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RE-MINDING OUR Ps AND Qs: MEDICAL COST CONTROLS IN CANADA

by Morris L. Barer, Jonathan Lomas, and Claudia Sanmartin

Prologue: Canada and the United States, neighboring countries whose health care systems have diverged over the past two decades, share with other industrialized nations a basic dilemma: how to accommodate the conflict between insatiable demands for health care and limited resources to pay for it. The United States is moving down a road that largely favors the allocation of these limited resources through market principles. By contrast, Canada, which provides universal coverage to its population through provincially based health insurance, is moving to place tighter constraints on the growth of health care spending through government-imposed expenditure caps that take a variety of forms. In this paper Morris Barer, Jonathan Lomas, and Claudia Sunmartin discuss the current policies that Canada’s provinces and territories are employing to control medical spending. Among the effects of these policies is growing friction among physicians amid the “zero-sum” nature of global expenditure caps and growing professional interest in controlling the supply of new doctors. All three authors are students of and two of them (Barer and Lomas) consultants to various provincial health insurance programs. Barer, an economist, is a professor in the Department of Health Care and Epidemiology at the University of British Columbia and director of its Centre for Health Services and Policy Research. Lomas trained in psychology at Oxford University and the University of Western Ontario but has experience on a wide variety of health policy issues upon which he has consulted with federal and provincial health ministries. He is a professor in the Department of Clinical Epidemiology and Biostatistics at McMaster University (Hamilton, Ontario). Sunmartin is a doctoral candidate at the University of British Columbia and is undertaking research on surgical wait lists within the Canadian system.
Abstract: During the past few years the landscape of Canadian physician reimbursement policy has undergone dramatic change. Rapidly eroding fiscal environments for provincial (and federal) governments have forced provinces to “get serious” about controlling a significant, previously uncontrolled, budget line: physician expenditures. All provinces now impose medical expenditure caps, with eight of these being hard caps under which any overruns are the responsibility of the profession. In addition, policies in five provinces now include individual income caps. One of the effects of this new environment has been a rush to adopt supply-control policies. This paper explores a number of other side effects, such as heightened interest in alternative methods of payment, as well as the emergence of, and difficulties for, joint province/medical association management committees.

The landscape of physician reimbursement policy in Canada has changed dramatically over the past decade. The changes have been driven in large measure by the rapidly eroding fiscal fortunes of the provinces and the Canadian federal government. The changes that were beginning to emerge in the late 1980s portended a provincial stampede to expenditure controls. At that time some Canadian provinces were beginning to go beyond negotiations over fee levels in their efforts to gain control over health care spending. In particular, mechanisms for partial expenditure control, involving the feedback of utilization changes in excess of negotiated targets back onto fee levels, were being introduced in a few provinces.

The stampede to expenditure controls was precipitated largely by a revenue crisis for Canadian provincial governments, brought on by slower economic growth and cutbacks in federal transfer payments to the provinces because of the federal debt load. Those responsible for health care spending have come under pressure to adapt to the new reality, quickly. Historically, fee-for-service physician expenditures have been one of the two largest open-ended financial “lines” in most provincial budgets (the other being the cost of servicing their debt). This has created a heightened urgency in the search for the holy grail of medical care cost control.

In this paper we revisit the issues raised by Jonathan Lomas and colleagues in Health Affairs, Spring 1989. Our purposes in so doing are threefold. First, we review current policies to control medical care spending in Canada’s provinces and territories. Second, we analyze some of the parallel policy changes and consequences associated with these policies. Third, we focus on one side effect of these policies: the emergence of comanagement structures involving governments and provincial medical associations as vehicles for overseeing the reimbursement control policies, but also for addressing other areas of medical (and even health) policy. Finally, based on these analyses, we extract updated lessons from Canada.

A ‘How-To’ Guide To Physician Services Cost Control

In the earlier days of Canadian Medicare, negotiations between provin-
cial Ministries of Health and medical associations focused largely on fees. Provinces either were not particularly concerned about overall physician costs or felt that they could exercise the necessary control through this single instrument. During the 1980s' as their fiscal situations deteriorated and they realized that fee controls were not synonymous with cost control, the provinces diversified their policy arsenals.

Exhibit 1 provides a useful analytic framework to evaluate the likely effects of different packages of cost control policies. Physician service expenditures are, by definition, equal to the product of three different sets of variables. Thus, the set of policy instruments through which governments can influence physician expenditures is exhaustively represented by the terms of each of these sets. For example, expenditures will be controlled only with a policy governing both fees and services per capita, or both physician supply and physicians’ average incomes, simultaneously.

The failure of fee control policies, in isolation, led some provinces to develop companion policies that were intended to control individual physicians’ incomes or physician supply. As recently as seven years ago no province had taken the steps necessary to control expenditures per capita.

A provincial government interested only in predictable and/or contained physician service expenditures simply has to determine a budget; arrange mechanisms to ensure that administrators of the public insurance plan remain within the budget; and let incomes, fees, and physician supply fall where they may. This constitutes a “pure” expenditure cap. Although no province has been quite so single-minded, the predominant concern among provincial/territorial Ministries of Health has been total expenditure predictability and/or control. Companion issues such as physician supply or interspecialty and intergenerational income redistribution, which

<table>
<thead>
<tr>
<th>Exhibit 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Control Options</td>
</tr>
</tbody>
</table>

Expenditures per capita =

Income per physician × Physicians per capita

Services per physician × Price per service × Physicians per capita

Services per capita × Price per service × Physicians per capita
bear on the variables in Exhibit 1 through which such control must play out, or derivative administrative issues such as utilization monitoring systems, fee feedback mechanisms, and overseer structures have received rather sporadic attention to date in most jurisdictions. This lack of attention to how cost control might be exercised, and the administrative mechanisms necessary to make it work, has created a number of side effects.

Some of the side effects of expenditure caps, such as the medical profession’s interest in supply control, were possible to predict. Others, such as physicians’ greatly heightened interest in other forms of remuneration and some of the frictions created within the profession, were less immediately predictable. In any case, provinces’ ability to foresee and plan for such consequences was compromised by the rapidity with which expenditure caps were introduced. This gave rise to reactive, sequential policy development rather than to a thoughtful, comprehensive “from first principles” policy package hammered out between the affected parties. This pace of change has meant relatively little interprovincial learning and exchange; numerous variants have emerged on the central theme of expenditure caps.

**Current Policies To Control Spending**

Here we describe the core elements of expenditure cap policies as of late 1995. We then review the related developments and side effects.

**Expenditure caps in the provinces.** Expenditure caps can be either “hard,” (implying that any costs in excess of such caps are to be fully recouped from physicians) or “soft” (implying that responsibility for cost overruns is shared between ministries and either the profession collectively or individual physicians). All of the provinces are now imposing expenditure caps of one sort or another (Exhibit 2). As of fall 1995 only the two territories were without a hard or a soft cap. Furthermore, eight of the ten provinces are operating under agreements that incorporate hard caps. Such hard caps, if enforced religiously and set at levels that do in fact represent “control,” are sufficient to control expenditures. Even if the level of the caps causes some to question whether they really represent control of costs, they at least reduce budgetary uncertainty. As shown in Exhibit 1, caps are most directly administered by adjusting fee levels in response to utilization volume and mix that result in expenditure targets’ being exceeded.

Whether a hard cap will control costs is, of course, critically dependent on the level at which the cap is set. This determination varies across provinces. Some provinces estimate the effects of population growth and demographic changes, while others such as New Brunswick and Prince Edward Island make explicit allowance for new physicians. Other factors include new technology, underserved areas, general public-sector wage
<table>
<thead>
<tr>
<th>Province</th>
<th>Type of cap</th>
<th>Factors in determining cap</th>
<th>Method of recouping overruns</th>
<th>Formal method of dispute resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>Soft/hard</td>
<td>Fee increases</td>
<td>Anticipatory across-the-board fee proration</td>
<td>Binding arbitration (1997)</td>
</tr>
<tr>
<td>Alberta</td>
<td>Hard</td>
<td>Fiscal targets</td>
<td>Retrospective fee proration if fee stabilization fund exhausted</td>
<td>Expedited arbitration for value of initiatives intended to achieve savings, or “issue of good faith”</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>Soft</td>
<td>Volume of service increases in excess of 1 percent year-over-year; new service items</td>
<td>Retrospective fee proration</td>
<td>Medical compensation review committee</td>
</tr>
<tr>
<td>Manitoba</td>
<td>Soft</td>
<td>Nothing formal</td>
<td>Retrospective selective fee proration</td>
<td>Manitoba Medical Services Council (with representation from profession and college) recommendations to Ministry of Health</td>
</tr>
<tr>
<td>Ontario</td>
<td>Hard</td>
<td>Under new legislation, may be set unilaterally by minister of health</td>
<td>Retrospective fee proration</td>
<td>Under new legislation, government will have unilateral authority</td>
</tr>
<tr>
<td>Quebec</td>
<td>Hard</td>
<td>Global expenditures for Ministry of Health</td>
<td>Currently under discussion</td>
<td>None</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>Hard</td>
<td>New physicians Negotiated fees New services</td>
<td>Anticipatory across-the-board fee proration</td>
<td>None</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>Hard</td>
<td>Fiscal targets</td>
<td>Retrospective across-the-board fee proration</td>
<td>Joint management committee; arbitration by mutual agreement</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>Hard</td>
<td>Population Demographics New services New physicians</td>
<td>Anticipatory across-the-board fee proration</td>
<td>Joint negotiating committee; no formal dispute resolution mechanisms</td>
</tr>
<tr>
<td>Newfoundland</td>
<td>Hard</td>
<td>Population growth and aging Approved changes in physician supply New technology</td>
<td>Anticipatory across-the-board fee proration</td>
<td>None</td>
</tr>
</tbody>
</table>

Source: Personal communication from provinces and territories.

Note: Yukon and Northwest Territories do not have physician expenditure caps; thus, they are not listed here.
increases, changes in practice overheads, and the like (Exhibit 2). In some provinces (most noticeably Alberta) the cap has been set below the level of previous years, as part of an overall policy package intended not just to control physician spending but to reduce public spending more broadly.

Adjustments are handled in one of two ways (although there are variants on each). In the concurrent or anticipatory adjustment approach, expenditures are tracked throughout the fiscal year, and downward adjustments to effective fee levels are made as necessary to guide the expenditure missile to its target. A final reconciliation takes place after all claims have been submitted and processed. In the retrospective adjustment approach, such as that in Saskatchewan, if a cap is exceeded, a downward adjustment is made to fee levels in the next period, or until the overrun is recouped. In either case, the challenges these pose to accounting and information systems are not trivial.

Related developments and side effects. The “zero-sum” nature of global expenditure caps clearly focuses practicing physicians’ attention on “the medical commons.”\textsuperscript{10} It is not surprising that expenditure caps have spawned, with the tacit approval of the established medical profession or even at its request, more widespread physician supply control policies (Exhibit 3).\textsuperscript{11} Those coming under the microscope have been recent and impending medical school graduates and colleagues trained outside Canada. All of these potential new income claimants represent threats to the incomes of the established profession under any global cap that is set at a level that does not explicitly factor in changes in physician supply.

Physician supply control. Supply control policies appear to fall into four generic groups: differential fees; billing number restrictions; special policies to deal with graduates of foreign medical schools; and adjustments to medical school enrollment. The first set of policies attempts to control physician supply through “indirect discouragement” by paying new physicians at some proportion of negotiated fees (for example, 50 percent for new physicians without hospital privileges in Prince Edward Island), presumably in the hope that fewer will decide to practice in the province.\textsuperscript{12} This has the predictable effect of doing nothing more than redistributing costs among the provinces, without any national coordination, since most of these physicians will choose to practice somewhere in Canada.

The second and third sets of policies address the supply problem rather more directly, by simply refusing access to public plan payment for new physicians (for example, Ontario, for physicians who were trained outside the province; Saskatchewan, for non-Canadian physicians).\textsuperscript{13} The final set of policies must be distinguished from the first three, because they can be expected to have no immediate effect on expenditures. Ontario and Alberta medical schools, for example, have recently reduced their numbers of
### Exhibit 3

**Physician Supply Control Policies In Canada, By Province Or Territory, 1995**

<table>
<thead>
<tr>
<th>Province</th>
<th>Policy</th>
<th>Overseen by</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>50 percent fees for new physicians</td>
<td>Tripartite Ministry of Health/medical association/public commission</td>
</tr>
<tr>
<td>Alberta</td>
<td>None</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>Restrictions on foreign-trained physicians</td>
<td>Joint Ministry/profession management plan</td>
</tr>
<tr>
<td></td>
<td>Comprehensive Physician Resource Plan may be implemented, although not part of current agreement</td>
<td></td>
</tr>
<tr>
<td>Manitoba</td>
<td>Temporary restrictions/conditions governing access to new billing numbers</td>
<td>Joint Ministry/medical association, Physician Resource Committee</td>
</tr>
<tr>
<td>Ontario</td>
<td>Restrictions on new billing numbers Ontario graduates exempted until March 1996; under new legislation, policy discretion rests with minister of health</td>
<td>Was Joint Ministry/medical association Management Committee; currently unilateral authority resides with minister of health</td>
</tr>
<tr>
<td>Quebec</td>
<td>Recruiting to abide by approved regional plans Retirement program for specialists over age sixtyfive</td>
<td>Ministry of Health and regional boards</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>Restrictions on new billing numbers in geographic areas exceeding targets Requires hospital privileges</td>
<td>Minister’s Advisory Committee</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>New billing numbers only in areas of need Billing number buyout option for physicians age seventy-one or older, and for physicians in oversupplied areas</td>
<td>Joint department/medical society management committee</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>50 percent fees for new physicians without hospital privileges</td>
<td>Tripartite Physician Resource Planning Committee</td>
</tr>
<tr>
<td>Newfoundland</td>
<td>50 percent fees for general practitioners who commence new practices in designated areas of oversupply</td>
<td>Physician Resource Advisory Committee</td>
</tr>
<tr>
<td>Yukon</td>
<td>50 percent fees for new physicians unless need-based exemption</td>
<td>Joint government/medical association Physician Resource Management Committee</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**Source:** Personal communication from provinces and territories.

**Note:** Policies described in this exhibit do not include recent reductions in first-year medical school enrollment.

First-year students. This may be the most important long-term expenditure control policy, but its effects likely will be felt after a considerable time lag.

Supply control policies have become pervasive—only in the Northwest Territories is some form of supply control absent. As shown in Exhibit 3, three provinces and one territory impose differential (reduced) fees on new
entrants, while five provinces have implemented some form of restricted “billing number” policy, whereby the province applies a stringent set of selection criteria before granting new rights to submit claims to the province’s medical insurance plan. Yet despite the best intentions of the ministers of health in declaring their commitment to a national physician resource strategy, in reality provinces have pretty much done their own thing to keep others’ graduates from their borders. 

*Individual income.* Under a global cap, the eating habits of one’s colleagues have direct consequences for one’s own financial nourishment. Four provinces have joined Quebec since 1989 in implementing some form of soft individual physician income cap (and Quebec has moved on to introduce a hard individual income cap) (Exhibit 4). This slows the pace at which the expenditure juggernaut moves toward the global expenditure cap by selectively penalizing physicians with the highest incomes. The way in which these individual income caps are set, and what happens when they are exceeded, again varies considerably across the provinces (Exhibit 4). For example, in Newfoundland, once a general practitioner has been paid $300,000 (Canadian) in any fiscal year, the next $50,000 in claims are reimbursed at sixty-seven cents on the dollar, and claims in excess even of that level are paid at one-third their face value. Similar arrangements, but

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**Exhibit 4**

**Individual Physician Income Threshold/Cap Policies In Canada, By Province Or Territory, 1995**

<table>
<thead>
<tr>
<th>Province</th>
<th>Policy in place</th>
<th>Method of adjustment for overruns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontario</td>
<td>67 percent of fees after $404,000</td>
<td>33 percent of fees after $454,000</td>
</tr>
<tr>
<td>Quebec</td>
<td>Trimestrial for GPs</td>
<td>25 percent of fees after trimestrial cap (GPs)</td>
</tr>
<tr>
<td></td>
<td>Annual for specialists</td>
<td>Annual hard cap of $300,000 (specialists)</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>Sliding fee schedule related to level of gross billings</td>
<td>About 88 percent of fees above $140,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>75 percent of fees above $400,000 (all physicians)</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>Separate thresholds for GPs and specialists</td>
<td>75 percent of fees for first $25,000 in excess of 1.75 times mean income</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50 percent of fees for next $25,000 in excess</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25 percent of fees for balance</td>
</tr>
<tr>
<td>Newfoundland</td>
<td>67 percent of fees above $300,000 (GPs)</td>
<td>33 percent of fees above $350,000 (GPs)</td>
</tr>
<tr>
<td></td>
<td>67 percent of fees above $400,000 (specialists)</td>
<td>33 percent of fees above $450,000 (specialists)</td>
</tr>
</tbody>
</table>

*Source:* Personal communication from provinces and territories.  
*Notes:* All figures are in Canadian dollars. The 1993 gross domestic product (GDP) purchasing power parity for Canada was 1.25, and the current (end of 1995) exchange rate is about 1.37. GPs are general practitioners. The only provinces shown here are those with a policy in place.
with different cap levels, apply to specialists in that province.

Relative incomes and fees. Nowhere is the administrative challenge posed by global expenditure caps more evident than in the complications and intraprofessional conflicts created when a cap is exceeded. The most common form of adjustment for overruns has been by an across-the-board percentage reduction of fees ("clawbacks") in the subsequent period. This creates an inequitable distribution of the "income pain" across different types of physicians. For example, the low-volume but "good-practice" family doctor suffers disproportionately relative to the high-volume procedural specialist, for two reasons. First, the procedural specialist may be better able to respond to a fixed-cap environment through increased utilization. Second, while the clawbacks are proportional, they will differentially affect the lower-income practitioners for whom fixed practice expenses represent a much larger share of gross revenues.\(^\text{15}\)

On the fee side, global expenditure caps have induced heightened interest, within some factions of the medical profession, in remediation of long-standing perceived inequities in fees through variations on resource-based relative value scale (RBRVS) processes.\(^\text{16}\) Although the issue of relative fees long predates the recent rush to global caps, such caps force the issue because relative inequities in fees per unit of effort or time can create "multiplier effects" in the differential impact across specialties.\(^\text{17}\)

Overseeing and monitoring. The need to negotiate the details of such consequences of global expenditure caps as clawback mechanisms was one of the motivations for establishing ongoing comanagement structures involving the medical profession and the government. In many provinces these structures were a "concession" granted to the profession to "compensate" them for the imposition of a global expenditure cap. More pragmatically, these structures provided a mechanism for monitoring and responding to payment and policy issues generated by the imposition of the cap. We describe some of the broader policy issues below.

The rapidity with which expenditure caps were introduced created another side effect. Few payment processing and information systems were capable of providing the information within a time frame necessary for the negotiated concurrent fee adjustments. Thus, many negotiated concurrent feedback mechanisms, which would have provided ongoing information to the profession as a fiscal year progressed, became retrospective clawbacks—a source of tension between the profession and the provincial governments and a source of frustration within medical associations (and even within Ministries of Health).

**Unforeseen side effects.** Given sufficient time, the parties might have been able to adjust to such side effects as the information system shortcomings, which were, after all, predictable. Less predictable, however, were the
pressures generated by the process for the internal integrity of the medical associations, the emergence (accelerated in some provinces) of interest in some forms of alternative remuneration, and the joint interest in removing certain services from the public medical insurance plans.

Medical association integrity. The joint management structures have created political difficulties for the medical associations, which have had to develop internal accountability mechanisms between existing executive structures, the general membership, and the newly created joint management structures. Consequently, these latter often have been left with neither a clear mandate to negotiate over critical issues nor a clear pathway through which to ratify or discuss such issues.

Furthermore, the medical associations have found themselves in the intractable position of having to put the best possible face on the results of negotiations, which often translated into clawbacks or otherwise reduced incomes for their membership. Perhaps this explains some of the rush to obtain the RAND formula in advance of entering into global expenditure caps. This formula is a Canadian Supreme Court judgment that decrees mandatory payment of association or union dues because all members may profit from the bargaining activities of the union or association. Of course, the RAND formula has tended to exacerbate dissatisfaction among already disgruntled members of the medical profession.

Alternative remuneration. Global expenditure caps on fee-for-service practice induced a rush of interest from within the medical profession in alternative payment mechanisms such as sessional fees in low-volume emergency rooms, salaries for academic faculty, and capitation for primary care physicians. Unfortunately, the global expenditure caps have tended to entrench or insulate a pool of fee-for-service funds. The medical profession, of course, wished funds for alternative payment mechanisms to be add-ons. Not surprisingly, Ministries of Health insisted that such funds be extracted from the fee-for-service pool (anything else would have made a mockery of the notion of a global cap). Joint management structures became the sites where this battle was fought. It has generally ended in stalemates, to the frustration both of Ministries of Health and physicians genuinely interested in alternative payment mechanisms.

Scaling back coverage. Finally, in many provinces there has been heightened interest in identifying services that could be removed from public coverage. This is in the interest of the profession because it provides an avenue whereby physicians can increase incomes by providing services not governed by the cap and now reimbursed through other means (by private insurance or out of pocket). For example, in Ontario the medical profession advocated, unsuccessfully, for the removal of annual physical examinations. Unlike the case of alternative payments, deinsuring services gener-
ates no additional cost for the public plan and, in fact, increases the space in the insulated fee-for-service pool for additional services. In addition, it offers a rare opportunity for Ministries of Health and the medical profession to make common cause.

Although the process of removing coverage for certain services is straightforward, there may not be much mileage in such initiatives, because attempting to deinsure any significant number of services would run a province fairly quickly up against the terms and conditions of the Canada Health Act. The items that are being removed in most provinces represent a very small proportion of total expenditures, at least to date.

The Rush To Joint Management Structures

Since the 1989 paper there has been a stampede to set up joint province/medical association management committees, in part a side effect of the need to oversee, monitor, and manage issues associated with global expenditure caps. However, there is a fundamental contradiction inherent in the roles of the two parties that has led to some inevitable frictions in some provinces. Provincial/territorial governments are largely interested in controlling expenditures; medical associations are interested in protecting (and enhancing) incomes and ensuring that the profession has a hand in any policy changes that might affect the work environments and professional relationships of their members.

Basic tasks. These structures are intended as the vehicles through which details of expenditure caps are negotiated and implemented. But they are also generally given three other management tasks and a general medical (and sometimes health) policy mandate. The management tasks involve developing physician supply policies (to reduce or control “physicians per capita”); investigating fee items that might be removed from coverage (to reduce publicly funded “services per capita”); and identifying mechanisms to influence practice patterns (“services per physician”) so as to reduce the rate of increase in utilization. Each of these is intended to make the effects of global caps less painful for practicing physicians.

For example, the supply control policy in Ontario, which effectively excluded the entry of new physicians trained outside the province, was a product of Joint Management Committee (JMC) negotiations in a context of provincewide cutbacks in social programs and a provincial determination to stay the course with a hard global cap. Another focus of Ontario’s JMC was services required by “third parties” (for example, insurance or summer camp requirements). These became uncovered benefits, payable by the consumer or the requesting agency, rather than by Ontario’s Health Insurance Plan. The process of removing other services from the provincial plan
was initiated by the JMC. The government and the Ontario Medical Association (OMA) also agreed to measures to identify and prosecute fraudulent use of health cards. This committee even became involved in a community health framework and the use of allied health personnel, and on some of these broader matters the profession negotiated a “right of veto.” However, this joint management process came to a grinding halt during summer 1995, hung up over the system of clawbacks to be used for recovery of 1994-1995 cost overruns, and in light of the proposed new legislation in Ontario, such a structure seems unlikely to reemerge any time soon.

Although the structural details of and the specific activities undertaken by these structures vary across the provinces and territories, the general objectives of the key parties do not. The motivations are crystal clear. How successful some of these committees will be in achieving their objectives is less clear. The breakdown in Ontario, one of the first provinces to establish a JMC, suggests that they may not have long-term viability.

**Redistribution of costs.** Beyond the strictly administrative function of determining when overruns (or underruns) have occurred and how to recoup or distribute excess costs (savings), two of the three comanagement tasks clearly are intended to redistribute costs to relieve pressure on global caps. Most of the supply control initiatives that have emerged to date redistribute the costs of global caps from existing physicians to new graduates or entrants to a province (referred to by some as the medical profession’s proclivity to “eat its young”). Similarly, efforts to cover fewer services mean that costs are shifted to patients or third parties. Providers’ incomes are not threatened; indeed, shifting services to the private sector creates an avenue for increasing services, and thereby incomes.

**Provincial versus national physician supply control.** The supply control plank of the comanagement initiatives is an unfortunate undermining of an essential national effort to manage physician resources. Despite the all-province/territory support for such a national initiative, the “deals” that have been cut by some provinces with their medical associations as part of these joint management initiatives have served to erect a series of provincial “tariffs” on the import of externally trained physicians. These are, of course, the antithesis of the spirit of the all-jurisdictional agreement but, even worse, tend to leave all newly trained physicians worse off.

A recent communique suggests that the provinces that have struck these agreements have seen the error of their ways and have agreed to recommit to a national strategy and eliminate their individual protectionist policies as the national strategy evolves. However, we remain somewhat skeptical as to whether this will ever occur in light of the “closer-to-home” imperatives and agreements of the joint management initiatives.

**Practice guidelines.** It is not particularly surprising that these joint
structures have, to date, been least successful in extracting cost reductions through the development of practice guidelines. In this case, there is no third party to whom the costs can be shifted. Cost reductions of this type will have a direct effect on services per physician and, through them, on income per physician. If protocols and guidelines are to have the effect that the provincial Ministries of Health are seeking, they must reduce average physician incomes (Exhibit 1). This is perhaps the most sensitive spot in the uneasy world of comanagement.\textsuperscript{29} Physicians can hardly be against practices that improve the quality of medical care. On the other hand, there is no disguising the fact that the provinces’ objectives in promoting utilization management are based at least in part on a largely unsubstantiated view that such practices can reduce global expenditures.\textsuperscript{30}

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**Do Cost Controls Control Costs?**

Although a detailed evaluation of the effects of the cost control policies in each province is well beyond the scope of this paper, it is worth noting briefly that costs are growing less rapidly in the 1990s in Canada than they did over the previous decade. Also, the full effect of the spread of the global caps is yet to be revealed. In the 1989-1993 period real expenditures per capita increased an average of 0.5 percent annually, down dramatically from the “heady” 4 percent of the previous decade. The most recent two years for which data are available represent the first time that there have been two consecutive years of decline in real expenditures per capita for this sector since the early 1970s) shortly after the last province entered Canadian Medicare. This is, of course, rather cursory and descriptive information, and the global capping policies may under detailed empirical scrutiny turn out not to have had any independent effect on historical trends. Nevertheless, it seems difficult to escape the preliminary impression that the “increasingly constrained environment” is more than just rhetoric,

To date, no in-depth evaluations have been completed of the particular policies enacted in an individual province. We know from previous work from Ontario that the policies in place there during 1983-1990 had no controlling effect on expenditures per physician; physicians were able to increase average billings, despite both an increasingly constrained environment and a declining supply of patients per physician.\textsuperscript{31} But the environment has changed considerably since then.

A more detailed evaluation of the mix of policies that have been enacted in British Columbia is under way.\textsuperscript{32} British Columbia was one of the first provinces to introduce global expenditure caps and was the first province to introduce a billing numbers policy. All of these changes had been introduced by the mid-1980s. Preliminary results suggest that the policy package
did have a dampening effect on expenditure growth in this sector, relative
to that in other provinces that introduced policies somewhat later. This
(admittedly preliminary) evidence suggests that provinces have become
more determined to control the size of the physician services financial
envelope and that they are succeeding. Longer-term success will depend
critically on the early and effective follow-through on the national physi-
cian supply policy sketched out by the ministers of health in Banff in 1992.

Revisiting The Lessons From Canada

We revisit briefly the lessons offered in the 1989 paper. The first, “intro-
duce price and quantity controls at the outset,” is as valid and important
today as it was seven years ago. Fee controls alone will not control expendi-
tures. A slightly revised lesson might be, Make clear your intention to
control overall expenditures, and negotiate over how this will be played out
in the various policy levers in Exhibit 1.

The second lesson was “set prospective rules” governing the size of a cap,
the mechanisms for making adjustments in the event of variances from the
cap (positive or negative)—including mechanisms for determining attribu-
tion for such variances—and the mechanisms for dispute resolution. In
1989 very few provinces had negotiated rules governing disputes. Such
mechanisms are now far more commonplace (although as yet not univer-
sal). But as noted earlier, the mechanisms through which these rules would
be implemented have been developed under duress, and information sys-
tems in particular have not generally been up to the task. There has been
very little progress in developing decision rules for attributing expenditure
overruns across causes or to sources of responsibility. This lack of prospec-
tive rules for dealing with cost overruns, particularly as they apply to the
distribution of the pain across different groups of physicians, appears to
have been a key factor in the recent demise of the Ontario JMC.

Lesson number three was to “set up a payer/physician committee.” The
role of these committees, particularly in overseeing the respective party
responsibilities for the expenditure experiences, is equally important today.
However, the early promise of these committees seems unfulfilled in the
utilization management area and, if anything, overfulfilled in the supply
control area. We are not particularly optimistic about the potential and
future course of these joint management structures. One should not down-
play the importance of the fact that the parties bring quite different, often
conflicting, objectives to the table. Unless there are redistributive ways out
of the fundamental conflict between expenditure control and income pres-
ervation, these joint initiatives are unlikely to make significant headway.

Indeed, the existence of hard caps has generated much tension within
medical associations. Not only have they found it exceedingly difficult to develop accountability pathways for the new JMCs, but they also are internally structured largely to distribute “goods” (such as fee increases). They are ill equipped to deal with the task of distributing “bads” (such as fee reductions). Memberships of the medical associations have tended to focus their resulting discontent on “unaccountable” joint management committees, which are seen as “sleeping with the enemy.”

The final lesson was to “include an all-payer system.” This is by now an old message from observers of the Canadian system. What the framework of Exhibit 1 should make clear, however, is that if one is seriously interested in overall physician-sector expenditure control, one will either learn the algebra the easy way or learn the lesson the hard way. In Canada the advent of global expenditure caps has created pressures on the profession to find ways out of the single-payer straitjacket. To date, the effects of scaling back coverage have been small, but they could presage the beginnings of the unraveling of overall physician-sector cost control, if more services are moved to the private sector.

To those four lessons we can now add a few others, born out of some of the unforeseen side effects of managing within a capped environment. In fact, the importance of attempting to anticipate some of the less obvious side effects is a lesson in itself. Although the medical profession’s heightened interest in physician supply control could have been predicted, the political difficulties encountered in attempting to articulate a process for restricting entry were less predictable. In particular, the natural preference of established physicians to have the full costs of supply reductions borne by new entrants has driven a significant wedge between medical associations and intern and resident associations.

A number of lessons suggest themselves. First, a rational national supply control policy cannot be achieved through short-run crisis management by the medical profession itself. The profession is suffering now from decades of failure to act by other parties with hands on the long-term supply control policy levers. Second, and following from this, comprehensive and equitable short-run supply control policies (that, for example, incorporate such things as early retirement incentive packages) must be included as components of any negotiated expenditure control policy package. Payers must be less willing to leave the details of supply control in the hands of the profession. Third, supply control should not be left exclusively to short-run, reactive policy development. Supply management and control are essential to long-term expenditure control, but if such policies are to avoid the unintended (and probably undesirable) redistributional effects we are witnessing in Canada, they should be developed within the context of national guidelines and regional objectives so as to avoid the artificial erection of
state trade barriers or tariffs on the movement of what is, in the end, an indispensable national resource.\textsuperscript{34}

Moving beyond supply control to other side effects, the Canadian experience suggests that payers must not grant the profession veto rights that hamstring broader policy initiatives. The most notable example in the Canadian experience to date has been the transfer of funds from fee-for-service to alternative payment arrangements such as capitation. This has created a paradoxical situation in some provinces. The capped expenditure environment has created heightened interest within the profession in such alternative arrangements and a new opportunity for governments to move forward in this area. Yet at the same time movement is roadblocked by the terms of many of the joint management agreements. The predominant interest among JMC physician members has been the preservation of the fee-for-service pool. They are not against the new initiatives, so long as these do not impinge on that pool. The predominant interest among JMC members from the government side has been in getting the capping agreements. This has then tended to work against those in the same ministries attempting to push broader and longer-term health care reform initiatives.

The emergence of many of the side effects described here appears to be attributable to inadequacies in the medical associations’ ability to deal internally with the effects of the zero-sum nature of global expenditure caps. This suggests that a final lesson for payers, on both sides of the border, might be: “Be aware of the dilemmas for the profession created by expenditure caps.” Whether it be the inability to distribute equitably the pain of clawbacks, or to control supply without discriminating against their newest members, or to facilitate the move to alternative payment systems, the fallout in medical politics threatens the very integrity of some Canadian provincial medical associations. Given that global expenditure caps were originally introduced by provincial Ministries of Health to achieve greater predictability for medical expenditures, it would be a great irony, indeed, if in so doing they created a whole new uncertainty by bringing about the demise of their Medicare negotiating partners.

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NOTES

1. J. Lomas et al., “Paying Physicians in Canada: Minding Our Ps and Qs,” Health Affairs (Spring 1989): 80-102. The paper noted that fee schedules could only control price per service, not the quantity of services provided (hence the Ps and Qs).

2. Because the earlier paper briefly described the Canadian health care system and the history of fee negotiations in Canada, we do not revisit much of that ground here.


6. To which a response might be, “But what about user fees?” However, a user fee simply changes the sources of funds underlying the “price per service.” For user fees to be effective in controlling costs, they would have to reduce prices or reduce services per capita. Neither effect emerges from the relevant research literature. See G.L. Stoddart, M.L. Barer, and R.G. Evans, “User Charges, Snares, and Delusions: Another Look at the Literature” (Toronto: The Premier’s Council on Health, Well-Being, and Social Justice, 1994); and T. Rice and K.R. Morrison, “Patient Cost Sharing for Medical Services: A Review of the Literature and Implications for Health Care Reform,” Medical Care Review 51, no. 3 (1994): 235-287.

7. In Quebec, for example, where individual physician incomes were constrained, expenditures tended to track physician supply. See J. Hughes, “How Well Has Canada Contained the Costs of Doctoring?” Journal of the American Medical Association 265, no. 18 (1991): 2347-2351.


12. Provinces such as Quebec, New Brunswick, Newfoundland, Ontario, and British Columbia also employ geographic supply policies intended to affect geographic distribution within a jurisdiction, not necessarily to control overall expenditures.

13. As of this writing, the Ontario policy was set to expire as of 31 March 1996. New Brunswick currently employs a “billing numbers” policy that requires prospective new
physicians to secure hospital admitting privileges before they are granted rights to the provincial plan. Hospital corporations can, in turn, grant such privileges only if the addition of new physicians is in keeping with provincially set physician/population targets for each region. This is an explicitly distributional, not supply, policy.


15. A whole host of physicians are differentially penalized by across-the-board fee reductions. These include part-time female physicians, cognitive specialists such as psychiatrists, and low-volume practitioners of all types in rural areas. On the differential responses to income constraints among and within different specialties, see J. Hurley, C. Woodward, and J. Brown, “Changing Patterns of Physician Services Utilization in Ontario, Canada, and Their Relation to Physician, Practice, and Market-Area Characteristics,” Medical Care Research and Review (forthcoming).


17. On the face of it, individual capped envelopes for different specialties would circumvent this problem. However, they would create a new intraprofessional problem: the relative size of the envelopes. If those envelopes were to be set on the basis of historical experience that was, in turn, a product of inequities in relative fees, the problem would remain.

18. See, for example, Alberta Medical Association, “Alternative Remuneration for Primary Care: Fee for Comprehensive Care Option” (Edmonton: AMA, 1994); and New Brunswick Health and Community Services and New Brunswick Medical Society, Physician Compensation in New Brunswick (Fredericton, December 1995).

19. In Canada private insurance cannot be offered for services covered under provincial medical insurance plans. Hence deinsurance “liberates” certain services to the private sector, usually on the grounds that they are not “medically necessary.”


21. This act stipulates that a province must include all medically necessary services in its benefit package, and for all residents of the province, if it is to be eligible for federal matching funds. Of course the disappearing federal funding may soon render this moot.


23. The terms and conditions under which proration or clawbacks will occur, including rules to be used to determine if a cost overrun has occurred, are central. The joint efforts to develop more sensitive ways of identifying the causes of increased utilization are, for example, intended to aid in apportioning responsibility for overruns. In fact, however, the language of most agreements does not tie clawback mechanisms to specific micro-utilization experiences, in large part because the utilization management initiatives lag behind the development of the expenditure control mechanisms.

24. A new bill (Bill 26), passed in January 1996, may make previous squabbles look like the “good old days” to the medical profession. Under this bill the minister of health has sweeping new powers to set fees unilaterally, to determine the eligibility of physicians to bill the provincial medical plan, to determine where new physicians can practice, and to declare unenforceable the existing agreements with the profession.

25. Quebec and Nova Scotia recently established new retirement or buyout policies that are notable exceptions.

27. For example, Ontario’s policy is intended to exclude entrants trained outside Ontario. This will include some Ontario residents who simply went outside the province for training. But even for Ontario graduates it seems likely to be counterproductive. Some other provinces have felt the need to erect protective barriers in reaction to Ontario’s stance. This has meant that Ontario graduates find themselves with a more restricted set of choices as a result of the policy of their own province. Since Ontario historically has been a net exporter of newly trained physicians, this policy also may backfire on the current members of the OMA, as it will almost certainly mean that more Ontario school graduates will stay in Ontario to practice than would have been the case in the absence of the policy. The net effect on new billing numbers issued is not yet clear.


31. Hurley et al., “Changing Patterns.”


33. Katz et al., “Physician Relations in Canada.”