Cite this article as:
J Lomas, C Fooks, T Rice and R J Labelle
Paying physicians in Canada: minding our Ps and Qs
Health Affairs 8, no.1 (1989):80-102
doi: 10.1377/hlthaff.8.1.80

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PAYING PHYSICIANS IN CANADA: MINDING OUR Ps AND Qs

by Jonathan Lomas, Catherine Fooks, Thomas Rice, and Roberta J. Labelle

Prologue: When Americans examine Canada’s ten provincial health insurance plans, they recognize that Canadians have been far more willing to delegate to government the central role in financing and regulating health insurance for the whole population than Americans. Provincial governments and the medical profession are the instruments through which the financial ground rules of health care are established. In recent years, though, as Canada’s physician population has grown and the use of medical care has risen, provincial governments have come under greater pressure to moderate the growth of health spending. Their efforts to deal with that issue—increasingly, by imposing expenditure targets or caps—have intensified the rancor between provincial governments and practicing physicians. In this paper, Jonathan Lomas, his colleagues Catherine Fooks and Roberta Labelle at McMaster University in Hamilton, Ontario, and Thomas Rice of the University of North Carolina (UNC) discuss how Canada’s larger provinces have been addressing these cost problems, particularly in relation to the quantity of services provided by physicians. The quantity issue is prominent in the United States as well because the growth in the volume and intensity of services has accounted for about half the increase in Medicare payments to physicians per beneficiary. Lomas, Fooks, and Labelle all are members of McMaster’s Faculty of Medicine. They hold appointments in the Department of Clinical Epidemiology and Biostatistics’ Center for Health Economics and Policy Analysis. Lomas holds a master’s degree in psychology from the University of Western Ontario. Fooks received a master’s degree in political science from Queen’s University, and Labelle has a master’s degree in economics from McMaster. Rice, who studied the Canadian system while spending last summer at McMaster, is an assistant professor of health policy and administration at the UNC School of Public Health. He received a doctorate in economics from the University of California, Berkeley.
As the 1980s wind to a close, the attention of the health policy community has focused sharply on the payment of physicians. Numerous studies have suggested various ways to control these rising expenditures, especially for Medicare. It is noteworthy that as studies of fee schedules for physician payment have progressed over the past two years, there has been increasing awareness in research and policy circles that fee schedules alone may not successfully control growth in physician expenditures. The reason is that while they can control price per service, fee schedules, by themselves, cannot control the quantity of services provided (thus our title, “Minding Our Ps and Qs”). A number of studies have shown that freezing physician fees may result in rapid increases in the number of services physicians provide.

One technique that can be used to control expenditures in a fee-for-service system is to account explicitly for changes in the quantity of services provided when updating fee schedules. For example, suppose that utilization rates rise by 3 percent in a year, resulting in higher expenditures than anticipated. One possible response is to lower the next year’s fees for each service by this (or a lesser) amount so that over time payers have control over expenditure increases. Such strategies have received a great deal of publicity recently.

West Germany has incorporated quantity responses into fee schedule negotiations for some time; more recently, several Canadian provinces have done likewise. In this article, we describe the systems that have developed, or are currently developing, in Canada. First, we provide a brief summary of the Canadian health care system and a history of the fee bargaining process. We then present the different approaches that provinces are using to control, simultaneously, physician price and quantity increases, and we discuss the impact of these approaches on utilization. We conclude with a discussion of the lessons the Canadian experience offers to others—particularly the United States—who may wish to adopt a similar system.

The Canadian Health Care System

There is no single Canadian health care system; rather, each of the ten provinces administers its own health insurance plan. To receive federal contributions, however, provincial health plans must fulfill national eligibility and coverage standards including public administration, portability of comprehensive benefits across provinces, and universal coverage. It is therefore possible to make some generalizations about the country’s health care system.

All Canadians are eligible for health insurance, which provides, at a
minimum, coverage for nearly all hospital and physician services. Although financing varies from province to province, user charges are rarely levied. In popular (although not economic) terms, all Canadians receive “free” medical care.

In spite (or maybe because) of this universal coverage, Canada has managed to control expenditures for hospital and physician services to a much greater extent than has the United States. Before all of the provinces adopted comprehensive health insurance in 1971, Canada spent slightly more of its gross domestic product (GDP) on hospital and physician services than did the United States. By 1985, however, the United States spent more: 6.2 percent versus 4.8 percent. As a proportion of GDP, U.S. spending on hospital and physician care was about 30 percent higher. There are many reasons given for Canada’s recent success at controlling costs, but the most important appears to be provincial governments’ monopoly over payments to providers: provincial governments are the sole source for nearly all payments to Canadian hospitals and physicians. There is nowhere else for providers and hospitals to go if they are dissatisfied with government reimbursements.

Hospitals, with very rare exceptions, are not for profit and are run by community boards with ownership by charitable, municipal, or religious organizations. They are funded by global (that is, prospective) budgets from provincial governments. Physicians are rarely employed by hospitals and gain access to hospital facilities through the granting of privileges. Approximately 55 percent of Canada’s physicians are general practitioners, not all of whom have hospital privileges.

As in the United States, physicians practice privately and are paid on a fee-for-service basis. Provincial fee schedules determine the price for each service, and physicians are not allowed to bill patients directly for charges above these prices (known in U.S. terms as “balance billing”). As described in detail below, updates in fee schedule rates are negotiated between provincial physician associations and the provincial governments.

The recent ban on billing patients for amounts over and above the fee schedule, coupled with rapid increases in physician supply in most of the provinces, has subjected physicians to increased financial pressures. With potentially fewer patients per physician, the provision of more services per patient has become an obvious way to increase or maintain income levels. The existence of some quantity increase, however, is not new in Canada. Between 1971 and 1985, utilization per capita rose by 68 percent, or at an annual rate of 3.8 percent. Until recently, most of the provincial governments have been willing to accept this. However, the provinces feel increasingly strapped for funds. This, along with the recent pressure of
more significant quantity increases, has resulted in actions designed to contain future expenditure increases.

Currently, five of the ten Canadian provinces—British Columbia, Saskatchewan, Manitoba, Ontario, and Quebec, representing over 80 percent of the country’s population—have incorporated some method of accounting for utilization increases in their fee schedule negotiations with their provincial medical associations. Before describing these approaches in detail, we present a history of fee negotiations in Canada.

### The History Of Fee Negotiations In Canada

**Quebec.** The negotiation of fee schedules in the province of Quebec reflects a substantively different approach than that used elsewhere in Canada. The political culture and mobility-restricting language situation of physicians in that province have resulted in a different health care environment. Therefore, the following history is not applicable to Quebec, which is discussed separately.

**Other provinces.** The process of negotiating fee schedules in the rest of Canada is an example of the gradual formalization of the various means by which the government and medical profession have interacted since the introduction of national health insurance. At the outset, most provincial governments adopted the existing fee schedules of the provincial medical associations and paid amounts ranging from 85 percent to 100 percent of that value (to account for the fact that physicians would no longer have unpaid accounts). Thus, each medical association’s schedule of fees became, on a prorated basis, the province’s schedule of benefits. Over time, the process of arriving at the global increase to that schedule—the average percentage increase in dollar value across all fee items in the schedule—became more formalized, with annual increases determined by periodic negotiations (usually on a one-to-three-year basis).

In the beginning, provincial medical associations were content to bargain in this relatively informal fashion. However, as they became aware of the significant unilateral power that provincial governments could exercise, the desire emerged for a formal negotiating mechanism that equalized power. Unfortunately for the medical associations, an unanticipated formal mechanism was imposed by the introduction of wage and price controls for three years for the entire economy, starting in 1975. During this time, dissatisfaction grew among physicians; upon cessation of controls in 1978, the fee bargaining process, although more formal, had to incorporate three symptoms of that dissatisfaction.

First, there was an increase in the proportion of practitioners who were extra-billing, or balance billing. This was the profession’s “safety valve”
for fee increases that were seen as unreasonably low. Second, some medical associations broke away from the governments’ schedule of benefits and set their own fee schedules at (higher) levels, which they considered to be reasonable compensation. The difference between these two schedules was often the basis for the extra-billing levels imposed on patients. Third, the size of annual utilization increases became more significant as services per physician showed consistent annual increases of 1 to 2 percent. This latter factor had become important enough that a legislative committee in one province (Ontario) suggested as early as 1978 that fee increases should be contingent on guarantees of “flat utilization,” and that future fee increases should be reduced if this turned out not to be the case.

Most attention, however, focused on the extra-billing issue. The result was a federal review in 1980 by Justice Emmett Hall. The banning of extra-billing was proposed, but only if it was combined with a binding arbitration mechanism to negotiate fees. This reflected the increasing formalization of provincial negotiation processes, which were becoming collective bargaining exercises.

The review precipitated prolonged consideration of what has become a major background issue in all fee negotiations in the 1980s: Are fees or incomes the subject of negotiation? For binding arbitration to work, there had to be some definition of what areas would be under arbitration. Provincial governments maintained that total outlays for physician services were of concern; therefore, they were interested in both the price of services (fees) and the quantity of services delivered. For their part, the medical profession maintained that they were only negotiating fees, and it was not their responsibility to be accountable for either the increased use of physician services by the population or, alternatively, the increased productivity of the average physician. The medical profession claimed that they would become “conscripted civil servants” if their income were the subject of negotiations.

The effective elimination of extra-billing in 1984 by the federal government through the Canada Health Act, and a legislative ban by each of the provinces by 1987, has been further cause for a focus on both negotiating processes and the validity of considering utilization. In two provinces (Saskatchewan and Manitoba), the ban on extra-billing was combined with the right to binding arbitration for fee settlements. Other provinces use nonbinding mediation, fact finding, or no formal dispute resolution mechanism. The exclusion of the right to extra-bill has, however, had repercussions for the rate of utilization increase: increasing utilization is the only mechanism left for physicians to increase income levels beyond the size of the fee increase.
In the two years following Ontario’s ban on extra-billing (1986–1987 and 1987–1988), services per physician increased by nearly 2.5 percent each year; in the previous seven years, the average annual increase had been 1.2 percent. When these developments were combined with the effects of an economic downturn in western Canadian provinces after 1982–creating a revenue crisis for provincial governments—medical associations found themselves in negotiating sessions with provincial governments that were no longer willing (or fiscally able) to ignore the impact of utilization increases on provincial medical care expenditures. Steps were taken to introduce utilization control mechanisms in several provinces.11

**Approaches To Controlling The Use Of Physician Services**

There are two approaches used in Canada to control, or attempt to control, increases in utilization: the “threshold approach” and the “capping approach.” Each has evolved from a different historical context and has employed different methods. The common principle in each approach, however, is the feedback of utilization growth on physician fees. In the threshold approach, no inviolable limit on expenditure is set; rather, some value is established above which only a preestablished or negotiated portion of the utilization increase feeds back onto the size of the fee increase. In the capping approach, a limit is set on annual expenditures that, by virtue of eventual complete feedback of utilization on fees, will not be exceeded. The approaches, with variations, are comparable to the concepts of “target” and “cap,” respectively, in the United States.

**The threshold approach.** The approach used by most provinces was to establish the principle that they would no longer automatically be responsible for the entire cost of increases in the volume of services delivered. Utilization increases became subject to scrutiny to attribute financial responsibility to either the medical profession or the government. Beyond a threshold level, the cost of increases in the volume of services is at least partly the responsibility of the medical profession.

Four provinces have adopted the threshold approach—British Columbia, Manitoba, Saskatchewan, and Ontario. This approach noticeably respects the profession’s concern that incomes per se will not be the subject of negotiations: the controls apply to aggregate government expenditures, not to expenditures at the level of individual physician income. The threshold level of utilization is set either at the previous year’s volume (sometimes an average of a number of previous years) or at the previous year’s volume plus some amount to account for factors such
as population increase, growth in the physician supply, natural disasters and public health epidemics, or new insured services/technologies.

The setting of the threshold is done either prospectively or retrospectively. Setting the threshold prospectively involves negotiations that define the causes of utilization increases that are allowable or the allowable size of the increase. This has been done in British Columbia, Saskatchewan, and Manitoba. In Ontario, the threshold is set in retrospective negotiations after the size of the utilization increase is known. In this case, there is no statement prior to the relevant benefit year that the upcoming year's utilization increase necessarily will be used to adjust the size of the next price increase. However, it is clearly the intent of the government to bring this principle to the bargaining table in each year's negotiations now that the precedent has been set. The retrospective application of utilization controls merely reflects that the judgments of "fact finders" (arbitrators) are now supporting the Ontario government's long-held contention that past quantity increases should receive some consideration when arriving at future fee increases. The intent is for the threshold eventually to be determined prospectively and explicitly.

The provincial governments use one of three ways to recoup expenditures on "excess" utilization above the threshold. Next year's fee increase is adjusted downward accordingly (as in Ontario and Manitoba), the profession temporarily works at reduced fees for a set period (as in British Columbia), or current fees are paid at a discounted rate to counteract the anticipated size of the utilization increase for the year (as proposed in Saskatchewan).

None of these approaches involves provincial governments in determining an individual physician's income; rather, they have an impact on the total funds available for distribution across the entire profession. This contrasts with the capping approach adopted by Quebec, in which the individual general practitioner's income is capped. These incomes, plus target income values for specialists, are aggregated to the total expenditure cap for Quebec.

Detailed descriptions of the different threshold and capping approaches follow. A summary is given in Exhibit 1.

British Columbia. Throughout the early 1980s) the provincial government tried unsuccessfully to incorporate concerns about increases in utilization into fee negotiations. In the 1985–1986 negotiations, however, they successfully incorporated a limit on their liability for utilization increases. There was no global fee increase for that year. In addition, a prospectively negotiated ceiling on utilization was implemented for one year. The ceiling allowed a 1.5 percent increase in utilization for population growth and a 2 percent increase for other factors. Any increases over
Exhibit 1
Approaches To Controlling Utilization In Canada

<table>
<thead>
<tr>
<th>Thresholds</th>
<th>Capping</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>British Columbia</strong></td>
<td>1985–1986</td>
</tr>
<tr>
<td><strong>Manitoba</strong></td>
<td>1984–1985(^a)</td>
</tr>
<tr>
<td><strong>Saskatchewan</strong></td>
<td>1987–1988</td>
</tr>
<tr>
<td><strong>Ontario</strong></td>
<td>1987–1988</td>
</tr>
<tr>
<td><strong>Quebec</strong></td>
<td>1976–1977</td>
</tr>
</tbody>
</table>

- Threshold beyond which rules change?
  - Yes
  - Yes
  - Yes
  - No
  - Yes

- Cap on individual incomes?
  - No
  - No
  - No
  - No
  - Yes

- Type of rule setting
  - Prospective
  - Prospective
  - Prospective
  - Retrospective
  - Prospective

- Focus of prospective rules
  - Agreed percent increase for population and technology
  - Grouping of justifiable and non-justifiable utilization
  - Average of previous five years' utilization
  - N/A
  - Quarterly income ceilings (GPs) and total cap for GPs and specialists

- Justifiable utilization factors
  - Population growth, advances in medical services, natural disasters, epidemics, physician supply
  - Population growth, public health problems, new services, technology, physician supply
  - None
  - Population growth, physician supply
  - Physician supply

- Method of recouping expenditures on excess utilization
  - Temporary reduction in size of fee increases
  - Reduction in global fee increase
  - Discounted fees in current year
  - Reduction in global fee increase
  - Reduction in specific and/or global fee increase

- Dispute resolution mechanism
  - None
  - Binding arbitration
  - Binding arbitration
  - Fact finder\(^b\)
  - None

- Utilization committee
  - No
  - No
  - Yes
  - Yes
  - Yes\(^c\)

\(^a\)No longer in effect.

\(^b\)As of 1989, the agreement establishing a mechanism for negotiating has been terminated and is to be renegotiated.

\(^c\)The utilization committee in Quebec differs in function from utilization committees in other provinces. In Quebec, the committee meets to negotiate actual distribution of fee increases across individual procedures. In other provinces, the committees are analyzing the determinants of utilization in general. Furthermore, the Quebec committee is an ongoing project, whereas the committees in other provinces were originally established as one-time initiatives. However, it is possible that these committees will evolve into ongoing initiatives.

that would be the responsibility of the profession and would result in a retrospective fee adjustment. No adjustment was in fact required.

The 1986–1987 agreement (which was for a three-year period) allowed for a 3 percent increase in total utilization (1 percent for population increase and 2 percent for new medical services).\(^{12}\) If utilization growth exceeded the threshold of 3 percent, monies would be withdrawn in
equal amounts from a Ministry reserve fund and the money budgeted for the fee increase to be awarded in the next year of the contract. If the threshold was exceeded by more than could be funded from these two sources, negotiations would be reopened for the subsequent years of the contract. The contract also stipulated that the government would fund any extraordinary utilization resulting from epidemics or natural disasters.

Under this arrangement, the medical profession has already had part of its second-year global fee increase temporarily reduced because of utilization increases that exceeded both thresholds. A 1 percent “excess” utilization in the first year was recouped with a 4 percent global fee decrease for three months of the second year of the contract.

Manitoba. An agreement was signed, beginning the 1984–1985 benefit year, which provided for binding arbitration for fee disputes and a 2 percent global fee increase. In addition, future fee increases would be adjusted for utilization increases above a threshold. Utilization increases would be classified into the “attributed” rise (increases in insured persons, increases in physicians, public health problems, shifts in health care delivery, and new insured medical services) and the “unattributed” (all other) increase. The percentage increase in future fees would be reduced by the amount of the unattributed utilization, Thus, the factors influencing utilization would be negotiated prospectively, but the actual size of the utilization feedback on future fees would not be known until the benefit year was complete and unattributed utilization calculated.

The 1986–1987 negotiations went to mediation (nonbinding, third-party mediator) and then to arbitration (binding, third-party board) almost immediately. Two issues were at the heart of the disagreement: the size of the global percentage increase in fees and the method of calculating unattributed utilization. The arbitration board was split on the issue, and, therefore, the decision was issued by the chairperson alone. It provided for a 5.7 percent global increase but noted a 1.9 percent increase in unattributed utilization, necessitating an increase of only 3.8 percent. Disagreement between the Manitoba Medical Association and the government over how this should be applied led to an informal, nonbinding reconvening of the board.13 The chairperson’s judgment supported the medical association’s interpretation of how much downward adjustment in the fee increase should occur because of unattributed utilization growth.

The government eventually paid the award according to these terms but terminated the arbitration mechanism for future negotiations on the not completely accurate grounds that it “provided no controls on volume.”14 In the spring of 1988, the Manitoba Medical Association, with-
out a contract since April 1987, threatened to strike unless the government agreed to reestablish the binding arbitration mechanism.

After a surprise spring provincial election, a three-year agreement was signed with the new government containing a 3 percent increase in the first two years and an increase based on the national inflation index in the final year. This new contract contained no mechanism to account for utilization growth. It also reinstated binding arbitration. The previously established explicit feedback of utilization on fees is, therefore, no longer in place in Manitoba, although increased utilization no doubt will be at least an implicit part of the next round of fee negotiations in 1990.

Saskatchewan. In Saskatchewan, the issue of utilization controls became entangled in a court case. Using a mechanism that fell just short of being a cap, the government opened the 1987–1988 negotiations by proposing a threshold based on prior years’ utilization increases. Negotiations quickly went to binding arbitration—the dispute resolution mechanism agreed to in 1985 when extra-billing was banned. The government wanted a 0 percent fee increase and a prospective threshold of a 0 percent increase in utilization; that is, the government did not want to fund any increase in utilization and did not want to provide any global increase in fees. The mechanism to be used to try to prevent funding of any utilization increase was discounting of fees for the entire year by the average of the previous five years’ utilization increase—4.2 percent. Therefore, there was a presumption that utilization would increase by 4.2 percent, and prospective discounting of fees by that amount would prevent the flow of additional monies as long as the utilization increase was less than 4.2 percent.

This mechanism aims to keep total expenditures in the contract year at the same level as in the previous year. At the end of the contract year, if utilization actually increased by less than the anticipated 4.2 percent, then the profession would receive what was owing from the withheld discounted sums. However—and here is why the system cannot be considered a true capping approach—if utilization increased by more than 4.2 percent, the government would continue to pay out fees, and the profession would not give back the excess—they would keep the additional monies above the previous year’s outlay.15

Disagreement by the Saskatchewan Medical Association with both the concept of a prospective threshold and this proposed utilization adjustment sent the matter to the arbitration board. The board ruled that the prospective threshold was legal, but that physicians should be financially responsible for only half of the anticipated increase in utilization. That is, fees should be discounted by only 2.1 percent.

Shortly thereafter, the Saskatchewan Medical Association took the arbitration decision to court on the grounds that the board exceeded its
jurisdiction in setting a fixed sum of money for insured services and by holding physicians responsible for even 50 percent of the anticipated increases in utilization. The court sided with the medical association and quashed the board’s ruling. The government appealed the decision, and, in December 1988, the appeal court’s judgment supported the government’s right to set a threshold that took account of prior utilization. However, it confirmed that a true cap would be considered illegal by stating that payments to physicians must continue even after such a threshold value of total expenditure had been reached in a year.

Because of the delay occasioned by the court case, the 1987–1988 negotiations have not been completed, and physicians were paid at 1986 rates for 1987. Negotiations for 1988–1989 had not begun as of December 1988, but the government undoubtedly will be using the favorable court judgment to enshrine their threshold approach into future agreements. During the time of the court case, recognition of the somewhat arbitrary nature of the fifty-fifty attribution between the government and the profession for any utilization increase led to the formation of a joint committee to examine utilization issues.

Ontario. Utilization was discussed during both the 1981 and 1982 fee negotiations in Ontario, although utilization controls were not incorporated in any formal way into the contract. The five-year term of the 1982 contract did, however, establish a joint Ministry of Health and Ontario Medical Association committee to study utilization.

The subsequent 1987–1988 negotiations went to the “fact finder”—a nonbinding arbitrator—after two months. During the negotiations, utilization increases had been discussed as the basis for a retrospective component of the global fee increase, but no consensus was reached. The fact finder concluded that the gradual increase in utilization per physician contributed significantly to physicians’ incomes, and financial responsibility therefore should be shared between the government and the profession. The fact finder chose a figure of 1.5 percent as the increase in utilization per physician for the previous year and recommended that the global fee increase for the current year be reduced by one-half of this increase, that is, by 0.75 percent. The fact finder arbitrarily chose this fifty-fifty split between the government and the profession “in the absence of more sophisticated analytical tools.” Both parties complied with the recommendation and also reestablished the joint government/Ontario Medical Association initiative to examine utilization. The previous committee had been disbanded after the medical association’s withdrawal during a strike action over the banning of extra-billing.

The most recent round of negotiations in Ontario (1988–1989) also went to a fact finder, as the medical association and the government
disagreed over the amount of the global fee increase. The fact finder again recommended an adjustment to the overall fee increase based on the prior year’s utilization growth. He estimated a 2.3 percent increase in utilization per physician after adjusting for population growth and, using the fifty-fifty split rule, recommended a reduction of 1.15 percent in the global fee increase. In June 1988, both sides studied the report, but the government, although not displeased with the continued acceptance of feedback of utilization growth on fees, rejected the recommendation in favor of their original (lower) offer of 1.75 percent for the global fee increase.

Informal talks took place with no resolution until December 1988, when the government unilaterally imposed the settlement of 1.75 percent on the Ontario Medical Association. In addition, the government gave notice that it was canceling the existing agreement governing the negotiating process and planned to establish an entirely new mechanism. The medical association recognizes that this new mechanism is being proposed “to try to impose utilization controls on the profession [and] . . . [w]e’re going to want some sort of a mechanism whereby if we go to a third party to settle, it’s going to be binding on both parties.” Therefore, the exact nature of the future mechanism for utilization feedback on fees in Ontario is still uncertain, but the fact of such a mechanism in the future is in little doubt.

The capping approach in Quebec. It is worth noting that while the Quebec approach to controlling utilization is interesting and worth recounting, it may well not be applicable either to other Canadian provinces or to the United States. Both the political culture in Quebec and the linguistic barriers to professionals seeking careers outside the province have allowed the government to adopt a more interventionist strategy with regard to physician payment than is politically feasible elsewhere in North America. Furthermore, the negotiating philosophy of the medical associations has been far more concerned with preventing regulatory interference with the medical practices of the profession than with protecting the entrepreneurial interests of individual high-earning members of the professional group. Indeed, individual income caps for general practitioners were introduced at the request of the profession, not imposed by government.

The capping approach, present for some time in Quebec, establishes individual income ceilings for general practitioners, as well as separate caps for overall expenditures on the services of general practitioners and specialists. The province discourages individual general practitioners from exceeding their income ceilings by discounting their fees severely once the ceiling has been reached. In addition, when the overall expendi-
ture cap for either general practitioners or specialists is exceeded in one year, the government recaptures funds by reducing fee increases for subsequent years. Therefore, although expenditures and individual income ceilings can exceed the cap in any particular year, the feedback mechanism prevents a cumulative departure from the series of caps because the overrun in previous years is, unlike the threshold approach, totally recaptured in subsequent years.

Fee negotiations in Quebec are between the government and two separate professional associations—la Federation des medecins omnipraticiens (general practitioners) and la Federation des medecins specialistes (specialists). Unlike in other Canadian provinces, negotiations are around the income level of physicians, which then becomes translated into a particular fee increase.

The history of fee negotiations in Quebec is quite different from that in the rest of Canada. From 1970 to 1975, physicians received no fee increase. In 1976, a large number of primarily English-speaking employers left Quebec after the election of a separatist government, thus reducing the province’s tax base. Even though there was recognition that a fee increase was in order, the government was not in a position to grant physicians a large increase and offered only 1 percent. Simultaneously, expenditure controls for general practitioners were introduced by establishing individual income ceilings and a total expenditure cap. One year later, target incomes for each specialist group were introduced, although these were not applied at the individual level but used to calculate an overall expenditure cap for specialist services.

This method of controlling utilization differs from that used in other provinces. First, each round of annual fee negotiations sets a global fund calculated from the aggregated target incomes per physician and the expected number of physicians. Thus, increased physician supply does increase the size of the cap. For general practitioners, ceilings are calculated for a three-month period. Once the limit is reached within a period, the general practitioner is paid only 25 percent of the full fee for additional services. For specialists, the income target (which is not a ceiling leading to within-period fee discounting) is for a twelve-month period. The current annual income levels are (CAN)$120,298 for general practitioners and (CAN)$151,782 for specialists.18

Second, the average amount of gross billings is used to adjust fees the following year by bringing actual incomes in line with the targets. Because physician supply is relatively stable—Quebec is the only predominantly French-speaking province in Canada, and it has the most stringent licensing requirements—targets for physicians’ gross incomes eventually translate into predicted limits on the total expenditures for physician
services. With the exception of a brief period in the early 1980s, this capping approach has been in place for over ten years and shows no signs of being disbanded.

The Impact Of Controls On Utilization

As Exhibit 1 indicates, controls on utilization are a relatively new concept in Canada. To date, controls either have been or are now in effect in five of the ten provinces. Of those five provinces, only Quebec and Manitoba have experience for more than three years. Thus, a comprehensive analysis of the effects of controls is premature; we are restricted, at this time, to reporting selective results.

We are reluctant to generalize the results from Quebec and Manitoba because both are somewhat atypical. Quebec has experienced some form of capping since 1976–1977. In Manitoba, although the threshold approach was introduced in 1984–1985, it was disbanded in the current contract for 1987–1990 and may not be reintroduced in future contracts. Nonetheless, the experiences of these provinces provide the only available evidence in Canada on the potential impact of utilization controls.

Exhibits 2 and 3 display the annual percentage changes in Quebec’s fee-adjusted billings per physician, and the number of base services (consults, examinations, and surgery) and actes complémentaires (minor diagnostic and therapeutic procedures, surgical assists, and anesthesia) per physician, for the five years preceding the cap and the eight years after. During the initial postcap period, the rate of growth in fee-adjusted incomes (taking into account the revisions—bundling and unbundling—of the fee schedule) declined (Exhibit 2). But this decline is confounded by a repackaging of fee items in 1977 that severely reduced the number of billable procedures and the opportunities for procedural multiplication. Billings per physician gradually recovered after the fee schedule restructuring in 1977, only to decrease again in 1981 when the general practitioner cap was reinstated after a one-year lapse due to contract negotiation problems. It is interesting to note that billings grew by 5.18 percent in the year in which the general practitioner cap lapsed—the largest single-year growth of any postcap year.

In 1977 the restructuring of the fee schedule and the inception of the cap on total expenditures for specialist services (the general practitioner cap had already been in place for one year) decreased the volume of actes complémentaires dramatically—by almost 40 percent in one year (Exhibit 3). The fact that base services were not affected to the same extent, and that the restructuring was targeted primarily at actes complémentaires (which had increased 14 percent per capita from 1971 to 1976), suggests
that most of the dramatic impact on utilization can be attributed to fee schedule restructuring rather than to the expenditure cap. The natural experiment afforded by the lapse of general practitioners’ caps in 1980 does suggest, however, that there is at least a short-run impact of the cap on utilization and income growth, although over time Quebec physicians are able to somewhat moderate the impact on billings by, presumably, shifting to more costly types of services. The Quebec experience with capping is, therefore, confounded by simultaneous introduction of fee schedule restructuring that appears to have been as effective as the cap, perhaps more so, in moderating utilization and expenditure growth.

Exhibit 4 displays evidence on average incomes per physician in Manitoba, adjusted to remove the contribution of negotiated fee increases to the income growth. The data are for the two years before the threshold, the three years after, and the first year of the new contract in which controls have been disbanded. The short time period makes interpretation difficult. These data are, however, consistent with an impact of utilization controls on the rates of growth in per physician expenditure, but could be in no way considered conclusive because of the low rate of growth in 1983–1984, when no controls were in place.
Exhibit 3
Services Per Physician, Quebec, Annual Percentage Change, 1972–1985

<table>
<thead>
<tr>
<th>Percentage change</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>−10</td>
</tr>
<tr>
<td>−20</td>
</tr>
<tr>
<td>−30</td>
</tr>
<tr>
<td>−40</td>
</tr>
</tbody>
</table>


Base services include consultations, examinations, and surgery.

Actes complementaires include minor diagnostic and therapeutic procedures, surgical assists, and anesthesia.

In 1976, fees for general practitioners (GPs) were capped.

In 1977, a specialist ceiling was added to the GP ceiling and income cap.

In 1980, the GP ceiling and income cap lapsed, but the specialist ceiling remained.

In 1981, the GP ceiling and income cap was reintroduced.

Summary Of The Canadian Experience

The incorporation of controls on utilization into fee schedule negotiations in Canada has been an incremental process that, with the exception of Quebec, is only now becoming accepted as inevitable by the medical profession. Among the provinces excluded from this article, some are now starting to consider mechanisms for the feedback of utilization growth on fees, although even here it is mostly being preceded by careful consultation in the form of royal commissions (Nova Scotia) or utilization task forces (Alberta). In the four provinces that already have, or had, threshold approaches, the formalization of the approach was also generally preceded by many years of discussion of the concept, usually within the context of the fee negotiations themselves. Hence the title of the article—“Minding Our Ps and Qs”—which underlines the care that had to be taken by the provinces when dealing with the medical profession on the issue.

The major issue of concern for the medical profession has been the income control implied by simultaneous price and quantity limits in fee schedule contracts. The introduction of threshold approaches, rather...
Exhibit 4  
Fee-Adjusted Billings Per Physician, Manitoba, Annual Percentage Change

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Percentage change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1982–1983</td>
<td>8</td>
</tr>
<tr>
<td>1983–1984</td>
<td>6</td>
</tr>
<tr>
<td>1984–1985a</td>
<td>4</td>
</tr>
<tr>
<td>1985–1986</td>
<td>2</td>
</tr>
<tr>
<td>1986–1987</td>
<td>0</td>
</tr>
<tr>
<td>1987–1988b</td>
<td>–2</td>
</tr>
<tr>
<td>1988–1989</td>
<td>–4</td>
</tr>
</tbody>
</table>

Source: Manitoba Health Services Commission and Health and Welfare Canada.

*a* In 1984, a new contract with the provincial government established a negotiated threshold.

*b* During 1987–1988, the threshold was absent because of a fee dispute.

than explicit caps, has been the political solution to the required compromise between the provinces and the profession. The threshold approach leaves individual income levels unregulated and only partially regulates the total funds available for physician services. Even with this solution, however, the medical profession has responded with legal challenges (Saskatchewan), political pressure leading to abandonment (Manitoba), or refusal to incorporate prospectively such controls into contracts (Ontario). Nevertheless, the concept has now become well enough established that within the next few years the majority (but not all) of Canadian provinces likely will have in place some mechanism for the feedback of utilization growth on fees.

The political difficulty of the process has, however, driven provinces to seek other avenues for controlling utilization as well. For instance, Ontario is aggressively promoting alternate remuneration systems to fee-for-service; British Columbia (unsuccessfully) attempted controls on the number of physicians allowed to bill the health insurance plan; and Quebec’s capping approach was accompanied by a significant restructuring of the fee schedule. This latter occurrence, in fact, confounds attempts to evaluate the impact of utilization controls on expenditures.
This, and the very recent inception of the threshold approaches in other provinces, leaves us in the unsatisfactory position of being unable to make any clear conclusions about the impact of combined price and quantity controls on overall expenditure growth for physician services. The initial indication is, however, that there is discernible but not dramatic impact. The simultaneous introduction of additional measures in other provinces may make such an analysis forever elusive.

Most of the lessons from the Canadian experience concern, therefore, the political considerations in smoothing the way for implementation of controls, rather than structural elements of a program to obtain maximum impact on expenditures. Combined price and quantity controls are too recently implemented and/or too confounded by other policies to allow for anything else. The intuitive appeal and implications of such utilization controls for expenditure growth have, therefore, to remain somewhat in the realm of “faith” or “hope” when considering the lessons outlined below.

The one exception to this is the implication of Canadian governments’ monopsony powers (the power of one buyer) in health care. Elsewhere we have described how the exercise of this power may be one of the most important elements in the relatively better cost control experience of Canada compared to the United States—two countries whose health care systems are otherwise very similar structurally. Controls on the quantity and price of physician services billed through provincial fee schedules in Canada are effectively controls on all sources of income for the physician.

This context for the Canadian experience helps to explain the strong resistance from the medical profession and, therefore, the relevance of the political lessons. But also it may be related to any eventual success claimed for such fee schedule price and quantity controls. In the United States, for example, unless Medicare has a highly potent symbolic value as a leader in health policy—a value that has not been in great evidence to date—the introduction of a fee schedule policy by the program may not be enough to control total societal expenditures on physician services. It may do little more than displace those burgeoning expenditures to other payers. It is in this vein that we offer the four lessons below.

**Lessons From Canada**

**Introduce price and quantity controls at the outset.** Payers who are introducing a fee schedule and wish to use it now or in the future to control expenditures should simultaneously introduce both the price and quantity controls at the outset. A major difficulty in Canada has been the
task of introducing the idea of quantity controls within fee negotiation processes that have existed for many years without any consideration of the topic or acceptance that it is even a legitimate item for negotiation. It is for this reason that Ontario has retrospectively established the rules for dealing with utilization increases, and that negotiations for all provinces except Quebec have avoided individual income or even total expenditure caps in the spirit of compromise.

The absence of quantity controls at the outset of government/profession fee negotiating in the early 1970s has led to a tenuous hold for the principle as it has emerged in the 1980s. In Manitoba, quantity controls have actually been put aside in the current contract. As long as there is no formalization of the rules that apply to utilization increases, each year’s negotiation has to deal with the issue anew and set retrospective rules.

Set prospective rules. Rules must be set prospectively concerning (1) factors determining the size of the threshold or the cap; (2) the mechanism for payback or discounting if the threshold or cap is exceeded; (3) the determinants of a utilization increase that are justifiable; and (4) the bargaining and dispute resolution processes. The absence of any formal dispute resolution mechanism calls the credibility of the process into question. The Ontario government ignored the recommendations of its independent fact finder in the last round of negotiations; therefore, the medical profession in that province is now asking for a binding arbitration mechanism for dispute resolution. Neither British Columbia nor Quebec has a formal dispute resolution mechanism in place. The absence both of clear dispute resolution mechanisms and of prospective rules has contributed to the arbitrary nature of the methods for dealing with the degree of physician responsibility for utilization increases. This, in turn, has been a major line of attack by the medical profession, as well as a source of discomfort for provincial governments.

Underlying the policy of the government’s recouping or not paying out for some or all of the utilization increase is an assumption that not all of this increase represents physicians meeting the legitimate medical care needs of the population. In the absence of specific service-level data to support this assumption, physicians have argued forcefully that patient demand, previously unmet needs, and technological change are driving utilization rates upward. For its part, the government has implied that induced demand by physicians is partly responsible. However, in the absence of data, they have generally taken recourse to justifications in public based on productivity gains by physicians that should, in a free and competitive market, partially flow back to the consumer (in this case, the taxpayer and the government) in the form of reduced prices (fees). The debate, however, has used the currency of assertion, claim, and
counterclaim in the absence of prospective rules that could be informed by careful scrutiny of specific areas of clinical practice where utilization increases have occurred.

**Set up a payer/physician committee.** A joint payer/physician committee should be established for ongoing scrutiny of specific clinical areas of utilization increase, to ascertain their impact on quality of care. This committee’s findings should be incorporated into the fee-setting process. Three of the five provinces have established joint committees as part of, or separate from, the bargaining process to undertake microlevel reviews of areas of utilization increase. Evidence from these joint initiatives is expected to make the apportionment of fiscal responsibility for the utilization increase a more sophisticated and fair process.

Without such a committee, the initiative of quantity controls is bald cost containment untempered by concerns for the “quality of care” or real changes in the medical care needs of the population. Perhaps to counteract this claim, in Canada the factors that have been considered “justifiable” in the utilization increase have tended to favor the profession. The most notable case of this has been the use of calculations that rely on the utilization increase per physician, thus removing the impact of growth in the total supply of physicians on the overall utilization increase. One alternative, not currently used by any of the provinces, is to focus on utilization per capita, thus removing the impact of population growth on the utilization increase and also allowing adjustment for changes in the age/sex mix of the population—the increasing proportion of the elderly, for instance.

The task of joint committees on utilization could be to feed into the fee-setting process their best estimates of the relative contributions of factors such as population growth, medical/technological change, or previously unmet needs to both observed and projected utilization increases. It would not be unreasonable from a planning perspective if changes in the prevalence of disease amenable to medical care intervention were also one of the factors under consideration. However, political pragmatism may make such an inclusion less reasonable.

**Include an all-payer system.** Without an accompanying all-payer system, price and quantity controls likely will be ineffective in controlling total health care expenditures. Canadian experience does suggest the advisability of accompanying the introduction of a fee schedule with quantity controls, rather than trying to add on quantity controls later, and the initiative has obvious intuitive appeal. However, the absence of a single-source payer makes the exercise less likely to succeed, when the definition of success is control of total societal expenditures on physician services. The balloon may be squeezed within the physician services
sector by displacing the quantity response from one payer with controls
to another without them.

One way to prevent this is to create an artificial single-source payer by
generating local or regional coalitions of all-payers, as has already been
done in some U.S. states or cities for hospital services. The hospital rate-
setting commissions would have a parallel in fee-setting commissions that
represented all insurers of care for the area. Thus, total quantities of
medical care delivered in the area would be the subject of negotiation, not
just the quantity attributable to one particularly concerned payer.

Such all-payer coalitions also facilitate the possibility of designing the
cap in a more creative way than just total levels of service provision. Many
of the factors justifying a utilization increase that we outlined earlier are
likely to vary in their importance by region and/or by specialty. A
centralized fee-setting exercise will not take account of these potentially
important variations. In an all-payer system, the level of justifiable
utilization increase could respect the local demographics and/or account
for major changes in local specialty circumstances such as the introduc-
tion of new facilities in the local hospitals.\footnote{22}

Furthermore, by imposing the constraint at the level of the region and/or
physician specialty, one problem of regulated utilization without
individual income caps—the threshold approach or Quebec's approach
for specialists—can potentially be ameliorated.\footnote{23} If there is a limit on the
total pool of funds available for physician services, but no limits on the
quantity of services billable by each physician, then the free rider who
merely adjusts by increasing personal billings is left unpenalized. The
"responsible" physician who carefully adjusts practice patterns in re-
sponse to the overall cap will suffer some income loss in the current year,
in addition to income loss in subsequent years if there is downward fee
adjustment to recoup utilization increases generated by the free riders.

By localizing the cap on utilization to not only a specific community,
but also a specialty, this perverse incentive is internalized to a small
enough peer group that it might enable physician communities to iden-
tify their free riders and take their own action to overcome the problem.
Thus the all-payer cap on local utilization might not only control the level
of utilization increase, but also put incentives in place for physicians
themselves to organize for the maintenance of local practice patterns
commensurate with high-quality care. There is an assumption underlying
this that physicians have a strong preference for, and a local ability to
enforce, the provision of necessary before discretionary care. If this is
true, then locally based control on the price and quantity of physician
services through fee schedules has the potential of being a panacea by not
only containing the cost of care, but also improving its quality.
NOTES


6. Universal coverage for hospital care was prompted by passage of the *Hospital Insurance and Diagnostic Services Act of 1957*, whereas coverage for physician care was brought about by the *Medical Care Insurance Act* of 1966. All provinces had instituted full coverage for hospital and physician services by 1971.


10. Barer et al., “Fee Controls as Cost Control.”

11. Although we use the term “utilization” or “volume” throughout the following section, this is not strictly accurate. Most of the provinces base their calculations on expenditures, not on the actual number of services delivered. Their reasoning is that changes in the mix of services can, theoretically, reduce utilization (as measured by services) but still increase expenditures. Their concern is overall expenditure; therefore, they consider expenditure data a reasonable proxy for utilization.

12. There is provision in the agreement to adjust the 1 percent for population growth if actual growth exceeds this target.

13. $3.5 million or 1.9 percent of a potential $183.5 million was recommended as the
amount due to unattributable volume increase. The Manitoba Medical Association interpreted the ruling to mean an increase of $10.26 million to the fee schedule—5.7 percent of $180 million. The government interpreted it to mean an increase of $6.97 million—3.8 percent of $183.5 million.

19. Fee-adjusted billings are those that have been deflated to take out the effects of fee increases using the Quebec Physicians Fee Index. For details, see M.L. Barer, R.G. Evans, and R. Labelle, “The Frozen North: Controlling Physician Costs Through Controlling Fees—The Canadian Experience,” monograph (Washington, DC.: Office of Technology Assessment, 1985).
22. A similar proposal for local “pools,” capitalizing on Canada’s single-source payer status, has been made for British Columbia in R.G. Evans, “Squaring the Circle: Reconciling Fee-for-service with Global Expenditure Control,” working paper no. 5 (Vancouver: University of British Columbia, August 1988).
23. Individual income caps also are not without their problems. The payment of only 25 percent of the fee to general practitioners once they have reached their income ceiling in a quarter leads, according to anecdotal reports, to larger than average number of physicians taking vacations toward the end of each quarter. This has obvious implications for patients’ access to physician services.