of Benefits Working Group (WG) most centrally facilitates the PSC’s review of service utilization. The WG is composed of OMA and MOHLTC representatives. It is required to ensure that the OHIP Schedule of Benefits adequately reflects current and best standards in practice of medicine. The WG identifies recommendations for “tightening” and “modernization”, and forwards these recommendations to the Expert Panel. The WG also consults with experts in each area of medical specialization during the course of its review, and consults medical literature where appropriate.

The Expert Panel, composed of MOHLTC staff, physicians, a nurse, and outside health care experts, considers and determines the effect of the WG’s recommendations. If the Expert Panel approves

---

<sup>41</sup> *Wharry, supra* note 35.

<sup>42</sup> *1997 Agreement, supra* note 12 at s. 5.2.

<sup>43</sup> This Committee consists of three members appointed by the OMA, three persons appointed by the Ministry and a chair to be 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](http://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”.

<sup>44</sup> The *2000 Agreement* also provided for the establishment of the System Management Committee 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.” -- *2000 Agreement, supra* note 18 at s. 8.1.

their proposed recommendations, it advises the OMA, the MOHLTC and the WG. If the Expert Panel requires more information or clarification with respect to any recommendation, it returns to the WG for that purpose. Similarly, if the Expert Panel does not support a recommendation, it indicates the basis of its decision and refers the recommendation back to the WG. The WG is still operational under the *2000 Agreement*, although it is not explicitly referred to in the text of the Agreement.<sup>45</sup>

## 5. Nature of the PSC Decision-Making Process

Both the *1997 Agreement* and *2000 Agreement* stipulate that savings are to be achieved through a mix of “tightening” and “modernization.”<sup>46</sup> Neither of the Agreements defines these key terms, but their meaning is somewhat clarified through supporting documents. Apart from these principles, however, there is no evidence of a systematic approach to the delisting process in either agreement.

### (a) PSC Decision-Making Process - 1997 Agreement

The *1997 Agreement* required the PSC to identify changes in the Schedule of Benefits that would result in annual savings of at least \$50 million. It was agreed that at least \$25 million would be in the nature of “tightening” and at least \$25 million would be in the nature of “modernization”.<sup>47</sup> Some clarification of the terms “tightening” and “modernization” can be derived from the *Summary of 1998 Updates and Definitions for the OHIP Schedule of Benefits – to February 24, 1998*<sup>48</sup>, a report released by the Schedule of Benefits Working Group. Under the *1997 Agreement*, the PSC’s mandate was to ensure that the “OHIP Schedule of Benefits adequately reflects current standards in the practice of medicine.”<sup>49</sup> The review is designed to ensure “value for money by removing services that are outdated or not medically necessary, so that they are no longer funded from the public purse.”<sup>50</sup> Thus, the term ‘modernization’ refers to the removal of outdated treatments and technologies, or those that have been surpassed by better and more 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.”<sup>51</sup>

---

<sup>45</sup> 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. *Supra* note 39.

<sup>46</sup> *1997 Agreement*, *supra* note 12 at s. 6.01 and *2000 Agreement*, *supra* note 18 at s.13.

<sup>47</sup> *1997 Agreement*, *supra* note 12 at s. 6.01

<sup>48</sup> Ministry of Health and Long Term Care, “Summary of 1998 Updates and Definitions for the OHIP Schedule of Benefits – to February 24, 1998” (February 1998) online:

<<http://www.gov.on.ca/Ministry/english/program/ohip/sobud/sobud98.html#7>> (date accessed: 4 March 2003).

<sup>49</sup> *Ibid.*

<sup>50</sup> *Ibid.*

<sup>51</sup> *Ibid.*

According to the “tightening” and “modernization” schema in the *1997 Agreement*, the changes to the OHIP Schedule of Benefits divided into three categories. The first category was composed of “procedures/services considered outdated or unproven.”<sup>52</sup> In some cases, these services were superseded in clinical practice by more efficacious and professionally accepted techniques and thus no longer considered the best treatment in the opinion of the profession.<sup>53</sup> Examples of these services include the removal of warts, benign male mastectomy, insertion of testicular implant and xanthomata. The second category included services classified as cosmetic and not medically necessary. In an attempt to align itself with other provinces, “Ontario [was] moving to de-insure any services or procedures intended solely to satisfy cosmetic concerns.”<sup>54</sup> The third category was constituted by the clarification of physician billings and included “items needed to up-date descriptions of when and how to bill OHIP for various new/changing services.”<sup>55</sup>

Appendix B of the *1997 Agreement* detailed the process of decision-making. Under the first two steps of the process, the Working Group (WG) identified recommendations for tightening and modernization, and an independent expert endorsed the recommendations. The central elements of this preliminary process included a consultation with experts of various medical specializations and clinical evaluations, as well as, the comparison of the Ontario Schedule of benefits with services provided by other provinces under the national Medicare system. The final stage in the process was the PSC’s consideration of the recommendations supported by the Expert Panel. If the PSC 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. The equal balancing requirement is absent in the *2001 Agreement*.

Beginning in 1997 and culminating with a major report in the March 1998 edition of the *Ontario Medical Review*<sup>56</sup>, the PSC carefully tracked the increasing rate of utilization of medical services in Ontario. The data showed that utilization exceeded the targets set in the *1997 Agreement*. Concerned with this result, the PSC issued reports to the OMA Clinical Sections describing those services that had experienced the most substantial rate of growth. The Committee sought input from the relevant OMA Sections regarding potential factors or trends that may have attributed to a significant utilization increase. This research undoubtedly factored into the PSC’s delisting decision-making. Members of some Clinical

---

<sup>52</sup> *ibid.* Examples of these services include: Eustachian tube catheterization, opening of dura, posturaography, and caloric testing.

<sup>53</sup> “Some treatments, which had been used in limited settings, were removed from the Schedule of Benefits 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.*

<sup>54</sup> *ibid*

<sup>55</sup> *ibid*

<sup>56</sup> See Bris Kralj “Examining Trends in Medical Service Utilization,” *Ontario Medical Review* 65:3 (March 1998).

Sections claimed, however, that the PSC failed to sufficiently analyze the exact causes of utilization increase. Instead, it pursued a strategy of claw-backs directed at selected specialities.<sup>57</sup> For example, the Ontario Association of Radiologists argues that during this period the “decisions made to recommend cutbacks were arbitrary and taken without any substantial degree of consultation with the sections of the OMA.”<sup>58</sup>

#### *PSC Decision-Making Process - 2000 Agreement*

Under the *2000 Agreement*, the parties also agreed to accomplish changes to the Schedule of Benefits through a mix of tightening and modernization. No required balance for the mix, however, was cited. Furthermore, the agreement stated that process for identifying and making changes was to be “agreed upon by the parties.” Appendix A provides the only procedural consideration. It states that the PSC is committed to giving opportunity to affected parties to provide timely input to the PSC before making recommendations to the MOHLTC and the OMA.<sup>59</sup>

Various participant verbatim accounts challenge the openness of the PSC decision-making process under the *2000 Agreement*. For example, the experience of the Ontario Association of Speech-Language Pathologists and Audiologists’ (OSLA) is recounted in a February 2002 paper, entitled “Unheeded Advice: Consumers Pay the Price.”<sup>60</sup> OSLA’s concern in the decision-making process arose from the PSC’s decision to de-list hearing-aid evaluation and restrict coverage of diagnostic hearing tests. On June 22, 2001, the MOHLTC de-listed all hearing tests not performed by an audiologist acting under a physician’s direct supervision, a requirement that demands the audiologist be employed by the physician’s office.<sup>61</sup> The report of the Schedule of Benefits Working Group III (SOBWG III),<sup>62</sup> dated April 25, 2001, was instrumental in the decision to de-list these hearing tests. Dr. Michael Hawke, the Chair of the Otolaryngology Section of OMA, and an otolaryngologist who employs audiologists, and Dr. Henry Phillips, a representative from the MOHLTC and a Ministry Medical Consultant<sup>63</sup>, co-chaired the

---

<sup>57</sup> C.I. Doris, “Ontario Association of Radiologists launches legal action against the Ontario Medical Association” *Forum*, CAR FORUM 42(4):1 (August 1998).

<sup>58</sup> *Ibid.*

<sup>59</sup> *2000 Agreement*, *supra* note 18 at appendix A.

<sup>60</sup> Ontario Association of Speech-Language Pathologists and Audiologists (OSLA), “Unheeded Advice: Consumers Pay the Price” (February 2002) online: <<http://www.osla.on.ca/pdf/Unheeded%20Advice%20Feb%202002%20re%20PSC%20RecommendationsPDF.pdf>> (date accessed: 4 March 2003).

<sup>61</sup> 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>

<sup>62</sup> As reported by OSLA in “Unheeded Advice: Consumers Pay the Price”, *supra* n. 60.

<sup>63</sup> For a discussion of the role of Medical Consultants in determining what is and out of publicly-funded Medicare see Mona Awad, Julia Abelson and Colleen M. Flood, “The Boundaries of Canadian Medicare: The Role of

SOBWG III. In its final report, the SOBWG III recommended that an estimated \$7.72 million could be saved annually through the delisting of services provided by independent audiologists.<sup>64</sup> The report also noted that the recommendation's implementation 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."<sup>65</sup> On June 8, 2001, then PSC co-chairs Mary Catherine Lindberg and Dr. Chris McKibbin issued a letter to Minister Clement and OMA President Dr. Kenneth Sky endorsing the SOBWG III's recommendations. In the letter, no mention was made of the prospect of reduced access to services for the hearing-impaired.

OSLA's account of PSC decision-making is *prima facie* troubling. First, participation is limited to invitation by either the MOHLTC or the OMA. A spokesperson for the former Health Minister Tony Clement is reported to have said that discussions regarding Medicare coverage should remain behind closed doors. In reference to patients who lobby to protect coverage of particular items, he said: "Let's be frank, there will always be somebody saying, 'Don't do that'."<sup>66</sup> The fear is that the greater the public and stakeholders are involved in decisions about priority setting and rationing, the harder it will be to control cost through the rationing of services.<sup>67</sup> Second, the membership of subcommittees formed by the PSC is no more diverse than the PSC itself. Furthermore, the membership of the Schedule of Benefits Working Group, particularly the inclusion of an otolaryngologist, whose profession indirectly benefits from the restriction on services provided by audiologists, raises the spectre of a conflict of interest and may undermine public confidence in the processes for determining what is in and out of Medicare.

The MOHLTC defends the decision-making process of the PSC and its various subcommittees by citing the required expertise of medical specialists and physicians.<sup>68</sup> Whilst the PSC must have the necessary technical and medical expertise for deciding questions of clinical efficacy, any decision taken by the PSC must not only be fair in fact, but be perceived as fair by those most affected by the decision. A lack of public participation, homogenous membership, and clear conflicts of interest necessarily detract from this perception.

---

Medical Directors and Public Participations in Decision-Making", forthcoming on-line at <http://www.law.utoronto.ca/healthlaw/basket/index.html> .

<sup>64</sup> As reported by OSLA in "Unheeded Advice", supra n. 60

<sup>65</sup> As reported by OSLA in "Unheeded Advice", supra n. 60

<sup>66</sup> V. Lu "More Cuts Coming to Medical Procedures" The Toronto Star (2 February 2002).

<sup>67</sup> 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 J. Oberlander, T. Marmor, and L. Jacobs, "Rationing medical care: rhetoric and reality in the Oregon Health Plan" *CMAJ* 164(11):1583-7 (2001).

<sup>68</sup> Hansard Exchange: Legislative Assembly of Ontario. Report of Debates (Hansard). Session Session, 37th Parliament, October 22, 2001.

### (c) Additional Considerations

Two further bodies play an important role in the PSC's decision-making: the OMA Central Tariff Committee and the Resource Based Value Schedule Commission.

First, services may be added to or deleted from the Schedule of Benefits on the recommendation of the OMA's Central Tariff Committee. The Committee's mandate is to keep the Schedule of Fees under review and to make recommendations with respect to such revisions as might be warranted.<sup>69</sup> This OMA Committee, which considers recommendations of the OMA Committee on Economics, often suggests candidates to the Schedule of Benefits Working Group for de-listing. The Central Tariff Committee generally meets eight times per year for a total of 12-14 workdays.

The Resource Based Relative Value Schedule Commission (RBRVSC) determines the relative value of services provided by physicians on a revenue neutral basis. The budget neutral schedule is designed to replace the current OHIP Schedule of Benefits. On July 24, 2002, the RBRVSC released its report to the OMA and the MOHLTC for review. Given the scope and complexity of the data, it is anticipated that this review will entail a considerable period of time. Once this process is complete, however, it will undoubtedly change the nature of review and delisting processes of OHIP services.<sup>70</sup>

## **6. Decisions: Record, Communication and Reasons**

The OMA releases notification of services de-listed from the OHIP Schedule of Benefits to its members via OMA Fax Network Membership Updates. Physicians are also able to access this information by referring to *OHIP Bulletins* located on the MOHLTC website.<sup>71</sup> Apart from this website, which clearly indicates that the information provided "requires knowledgeable interpretation and is intended primarily for members of the professional health care community", there is no mechanism by which members of the public are alerted to delisting services other than through the press.

Affected providers have made numerous complaints respecting the lack of warning of benefit deletions. For instance, on June 22, 2001, the MOHLTC released changes to the OHIP Schedule of Benefits regarding various physical therapy and related procedures, as well as hearing aid evaluations and re-evaluations.<sup>72</sup> These changes were to become effective as of July 1, 2001, a mere eight days after the

---

<sup>69</sup> By-law 12:6 CTC Orientation Manual, November 2000. Mandate of the CTC is being reviewed – OMA Report to Council, November 2000.

<sup>70</sup> The report was previously available on the RBRVSC web site at <http://www.rbrvs.on.ca/c.reports/c.reports.html>. This website is defunct. It is unclear if the report is still publicly available.

<sup>71</sup> See The Ministry of Health and Long Term Care, "OHIP Bulletins," Online: <[http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/bulletin\\_mn.html](http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/bulletin_mn.html)> (date accessed: 27 February 2004).

<sup>72</sup> The 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:

notification. In response to criticism directed at the extremely short notification, the MOHLTC released a second bulletin explaining that “the effective date ... has been extended from July 1, 2001 to August 13, 2001.”<sup>73</sup>

A further complaint leveled against MOHLTC vis-à-vis notification of decisions is the lack of sufficiently detailed reasons justifying the de-listing. In some instances, the notices simply state that services do not need to be supervised or performed by a physician, and therefore should not be included in OHIP. In other instances, a “Question and Answer” page is provided with the OHIP Bulletin to explain the nature of and reasons for the change. Unfortunately, this addendum material provides only cursory reasons.

Moreover, the MOHLTC appears intent on keeping the proceedings and deliberations of the PSC confidential, as evidenced by a recent appeal filed through the Ontario Privacy Commission.<sup>74</sup> The applicant requested all information from the MOHLTC, including OHIP offices and any associated advisory panels and working groups, related to the PSC creation, mandate, membership, financial support and processes that impacted the PSC’s decision to delist travel medicine services. On July 1, 1998, the Schedule of Benefits was amended such that OHIP no longer covered pre-departure travel medicine services obtained by travellers solely for the purpose of travel outside Canada. These services include assessments, counselling and administration of vaccines or drugs for prevention of communicable diseases not endemic to Canada. While the actual cost of such drugs was never insured by OHIP, the amendment requires travellers who elect to obtain the services to assume the full costs of the services. OHIP Bulletin #4317,<sup>75</sup> issued on July 30, 1998, provided a fact sheet explaining the Schedule changes. It states that because “travel for business or pleasure is considered voluntary in nature ... [and] [m]any vaccinations are only required by destination countries to avoid importation of disease. It is therefore considered reasonable that, in comparison with the overall cost of international travel, the traveller assume the cost of associated pre-departure services.”<sup>76</sup> The MOHLTC refused, however, to provide additional evidence or support for its decision to delist pre-departure travel medicine services. More specifically, the MOHLTC relied on seven bases for its refusal to divulge 62 requested records. These

---

<<http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bul4369.html>> (date accessed: 27 February 2004).

<sup>73</sup> The 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:

<<http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bul4370.html>> (date accessed: 27 February 2004).

<sup>74</sup> 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](http://www.ipc.on.ca/scripts/index_.asp?action=31&N_ID=1&P_ID=4003)> (date accessed: 4 March 2003).

<sup>75</sup> Ontario Ministry of Health and Long-Term Care. “Travel Medicine Services – Fact Sheet” (1998) online:

<<http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bul4317b.html>> (date accessed: 27 February 2004).

<sup>76</sup> *Ibid.*

bases included: lack of jurisdiction, cabinet-records, solicitor client privilege, advice or recommendation, third-party information, economics and other interests. Tom Mitchinson, the Assistant Commissioner, upheld some of the MOHLTC's defences on the basis of solicitor-client privilege, but refused to recognize others.

## 7. Legal Challenges

A number of legal actions have been commenced against the MOHLTC for its decisions regarding the OHIP Schedule of Benefits.

On November 27, 2001, the College of Audiologists and Speech Language Pathologists of Ontario (CASLPO) and MOHLTC presented arguments before the Ontario Superior Court of Justice in *Shulman v. College of Audiologists and Speech Language Pathologists of Ontario*.<sup>77</sup> The applicant claimed relief from the restrictions, occasioned by the decision to de-list services, placed on audiologists in the practice of their profession and the restrictions on the public from accessing their services. It was claimed that the restrictions were not based on the principle of "medical necessity" and disenfranchised audiologists from their right to practice independently under the *Regulated Health Professions Act (1991)* and *The Audiology and Speech-Language Pathology Act (1991)*. They further argue that the decision entrenches a public funding gatekeeper function for a much smaller group of physicians. The applicant also sought a declaration that the governments' decision to stop insuring costs of hearing aid evaluations and re-evaluations and to attach conditions to terms of payment to physicians for diagnostic hearing tests violates equality rights guaranteed by s. 15(1) of Charter of persons with hearing disability. In response, the MOHLTC argued that to overrule recent changes would restrict its ability to properly administer OHIP and to control costs for all persons receiving care under OHIP.

On December 20, 2001, the Ontario Superior Court of Justice issued its judgement. Pardu J., speaking for a unanimous Court stated "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*."<sup>78</sup> Furthermore, the court found that the government's concern that it may have been paying for medically unnecessary diagnostic hearing tests is a legitimate one. He continued, "requiring physicians to assess medical necessity is one means whereby the long term financial sustainability of the publicly funded health insurance plan can be maintained".<sup>79</sup>

---

<sup>77</sup> *Shulman v. College of Audiologists and Speech Language Pathologists of Ontario*, [2001] O.J. No. 5057.

<sup>78</sup> *Ibid.* at para. 40.

<sup>79</sup> *Ibid.* at para. 42.



The Court thus deferred to the government on policy-making grounds. Pardu J. concluded that the “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.”<sup>80</sup> In this case, the changes to the SOB-PS were found not to discriminate within the meaning of s. 15(1) of the Charter and the application was dismissed on that ground.

A further fact should be noted with respect to the delisting of audiology services and the ensuing litigation. On November 21, 2001, mere days before the *Shulman* case began, the Ontario government issued an OHIP bulletin, entitled “Clarification of Commentary Regarding Diagnostic Hearing Tests.”<sup>81</sup> The bulletin stated that it “has been brought to the MOHLTC’s attention that content of the Commentary note regarding compliance with CPSO standards may be unclear.”<sup>82</sup> In other words, the advisory notes intended to assist readers in understanding the changes to diagnostic hearing tests introduced into the *Schedule of Benefits* were unclear. The OHIP bulletin was thus intended to revise and clarify the commentary. The failure to clearly indicate the nature of changes in the schedule of benefits can impede access to medical services to a degree unjustified by the evidence considered in the PSC’s decision-making process. Without the benefit of reasoned judgment, there is an increased opportunity for such misunderstandings which again undermines public confidence in the processes for determining what is in and out of Medicare.

The decision in *Shulman* did not deter Ontario citizens from subsequently challenging perceived discriminatory effects of government decisions to delist services. On October 1, 1998, the Ontario government de-listed sex reassignment surgery.<sup>83</sup> From 1970 to 1998, OHIP coverage had been provided for sex reassignment surgery for individuals approved by the Clarke Institute of Psychiatry. According to the *National Post*, a lack of both warning and reasoning accompanied the benefit deletion. On September 28, 1998, Dr. Robert Dickey, the head of Toronto's Gender Identity Clinic of the Centre for Addiction and Mental Health -- Clarke Division, received a letter stating that "gender reassignment surgery has been de-

---

<sup>80</sup> *Ibid.* at para. 43

<sup>81</sup> Ontario Ministry of Health and Long-Term Care. “Bulletin #4378: Clarification of Commentary Regarding Diagnostic Hearing Tests.” (21 November 2001). online: <<http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bul4378.html>> (date accessed: 27 February 2004).

<sup>82</sup> *Ibid.*

<sup>83</sup> Ontario Ministry of Health and Long-Term Care. “OHIP Bulletin #4330: Changes to Regulation 552 under the Health Insurance Act”. 24 December 1998. Online: <<http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bul4330.html>> (date accessed: 27 February 2004). A clause in the new regulation did allow coverage for all people who had completed the program the Gender Identity Clinic at the Clarke Institute of Psychiatry and had been recommended for surgery as of October 1, 1998.

insured from the Schedule of Benefits effective Oct. 1, 1998."<sup>84</sup> Moreover, the MOHLTC did not formally provide any rationale for the decision. According to one news report, Jeremy Adams, the communications assistant to the then Ontario Minister of Health, explained that sex-change operations were de-listed because "it was not a priority area of health resources at this time and these funds should be redirected elsewhere."<sup>85</sup> As reported by numerous sources, the funds were to be redirected for use in cardiac care.<sup>86</sup> Tim Hudak, parliamentary assistant to the then Minister of Health, admitted that some members of the Tory caucus saw sex-change operations as a "lifestyle choice." He stressed, however, that this was not a factor in the de-listing decision. Rather, the decision was a part of a larger ongoing process of reprioritizing health-care dollars.<sup>87</sup> Despite such assurances, the transgender community interpreted the de-listing decision as a statement that the government did not consider the issues of transgendered people as valid, significant, or important.<sup>88</sup> Several transgendered citizens thus brought legal challenges against the government.

In 1999, Michelle Josef filed an application in the Ontario Superior Court of Justice challenging the Ontario government's decision to delist sex-reassignment surgery. According to a newspaper report, her lawyer, Cynthia Peterson, argued that "the government's decision to delist the procedure after 30 years is discriminatory ... [and] runs counter to the right of all citizens to obtain medically necessary treatment under the *Canada Health Act*."<sup>89</sup>

In 2002, an Ontario Human Rights Commission investigation found that the Ontario government's decision to delist sex reassignment surgery was discriminatory.<sup>90</sup> As a consequence of this finding, on September 26, 2003, the Ontario Human Rights Commission conducted a hearing to determine whether or not the Ontario government's decision violated the *Ontario Human Rights Code*.<sup>91</sup> The Commission has yet to issue its decision. It is noteworthy, however, that the Ontario Human Rights Commission has previously commented upon the Government's decision to delist sex reassignment

---

<sup>84</sup> "The Cruellest Cut - The Ontario government no longer funds sex-change operations and there's a patchwork of policies in other provinces. Confusion reigns: Are the surgical procedures a medical necessity or a lifestyle issue?" *The National Post*. (25 November 1998). B5.

<sup>85</sup> *Ibid*.

<sup>86</sup> *Ibid*. See also See J. Harder, "Sex change surgery gets axe: Ontario cuts funding for expensive 'lifestyle' procedure", *Toronto Sun* (3 Oct 1998) 18; also letter from Dr. Paul E. Garfinkel, President of the Clarke Addiction Research Foundation to Sandra Lang, Deputy Minister of Health, Ministry of Health, dated Oct 20, 1998.

<sup>87</sup> *Cruellest Cut*, *supra* note 84.

<sup>88</sup> Ontario Human Rights Commission, "Towards a Commission Policy on Gender Identity: Discussion Paper" (1999). online: <<http://www.ohrc.on.ca/english/consultations/gender-identity-discussion-paper.pdf>> (date accessed: 27 February 2004).

<sup>89</sup> Rita Daly. "Michelle Josef goes to court to free the woman within". *The Toronto Star*. (2 May 1999).

<sup>90</sup> Karen Palmer, "Sex-change delisting 'prejudiced' - Probe finds OHIP bias against transsexuals Tribunal to decide on issue of coverage" *Toronto Star*. (7 December 2002).

<sup>91</sup> *Egale Canada*. "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." Press Release (26 September 2003). online: <<http://www.egale.ca/index.asp?lang=E&menu=34&item=427>> (date accessed: 27 February 2004).

surgery. In 1999, the Commission issued a discussion paper entitled, “Towards a Commission Policy on Gender Identity.” The paper states that:

The removal of OHIP coverage is unfortunate. ... The assessment and decision to undergo sex reassignment surgery is, for some, basic to their life identity and is not a ‘lifestyle’ procedure. It is hoped that, in consultation with medical professionals who work in this very complex field, the MOH will reconsider its position ... Further examination of OHIP policies may determine whether the current practice and new regulations amount to an infringement of the [Ontario Human Rights] *Code*. The effect this practice may give rise to complaints based on gender identity, as interpreted under the ground of sex in the *Code*.<sup>92</sup>

The Commission’s decision may also be influenced by the fact that on January 30, 2003, the Federal Court of Canada upheld a decision by the Canadian Human Rights Tribunal, which found that Correctional Services Canada refusal to pay for sex change operations that 'medical opinion' deems to be an "essential service for a particular inmate [of federal prisons]" was discriminatory.<sup>93</sup> Corrections Canada has indicated that it will revise its policy as a result of this decision.

## **8. Assumptions, Effects and Proposals**

The PSC plays an important, yet relatively hidden, role in determining the boundaries of publicly-funded Medicare in Ontario. As the gatekeepers to the health care system, physicians largely dictate the services provided not only by general practitioners, but also within hospitals. By virtue of this position, “physicians [can] serve as leaders and as patient advocates in discussions [with government] about the future of health-care resource management and allocation.”<sup>94</sup> The question arises, however, as to whether or not the current structure and processes of the PSC enable physicians to do so.

First, the PSC’s limited membership structure presents a cause for concern. Who is represented in discussions about candidate services for de-listing? Whose values are reflected in the decision-making process? The PSC, its various subcommittees, and its related working groups are almost entirely populated by representatives from the OMA and the MOHLTC. While it is undeniable that de-listing decisions require the clinical expertise offered by physician experts, it is unclear that the rationing of decisions in the health care context is purely a function of clinical expertise and government spending. In fact, it is widely recognized that healthcare priority setting cannot be accomplished systematically from

---

<sup>92</sup> *Ontario Human Rights Commission, supra* note 88.

<sup>93</sup> *Canada (Attorney General) v. Canada (Human Rights Commission)*, 2003 FCT 89.

<sup>94</sup> Larry Erlick. “Inaugural Address - Negotiations readiness, restored membership confidence, grassroots communications key priorities for 2003-2004” *Ontario Medical Review* 70:5 (May 2003).

cost-benefit analysis alone.<sup>95</sup> If the PSC is to account for the various goals and values implicated in health priority setting, its membership structure should arguably include a range and diversity of members. Given that public values are particularly implicated in decisions about publicly funded services, consideration should be given to greater public participation in decision-making and what form that public participation should appropriately take. Through increased public participation, by which public values are identified and articulated, the PSC may be better able to design a medicare plan reflective of public needs, values, culture and attitudes. Public participation thus renders the decision-making process more accountable to those most affected by it. In recognition, however, that there is no single, best way to involve the public in deliberative consultations,<sup>96</sup> the question arises as to which mechanisms most effectively reflect and account for public values in this particular decision-making process? Traditionally, public participation in health planning has involved a more passive or consultative role, where the public's views are sought as input to a planning or decision-making process.<sup>97</sup> A more active mechanism of public participation is available through direct participation in decision-making processes and structures.<sup>98</sup> In citizen involvement mechanisms, community members participate in the development, implementation and evaluation of health planning.<sup>99</sup> In other words, under this latter mechanism, the limited membership of the PSC would be expanded.

The PSC's limited composition also raises concerns about the degree to which the OMA committee members adequately represent various physician groups. Physician groups particularly affected by delisting decisions have complained that they were neither consulted nor afforded an opportunity to participate in the decision-making process. Complaints are certainly expected in a process by which physician services are removed from the scope of public funding. Nevertheless, these complaints raise the question of whether or not the PSC is sufficiently accountable to those physicians and other health care providers most affected by its decisions. For instance, the Coalition of Family Physicians of Ontario (COFP) believes that the OMA needs to be "more representative" to its members.

---

<sup>95</sup> Ramsay, *supra* note 1 at 12.

<sup>96</sup> Commission on the Future of Health Care in Canada, *How Can the Public Be Meaningfully Involved in Developing and Maintaining an Overall Vision for the Health System Consistent with Its Values and Principles?: Discussion Paper No. 33* by Harley D. Dickinson (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at 14, citing Pickard, S. 1998. *Citizenship and Consumerism in Health Care: A Critique of Citizens' Juries. Social Policy and Administration* 32(3), 226-244; OECD. 2001. *Engaging Citizens in Policy-Making: Information, Consultation and Public Participation. PUMA Policy Brief No. 10*, July, pp. 1-6

<sup>97</sup> Commission on the Future of Health Care in Canada, *Practical Strategies for Facilitating Meaningful Citizen Involvement in Health Planning: Discussion Paper No. 23* by Jayne Renee Pivik (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at 3.

<sup>98</sup> Commission on the Future of Health Care in Canada, *Public Participation and Citizen Governance in the Canadian Health System: Discussion Paper No. 7* by Julia Abelson, and John Eyles (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at 1.

<sup>99</sup> Pivik, *supra* note 97 at 3, citing Meleis, A. I. 1992. *Community participation and involvement: Theoretical and empirical issues. Health Services Management Services* 5(1), 5-16.

Dr. Douglas Mark, President of the COFP, feels that many Ontario doctors probably do not even know the PSC exists. He said: "The OMA and government work together seemingly in secret through this committee ... We don't know what's happening there, and we get the feeling the OMA board doesn't even know what's going on within the PSC."<sup>100</sup> There are also potential conflict of interest concerns when the PSC renders decisions affecting non-physician services. It is interesting to note that the Ontario Hospital Association (the "OHA") has tried unsuccessfully on a number of occasions to render the PSC trilateral.<sup>101</sup> David MacKinnon, the OHA president and CEO, believes that the process needs to be broadened. He stated: "The issue with the PSC is how to build on a reasonably orderly process."<sup>102</sup>

It should be noted that in May 2003, the OMA explicitly recognized that "[a]s an organization, [it] has not been as effective as it could be in listening to the concerns of all our members at the grassroots level, in communicating with the membership at large, and in involving them in our strategies and programs."<sup>103</sup> In his inaugural address, Larry Erlick, president of the OMA, vouched to "re-establish the democratic principles on which our organization is based, and strengthen our processes of communication, transparency and inclusiveness."<sup>104</sup> The recognition of the importance of democratic principles, and processes of inclusiveness is an important step toward enhancing the democratic legitimacy of the PSC. The next step is to apply these principles and processes beyond the OMA membership.

A second concern relates to the lack of transparency in the PSC's decision-making process. Sufficiently detailed reasons rarely accompany notifications of delisting, and the MOHLTC appears intent on keeping the proceedings and deliberations of the PSC confidential. In defense of its position, the MOHLTC relies on the assumption that greater transparency in the decision-making process renders it more difficult to ration or to make cutbacks. Is there evidence to support this assumption? In both Oregon there is some evidence that explicit priority setting resulted in more services being covered rather than fewer.<sup>105</sup> But even if this assumption is true, then it begs the larger question of whether or not reducing the range of services funded is actually in the public interest? Surely the goal should be insure that the most beneficial services are publicly-funded and those of relatively small benefit may be eliminated or

---

<sup>100</sup> Matt Borsellino. "Joint management vehicle could get an overhaul - Physician services committee under fire for secret" *Coalition of Family Physicians* 39:09 (04 March 2003). Online: <[http://www.cofp.com/media/mar04\\_03medpost2.asp](http://www.cofp.com/media/mar04_03medpost2.asp)> (date accessed: 27 February 2004).

<sup>101</sup> *Ibid.*

<sup>102</sup> *Ibid.*

<sup>103</sup> Larry Erlick, "Inaugural Address - Negotiations readiness, restored membership confidence, grassroots communications key priorities for 2003-2004" *Ontario Medical Review* 70:5 (May 2003).

<sup>104</sup> *Ibid.*

<sup>105</sup> Ramsay, *supra* note 1 at 12, citing Coulter, Angela and Chris Ham. 2000. Introduction: International Experience of Rationing (or Priority Setting) and Where Are We Now?, in *The Global Challenge of Health Care Rationing*, edited by Angela Coulter and Chris Ham. Buckingham and Philadelphia: Open University Press, p. 1-12, 233-250.

only available under certain conditions. A second, but related, question asks whether rendering decision-making by the PSC more transparent, would result in little or no support for the PSC's decisions? There is strong evidence to suggest that an open decision-making process would produce precisely the opposite result. Publicly accessible decisions can enhance the public's awareness of the complexity of health care funding decisions. Moreover, publicity can ensure the public that delisting decisions are reasonable, in so far as they are based on evidence, reasons, and principles that physicians, the public and other interested parties agree are relevant to deciding how to meet the diverse needs of the provincial population. For instance, the OSLA cited its particular concern that the MOHLTC's decision to delist services provided by independent audiologists failed to adequately consider the resultant impact on access to services for the hearing-impaired. Without public reasons, there were no means by which the public could verify that its interest in access was reasonably addressed.

Currently, the PSC decision-making appears to lack any meaningful principles by which decisions are made to include or exclude services. Concepts such as "tightening" and "modernization" provide no significant guidance. If the public is to accept difficult Medicare choices, it is incumbent on those responsible for decision making to show that they have followed rigorous and fair processes in arriving at their decisions.<sup>106</sup> This certainly includes the development and explanation of meaningful principles or standards. As confirmed by Norman Daniels, there must be "accountability for reasonableness."<sup>107</sup> This fact is especially true when the committee provides little or no opportunity for public participation.

Without a diverse membership, there is a greater potential in the PSC and its subcommittees to be challenged on the grounds of perceived conflicts of interest. The existence or potential existence of private markets for candidate services may present conflicts of interest for physicians acting in the PSC decision-making process. Public access to the PSC decision-making process could better insure public confidence in PSC decision-making.

Under the current structure of the PSC, precisely because of the lack of public participation, the public must rely on the MOHLTC to represent the larger public interest in its funding negotiations with the OMA. The public harbours a legitimate fear, however, of the risk of "capture." In dealing with the OMA from day to day, the MOHLTC there is the risk that unconsciously it will begin to favour the OMA's interests over larger, more diffused public interests. This is a legitimate fear because, at present, the process for determining what is "medically necessary" is intimately connected to the process of

---

<sup>106</sup> Chris Ham, "Tragic choices in health care: lessons from the Child B case." *British Medical Journal* (6 November 1999).

<sup>107</sup> *Ibid*, citing Daniels, Norman. 2000. Accountability for Reasonableness in Private and Public Health Insurance, in *The Global Challenge of Health Care Rationing*, edited by Angela Coulter and Chris Ham. Buckingham and Philadelphia: Open University Press, p. 87-106.

determining compensation rates for physicians.<sup>108</sup> Moreover, the OMA has explicitly stated its concern that “the province of Ontario is no longer a preferred practice destination ... [attributable to the] gradual comparative decline of [the] fee schedule.”<sup>109</sup> It is thus seeking to secure “financial and other resources that recognize [physicians] outstanding contributions to the health-care system.”<sup>110</sup> In light of these concerns, the OMA views the upcoming negotiations for the new framework agreement as “a watershed for the medical profession in Ontario and our Association.” The president of the OMA, Dr. Larry Erlick, confirmed that the “OMA is determined to deliver an Agreement that will ... restore recognition to the province of Ontario as a preferred practice environment.”<sup>111</sup> Can the MOHLTC ensure fair compensation for physicians, while balancing the OMA demands against other legitimate public interests? More importantly, how can the public insure the MOHLTC represents the larger public interest in its funding negotiations, when there are no reasons or record of the deliberations? Without any measure of transparency, the public is incapable of verifying that the MOHLTC has indeed represented the interests of the public.

It should also be noted that a decision-making body whose practice requires it to articulate explicit reasons for its decisions often becomes more focused in its decision-making.<sup>112</sup> The benefits of transparency thus include not only increased accountability for decision-making but also greater consistency in the decision making process.

A third concern relates to the present lack of any mechanism by which to challenge de-listing decisions, including an opportunity to revise a decision in light of further evidence or arguments. Without any internal review process, the result of the PSC’s refusal to open the decision-making process, *in any sense*, will likely be increased legal challenges. This fact reinforces the need to make the decision-making process both fair and transparent.<sup>113</sup> The decision in *Shulman* suggests that courts will be extremely deferential to governmental decision-making to de-list services. The courts approach may change, however, if evidence is provided that governmental decision-making is discriminatory, not principled, or not reflective of the larger public interest. The decision of the Ontario Human Rights Commission with respect to the delisting of sex reassignment surgery promises to be an important indicator of the judicial trend’s direction.

---

<sup>108</sup> *Flood, supra* note 3 at 9.

<sup>109</sup> Larry Erlick. “Embracing change.” *Ontario Medical Review* 70:9 (October 2003).

<sup>110</sup> Elliot Halparin, “Editorial: Due Rewards” *Ontario Medical Review* 70:3 (March 2003).

<sup>111</sup> Larry Erlick. “Negotiations Update” *Ontario Medical Review* 70:11 (December 2003)

<sup>112</sup> *Ham, supra* note 106, citing Daniels N, Sabin J. Limits to health care: fair procedures, democratic deliberation and the legitimacy problem for insurers. *Philosoph Public Affairs* 1997;26:327-8.]

<sup>113</sup> *Ramsay, supra* note 1 at 12, citing Coulter, Angela and Chris Ham. 2000. Introduction: International Experience of Rationing (or Priority Setting) and Where Are We Now?, in *The Global Challenge of Health Care Rationing*, edited by Angela Coulter and Chris Ham. Buckingham and Philadelphia: Open University Press, p. 1-12, 233-250.

## 9. Conclusion

At present, the decision-making process of the PSC remains confined to the world of negotiations between the OMA and the MOHLTC. In September 2003, Dr. Larry Erlick confirmed that the “OMA Board of Directors [was] making sound progress in its continuing work to prepare for the next round of negotiations with government for a new Physician Services Agreement.”<sup>114</sup> One hopes that the preparation included thoughts on the creation of organizational structures and processes to institutionalize features of democracy, transparency and accountability. While the members of the Physician Services Committee will never possess the Wisdom of Solomon, solace can be found in informed, principled and accountable decision-making.

---

<sup>114</sup> Larry Erlick. “Negotiations preparedness continues.” *Ontario Medical Review* 70:8 (September 2003).