Chapter 15

Cost of Health Services

More than in the past a growing number of voluntary community associations and programs paid for by all levels of government are dealing with issues affecting population growth. There is usually a sharp distinction made in most public programs in Canada between services and programs involving abortion, contraceptive counselling and services, and general family planning programs. These services and programs relate to the knowledge and practices which enable couples either to avoid or to terminate unwanted pregnancies or to bring about wanted births.

The health costs associated with induced abortions may include: (1) the personal expenses for a woman who may travel some distance to a hospital or who may lose income while being away from work; (2) additional medical expenses, if extra-billing is involved; (3) the medical and hospital costs which are paid for under national health insurance; and (4) for women who go abroad, the total direct costs of travel and the surgical operation. Health costs are one factor which influence the decisions made by women about where they obtain abortions in Canada or abroad. In considering the health costs associated with induced abortions, it is relevant to compare these expenditures with the costs of related programs, and where additional charges are involved, whether these are apportioned equitably by the social circumstances of the women.

In its work the Committee found that many patients, physicians, and hospital administrators were reluctant to discuss the issue of health costs associated with induced abortion. The reluctance of some abortion centres in the United States to provide information on their monetary charges and the number of Canadian patients whom they treated may have stemmed in part from a concern that such information might be used for the purposes of income tax calculation. There was an initial concern among some of the hospitals involved in the national patient survey that the doctor-patient relationship might be affected if private patients were to be included (for most hospitals, they were) and if information about the medical costs to these patients was obtained.

The Terms of Reference set for the Committee included the stipulation to determine "What types of women are successful and what types unsuccessful

in obtaining legal abortions in Canada?" Information is given here about the economic circumstances involved in obtaining an induced abortion in Canada and abroad, and a comparison is made between the relative costs of induced abortion, childbirth, and family planning programs.

Non-profit voluntary associations

National non-profit voluntary associations concerned with various aspects of family planning have been active over a period of several decades. Their growth has increased in recent years to include a broad spectrum of interests. The primary concerns of most of these non-profit associations were with the dissemination of information about family planning and the counselling of women and men about critical family choices. Their involvement in abortion may be part of these general activities, but it was seldom their central purpose. From its survey of these agencies the Committee found that most reported there were no direct cost charges involved in providing these services. When costs were involved (10.7 percent), these were intended to cover the expenses of clinical testing services and, on occasion, were considered a donation or involved a membership fee. Depending upon the type of services provided, the fees charged by the community referral agencies were:

	No Charge	Ability to Pay	Fixed Fee	Average Fee
	percent	percent	percent	dollars
Pregnancy Counselling	96.1	—	3.9	2.25
Contraceptive Counselling	96.2	1.9	1.9	2.50
Abortion Referral	98.0	2.0	—	—
Clinical Services	10.0	—	90.0	3.11

Approximately 1 out of 5 women in the national patient survey had contacted one or more community referral agencies prior to obtaining their abortions. These women were asked if they had paid any charges for these services, and if so, how much had been paid. There was a discrepancy between the reports of these patients and the information provided by the community referral agencies which suggests that while these services may have been based on a non-profit principle, there were still attendant costs for some women who turned to them for assistance. Among the women in the national patient survey who used each resource, the proportion who said they had paid for the services was: 3.1 percent, school nurse; 10.5 percent, social service agency; 8.2 percent, Planned Parenthood; 9.4 percent, Birthright; and 37.4 percent, abortion referral agencies.

The charges paid by the women obtaining abortions who had used non-profit community referral resources varied by their social circumstances and where they lived in Canada. About 1 out of 5 of the women in the national patient survey who lived in Ontario (21.0 percent) and British Columbia (18.1

percent) had paid when they had contacted these agencies. Making such payments was unusual elsewhere (0.0 percent, Maritimes; 1.2 percent, Quebec; and 1.6 percent, Prairies). **Younger patients, women who were born abroad, and women who had more formal education more often made such payments.** One out of ten women (12.4 percent) who were 19 years or younger had paid for this assistance while the experience among women who were older was: 12.5 percent, 20-24 years; 8.6 percent, 25-29 years; and 6.3 percent, 30 years and older. Almost 1 out of 5 (19.8 percent) of the women who had been born in other countries had paid for these services, a proportion double that of women who had been born in Canada (9.2 percent). There was a direct association between the level of education of these women and the payment of charges. One out of twenty women (5.9 percent) who had an elementary school education said they had made such payments, while this was the case for 10.3 percent of the women who had been to high school and 13.2 percent of the patients with college and university training.

TABLE 15.1

FEES AND/OR CHARGES PAID BY WOMEN USING NON-PROFIT COMMUNITY AGENCIES

NATIONAL PATIENT SURVEY

	$1-$15	$16-$30	$31-$45	$46-$80	$80+
			percent		
School Nurse	3.1	0.0	0.0	0.0	0.0
Social Service Agency	10.5	0.0	0.0	0.0	0.0
Planned Parenthood	7.8	0.4	0.0	0.0	0.0
Birthright	6.3	3.1	0.0	0.0	0.0
Abortion Referral Agency	8.4	1.1	25.3	2.1	0.5

The non-profit voluntary associations dealing with family planning have an important responsibility in serving the needs of individuals who seek their assistance. Most of these agencies relied upon the dedication and the substantial effort of volunteers, and their services were provided free without regard to a woman's circumstances. In the case of the women obtaining abortions in the national patient survey, where some form of payment was involved, these charges were not evenly distributed.

Commercial abortion referral agencies

The Committee obtained information on commercial abortion referral agencies from several sources, but when these are put together, only an incomplete summary of their work is possible. They were cautious to divulge information which might be of use to competitors, professional regulatory agencies, or government inquiries. Since they were in this work as profit-making enterprises, most of these commercial abortion referral agencies neither kept full records of what they did, nor were they prepared to release detailed information about the scope of their work. Much of the Committee's informa-

tion about these commercial enterprises came from secondary sources which included: provincial government health departments; the registrars of provincial medical licensing authorities (colleges of physicians and surgeons); direct reports from women who had used these agencies; the results of the survey done by the Committee of abortion clinics in the United States and the national patient survey; and site visits to hospitals across Canada made by the Committee. From these sources of information as well as a review of advertisements in newspapers of all major cities across Canada and a search of telephone directory listings of all cities with a population of 10,000 or above, a total of 13 commercial abortion referral agencies were identified. The use of the word *abortion* only occurred in the white pages of the telephone directories of larger cities, and in particular, was used by American agencies which advertised their abortion services in Canadian telephone directories. In some instances these agencies provided a toll-free long-distance telephone number which could be used. Newspaper advertisements were usually listed in two or three lines in the personal columns; in a few instances these announcements were commercially drafted larger advertisements.

One provincial health department had obtained extensive statistical information with the cooperation of the director of one commercial agency. None of the other provincial health authorities had any direct information about the work of these agencies or the types of services which were provided. Like provincial health departments, the professional medical licensing authorities had little first-hand information about the work of commercial abortion referral agencies. From the information obtained from the registrars of the provincial colleges of physicians and surgeons, a brief social history of these enterprises emerged. Most of these commercial agencies had started in the mid-1960s or later and their work had become more visible with the change in the abortion legislation in the United States. Their number and the scope of their work was directly related to the existence of alternative sources of public information about family planning. Where other sources of information were more extensive and better known to the public, there were few, if any, commercial agencies. While a number of commercial abortion referral agencies had been started, most of these had been closed. The enterprises which remained were located in a few major cities. The continued existence of these agencies was a relative measure of the existence or the non-existence of other active and known sources of information about family planning, and in particular about abortion.

The commercial agencies which were known to be in operation in 1975-76 were requested by the Committee to provide information about their work on the same basis as non-profit volunteer associations. It was indicated that the information to be obtained would be used for the purpose of assembling a statistical summary and there would be no identification of any agency. With one exception, an agency which had a trained professional staff, strong ties with a local university, and whose director had been a consultant to government,[1] none of these agencies provided detailed statistics about their

[1] In its principles of counselling, the training of its staff and its carefully assembled records, this commercial agency was the exception. The general findings about commercial agencies do not apply in this instance.

operations, their services, or the costs which were charged. Some of the information about these agencies, while incomplete, was assembled from the various secondary sources contacted by the Committee. No information was obtained about the operations of three commercial agencies, two of which used telephone answering services. One agency which had been established by an abortion clinic in upstate New York had subsequently closed.

At several of the commercial agencies clients were routinely told that obtaining an abortion was illegal in Canada, misinformation was given about the actual costs involved, and alleged trained counsellors were paid on a commission basis. Nine of these agencies routinely referred women who were seeking an abortion to clinics across the border in the United States. The staff members of one semi-commercial agency were privately employed by a group of physicians who performed abortions in two Canadian hospitals. This agency did not directly charge fees, but received most of its referrals through the agency from physicians. How these arrangements were sometimes made with these commercial agencies is illustrated by the experience of one woman who obtained an abortion in the United States.

> I contacted Mrs. _____ by phone. She insisted that there was no charge to the women who called her number asking for assistance and it very much depended upon what they asked, what information they were given in return. She repeatedly insisted, "goodness of her heart". She said that she was not receiving a salary from anyone and that her service was not supported by agency funds. There was one other woman present who also did counselling. She at one point said she received a salary from the doctors.
>
> I was told that it was understandable that I didn't want to have the abortion in _____ where I lived because there were "too many people". She was referring to the abortion committee which I would have to go through.
>
> I was asked if I planned to drive or to fly to _____. I said that I would fly and was told that I should use a flight connecting with _____ airport. The fee for the abortion was $150 and I must stay in the office for two to three hours.
>
> The woman then said that our connection was poor and she would have to hang up and call me back. In about 30 minutes, a different woman, whose name was _____ and who was a receptionist at the office, returned the call. She gave me the address of the office and told me that I must bring $150 in American currency (cash or money order).
>
> Since my pregnancy was about 12 weeks, it was necessary that I come the next day at 9:00 a.m. for the abortion. She had told me before that they could only do the abortion up to 12 weeks. I was told that if I was between 12 and 13 weeks I could still have the abortion done but it would cost $225. Since my pregnancy was on the "borderline" of 12/13 weeks, she advised that I bring an extra $75.

Nine of the commercial abortion referral agencies had made special arrangements with American clinics and operated on a cost-sharing basis. At each of these agencies the full fee was paid prior to a woman leaving a Canadian centre to obtain an abortion. The average fee for a first-trimester abortion was $250 and for abortions done between 13 and 16 weeks of

gestation the amount varied between $325 and $350. In some instances travel costs were included while for other agencies the charge for a chartered bus or limousine service was an option amounting to $50. The costs of one referral agency which had been established in conjunction with an American clinic operated on an "at cost" basis were $130, which included transportation to New York City and the charges for a first-trimester abortion.

The owner of one busy American clinic located near the Canadian border provided the Committee with a breakdown of that centre's operating costs. This clinic which performed between 75 and 100 abortions each week had several gynaecologists on its staff. The attending physicians were paid $35 for each abortion operation; the costs for administration, personnel, and maintenance amounted to $35, and a profit was made of $80. The fee for each patient was subsequently raised from $150 in 1975 to $160 in 1976.

In its survey of abortion centres used by Canadian women in the United States, the average cost of a first-trimester abortion was $163.75 and for second-trimester abortions, $438.88. Among the American abortion clinics to which most patients were referred by commercial agencies in Canada, the costs for patients—had they gone directly without using a commercial agency—were between $140 and $190. The most common charge was $160. Based on the location of these agencies, the average return bus fare to reach the American clinics to which Canadian women were referred by commercial agencies was from $11.20, $12.20, to $20.55. Depending upon the nature of the financial arrangements which were made between Canadian commercial agencies and abortion clinics in the United States to which they referred women, the average profit made directly by the commercial agencies was at least $75 per client.

From the review of all referral and counselling agencies across Canada, it was estimated that non-profit associations referred some 3,500 Canadian women each year to abortion clinics in the United States. The number which it is estimated were referred by commercial abortion agencies was approximately 3,200. The Committee calculated that approximately 9,627 Canadian women obtained abortions each year in the United States. The difference between the number of patients referred by the two groups of agencies and the estimated total of all Canadian women who went to the United States for this purpose is accounted for by referrals made by physicians or direct contacts made with the clinics by women themselves. In terms of the average annual costs involved for the women routed to American clinics by commercial agencies, these women spent approximately $780,000, while patients who contacted these clinics through other sources paid $1,028,320 for a combined total of $1,808,320.

From information received by the Committee, few complaints had been made to provincial colleges of physicians and surgeons about the commercial abortion referral agencies. For the most part it was felt by these provincial medical licensing bodies that they had no direct authority to obtain such information or to monitor the activities of these agencies. Established to supervise the licensing of physicians and to monitor the operation of statutory professional medical codes, a central concern of these professional colleges was to enforce the requirement that no person should engage in the practice of

medicine who had not been licensed by a provincial college. Under the statutory authority of these colleges, only licensed physicians are entitled to make a diagnosis of pregnancy. Once such a confirmed medical dianosis has been made by a licensed physician, the counselling of individuals was not a field restricted to the medical profession. These professional statutory regulations were breached only when a diagnosis of pregnancy was made by individuals other than physicians prior to a medical consultation and when based on this non-medical diagnosis a fee was charged for this service and a referral was made to a physician.

In the context of the regulatory powers of provincial colleges of physicians and surgeons, there is reasonable doubt about the propriety of the work of most commercial abortion referral agencies. In one respect these agencies, like many voluntary family planning programs which are staffed by non-professionals, and like drugstores, provide pregnancy testing services whose main purpose is diagnostic. There is a fine distinction between indicating that the results of such tests are positive or negative and telling a woman that she is or is not pregnant, a step which constitutes making a diagnosis. In practice no such distinction is made. Acting upon the results of this simple laboratory test, women seeking an abortion are accordingly referred to clinics or hospitals. While the full extent of this practice is unknown, it is so widespread that it has become an accepted custom, one which may contravene the statutory responsibilities of provincial medical licensing bodies.

In a second respect there is reasonable doubt about the propriety of the work of commercial abortion referral agencies. This concern is with the practice of referring clients for abortion without consultation with a physician and charging a fee for this service. The major service provided by commercial abortion referral agencies was a link-up function between women seeking an abortion and abortion clinics, most of which were located in the United States. With the exception of one professionally staffed agency, the clients of these agencies got little or no counselling. The advice which was given was provided by individuals who neither had long experience nor professional qualifications. For an average profit of at least $75 obtained from each client, a sum which the Committee estimates to be the minimum amount gained, some of these agencies did not seek a confirmation of pregnancy by medical consultation but made a lay diagnosis for which a fee was charged. The essential services provided for by this payment were the arrangements for transportation and an appointment which was booked with an American abortion clinic with which these agencies had a continuous affiliation.

Several allegations have been made in the mass media that commercial abortion referral agencies may be storefronts for abortion clinics in the United States. Based on information received by the Committee, these assertions neither can be confirmed nor refuted. But what is known is that the client referral patterns were so consistent that they were not a matter of chance. Most of these agencies (with the two exceptions which were cited) had special cost-sharing arrangements with American abortion clinics.

Some of these agencies fostered an illicit atmosphere about abortion, a stance which contributed to their continued operation on a profitable basis.

These commercial abortion referral agencies existed opportunistically, at a stiff price for their clients. There was reasonable doubt about the propriety of their work. They existed because there was a demand for their services which was not otherwise being met. Because of the stigma associated with abortion, there have been few direct complaints made by the clients of these agencies either about the charges which were levied or the quality of the services which were provided.

Physician income and induced abortion

Under the financial arrangements for national health insurance in Canada, there is a central statistical accounting for each medical or surgical service provided to patients by physicians. The physician reimbursement formulae vary between the provinces according to the amount of the fees listed in medical fee schedules which are paid for by the provincial governments. A majority of physicians in the country have "opted in", that is, they have accepted the payments made for their services by government health insurance programs as the full payment for the services which they provide to patients. It is on the basis of this information, not the total earnings of physicians, that the proportion of income derived by physicians from performing induced abortions has been calculated here. This information does not list the earnings of physicians who treated patients who had spontaneous abortions or the number of patients who had abortions not indicated as being induced or spontaneous. This information provides a summary for nine provinces for 1974-75, the last

TABLE 15.2

PAYMENTS FOR THERAPEUTIC ABORTIONS AS A PERCENTAGE OF TOTAL PROVINCIAL PLAN PAYMENTS TO PHYSICIANS PERFORMING ABORTIONS

Fiscal Year 1974-75

DEPARTMENT OF NATIONAL HEALTH AND WELFARE

Province	Percentage
1	2.99
2*	3.81
3**	2.90
4***	2.21
5	2.05
6	2.37
7	4.47
8	2.39
9	0.86
AVERAGE	3.82

* First half on Fiscal Year 1974-75
** Fiscal Year 1973-74
*** First half of Fiscal Year 1975-76

TABLE 15.3

DIFFERENCES IN AVERAGE PLAN-PAYMENTS BETWEEN OBSTETRICIAN-GYNAECOLOGISTS* WHO PERFORM AND DO NOT PERFORM ABORTIONS: BY PROVINCE AND NUMBER OF THERAPEUTIC ABORTIONS PERFORMED

Fiscal Year 1974-75**

DEPARTMENT OF NATIONAL HEALTH AND WELFARE

Number of Therapeutic Abortions Performed	Provinces								
	1	2	3***	4	5	6	7	8	8 Provinces Combined
1-5	−8,711	−7,048	+14,719	+38,541	+48,056	−3,315	−2,219	+37,184	−191
6-10	−2,481	−6,807	+31,822	–	+30,168	+6,255	–	–	+3,383
11-15	−3,904	+9,834	+17,195	−32,927	–	+7,241	+12,679	–	−840
16-20	+1,853	+30,534	+11,268	–	+736	+1,706	–	–	−793
21-25	+11,371	+18,682	−4,435	–	–	+12,789	+39,166	–	+7,448
26-50	+19,244	+27,435	+16,064	–	+20,266	+6,229	+76,822	+70,282	+8,351
51-75	+35,432	+57,705	+10,004	–	–	+14,116	–	–	+15,947
76-100	+40,424	+35,065	+41,700	–	+22,038	+20,375	–	–	+21,252
100+	+38,251	+60,234	+30,649	+32,624	+24,051	+33,455	+67,277	–	+31,066

*Includes physicians who received from the provincial plan at least one payment for their services during the year.

** One province is deleted because its data are available only for the first half of Fiscal Year 1975-76.

*** Fiscal Year 1973-74.

financial year for which a complete tabulation was available. The special tabulation was commissioned by the Committee from the Health Insurance and Resources Directorate of the Department of National Health and Welfare.

On an average, physicians who performed therapeutic abortions during 1974-75 earned 3.8 percent of their total incomes from doing this surgical procedure. For the nine provinces for which information was available, the proportion of incomes of physicians who performed induced abortions ranged between 0.86 to 4.47 percent. The Committee was provided with information on the average health insurance payments to obstetrician-gynaecologists who performed and who did not perform therapeutic abortions in eight provinces. The average annual income derived from national health insurance payments of physicians in eight provinces who performed therapeutic abortions was substantially higher than the reported average annual income of physicians who did not do this surgical operation. Overall, **obstetrician-gynaecologists who did 20 or fewer therapeutic abortions during 1974-75 earned slightly less money from medical care insurance sources than the 48.9 percent of the members of this medical specialty who did not do this operation. The 323 gynaecologists, or 30.0 percent of the active specialists in this field in eight provinces who did 20 or more abortions, earned on an average $18,099 more that year than their medical colleagues who did no therapeutic abortion operations. Gynaecologists who did between 21 and 25 of these operations annually had incomes which were $7,448 higher than for members of this speciality who did none, an amount which rose to $31,066 above the specialty's average income for 95 gynaecologists who did over 100 abortions each year.**

The decision to perform or not to perform therapeutic abortions is based on the specialization within obstetrics-gynaecology and on the professional and ethical decisions made by physicians about the issue of therapeutic abortion. While overall the *average* contribution to the annual incomes of gynaecologists involved in this operation was 3.8 percent, because many gynaecologists did none or a limited number, the reported incomes from medical care insurance sources of the specialists who did this procedure more often were considerably higher. As the difference in these incomes is not accounted for by income earned directly from fees paid for this operation, it is concluded that these physicians were in general more active than their colleagues in doing general surgical procedures as gynaecologists than in providing medical services as obstetricians.

Extra-billing of medical fees

Consisting of three major parts which were introduced over a period of two decades, coverage under national health insurance became virtually universal when the Northwest Territories entered this federal-provincial cost-sharing program on April 1, 1971. The National Health Grants Program was started in 1948, the Hospital Insurance and Diagnostic Services Act was introduced in 1958, and the Medical Care Act went into effect in 1968. Under the four terms

of the Medical Care Act, coverage for insured individuals was to be comprehensive, universally available, portable, and the programs were to be operated on a non-profit basis. By comprehensive care was meant the inclusion of all medically required services provided by physicians for individuals who were insured. The program was intended to be widely available, or to be universal to the extent that 95 percent of the population in a province were to be insured. The third requirement, that insurance benefits be portable, allowed for the continued coverage of individuals who might move between provinces. The programs were to be administered on a non-profit basis and be accountable for their financial operations to provincial governments.

Extra-billing is a sensitive and divisive matter for the public and the medical profession. When it is coupled with the issue of therapeutic abortion, it assumes emotive proportions. This fact was made clear to the Committee on its visits to hospitals across the nation and from some of the written replies from doctors who responded to the national physician survey. The extra-billing of medical fees poses a dilemma for a number of groups which may be concerned with this practice. In 2 out of 10 provinces the extra-billing for insured medical services was allowed, while elsewhere if physicians participated in provincial medical care insurance programs, with minor exceptions, extra-billing was not permitted. How extra-billing was seen by the medical profession varied between regions, by medical specialties, and by the type of work or hospital privileges which physicians had. In some instances this practice was well accepted and was widespread. Traditionally, a high quality of medical service has been associated with high medical charges, as for example the costs of treatment at several distinguished medical centres with international reputations. From another perspective the extra-billing of patients was seen as unnecessary, unethical, and in some instances, illegal. At a number of prestigious medical centres visited by the Committee, concern was expressed that extra-billing, if it occurred, would tarnish the public reputation of the medical specialty involved and of the hospital where it occurred.

When this practice involved patients who were treated at a hospital, and if a decision in principle had been made to curb or eliminate this practice, the administration and the senior medical staff had little or no direct authority to do so. This was the case at a number of hospitals visited by the Committee as extra-billing related to patients seeking or obtaining therapeutic abortions. The position of a majority of physicians who held hospital appointments in Canada, with the exception of physicians who were paid on a full-time basis, is analogous to that of being working guests. The hospital is the workplace where much of their medical practice is done. The quality of medical practice which is done in hospitals may be subject to professional review, a principle which underlies the accreditation of hospitals by the Canadian Council on Hospital Accreditation. But the hospital has no authority to audit directly the billing practices of its medical staff. Such a review, were it to be attempted, would be regarded as an unwarranted intrusion of individual and professional rights.

Some regional and provincial medical associations have considered the issue of medical fee extra-billing, and in some instances, resolutions have been passed about the practice. But as with the administration of hospitals, these

associations have little direct authority to monitor the effects of their decisions. In a similar fashion, while provincial medical care insurance authorities variously audited reported charges for insured medical services, they were seldom provided with full information about extra-billing by physicians. Such information was not considered to be in the public domain. In some cases extra-billing could have implications for income tax, or such practices could be illegal when done by physicians participating in some provincial medical care insurance programs which do not make provisions for this practice by participating physicians. Few of the senior administrators of provincial health departments whom the Committee met across Canada were aware of the extent of extra-billing of abortion patients. In some cases it was concluded that it did not occur, or if it did, it involved a handful of cases.

For their part, patients, unless they are directly asked and even then except under unusual circumstances, are unlikely to volunteer easily such information. This is particularly the case when the treatment for which they seek medical counsel is one about which there is much apprehension, or as in the case of induced abortion, involves much social stigma. Little is known for these reasons about the extent of extra-billing, how it affects the accessibility of patients to medical treatment or whether the extra charges which are made were equitably apportioned by the social circumstances of the patients involved. The personal account given by one woman who had an abortion illustrates the patient's dilemma.

> In 1974, shortly after being fitted with a Lippes Loop, I found myself pregnant . . . A doctor referred me to the women's clinic at the hospital. He assured me that my insurance would cover all costs . . . The actual abortion was horrifying. My husband, who was suffering through this decision also, was literally shoved aside by a cold hospital staff who paused with us just long enough to insist on a $52 fee (which [provincial medical insurance] refused to reimburse).

At 24 hospitals visited by the Committee, administrators, senior medical staff, or directors of nursing services reported that the extra-billing of abortion patients occurred. How this medical billing practice was seen varied from one region to another. A number of senior gynaecologists, including specialists who followed and did not follow this custom, felt that the usual fee for a therapeutic abortion was too low for the amount of work which was involved. One gynaecologist noted that in his practice the fee which was charged included services for: (1) between half an hour to an hour spent with each patient on an initial visit; (2) the time involved in the surgical operation; and (3) the follow-up visit. Another physician told the Committee that most gynaecologists who did therapeutic abortions did this procedure out of a sense of professional obligation to their patients. There were other services, this physician noted, upon which members of this specialty could spend their time more profitably. In his words, "Financially, these operations are a loser."

Indirect income benefits accruing from performing therapeutic abortions were cited by a number of gynaecologists. The augmented income of these physicians, it was suggested, did not result from direct or additional charges from doing this operation, but came about because some abortion patients

continued to consult these physicians for other gynaecological services. The collection of additional fee charges was often done prior to the operation, sometimes by a mailed invoice, while on occasion the assistance of the nursing staff was involved. Several examples were reported to the Committee by directors of nursing services of family physicians, gynaecologists, or anaesthetists who asked the nurses in the operating rooms or the day-care surgical units to collect fees from patients. In one instance this custom was discontinued after the director of nursing requested a review be made by the hospital's chief of medical staff. At another hospital the nursing director of the operating room reported it was customary for abortion patients to pay physicians in cash immediately prior to the operation.

At half a dozen large university-affiliated teaching hospitals, the chairmen of departments of obstetrics and gynaecology considered the extra-billing of abortions to be unethical professional behaviour. The major dilemma raised by these senior gynaecologists was the difficulty of obtaining exact information on the extent to which this practice occurred among their medical colleagues, particularly those physicians who had part-time staff appointments. At one major university hospital, the chairman had reviewed this issue at several staff meetings. It had been decided at this hospital that if this practice became too extensive, the hospital privileges would be revoked for the physicians who were involved. But it was recognized at this hospital that it was inappropriate for the hospital administration to seek to review directly the medical fee charges which were made by medical staff colleagues. At another major hospital which was affiliated with a faculty of medicine, the medical advisory committee had endorsed a resolution that there would be no extra-billing of abortion patients. The chairman of the medical staff subsequently wrote to each physician about this decision adding the proviso that if the extra-billing of abortion patients continued, the hospital staff appointments and privileges of the physicians involved would be cancelled.

In their written replies returned to the Committee in the national physician survey, a number of obstetrician-gynaecologists and family physicians commented on the practice of extra-billing and the costs involved in induced abortions.

> As far as fee is concerned, it should be as is done in plastic surgery, for example, with the physician obtaining fees set out by fee schedule only.
>
> • • •
>
> Reduce the fee and the number of abortions would be reduced . . . (provincial health insurance) should not pay this fee, nor should it pay for voluntary sterilization—this has become a rape of the provincial taxpayers' money.
>
> • • •
>
> I do abortions, but I find them an unpleasant part of my practice. Every abortion is a failure of birth control. Even when I do them I don't like doing them, as they are dangerous, difficult, messy, and not satisfying. Since the Government pays so little for doctors' services, one of the benefits we do get that the government can't tax is the pleasure of doing something for a patient—a healthy baby is much more pleasant to give a patient than an abortion.

Colleagues are unscrupulous in recommending and performing for financial gain . . .

• • •

It should not necessarily be paid for by medical plans and hospital insurance. But payment should not be an issue. I don't believe any blanket statements can apply in medicine or abortion. Some patients' cases are valid, others, particularly the very young, often regard abortion as an extension of birth control. Last year in _____ we had an abortion bill of over $1,000,000. The hospital beds and physicians' time involved are often wasted by too liberal interpretation.

• • •

Far too costly to the taxpayer; where affordable it should not be covered by (provincial health insurance). It has no place in publicly supported hospitals. Far, far too liberal.

• • •

The fee for this service should be small—or the same as for a D & C. Many patients are ripped off by unscrupulous practitioners.

• • •

I know of no physician doing abortions who does not extra bill 100 percent to 200 percent of the fee schedule in advance. Surely, this is taking advantage of a person in distress . . .

• • •

The Committee would do well to investigate the structure, and financial support of anti-abortion groups. Several physicians participate and add their names to such organizations, subjecting their colleagues to tasteless, sensationalistic anti-abortion propaganda (photos of aborted foetuses, etc.).

• • •

Abortion makes up for a large portion of income of gynaecologists who extra-bill for this procedure.

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Therapeutic abortion blackmail is abhorrent. Patients have encountered large surcharges payable in advance. One doctor asks the patient to bring $100 on the first visit as his charge over and above _____ . In the past, patients referred to England were charged $400 for the minor operation of abortion. Other patients I have referred for abortion have encountered delays for many weeks until a simple suction procedure will no longer suffice. They have then been subjected to hysterotomy, which is 100 times as hazardous, but of course is more lucrative for the doctor. The restrictive abortion law in Canada has not brought out the best in the medical profession. It has resulted at times in undignified scrambling for control of public facilities where abortions are permitted.

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> When Canada's 50,000 abortions annually must be done by law in hospital, an unnecessary expense is incurred by the taxpayer. A few years ago the average hospital stay in abortion cases was four days. At present, with more procedures being done in ambulatory care facilities at the hospital, the average stay is likely two days. Hospital care costs about $300 per patient, therefore, or $15 million annually of the taxpayers' money in unnecessary expense. Is this prudent?

The provinces made payments to physicians under the terms of the *Medical Care Act* which were variously set at between 85 percent or above the designated provincial schedule of medical fees. The assumption on which these reimbursement arrangements were made was that participating or "opted-in" physicians would have a reduced cost overhead in the collection of their fees, and losses incurred through the non-payment of bills would be reduced or eliminated. Regulations governing the payment of physicians who work under national health insurance vary across Canada. In all provinces there is a statute in the medical care legislation specifying that physicians who practice outside these plans retain their full billing prerogatives. These private practitioners with the consent of their patients may bill for their medical services on the basis of the schedule of fees drawn up by regional or provincial medical societies, or they may charge above these recommended fee levels. The majority of the members of the medical profession have "opted in", that is, they work within the provincial regulations under which provincial medical care insurance programs operate. Like other facets of Canadian society, and in particular provincial legislation, there is a broad diversity in these regulations which establish slightly different conditions for medical practice and the payment of physicians in each province.

In eight of the ten provinces, physicians who participate in provincial medical care insurance programs with minor exceptions accept as payment in full the fees for their medical services which are set out in the designated schedule of fees.[2] In these eight provinces (excluding Nova Scotia and Alberta), the extra-billing of patients by physicians is allowed only under special circumstances which usually involve patients who are not referred to specialists by family physicians, the provision of treatment which is deemed not to be medically necessary, or work which is particularly unusual or time-consuming.

In Newfoundland specialists may extra-bill patients who have not been referred to them by other physicians. The two conditions under which extra-billing is allowed in Prince Edward Island are for services which are not deemed to be medically necessary, or where an insured patient does not supply

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[2] *The Newfoundland Medical Care Insurance Act*, R.S.N. 1970, c. 265 as amended.

Prince Edward Island, *Health Services Payment Act*, R.S.P.E.I. 1974, c.H-2.

New Brunswick, *Regulation 70-124 under the Medical Services Payment Act*, consolidated to April 30, 1975.

Quebec, *Health Insurance Act*, S.Q. 1970, c.37 as amended.

Ontario, *An Act Respecting Health Insurance*, S.O. 1972, c.91 as amended.

Manitoba, *The Health Services Insurance Act*, R.S.M. 1970, c.H-35 as amended.

The Saskatchewan Medical Care Insurance Act, R.S.S. 1965, c.255 as amended.

British Columbia, *Regulations* 5.04, 5.10 and 5.11, Division 5 under *An Act Respecting Medical Services* as amended.

a physician with his medical care insurance identification number within 30 days of having received treatment. In New Brunswick when a participating specialist in obstetrics provides obstetrical delivery service including pre-natal and post-natal care, he may charge a patient up to $43.50 in addition to the amount paid for under provincial health insurance. No allowance is made for the extra-billing by physicians participating in provincial medical care insurance programs in Quebec, Ontario, Manitoba, or British Columbia. In Manitoba the provincial agency may reimburse at its discretion the higher charges which have been made to patients by physicians working outside the public health insurance program. In most of these provinces if insured patients are served by physicians who work outside the programs, either they or the physicians are reimbursed for these charges according to the designated schedule of fees.

The situation in Saskatchewan is somewhat different in terms of the options for the modes of medical practice but comparable in their consequences for the payment of physicians. This province, the first to start a universal and comprehensive public program of medical care insurance in 1962, allows for four methods of payment for medical practice.[3] These means of payment of physicians are: (1) private agreement—where a practitioner advises a beneficiary that he wishes to treat him on a private basis and the patient agrees, an itemized statement submitted to the Commission is not required and extra-billing may occur; (2) direct payment to physicians—accounts are submitted directly to the Commission and except for certain authorized charges, physicians working under this method accept the Commission payment as reimbursement in full for their medical services; (3) payment through an approved health agency—if the patient and the physician are members of the same approved health agency which involved an enrolment charge for patients, accounts submitted to the Commission by the agency which are reimbursed to physicians are taken as payment in full; and (4) payment to patients—insured patients who submit physicians' bills to the Commission are reimbursed at designated rates, and pay their medical bills which may involve extra-billing. In 1975, of $49,316,809 paid for medical services in Saskatchewan, 77.6 percent were direct payments to physicians (method 2), 19.4 percent were through approved health agencies or community health associations (method 3), and 3.0 percent were payments to patients (method 4). Under these different payment arrangements, 3.0 percent of physicians who received indirect reimbursement from the Commission (method 4) were eligible to extra-bill their patients.

Allowance is made in provincial medical care insurance statutes in Nova Scotia and Alberta for the medical fee extra-billing of patients by physicians participating in these public programs. In Nova Scotia[4] a participating physician who provides an insured medical service to a patient may extra-bill if: (1) prior to giving the service, he gave reasonable notice to the patient of his intention to do so; (2) the patient, or someone acting on the patient's behalf,

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[3] Saskatchewan Medical Care Commission, *Annual Report 1975* (Regina: Government of Saskatchewan, February 1976).

[4] *Nova Scotia Health Services and Insurance Act*, S.N.S. 1973, as amended by S.N.S. 1974, c.31.

consents in writing to the extra charge; and (3) the amount of the extra charge is made known to the Commission. Participating physicians in Alberta who provide a basic insured health service may charge in excess of the amount of the benefits payable by the provincial Commission, if the receipt provided to patients clearly shows the amount of the benefits payable by the Commission for that service.[5]

TABLE 15.4

PARTICIPATION OF PHYSICIANS IN NATIONAL HEALTH INSURANCE AND THE EXTRA-BILLING OF MEDICAL FEES

DEPARTMENT OF NATIONAL HEALTH AND WELFARE

Province	Participation and Extra-Billing	
	1974*	1975**
Newfoundland	4 opted out.	3 opted out.
Prince Edward Island	None opted out. Extra-billing: 0.5 percent	None opted out. Extra-billing: less than 0.5 percent
Nova Scotia	Extra-billing: 3.1 percent of payments (1971-72).	2 opted out: 2.9 percent extra- billing (1972-73).
New Brunswick	4 opted out.	4 opted out. 1.7 percent claims by patients.
Quebec	7 specialists and 3 family doctors opted out.	53 specialists and 17 family doctors opted out.
Ontario	9 percent opted out.	9.8 percent opted out.
Manitoba	5 percent opted out.	3 percent opted out.
Saskatchewan	3 to 4 percent opted out.	2.4 percent of claims submitted by patients.
Alberta	None opted out. Extra-billing allowed under certain circumstances.	None opted out. Extra-billing allowed.
British Columbia	None opted out.	None opted out.
Yukon	—	None opted out.
Northwest Territories	—	None opted out.

* Maurice LeClair, "The Canadian Health Care System", in S. Andreopoulous, ed., *National Health Insurance: Can We Learn From Canada?* (New York: John Wiley & Sons, 1975), pp. 54-56. At the time of this report, Dr. LeClair was Deputy Minister of Health, Department of National Health and Welfare, Canada.

** Health Insurance and Resources Directorate, Department of National Health and Welfare, Ottawa, June 1976.

The Health Insurance and Resources Directorate of the Department of National Health and Welfare estimated that in 1975 over 90 percent of physicians across the nation were participating in provincial medical care insurance programs, or had "opted in". In most instances these participating physicians agreed to accept as reimbursement in full the prorated fee schedule

[5] *The Alberta Health Care Insurance Act*, R.S.A. 1970, c.166 as amended.

payments established by provincial health authorities for each category of medical service provided to insured patients. The extent to which the opting-out of physicians and the practice of extra-billing of patients occurred varied across the country in 1975. In general, few physicians in eastern Canada followed either practice. Almost all of the physicians in Newfoundland, Prince Edward Island, Nova Scotia, New Brunswick, and Quebec participated in provincial medical care insurance programs. It was estimated that less than 0.5 percent of physicians in Prince Edward Island and 2.9 percent of physicians in Nova Scotia (1972-73) extra-billed their patients under the provisions allowed for in provincial medical care insurance statutes. The Health Insurance and Resources Directorate made no estimate of the extent of extra-billing in eight provinces. The trend toward an increased proportion of physicians who had opted out rose in Ontario and two of the Prairie provinces. The proportion of physicians who practiced outside these provincial medical care insurance programs in 1975 was: 9.8 percent in Ontario; 3 percent in Manitoba; and about 2.4 percent in Saskatchewan. All of the physicians in active medical practice in Alberta and British Columbia participated in the public insurance programs, and in Alberta, physicians could extra-bill patients under certain circumstances.

The issue of extra-billing was reviewed by the Committee on its visits to provincial health departments and hospitals across the nation. There were no reports of this practice in five provinces. In Nova Scotia, Ontario, Manitoba, Alberta, and British Columbia, while it was known that extra-billing occurred, its proportions were seldom known to the senior staff of provincial health departments. The Saskatchewan Medical Care Insurance Commission provided the Committee with information about extra-billing for therapeutic abortions for that province.

On the basis of the provincial medical care insurance statutes, information about the extent of physicians participating in these programs and the reported prevalence of extra-billing, few extra charges would be expected to be made to patients seeking induced abortions in Newfoundland, Prince Edward Island, New Brunswick, Quebec, or British Columbia. In provinces where more physicians did not participate directly in these public programs such as Ontario, Manitoba, or Saskatchewan, or where as in the case of Nova Scotia and Alberta, additional charges were allowed, the extent of extra-billing of abortion patients might be expected to be more extensive. The ratio for each province of the number of physicians who did not participate in provincial medical care insurance plans or who were eligible to extra-bill patients was calculated on the basis of the number of physicians in active medical practice listed by the *Canada Health Manpower Inventory 1975*. On this basis the extra-billing for medical services, if this practice was uniformly distributed among physicians and patients, would be: 0.6 percent in Quebec; 9.8 percent in Ontario; 3.0 percent in Manitoba; about 2.4 percent in Saskatchewan; and none in British Columbia. In the case of Ontario, this proportion rose to about 15 percent as between April 1974 and April 1975, the number of obstetrician-gynaecologists who had opted out of the provincial health insurance plan varied between 10 and 21 percent. In Manitoba in 1975, 5.17 percent of obstetrician-

gynaecologists and 3.85 percent of family physicians and general surgeons practiced outside the provincial plan.

Where precise information was not available, these ratios were based on the number of physicians known to be working outside the provincial medical care insurance programs relative to the total number of physicians in active medical practice in that province (e.g., 70 "opted-out" physicians in Quebec out of a 1974 total of 11,051 active physicians). In two provinces, Nova Scotia and Alberta, where extra-billing was allowed by participating physicians, the rates were calculated in the case of Nova Scotia on the known rate of 44.8 percent extra-billing of induced abortion services (1975-76)[6] and for Alberta, this rate was set at its potential maximum of 100 percent. The rate for New Brunswick was based on the proportion of claims submitted by patients for incurred services to all claims including those submitted for payment directly by physicians. The rates for two provinces, Newfoundland and Prince Edward Island, were not derived as these provinces were not included in the national patient survey.

Patients from whom information was obtained in the national patient survey were asked if they had health insurance, if the costs of the abortion were completely paid for by health insurance, and, if this was not the case, if they had to pay extra and how much they had to pay. When these findings are compared for the eight provinces included in this survey with the extent to which additional charges might have been expected on the basis of the number of physicians who had "opted-out" or who were eligible to extra-bill patients, on an average a higher than expected number of patients who obtained therapeutic abortions had been extra-billed for this surgical procedure. The provincial rates for the extra-billing of patients were calculated on the basis of the number of patients in this category compared to the total number of patients in that province who had abortions and who were included in the 1976 national patient survey.

When the expected and the actual rates of the medical fee extra-billing of abortion patients are compared, on a national average women who had this operation were extra-billed more often than might be expected in 5 out of 8 provinces and this situation likely occurred in a sixth province. This practice was most frequent in Alberta which allows extra-billing and where 91.6 percent of abortion patients reported paying extra charges. In Nova Scotia where on an average 2.9 percent of medical services involved extra-billing in 1972-73, the reported extra-billing of women having induced abortions in 1975-76 involved 44.8 percent of these patients. This level then is considerably higher than would be expected for all patients consulting physicians for other services. In the national patient survey, 20.1 percent of abortion patients were extra-billed. The extent of extra-billing of abortion patients in New Brunswick was over twice the expected rate of extra-billing. Participating physicians in New Brunswick have the right to choose not to participate or to participate for

[6] Of a total of 958 therapeutic abortions for 1975-76, there were additional charges for 429 of these operations. Of 768 abortions done by obstetrician-gynaecologists, 423 had extra charges; of 130 abortions performed by family physicians, 6 had extra charges; and none of the remainder (60) done by other specialists involved extra charges.

a particular service. When participating obstetricians in this province provide obstetrical delivery service including pre-natal and post-natal care, an additional charge of $43.50 can be charged the patient which is in addition to the amount paid for under provincial medical care insurance.

TABLE 15.5

EXTRA-BILLING OF ABORTION PATIENTS IN EIGHT PROVINCES, 1975

NATIONAL PATIENT SURVEY

Province	Expected Extra-Billing Rate*	Proportion of Abortion Patients who were Extra-Billed
	percent	
Nova Scotia	44.8 (2.9)	17.0
New Brunswick	1.7	3.9
Quebec	0.6	1.4
Ontario	15.0	18.3
Manitoba	5.2	1.0
Saskatchewan	2.4	32.9
Alberta	100.0	91.6
British Columbia	0.0	12.9

* This rate is based for six provinces on the number of physicians not participating in provincial medical care insurance programs compared to the total number of physicians in active medical practice in a province. For Nova Scotia a rate of 44.8 percent was reported for 1975-76, while the number of "opted-out" physicians was estimated to be considerably lower (2.9 parcent). The rate for Alberta was the potential maximum of extra-billing.

The extent of extra-billing of abortion patients in Quebec and Ontario were respectively 2.3 and 0.2 times above the expected rates. Extra-billing was reported by obstetrician-gynaecologists at 12 of the hospitals visited by the Committee in Ontario; it was alleged to be extensive at one hospital in Quebec. In Quebec, as none of the "opted-in" physicians were eligible to extra-bill patients and as most physicians participated in the provincial health insurance program, it would appear that many of these extra charges may not be in accord with provincial policies. In Ontario the 1975 fee schedule for specialists performing abortion services for patients was: $60, abortion incomplete and including dilatation and curettage; $75, therapeutic abortion/intra-ammiotic injection of saline; $10, ammiocentesis; $35, genetic ammiocentesis (within 16 weeks of pregnancy); and $150, hysterotomy. Based on information received by the Committee, the fees were listed of 25 identified obstetrician-gynaecologists affiliated with hospitals which performed 22.9 percent of the province's therapeutic abortions in 1974. The charges of these 25 physicians indicated that in most instances abortion patients were extra-billed over the provincial schedule of fees for which payments were prorated at 90 percent. Eighteen of these physicians requested payment in cash or a certified cheque at the time of a patient's first visit or prior to the operation.

TABLE 15.6

FEE BILLING PRACTICES OF 25 PHYSICIANS IN ONTARIO

Physician	Abortion Services and Fee Charges			
	Up to 12 Weeks	Saline	Tubal Ligation	Without Ontario Health Insurance Plan (OHIP)
1	$125.00	$125.00	$100.00	$125. + $169./day + anaesthetic
2	$110.00	$110.00	$135.00	$110. + $169./day + anaesthetic
3	$100.00	$100.00	$100.00	$100. + $169./day + anaesthetic
4	$ 67.50	—	—	—
5	$150.00	$150.00	$150.00	$150. + $187./day + anaesthetic
6	$125.00	—	—	—
7	$150.00	—	$150.00	$150. + $187./day + anaesthetic
8	OHIP	OHIP	OHIP	+ $187./day + anaesthetic
9	$125.00	—	$150.00	$125. + $169./day + anaesthetic
10	$100.00	—	$125.00	$100. + $169./day + anaesthetic
11	$125.00	—	—	—
12	$100.00	$100.00	$100.00	$100 + $169./day + anaesthetic
13	$150.00	—	$150.0	$150. + $187./day + anaesthetic
14	$200.00	200.00	$175.00	$200. + $187./day + anaesthetic
15	$125.00	—	—	—
16	$200.00	$200.00	$175.00	$200. + $187./day + anaesthetic
17	$100.00	$100.00	$100.00	$100. + $169./day + anaesthetic
18	$150.00	$150.00	$150.00	$150. + $169./day + anaesthetic
19	$125.00	—	—	—
20	$190.00	$250.00	$250.00	$190. + $169./day + anaesthetic
21	$200.00	$200.00	$175.00	$200. + $187./day + anaesthetic
22	$125.00	—	—	—
23	$220.00	—	$150.00	$220. + $187./day + anaesthetic
24	$350.00	—	$350.00	$350. + $187./day + anaesthetic
25	$ 67.50	—	—	—

Source: Community service agency survey and hospital site visits by Committee

With the exception of Alberta where extra-billing occurred extensively, Manitoba was the only province where the extent of extra-billing of abortion patients was subsantially lower than might have been anticipated on the basis of the number of physicians who did not participate in the provincial medical care insurance program.

The extent of extra-billing of abortion patients in Saskatchewan was 13.7 times the expected rate. The payment schedule used by the Saskatchewan Medical Care Insurance Commission for therapeutic abortions and related procedures in 1975 was:

	Specialists	Family Physicians
Therapeutic Abortion	$ 64.00	$ 51.00
Dilatation and curettage	38.30	38.30
Hysterotomy—abdominal	128.00	102.00
Hysterotomy—vaginal	115.00	92.00
Amniocentesis	25.50	25.50

Information provided to the Committee by the Commission listed 253 services to therapeutic abortion patients in 1975 where extra-billing had occurred. The average amount billed for therapeutic abortion services was $86.09 and the average amount paid by the Commission was $61.04. The average amount involved in the extra-billing was 41.0 percent above the customary charges paid for by the Commission. In some instances these amounts were considerably higher as in the case of one bill for $150 which was reimbursed by the Commission at the fee schedule amount of $64.

The practice of extra-billing which was allowed under provincial legislation in Alberta extended to most patients in that province who had induced abortions and who were included in the hospital abortion survey. Nine out of ten (91.6 percent) of these patients paid extra charges for this operation.

In British Columbia the *Medical Services Act* stipulates that extra-billing is allowed where a practitioner has treated a patient "who requires unusual time-consuming service over and beyond ordinary required care", if the practitioner complies with the regulations. The 1975 Approved Schedule of Fees in British Columbia listed the gross fees paid for the methods used for therapeutic abortion as: $56.65, operation only—therapeutic abortion (vaginal) by whatever means, less than 12 weeks of gestation; and $113.30, therapeutic abortion over 12 weeks of gestation. In the autumn of 1975 the Executive of the British Columbia Medical Association reviewed the question of medical fees for patients obtaining abortions with members of the Section of Obstetrics and Gynaecology. It was then indicated that the extra-billing of patients by physicians participating in the public program was contrary to the regulations of the *Medical Services Act*. At that time none of the physicians in active medical practice had opted out of the provincial health insurance program.

According to information received from the British Columbia Department of Health, this review was effective as since that time only a small number of claims made by abortion patients indicated extra-billing. In the national patient survey undertaken in 1976, 12.9 percent of abortion patients from whom information was obtained in British Columbia were extra-billed on an average of $85.39 for medical services. Among the patients who were extra-billed, on an accumulative basis, 8.6 percent were charged over $200; 11.5 percent over $150; and 35.6 percent, over $100.

Members of several medical specialties are involved in the performance of therapeutic abortions. These specialties include: obstetrics-gynaecology, family medicine, general surgery, and anaesthesiology. In addition, other physicians such as psychiatrists who are required as consultants may be involved prior to the review of an application by a hospital's therapeutic abortion committee. Based on information received from provincial health authorities, obstetrician-gynaecologists did 84.9 percent of the reported abortions in seven provinces in 1974-75, followed by family physicians who did 13.0 percent, general surgeons who did 2.0 percent, and other medical specialists, 0.1 percent. It is estimated that this pattern was similar for the remaining provinces where the majority of therapeutic abortion services were done by specialists in obstetrics-

gynaecology. At its June 1971 meeting, the Society of Obstetricians and Gynaecologists of Canada passed the following resolution:

> That for the time being the fees for the performance of termination of pregnancy should not exceed that set in the local and provincial fee schedules.

On the basis of the findings of the national patient survey, this resolution does not seem to have been fully adhered to in 1976 by some members of this medical specialty.

In the 1976 national patient survey undertaken in 24 hospitals in eight provinces (Newfoundland and Prince Edward Island were not involved), patients were asked whether they had health insurance coverage and if they had to pay extra fee charges for the abortion operation. At some of these hospitals there was a concern among medical staff members that information about physician's fee charges would be obtained. At several of the hospitals included in the survey a distinction was made between public and private patients, with some of the latter being excluded from the group of patients from whom information was obtained. Despite this fact, information was obtained from a substantial number of public and private in-patients at each of these medical centres. *The information obtained on the extent of extra-billing in the national patient survey is a minimal estimate.* The actual proportion of extra-billing, if the total experience of hospitals where extra charges were involved had been documented, would lead to a projection on an average basis of at least 10 percent higher than the reported rate.

At 6 of the 24 hospitals included in the national patient survey, there was no extra-billing of abortion patients. The provincial distribution of these hospitals was: 1, New Brunswick; 2, Quebec; 2, Ontario; and 1, Manitoba. There was medical fee extra-billing of abortion patients at the 18 other hospitals which were located in each of the eight provinces included in the survey (Nova Scotia, New Brunswick, Quebec, Ontario, Manitoba, Saskatchewan, Alberta, and British Columbia).

While it is known from provincial medical care insurance annual reports that over 95 percent of the Canadian population is enrolled in these public programs, there has been no national review of the extent to which this coverage may extend to all Canadians or how participation may vary among groups in the population. In the *national patient survey*, 96.3 percent of abortion patients said they had health insurance. At this high level of public participation not much variation could be expected, but this in fact did occur on the basis of self-reported coverage among these patients. Almost all of the abortion patients (99.2 percent) in the Maritimes were enrolled in provincial medical care insurance programs, while only 92.8 percent of abortion patients in British Columbia said they had health insurance coverage. Representing their inclusion as family members, all abortion patients who were 15 years or younger had health insurance. There was a predictable dip in the extent of health insurance coverage followed by an increase as the ages of the patients rose. Among women who were between 18 and 19 years, 94.9 percent were enrolled in these public programs, a trend which may represent an uncertainty about their health insurance status, or a time of transition in their coverage

between the enrolment provided for them by their parents and when they started to work or got married.

Participation in medical care insurance programs was associated with where abortion patients had been born, again an expected trend which was partly contingent upon the length of residence in Canada and an individual's familiarity with the nature of social security and health insurance measures. Among abortion patients who had been born in Canada, 97.4 percent had health insurance, while the proportions were lower for all groups of women who were born abroad. The distribution of health insurance coverage by place of birth was: 96.6 percent, Europe; 94.3 percent, India; 93.3 percent, United Kingdom and United States; 90.7 percent, West Indies; and 92.0 percent for all other individuals.

At one hospital which was visited by the Committee, the chief of obstetrics and gynaecology observed that medical fee extra-billing by his colleagues varied by the social circumstances of the patient. Most physicians, this senior specialist noted, considered the issue of abortion with distaste, if not repugnance. The physicians who performed this operation did so out of a deeply held sense of professional obligation. But the personal outlook and background of physicians affected how they reached their decisions on this matter, decisions which were not made solely on the basis of impartial professional judgment. "If a woman is physically attractive, well educated, and can otherwise relate," this physician observed, "then the fee is sometimes reduced." In the context of the 1 out of 5 abortion patients (20.1 percent) who were extra-billed, this observation was partially valid.

Patients in the national patient survey were asked if they had to pay extra money which involved a sum over the usual and customary charges for the abortion operation. There was substantial variation among the patients who were extra-billed by: their age, level of education, religion, and where they lived. One-third (33.3 percent) of teenage females who were 15 years or younger paid extra medical charges in contrast to 13.3 percent of women who were 35 years or older. When abortion patients of all ages are considered, there is a direct decrease by the age of patients and the proportions who were extra-billed by physicians. Consistent with this finding, but representing a difference of smaller proportions, fewer married women were extra-billed than either single women or women who were widowed, divorced, or separated. The proportion of women with college or university training who were extra-billed (22.0 percent) was double that of women who had an elementary school level of education (10.9 percent). Fewer Jewish and Catholic patients and more Protestants and women affiliated with other faiths were extra-billed.

The average amount which abortion patients in the eight provinces were extra-billed was $73.71. Among the fifth of all patients who had extra medical fee charges, 16.2 percent paid up to $30; 29.4 percent, $31 to $63; 32.5 percent, $66 to $90; 15.7 percent, $91 to $150; 3.1 percent, $151 to $200; and 3.1 percent, $200 to $300. The distribution of these charges among abortion patients was different from the distribution of attributes of all of the women who were extra-billed. While considerably more younger abortion patients had

TABLE 15.7

HEALTH INSURANCE COVERAGE AND MEDICAL FEE EXTRA-BILLING OF ABORTION PATIENTS

NATIONAL PATIENT SURVEY

Characteristics of Patients	Health Insurance Coverage and Extra-Billing		
	Have Health Insurance Coverage	Proportion of Patients Who Were Extra-Billed	Average Sum Paid for Extra-Billing
	percent	percent	dollars
AGE			
15 years and under	100.0	33.3	76.09
16-17 years	96.8	24.4	74.69
18-19 years	94.9	26.3	78.32
20-24 years	95.3	19.9	75.83
25-29 years	96.6	17.3	75.60
30-34 years	98.1	14.5	71.63
35 years and above	97.4	13.3	73.16
COUNTRY OF BIRTH			
Canada	97.4	21.1	72.12
Europe	96.6	15.6	86.25
India	94.3	14.4	78.33
U.K. and U.S.A.	93.3	20.5	75.23
West Indies	90.7	17.7	102.52
Other	92.0	19.4	78.76
EDUCATION			
elementary school	96.5	10.9	79.06
high school	96.3	20.5	74.12
college/university	96.2	22.0	71.96
MARITAL STATUS			
single	95.7	21.0	74.18
married	97.8	16.2	67.88
widowed, divorced, separated	96.2	22.0	78.47
REGION			
Maritimes	99.2	13.7	25.97
Quebec	96.8	1.8	78.50
Ontario	96.9	18.4	75.49
Prairies	97.3	58.8	74.95
British Columbia	92.8	11.3	85.39
RELIGION			
Catholic	96.1	14.1	79.09
Jewish	95.5	11.7	101.72
Protestant	97.0	29.0	70.45
Other	95.0	18.0	76.92
AVERAGE	96.3	20.1	73.71

been extra-billed, there was little difference by the ages of the patients in the actual sums involved. The reverse trends were the case by the level of education and religious affiliation of abortion patients. While fewer women with an elementary school education were extra-billed, the women with less education

who actually paid extra charges had an average bill of $79.06, while women with college and university training paid on an average $71.96, or a difference of 11.0 percent. While fewer Jewish and Catholic women than Protestant women were extra-billed, among the patients who paid extra medical charges, there were sizeable differences by their religious affiliations. Protestant women on an average paid $70.45, Catholic women $79.09, and Jewish women $101.72, or an amount which was 30.7 percent more than for Protestant women. The usual charge for married women was less than for single women or women who were widowed, separated, or divorced.

There was a difference of 29.7 percent in the average extra-billing charges between abortion patients who had been born in Canada, who paid $72.12, and women from the West Indies, who on an average were extra-billed by $102.52. The extra-billing charges for women born in other countries were: $86.25, Europe; $78.33, India; $75.23, United Kingdom and United States; and $78.76, individuals from other countries.

In its *Review of Health Services in Canada, 1975* the Department of National Health and Welfare indicated that:

> Utilization charges at the time of service are not precluded by the federal legislation if they do not impede, either by their amount or by the manner of their application, reasonable access to necessary medical care, particularly for low-income groups.[7]
>
> Seven of the 12 provincial (or territorial) medical plans finance their share of the cost from general revenues only and in those plans there is virtually no direct cost to families, apart from additional billing that doctors may impose in some instances . . . It should be noted that all provinces permit specialists to extra-bill for non-referred care if the specialist rate is higher than the rate the plan will pay for such services.[8]

In reviewing the establishment and the operation of the Canadian health care system, Maurice LeClair, then Deputy Minister of Health of the Department of National Health and Welfare, concluded in 1975 that:

> The greatest benefit has been the provision of financial accessibility to health care . . . : no longer do people wait to seek care because they cannot afford it and a sudden illness or accident is not a financial catastrophe for an individual or a family. It is a fact though that the very poor are still not utilizing the system as much as they could for a variety of reasons: lack of a baby-sitter, taxi, or bus fares, etc.[9]
>
> In a health insurance system with no direct financial burden on the patient, the only deterrents to seeking care are the time and trouble involved, and there is a large untapped reserve of "beneficial" services which can be offered.[10]

There has been no comprehensive national review of the extent to which the extra-billing of medical fees may occur across Canada, the specialties of

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[7] *Review of Health Services in Canada, 1975* (Ottawa: Health Economics and Statistics Division, Health Programs, Department of National Health and Welfare, 1975), p. 4.

[8] Ibid., p. 24.

[9] Maurice LeClair, "The Canadian Health Care System" in S. Andreopolous, ed., *National Health Insurance: Can We Learn From Canada?* (New York: John Wiley & Sons, 1975), p. 42.

[10] Ibid., p. 79.

the physicians who adopt this practice, what types of health conditions or diseases may be involved, or the social attributes of patients who pay extra medical fee charges. **The conclusion that there are no financial deterrents to obtaining health services was not valid for the 20.1 percent of 4,754 women who had therapeutic abortions in eight provinces in 1976.** Between a quarter to a third of young abortion patients were extra-billed. There were sharp regional differences in this practice and in the actual amounts of money which many women were charged. In general, women who had less education and who had not been born in Canada had to pay more. The direct impact of these charges influenced the relative accessibility by the social circumstances of women to these medical services. **The combined consequences of either the largest fee charges or the most extensive extra-billing involved abortion patients who were the most socially vulnerable: young women; newcomers to Canada; and the least well educated.**

Medical and hospital costs of induced abortion

The calculation of the financial costs attributable to therapeutic abortion which are paid for directly by national health insurance involves various provincial accounting procedures and rests upon a number of assumptions. There is some variation between provincial programs in how medical fee schedule items are coded and paid for, in the timing of the financial year which is used for accounting purposes, and the extent to which all medical and hospital services associated with the therapeutic abortion procedure are completely documented and indicated as relating to this operation in terms of their costs to the public purse. In the context of the different provincial health systems and their cost-accounting procedures, there is much variation in the average *per diem* costs of hospital care for patients, differences in the provincial fee schedules for medical procedures which are involved in the surgical operation of therapeutic abortion, and different styles of medical practice for the procedure of first-trimester induced abortions which may be done on a day-care (out-patient) basis or involve one or more days of in-patient hospital treatment.

While the Committee received information from provincial departments of health on the medical care insurance costs and medical fee payments made for therapeutic abortion procedures, this information involved different and non-comparable periods of time in the listing of abortion procedures and due to different accounting procedures these sources were not complete for 1974-75. In January of 1975, the Health Economics and Statistics Division, Policy Development and Coordination Directorate of the Department of National Health and Welfare completed a review of the known direct costs associated with the total number of therapeutic abortions done in Canada in 1973. This review was subsequently updated to 1974 at the request of the Committee. This analysis indicated the general nature of public expenditures for this surgical operation. In terms of subsequent increases in the cost of living, the information for 1973 and 1974 provided a comparison which is still valid in the

analysis of the relative costs of therapeutic abortion and the health costs which would have been incurred if these pregnancies had not been terminated. These cost estimates dealt only with monies paid from the public purse. Excluded from these estimates were the personal costs incurred by women who obtained induced abortions, the payment of medical fee charges which were made by patients in addition to the various medical care insurance fee reimbursement schedules, or the costs involved for women who obtained abortions in the United States.

Several assumptions were made in calculating the cost estimates for therapeutic abortions in 1973 and 1974. Included in these expenditures were the direct costs of medical and hospital care including related anaesthetic services. Medical care cost estimates were based on the quarterly medical care utilization information provided by the provinces to the Department of National Health and Welfare. No estimates were developed to determine the costs of medical complications which might develop following induced abortion. Allowance was made in deriving medical care costs for different rates established in provincial medical care payment schedules. These charges varied between the provinces by 33.2 percent, being on an average $50.68 for 1973 in British Columbia and $67.50 in Newfoundland.

The calculation of hospital costs was based upon the valid assumption that a majority of therapeutic abortions were done in larger rather than smaller hospitals and *per diem* patient costs were derived on this basis. Like medical care costs, average *per diem* hospital costs in 1973 varied across the country: by 77.9 percent from $60.95 in New Brunswick to $108.45 in Nova Scotia.

With the exception of Ontario, Manitoba, and British Columbia, there was an inverse relation among the seven other provinces between the average medical care costs and the average *per diem* hospital costs. For those provinces whose medical care costs were higher in 1973, average *per diem* hospital costs were considerably lower. The reverse situation obtained as where there were higher hospital costs, the average medical care costs were lower. The broad regional cost differences resulted from different health priorities set by the provinces, coupled with different patterns of medical care which were followed throughout the nation. There were differences between the provinces in the average number of annual visits made by patients to physicians and in the average length of hospitalization for specific hospital treatment procedures. These differences in how provincial health services were organized affected the health costs involved in the payment for therapeutic abortions under national health insurance.

More complete information on the experience of women who had therapeutic abortions was available for eight provinces in 1973 and information was available for all provinces in 1974. In 1973 the average length of hospital stay of patients having induced abortions was 2.5 days, a level which dropped slightly to 2.4 days by 1974. This level was then uniform for all provinces but where major differences occurred was in the proportion of patients who were treated on a day-care basis or as in-patients in hospitals. Almost all of the induced abortion patients in two provinces were treated in hospital and these two provinces predictably accounted for the highest average health costs per

abortion patient. In general, the experience of the other provinces showed that there was an association with average health costs involved with the abortion procedure by the extent to which these patients were hospitalized. The estimated health costs arising from the combined medical and hospital services provided for each therapeutic abortion patient in Canada was $284.17 in 1973. In terms of national expenditures for all reported therapeutic abortions, the estimated total costs of therapeutic abortions for that year were $12,242,000 of which $3,296,700 were medical care costs and $8,945,300 resulted from hospital services. Total average health costs for each therapeutic abortion patient varied between the provinces from $199.12 to $418.13. **By 1974, the average hospital and medical care costs for the treatment of each woman having a therapeutic abortion dropped to $270.76, or by 4.7 percent. The range between the 10 provinces was between $195.45 and $320.00, or a variation in health costs of 61.1 percent.**

Differences in health care costs may be associated with the types of procedures which are performed, whether services are provided by family physicians or medical specialists, whether treatment is given on an in-patient or out-patient basis, and by a difficult-to-measure factor, the quality of medical care which is given to patients. Many different standards have been used to measure the quality of medical care. These measures have included: optimal standards of care; the assessment of the health needs of patients or a population; the average pattern of medical services; and the use of outcome indices which may involve the number of deaths associated with a disease, related morbidity, physical and social functioning measures, or subsequent complications related to a specific medical or surgical procedure. Information on two of these indices related to therapeutic abortion was available. Only one death associated with abortion occurred in Canada in 1973. The assessment of medical complications associated with therapeutic abortions depends upon how such complications are defined, whether they are recorded in connection with this procedure, and whether they are measured as short-term or long-term sequelae. There is no information available to determine if there are different means used across the country in the listing of complications associated with therapeutic abortions. This may be the case, for there are substantial variations in the complication rates per 100 therapeutic abortions between provinces which are geographically adjacent. Until much more is known about the definition and the codification of abortion complications, their analysis must be seen with some reservation. It is within this context that they are considered here in conjunction with health costs.

In 1973 there were on an average 4.2 complications per 100 therapeutic abortions which were done in the eight provinces for which health cost information was available relating to therapeutic abortion. This rate of reported complications declined to 3.1 per 100 therapeutic abortions in 1974, but this rate was based on the experience of more provinces for that year and for Ontario from May to December of 1974.

In 1974 the complication rate per 100 therapeutic abortions among the provinces ranged from 2.0 to 8.0. Allowing for the difficulties involved in interpreting what medical complications may mean, on the basis of officially

reported morbidity information, **there was no apparent association between different provincial complication rates and the average length of hospital stay of patients who had therapeutic abortions, the proportion who were treated on an out-patient or in-patient basis, or the average health costs which were paid for the medical and hospital services which were required by this procedure.**

TABLE 15.8

MEDICAL AND HOSPITAL COSTS, PROPORTION OF PATIENTS HOSPITALIZED, AND COMPLICATIONS ASSOCIATED WITH THERAPEUTIC ABORTION: BY PROVINCE, 1974*

Province	Services Associated with Therapeutic Abortion			
	Average Health Costs per Patient		Proportion of Abortion Patients Who Were Hospitalized,	Complication Rate per 100 Therapeutic Abortions,
	1973	1974	1974	1974**
	dollars		percent	percent
1	343.90	320.00	98.0	2.0
2	418.13	315.22	97.3	3.8
3	349.36	289.07	55.6	8.0
4	392.93	279.14	66.8	5.5
5	293.68	275.30	70.0	2.2
6	233.91	268.56	73.4	2.1
7	314.52	264.46	76.7	4.2
8	266.40	253.25	79.3	4.7
9	258.70	235.30	47.5	5.9
10	199.12	195.45	52.0	1.4
CANADA	284.17	270.76	70.5	3.1

* Health care cost information is based upon information from Health Economics and Statistics Division, Policy Development and Coordination Directorate, Health and Welfare Canada, Ottawa, 1976; the average length of hospital stay and complications associated with therapeutic abortions come from Statistics Canada.

** Relates to first complications only.

The health costs which would have been incurred if all of the reported therapeutic abortions in 1973 and 1974 had not been performed in Canadian hospitals, that is, if these pregnancies had been allowed to come to term, were estimated by the Health Economics and Statistics Division of the Department of National Health and Welfare. Allowance was made in these estimates for the expected number of foetal losses (stillbirths and spontaneous abortions) and the length of gestation in the calculation of the number of pregnancies which would have gone to term. No cost estimates were made of the expenditures involved in the treatment of patients who had had foetal losses or of the costs paid for by government for the transportation of patients in northern Canada. Likewise, no estimates were developed of the costs of pre-natal and post-natal care, the costs of well-baby care outside the hospital, or the treatment of special conditions such as congenital anomalies, premature births, or of other conditions of the newborn, or of women requiring further treatment. For these reasons the cost estimates associated with childbirth represented minimum expenditures.

In 1973 the total medical and hospital care expenditures involved (allowing for foetal losses), had the therapeutic abortions that year gone to term, would have been $27,164,000. This expenditure would have included $6,114,000 in medical care costs and $21,050,000 in hospital costs, or an average cost per patient of $728.22. In comparison with the estimated average cost of $284.17 in 1973 of performing a therapeutic abortion in eight provinces, there was a difference of $444.05 if routine treatment for pregnancy care had been provided. In 1974 the average cost per therapeutic abortion patient was $270.76 and the cost, allowing for stillbirths, if these pregnancies had continued to term, was estimated to be $865.47.

Cost of Therapeutic Abortion	1973	1974
Total Estimate	$12,242,000	$13,030,000
Cost per Case	$284.17	$270.76
Costs Incurred in Routine Pregnancy Care of These Induced Abortion Patients		
Total Estimate	$27,164,000	$36,064,000
Cost per Case	$728.22	$865.47

The costs involved from hospital and medical care insurance payments on a per capita basis for 22,095,000 individuals in Canada in 1973 were $0.55 per person for the therapeutic abortions done that year in Canadian hospitals. If the pregnancies of these women had gone to term, the cost would have been $1.23 for each person in the country. In 1974 this cost for each Canadian was $0.58 for all induced abortions, or $1.61 if these pregnancies had gone to term.

Contraceptive sales

In terms of information received by the Committee, the national sales of the various categories of contraceptive means to pharmacies and hospitals in 1975 were estimated to total $29,187,000. With an estimated price markup to the consumer, these sales amounted to $41,528,666. The volume of sales of contraceptives was distributed between six major categories, with oral contraceptives being the major component.

Contraceptive Means	Percent of Sales, 1975
Oral Contraceptives	86.5
Condoms	8.3
Vaginal Foams	2.4
Creams, Gels	1.5
Diaphragms	0.3
Intra-Uterine Devices	1.0
	100.0

The usual price markup for oral contraceptives was 33.3 percent, while the customary markup for other contraceptive means was 50 percent or higher. The average oral contraceptive costs to a woman were $3.00 per cycle, which on an annual basis averaged between $36 and $40. Between 1974 and 1975, sales of condoms showed a 50 percent greater increase than sales for other types of contraceptives combined. Sales of oral contraceptives showed the next highest increase over this period. Relatively few condoms were sold through vending machines, with the majority being available at retail pharmacies, through which some of the largest distributors exclusively made their sales. The four remaining contraceptive means together accounted for 5.2 percent of this market in 1975, with the sales of vaginal foam decreasing by 18 percent between 1974 and 1975. The sales of intra-uterine devices in 1975 represented between 50,000 and 60,000 new users of this device during that year, but these sales did not include their distribution to surgical supply companies which sold directly to physicians.

TABLE 15.9

CONTRACEPTIVE SALES IN CANADA, 1975
DOLLAR SALES TO RETAIL PHARMACIES AND HOSPITALS

Type of Contraceptive	Dollar Sales to Pharmacies and Hospitals	Estimated Consumer Expenditures
		33⅓ percent markup
Oral Contraceptive	$25,268,000	=$33,690,666
		50 percent markup
Condoms	$2,418,000	=$4,836,000
		50 percent markup
Vaginal Foam	$691,000	=$1,382,000
		50 percent markup
Spermicidal Creams & Gels	$430,000	=$860,000
		50 percent markup
Diaphragm	$80,000	=$160,000
		50 percent markup
Intra-uterine Device	$300,000	=$600,000
TOTAL	$29,187,000	$41,528,666

Source: Committee survey, 1976.

In terms of sales of the contraceptive means used by women, and if only women between the ages of 15 and 49 years are considered, the average consumer expenditure was $6.14. **The per capita costs paid by Canadians in 1974 for the use of contraceptives was $1.85.**

Expenditures on family planning

There has usually been a distinction made in public programs in Canada between services and programs involving: (1) abortion; (2) contraceptive counselling and services; and (3) family planning programs. The service and programs involved in family planning programs relate to the knowledge and

practices which enable individuals either to avoid or to terminate unwanted pregnancies, or to bring about wanted births.

Information about expenditures on family planning programs was obtained from the provincial and federal governments. No information on these types of programs was obtained from municipalities. A limited amount of information was available on the expenditures of a number of voluntary non-profit associations or organizations. The information which is available about the *designated* expenditures on family planning programs of the federal and provincial governments indicates the broad dimensions of what these activities cost. How health budgets approved by legislatures were administered and categorized varied between the provinces. In some instances specific family planning programs were identified, while in other cases public health staff were assumed to have the requisite competence in this field and family planning programs were included in the general operating budgets of public health agencies.

Newfoundland did not have a family planning program. While the provincial government had officially supported the Family Planning Association of Newfoundland, no direct financial support was granted to this agency. There was no designated program, separate staffing, or special budget for family planning in Prince Edward Island. It was reported that these activities were carried out by public health nurses in connection with pre-natal classes and post-natal visits to mothers.

The Nova Scotia Department of Public Health did not have separate staffing or a budget for family planning. As in Prince Edward Island, a family planning education program was undertaken by public health nurses which involved the distribution of pamphlets and the use of teaching aids. The Nova Scotia Department of Social Services made an annual grant of $10,000 to the Metro Area Family Planning Association. In New Brunswick the family planning program was carried out in the context of health promotion as part of the program of the Public Health Services Division. An annual grant of $4,000 was made to the Planned Parenthood Association of New Brunswick.

The organization of the Quebec Ministry of Social Affairs in 1976 was not structured on the basis of specialized programs. In conjunction with six senior professionals, one staff member had the designated responsibility for the review of family planning programs. While the Ministry had no annual budget specifically allotted to family planning, the Program for Preventive Information in Schools was assigned $122,629 in 1973, $176,000 in 1974, and $256,000 in 1975. A policy developed in 1972 committed the Ministry to finance a quarter of any funds which were granted to community associations from other sources. Amounts above these norms were granted from the second year onward of the operation of the programs. In 1974-75 the Ministry made the following grants for family planning.

Quebec Family Planning Association	$ 72,600
Séréna	27,750
S.O.S. Grossesse	12,500
TOTAL	$112,850

Based on a statement of the Minister of Health in December 1974, the provincial family planning program of the Ministry of Health of Ontario sought to promote comprehensive services in this field by providing financial support to local health agencies. All administrative units were included in the provincial program in 1976, with the interests of local communities and how they saw their needs in this field reflected in the scope of family planning services which were offered. An annual budget for family planning of $2,000,-000 in 1976 was allocated for distribution to local public health agencies. Among the provincial health units, 34 had counselling services and 28 provided some clinical services. Local health units at their discretion either could operate directly these family planning programs or provide financial support for this purpose to non-profit community associations. By 1976 this type of liaison had been established in five areas of Ontario.

A set of guidelines for the development of a family planning program was approved in 1970 in Manitoba. The Manitoba Department of Health and Social Development considered family planning information and counselling as an integral part of the more comprehensive services provided by public health nurses and social workers. Contraceptive devices were distributed, if requested, to low-income individuals through local health units. Where feasible, family planning clinics had been established in local health units. A full-time health educator was employed to arrange training sessions for Departmental personnel. The Department had no designated or separate budget items for its family planning activities. A grant of $15,000 was made in 1975 to the Family Planning Association of Manitoba.

The appointment of a family planning coordinator in the Saskatchewan Department of Public Health was made in March 1974. The provincial government's program in this field was started in the fiscal year 1973-74. At that time an advisory committee was appointed which subsequently tabled its report with policy recommendations for programs in the future. The 1975-76 budget for family planning was $93,120. In addition, the Family Planning Association of Saskatchewan received $25,337 in 1974-75.

The Alberta Minister of Health and Social Development approved a general statement on family planning policy in 1976. It was then estimated that the provincial Department would allocate $250,000 in 1976-77 to continue the family planning projects which had been previously funded by the federal government. The Department's Division of Local Health Services provided, when requested, the services of a medical consultant and a nursing consultant to community groups and agencies. Two community family planning associations were funded for an amount of $49,185 by the province's Preventive Social Services Program.

The Family Planning Program of the British Columbia Department of Health Services and Hospital Insurance had a budget of $100,000 in 1976 of which $20,000 was granted to the Planned Parenthood Association of British Columbia. This support was provided in order that the Association could seek federal funding for its educational and service programs. The Association established and staffed family planning clinics throughout the province whose operating expenses were paid for by the provincial government.

TABLE 15.10

FEDERAL AND PROVINCIAL GOVERNMENT DESIGNATED FAMILY PLANNING EXPENDITURES: 1975-1976*

Branch of Government	Family Planning Expenditures		
	Government Department	Community Agencies	Total
	dollars		
Newfoundland	—	—	—
Prince Edward Island	—	—	—
Nova Scotia	—	10,000	10,000
New Brunswick	—	4,000	4,000
Quebec	256,000	112,850	368,850
Ontario**	2,000,000	—	2,000,000
Manitoba	—	15,000	15,000
Saskatchewan	93,120	25,337	118,457
Alberta	250,000	49,185	299,185
British Columbia	80,000	20,000	100,000
Canada:			
(1) Grants***	668,000	1,750,000	2,418,000
(2) International**** (IDRC)	—	(1,108,798)	(1,108,798)
TOTAL	3,347,120	1,986,372	5,333,492

* Based on information provided by federal and provincial health departments. These sources did not designate the costs of family planning programs which were considered to be integral to other health services' programs (e.g., public health nursing, health promotion).

** Allocated to programs operated by local health units and/or community agencies.

*** Designated expenditures for 1974-75.

**** International Development Research Centre (IDRC) expenditures are excluded from the total as this represents support given to other nations.

The Family Planning Grants Program of the Department of National Health and Welfare was established in May 1972. By April 1976 the staff of this program consisted of 8.5 positions and the program had an operating budget of $668,000. The senior staff of the federal program consisted of a director, a principal program officer, three consultants (nursing, community education, social work), and a resource centre officer. This program provided grants to assist the programs of national and local voluntary associations, universities, and provincial and municipal governments to develop and extend their family planning services. These grants were based on the principle of providing short-term "start-up" funds; the agencies which were supported were expected to obtain ongoing operating funds from provincial governments, philanthropic sources, or fund-raising campaigns.

The grants made under this federal program were in five categories: demonstration, fellowship, research, service, and training. In 1972-73 the program had a budget of $1,150,000, an amount which increased to $1,750,000 in 1974-75. In addition to this designated budget, the federal government

shared in the costs of family planning activities which were paid for under the federal-provincial cost-sharing programs of hospital and medical care insurance. The Department of National Health and Welfare in 1974 circulated 1,207,255 pamphlets on family planning. A total of 1,186,641 of these pamphlets was distributed in 1975. The objectives of the Family Planning Grants Program were:

1. to inform Canadians about the purpose and methods of family planning so that the exercise of free individual choice in this area will be based on adequate knowledge,
2. to promote the training of health and welfare professionals and other staff involved in family planning services,
3. to promote relevant research in family planning, including population studies,
4. to aid family planning programs operating under public and voluntary auspices through federal grants-in-aid and joint federal-provincial shared-cost programs.

The training and research grants program of the Department of National Health and Welfare is intended to advance the concepts of family planning.

There is no specific administrative division in the Department dealing with abortion. The reasons for this apparent deficiency may not appear clear initially; however, a review of the departmental position would serve to point out the "raison d'être". There is a full-time physician who maintains familiarity with current issues and problems and public reaction to the functions of existing abortion programs. In addition, statistical information on abortion is kept on file and up-to-date.

The Federal Government does not regard therapeutic abortion as an acceptable method of birth control. It does, however, support the concept of family planning whereby a couple may decide, according to their own beliefs and consciences, whether they want to use family planning methods to prevent unwanted pregnancies. To this end, the Department has a Family Planning Directorate, and supports a program directed to advancing the concepts of family planning practices in the general population across Canada.

The Federal Government recognizes that unwanted pregnancies may occur as a result of failure to abide by good family planning practices. In these situations, the pregnancy may have given rise to a condition which, in the opinion of a therapeutic abortion committee of an accredited or approved hospital, provides appropriate reasons for termination of the pregnancy in accordance with the terms of Section 251 of the Criminal Code regarding abortion.

As a health matter, abortion comes under provincial jurisdiction. The administation and operation of such programs and their implementation are responsibilities of the provinces. It should be added that the decision to establish or not establish a therapeutic abortion committee in an individual hospital is left to the discretion of the board of that hospital and the authorities of the province in which the hospital is located. This may explain, in part, the unevenness in distribution of hospital facilities for therapeutic abortion.

> The Health Insurance Directorate, Department of National Health and Welfare, receives requests from the provinces for shared medical costs under the terms of the Hospital Insurance and Diagnostic Services and Medical Care Acts. The charges for therapeutic abortions, when considered by a province to be a required medical service, would come, among others, under the terms of the shared Federal-Provincial Health Insurance Program. To date, all provinces consider therapeutic abortion as a required medical service. Under these circumstances, and considering the Departmental role, as described, it is not considered that there is any immediate need for a separate division of the Health Department to become involved solely in the subject of therapeutic abortion.

The review of grants which were made between 1972 and 1975 under the Family Planning Grants Program indicates that of a total of $4,029,203 disbursed during this period, $62,428, or 1.6 percent, dealt directly with three projects involving demonstration services for or research on induced abortion. One demonstration project which was funded at a university-affiliated teaching hospital was intended to assess the impact of professional counselling on the prevention of unwanted pregnancies. Two other projects dealt with the counselling or the follow-up of women who had induced abortions. From August 1973 to August 1974 the Department of National Health and Welfare received 204 requests for information on abortion, a number which dropped to 125 requests in 1975.

Two national voluntary associations, the Planned Parenthood Federation of Canada and Service de Régulation des Naissances (Séréna), were awarded the largest portion of the funds available under the Family Planning Grants Program. Between 1972 and 1975 these two national associations accounted for 50.6 percent of the federal program's funds, a proportion which declined from 58.4 percent in 1972-73 to 44.6 percent in 1974-75. The funds assigned to other national associations were $45,956 between 1972 and 1975, or 1.1 percent of the available funds. These two major national voluntary associations used the federal funds to establish and maintain their national headquarters and assigned funds obtained from the federal government to support the work of affiliated provincial and local programs. The two associations prepared annual reports which documented their services and expenditures. Much of their work during these years was contingent upon federal support. While extensive educational and counselling services were provided by these associations, little is known beyond the actual listing of these services about their immediate or long-range impact on the public whom they were intended to serve. There has been no independent audit of their public impact, nor is it apparent once the short-term federal funding has served its start-up function where replacement funding will be obtained.

Based on the findings of the national population survey and the national patient survey done for this inquiry, the services provided by these national agencies and their provincial affiliates had had little direct impact on the public. Their services had not been extensively used in terms of the total population to obtain information about family planning and contraception, or for advice and referral for abortion. This problem is not unique as it concerns the work of these two assocations. It poses the question faced by other public

programs of what is to be expected, how much, and over what length of time from designated public expenditures.

The remainder of the budget of the Family Planning Grants Program which had not been assigned to national associations was used to support a range of grant applications which were funded on a competitive review basis. In terms of regional averages involving the number of applications which had been approved, or rejected/withdrawn between 1972 and 1975, the craftsmanship in the preparation and the seeking of these grants was more effective in some parts of the country than in others. Of a total of 185 formal applications between 1972 and 1975, 57.3 percent were approved. The remainder were either rejected or withdrawn. Among the 10 provinces and two territories, the percentages of approved grants to all applications which had been submitted were: Yukon and the Northwest Territories, 0.0 percent; Saskatchewan, 33.3 percent; and Quebec, 34.9 percent. A larger proportion of applications for family planning projects had been approved for British Columbia (70.0 percent), Alberta (65.9 percent), Ontario (65.3 percent), and New Brunswick (63.6 percent).

Calculated on the basis of the 1974 population of Canada, **the average per capita amount of 9 cents for family planning grants involving competitively reviewed applications had been funded by the Department of National Health and Welfare between 1972 and 1975.** The amounts of grants on a per capita basis among the provinces were: 5 cents, Newfoundland; 14 cents, Prince Edward Island; 7 cents, Nova Scotia; 16 cents, New Brunswick; 8 cents, Quebec; 7 cents, Ontario; 9 cents, Manitoba; 9 cents, Saskatchewan; 18 cents, Alberta; 9 cents, British Columbia; and none, Yukon and the Northwest Territories.

TABLE 15.11

DISTRIBUTION OF FAMILY PLANNING GRANTS PROGRAM INVOLVING COMPETITIVE REVIEW OF APPLICATIONS 1972-1975*

DEPARTMENT OF NATIONAL HEALTH AND WELFARE

Province or Territory	Competitively Judged Grants			
	Approved Applications	Rejected/ Withdrawn Applications	Percent Approved Applications	Per Capita Dollar Amount Approved**
Newfoundland	2	2	50.0	5 cents
Prince Edward Island	1	1	50.0	14 cents
Nova Scotia	5	4	55.6	7 cents
New Brunswick	7	4	63.6	16 cents
Quebec	8	15	34.9	8 cents
Ontario	32	17	65.3	7 cents
Manitoba	5	4	55.6	9 cents
Saskatchewan	5	10	33.3	9 cents
Alberta	27	14	65.9	18 cents
British Columbia	14	6	70.0	9 cents
Yukon, Northwest Territories	0	2	0.0	0 cents
CANADA	106	79	57.3	9 cents

* Social Service Programs Branch, Department of National Health and Welfare, Ottawa, December 1975. Support for national associations is excluded.

** Calculated on the basis of 1974 provincial population listing.

In its terms of reference and its objectives, the federal Family Planning Grants Program excludes abortion from its definition of family planning. In its work the Committee became aware of two sides of this situation. On the one hand, the virtual absence of federally supported projects which dealt directly with induced abortion resulted in part from the fact that there were relatively few projects dealing with this topic which had been submitted for review and potential funding. Between 1969 and 1975, 3 out of 7 submissions dealing directly with some aspect of induced abortion were funded. On the other hand, it was apparent that in its definition of family planning and how the operation of the federal program was seen by some professionals and agencies across Canada, applications dealing with induced abortion were not seen to have been encouraged.

On its site visits to hospitals across the country and in its meetings with experienced investigators, the Committee found there was considerable dissatisfaction that there was so little public support for demonstration programs and research dealing with induced abortion. Most of the provinces did not have a health grants research program. The Medical Research Council of Canada which provides support for basic medical research and graduate training fellowships had not received nor had it funded any projects dealing directly with induced abortion. This issue had not been supported by Canadian philanthropic foundations. In accord with its mandate, the federal Family Planning Grants Program was seen by many capable researchers as not dealing with induced abortion.

Several examples were cited to the Committee by researchers who said that they had been asked, if their projects dealt with induced abortion, to revise their submissions to granting sources. It was also alleged that senior civil servants were often put in a difficult position. If they became interested or developed competence in the field of induced abortion, they were likely to be re-assigned to other posts. As a result of the sensitive nature of the issue, it was asserted that the support which was given by federal and provincial agencies was allocated to socially safe stand-by services which did not deal directly with demonstration programs and research involving induced abortion or with the basic issues in family planning. These programs, it was suggested, had effectively pre-empted the field. For these several reasons the existing funding programs had little respect among many experienced researchers.

One senior researcher with an established international reputation and who had obtained a number of sizeable research grants observed to the Committee: "The situation for research and effective demonstration programs is a closed shop in Canada. If support for relevant work is to be obtained, the funding has to come from outside the country." This observer further noted: "It is easy to turn down grant applications on the basis that they are methodologically unsound. But until competence is built up, it is difficult to see how this can be otherwise. And competent researchers will not submit applications, because they know they have no chance of being funded."

In addition to monies made available under the Family Planning Grants Program of the Department of National Health and Welfare, $3,824,727 was funded for 22 international projects between September 1971 and March 1976 by the International Development Research Centre (IDRC). As part of

Canada's foreign aid program, these projects dealt directly with different aspects of family planning, abortion, and fertility regulation in 13 nations (Colombia, 1; Dominica, 1; Egypt, 3; India, 1; Mali, 1; Mexico, 2; Nigeria, 1; Philippines, 2; Singapore, 2; Thailand, 2; United States, Population Council, 2; West Indies, 1; and West Malaysia, 1). In addition, two grants had been made to the World Health Organization to support that United Nations agency in its work on human reproduction and fertility control. Two grants had been made by IDRC to the Canadian Committee on Fertility Research (affiliated with the World Health Organization) to develop a scientific advisory committee for the design and implementation of research studies and for the administration of an international collaborative research program on fertility control.

This foreign aid program provided direct financial support and, where appropriate, consultants to family planning programs of national and local health departments, universities, and voluntary agencies in these nations. Among the projects supported by the IDRC were:

- development of a national family planning program;
- assessment of the costs resulting from the use of different contraceptive means and from their long-term use;
- health promotion programs for fertility regulation;
- the effectiveness of different types of health workers and laymen in maternal and child health programs and family planning programs;
- the development of designated research centres for fertility research;
- epidemiological research on the extent of induced abortions;
- research on the social, clinical, and pathological factors involved in subfertility and infertility;
- study of the morbidity and mortality rates associated with early induced abortion;
- the impact of abortion on mothers and the family unit;
- the morbidity and mortality rates and the side effects of tubal ligation;
- the clinical trials of the use and effectiveness of various contraceptive means;
- the production of films on different aspects of family planning;
- the establishment of clinics and training programs in family planning.

While this exemplary foreign aid program provided assistance to other nations to develop training and research centres, to support demonstration projects, and to provide a broad range of research inquiries dealing with family planning, including abortion, for most of the topics for which foreign aid was given there were no comparable programs in Canada. Repeatedly in its work the Committee was told by experts about service programs or research which had been done abroad, but seldom about comparable work in Canada. If such studies were available dealing with the Canadian experience, they dealt with a small number of individuals or represented special circumstances. This point was verified by the search of the available research literature dealing with

family planning, the use of contraception, or induced abortion involving Canadians. Many of these reports were general statements, often having a charged intent. There were few studies which fully merited the designation of well undertaken scientific inquiries in terms of the research methods which had been used.

In its work abroad Canada has helped to initiate on a cooperative basis with other nations the components of a comprehensive family planning program. This endeavour stands in sharp contrast to the efforts in these respects which have been undertaken in this country. The work of this inquiry would have been facilitated at every stage had similar information been available dealing with family planning and abortion for which Canada has given assistance to other nations. **The research work to date in Canada has been fragmentary; most of the relevant questions have not been studied.**

Allocation of expenditures

The review of health costs and expenditures associated with pregnancy, family planning, and abortion provides an overview of general trends. Not all of the sources of the information on these points are complete. In the case of women who obtained induced abortions, no cost estimates were made for individuals who obtained abortions from illegal sources or the costs associated with room and board and transportation when this operation was obtained out of the country. Likewise, in the calculation of the costs involved in childbirth, only the immediate expenditures were considered. No estimates for instance were made of the subsequent health costs which might be incurred or the costs resulting from specialized post-natal care. Because health accounting procedures vary, only the expenditures which were directly designated for family planning activities by government were listed. It was not fully known how much money was spent directly by individuals or voluntary community associations on these activities. It is within the context of these reservations that the general trends in the expenditures on family planning and induced abortion are considered.

From what is known about the expenditures on childbirth, family planning, and abortion, **more money from the public purse was spent on providing treatment services and facilities for abortion patients than on the public effort to undertake effective preventive measures. In the broad terms of per capita expenditures it was estimated that $0.58 was spent by each Canadian in 1974 to pay for the costs of therapeutic abortions and $1.61 for the immediate costs associated with normal childbirth. At the same time from designated expenditures, $0.24 was spent on federal and provincial family planning measures.**

The dilemma of providing a balance in expenditures and effort between treatment services and preventive measures has been long known. All too often, because the former presents an immediate problem which has to be resolved, it receives most of the public attention and garners most of the available resources. This has been the case in the distribution of public resources and expenditures for induced abortion. Most of the public funds have been allocat-

ed to provide treatment services for these patients, while considerably less public support has been turned to the reduction of unwanted pregnancies.

In *A New Perspective on the Health of Canadians: A Working Document*, a series of national health priorities were set for the future. This document recognized the complex interplay between social forces, the distribution of disease, and the life styles of individuals. On the point of establishing a balance between treatment and prevention services, this document observed:

> One point on which no quarter can be given is that difficulties in categorizing the contributing factors to a given health problem are no excuse for putting the problem aside; the problem does not disappear because of the difficulties in fitting it nicely into a conceptual framework.
>
> ...if the incidence of sickness can be reduced by prevention, then the cost of present services will go down, or at least the rate of increase will diminish. This will make money available to extend health insurance to more and more services and to provide needed facilities, such as ambulatory care centres and extended care institutions. To a considerable extent, therefore, the increased availability of health care services to Canadians depends upon the success that can be achieved in preventing illness through measures taken in human biology, environment and life style.[11]

These observations are relevant to the issue of therapeutic abortion. Its current prevalence is not likely to disappear by itself or to be reduced in the absence of public measures. **There is an imbalance between the expenditures and effort in this field. The resources which are devoted to its treatment in no way are matched by comparable public support for programs mounted for its prevention. As long as this situation involving induced abortion persists, there is little likelihood that there will be a reduction in its volume or its costs.**

[11] Hon. Marc Lalonde, *A New Perspective on the Health of Canadians: A Working Document* (Ottawa: Government of Canada, April 1974), pp. 36-37.

Appendices