Intelligence MEMOS

From: Åke Blomqvist

To: Christine Elliott, Ontario Minister of Health

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Re: ONTARIO NEEDS A NEW APPROACH TO MEDICARE, NOT BINDING ARBITRATION FOR DOCTORS

After a three-day hiccup last month the Ontario government agreed to resume arbitration hearings in its dispute with the Ontario Medical Association about a new contract. But with or without arbitration, chances are that when there is some kind of new agreement, it's going to be costly.

Once the dust settles, the government should turn its attention to things it can do to avoid expensive conflicts like this, and, more generally, what it can do to promote better use of physicians in our healthcare system.

The previous government agreed to the OMA's request for binding arbitration in 2017, following several years of unsuccessful attempts at agreeing to a new physician services contract. It probably did so in part because of a Supreme Court of Canada decision in 2015 striking down a Saskatchewan law prohibiting strikes by essential workers as unconstitutional. Following that decision, the general principle that now applies is that all public-sector workers in Canada either should have the right to strike, or, if they are classified as essential workers that don't have this right, should have the access to a mechanism such as binding arbitration.

Given that this is now the law of the land, binding arbitration is likely to become more common and Ontario and other provinces should urgently address the question whether existing laws and regulations with respect to arbitration should be modified in public-sector disputes. One of the factors that arbitrators are supposed to take into account is the employer's "ability to pay". But government pays its workers (and its doctors) out of tax revenue, and the question how much money to collect in taxes should be decided by elected politicians, not by arbitrators.

Contracts between provincial governments and medical associations also govern the methods used to compensate doctors. Critics of Canada's model of universal health insurance have argued that the current approach, which continues to be dominated by the traditional fee-for-service, is not well suited for efficiently managing today's high complex and specialized healthcare system. In particular, it does not promote innovative exploitation of the opportunities created by new technology. Ontario has had some success in introducing changes in the way primary-care doctors are paid, but the process has been slow and costly. Attempts to deepen the reforms and extending them to specialist compensation are likely to be highly controversial and may well end up in another standoff between the government and the OMA. Binding arbitration is even less likely to be an effective way to bring about a good outcome in that type of conflict.

What to do? Under Canada's single-payer model, all issues relating to compensation and working conditions of physicians and other health services professionals become heavily political. With little or no room for private medicine, doctors in Canada essentially have no option other than to work under the government plan. Patients, by the same token, have nowhere else to turn if wait times become long, unless they can afford to go to the US. Many doctors would welcome fewer restrictions on private medicine. They would have no trouble finding patients, and a little more competition from private medicine might actually make politicians more willing to address the problems in the public plan.

Allowing for more competition between the government plan and private medicine doesn't have to mean accepting "US-style healthcare." Many countries with universal health insurance, including the Netherlands and Switzerland, but also Australia and even the United Kingdom, have healthcare systems in which there is more room for competition between private medicine and insurance and government plans. In comparisons of per capita costs and quality of care, these countries typically rank above Canada.

If we had a system like Australia's, private clinics and hospitals would be allowed to compete with public hospitals, putting pressure on them to become more efficient and manage wait times better. Fewer Canadians would travel to the US to get faster care, and with more private care there would be less pressure on healthcare budgets. Young specialists who are unemployed today because there are no hospital facilities where they can practice might be able to find jobs if more private clinics were allowed, and labour relations in healthcare might be less acrimonious if health professionals have a choice between working in the public or private sectors.

Hardline defenders of Canadian medicare will object because more room for private medicine may mean that rich people will be able to buy more expensive care than what the government provides for the rest of us. But if the result is a more efficient and innovative system with the rest of us getting care that is as good or better than what we have now, does it really make sense to let ideology stand in the way?

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