NEWS

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The high cost of care

The recent collapse of fee deal negotiations in Ontario raises questions about the sustainability of our health-care system and sheds light on how those caught in the crosshairs—doctors and patients—will be affected in future

BY TRISTAN BRONCA • Toronto

HEALTH CARE IS A BUSINESS, and in that business, fee codes and financial incentives are used to compensate physicians. When changes to remuneration are imposed, doctors must adapt to make up for service cuts and financial shortfalls, meaning that effective care is harder to provide. All this may be well known to physicians, and the government representatives who set their fees, but it is foreign to a large segment of the general public. However, grasping this perspective is essential to understanding how and why the recent fee negotiation talks in Ontario collapsed, and the implications this might have on patients throughout the country.

"The public may know that something is going on," said Dr. Shawn Whatley, a family physician in the town of Mount Albert, Ont. "But unless they're really keen, I don't think they appreciate the major impact that this will have on their lives." After the recent breakdown in talks, the Ontario government portrayed physicians as high earners looking for another income-padding opportunity. In contrast, physician representatives have been adamant that these talks are not about money, but about patient care. Indeed, as they've argued, when austerity measures are imposed, doctors do suffer, but it's the general public, and especially those most in need, that bears the brunt of the cutbacks.

Opening up the debate

In January 2014, the Ontario Medical Association began negotiations with the provincial government after a previous deal—which had cut physician fees in 2012—expired (see timetable on page 22). For 12 months, these negotiations remained confidential, but on Jan. 15 of this year, the OMA publicly announced it had rejected the government's offer. The reason? The proposition would (along with over a half-

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Pictured above, Dr. Ved Tandan (left), president of the Ontario Medical Association and Dr. Eric Hoskins (right), Ontario health minister, were embroiled in an unsuccessful year-long negotiation process over physician fees.

Left: The Windsor Star/Tyler Brownbridge; right: CP/Darren Calabrese

Annual MedPost fee deal survey

GUIDE TO CHART

Clinical earnings: We've ranked the provinces from highest to lowest based on Canadian Institute for Health Information data on average gross clinical payments. We've also included StatsCan data on cost-of-living variations.

Source: CIHI/StatsCan

How much total expenditure on physicians has been going up annually: This is driven by population growth, fee increases, changes in number of doctors plus changes in number of fees billed per doctor. The 2013 and 2014 numbers are forecasts.

Source: CIHI

Update on where province is in master agreement cycle.

TOP CLINICAL EARNERS

ON

Average gross clinical payment per MD, 2012/13: **$370,731**

Variation from nat'l average: **+13%**

Price differential from national average of consumer goods and services for city in region, 2013: **Toronto: +8%** **Ottawa: +2%**

Annual percentage change in total funding to physicians:
2011: 6.0%
2012: 3.2%
2013: 2.9%
2014: 3.2%

Fee deal status: **Negotiations collapsed.** Beginning Feb. 2, the government imposed a unilateral 2.65% discount on all fee-for-service payments. Total physician funding, however, will increase 1.25% annually for the imposed two-year policy which expires in March 2017.

SK

Average gross clinical payment per MD, 2012/13: **$365,511**

Variation from nat'l average: **+11.4%**

Price differential from national average of consumer goods and services for city in region, 2013: **Regina: -1%**

Annual percentage change in total funding to physicians:
2011: 8.7%
2012: 2.6%
2013: 8.1%
2014: 4.6%

Fee deal status: The Saskatchewan Medical Association is **currently in negotiations** with the government. The last deal, covering four years, expired in March 31, 2013. That last deal featured an increase of 13% over four years.

AB

Average gross clinical payment per MD, 2012/13: **$348,221**

Variation from nat'l average: **+6.1%**

Price differential from national average of consumer goods and services for city in region, 2013: **Edmonton: 0%**

Annual percentage change in total funding to physicians:
2011: 9.5%
2012: 3.6%
2013: 5.4%
2014: 7.8%

Fee deal status: Alberta's current seven-year deal expires on April 1, 2018. The deal features no increases in the first three years, then two years at 2.5% and then two years of cost-of-living increases.

MB

Average gross clinical payment per MD, 2012/13: **$318,256**

Variation from nat'l average: **-3.0%**

Price differential from national average of consumer goods and services for city in region, 2013: **Winnipeg: -5%**

Annual percentage change in total funding to physicians:
2011: 2.9%
2012: 5.1%
2013: 9.4%
2014: 5.8%

Fee deal status: Doctors Manitoba is **currently in negotiations** with the government. The current four-year deal, which expires March 31, 2015, had fees frozen over the first two years of the agreement with a 10.6% increase in years three and four.

MIDDLE – LOW CLINICAL EARNERS

QC

Average gross clinical payment per MD, 2012/13: **$279,206**

Variation from nat'l average: **-14.9%**

Price differential from national average of consumer goods and services for city in region, 2013: **Montreal: -7%**

Annual percentage change in total funding to physicians:
2011: 7.5%
2012: 6.5%
2013: 11.5%
2014: 6.8%

Fee deal status: In Quebec, family doctors and specialists negotiate separately and fee negotiations are done on an ongoing basis, sector by sector.

NL

Average gross clinical payment per MD, 2012/13: **$276,508**

Variation from nat'l average: **-15.8%**

Price differential from national average of consumer goods and services for city in region, 2013: **St. John's: -2%**

Annual percentage change in total funding to physicians:
2011: 6.8%
2012: 2.3%
2013: 3.3%
2014: 1.3%

Fee deal status: The Newfoundland and Labrador Medical Association is **currently in negotiations** with the government. The last agreement, which expired Sept. 30, 2013, included an average 26.6% pay increase over the four-year deal.

NB

Average gross clinical payment per MD, 2012/13: **$275,931**

Variation from nat'l average: **-15.9%**

Price differential from national average of consumer goods and services for city in region, 2013: **Saint John: -4%**

Annual percentage change in total funding to physicians:
2011: 5.8%
2012: 3.4%
2013:-1.5%
2014:-0.3%

Fee deal status: The New Brunswick Medical Society inked a new two-year deal with the province last spring that runs April 1, 2014 to March 31, 2016. The deal features 2% increases in the medicare budget each year.

BC

Average gross clinical payment per MD, 2012/13: **$271,145**

Variation from nat'l average: **-17.4%**

Price differential from national average of consumer goods and services for city in region, 2013: **Vancouver: +4%**

Annual percentage change in total funding to physicians:
2011: 5.6%
2012: 1.3%
2013: 1.7%
2014: 2.2%

Fee deal status: In December, B.C. doctors ratified an agreement which would see compensation and incentive increases of 5.5% over the course of a five-year deal which expires in March 2019.

BOTTOM

NS

Average gross clinical payment per MD, 2012/13: **$261,422**

Variation from nat'l average: **-20.4%**

Price differential from national average of consumer goods and services for city in region, 2013: **Halifax: 0%**

Annual percentage change in total funding to physicians:
2011: 4.8%
2012: 5.3%
2013:-0.1%
2014: 5.8%

Fee deal status: In 2008, Nova Scotia reached a five-year deal with the province. In 2011, that deal was extended by two years to expire in March 2015. Physician fees increased 1% annually except in 2009/10 (when they increased 1.5%). After the deal renewal, they rose 2% between 2013/14 and another 2% between 2014/15. The two sides are **about to start negotiations**.

P.E.I opts out
According to CIHI, P.E.I. requested that their figures be witheld because physician counts and their associated payments were "significantly skewed" by visiting specialists and locums.

PEI

Average gross clinical payment per MD, 2012/13: **n/a**

Variation from nat'l average: **n/a**

Price differential from national average of consumer goods and services for city in region, 2013: **Charlottetown: -5%**

Annual percentage change in total funding to physicians:
2011: 1.3%
2012: 0.7%
2013: 4.2%
2014: 2.7%

Fee deal status: Island doctors are **coming up to the expiry of their fee deal** as the Medical Society of Prince Edward Island's current five-year deal expires on March 31, 2015.

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dozen other adjustments; see details at right) cut all physician fees by 2.65% to guarantee a $580-million savings target was met. Complicating matters, Ontario's health minister, Dr. Eric Hoskins, allegedly told the OMA's board that if they walked away from the table deeper cuts would be imposed.

In the ensuing fallout, the OMA launched a public outreach campaign, attempting to draw the government back into negotiations by having the public apply pressure. OMA president Dr. Ved Tandan began to make media appearances, explaining that it was patients, not doctors, who would feel the impact of these cuts. The OMA's message was clear: You cannot pull $580 million in funding out of the system without negatively affecting its operation.

Coinciding with these media appearances, the OMA sent out dozens of daily tweets marshalling support for the campaign. The OMA's Twitter account was flooded with feedback from physicians and patients alike, much of which the OMA poured back into its feed for all its followers to see.

In the first two weeks, the "#CareNotCuts" hashtag—created by the OMA to galvanize online support—appeared in over 5,000 tweets and in the Twitter feeds of 2.2 million users. The OMA's Facebook page registered a 500% increase in engagement after the organization began to disseminate infographics and messages explaining how Ontario's growing health-care needs were outpacing increases in funding.

If the OMA's perspective was clear, however, Dr. Hoskins has been equally unambiguous. At a Jan. 15 press conference, he argued that Ontario's doctors were some of the highest paid in Canada and that the recent negotiations have been about physician earnings and nothing more. "No services will go unlisted, no services will go unpaid," he added in an interview with CBC Radio One. "To scaremonger about access to family doctors and surgeries and wait times is reckless and, quite frankly, unbecoming of a professional organization of which I am a member." (Efforts to contact Dr. Hoskins to clarify comments and obtain an interview were unsuccessful).

On Feb. 1, the government unilaterally imposed its cuts. For his part, Dr. Tandan remains hopeful that the government will return to negotiations (the OMA's counteroffer to freeze physician fees for two years is still on the table). However, Dr. Hoskins has said the government will stand firm on its decision.

In the midst of this public debacle, many Ontario doctors are left wondering what the future of health care in their province will look like, and how patients most in need will be affected.

Why the OMA walked away

On Dec. 20, 2014, Dr. Tandan and the OMA's board called an informal meeting of the association's leadership council to review the details of the government's final offer. The conciliation phase—a month-long, adjudicator-led push to reach an agreement—had just concluded and the council's 150 physicians had travelled to Toronto on less than 10 days' notice.

"We were still in negotiations so everything had to be done in a confidential manner," said Dr. Tandan. Non-disclosure agreements were passed around and signed before the OMA president began his two-hour presentation, detailing the negotiation process that had taken place up until that point. During this meeting, Dr. Tandan also distributed a report issued by the leader of conciliation, former Chief Justice of Ontario Warren Winkler, containing his recommendations based on feedback from both the government and doctors.

"We gave everyone time to read everything and think about it all," said Dr. Tandan. "We then came back and had several hours of negotiation to get feedback from the group." There was no vote, but Dr. Tandan confirmed those physicians made it "loud and clear" that the offer would be bad for patients.

Now public, the Winkler report ends by recommending the government stand behind its offer and that the OMA ought to "reconsider" rejecting it. Despite this, Ontario doctors are latching onto a very different detail of the report. As Winkler wrote, without some systemic changes to our health-care system, both the government and the OMA would reach a point where savings and the ability to provide care could become irreconcilable.

To look at these systemic issues in coming years, Winkler proposed two initiatives—"the task force" and "the Minister's roundtable"—to recommend changes to "delivery and funding" of physician services. For the immediate future, however, he seemed to suggest that this deal offered a temporary fix. While the system would take a hit in the first two years when the government collected its $580 million in savings, the third-year hike of 1.4% (a $117-million increase to the physician services budget) would make for "a cost-neutral year" and "offer a meaningful payment towards physicians' cost of practice," Winkler wrote.

The OMA's membership felt differently. "Even knowing that unilateral action imposed by the province would likely be worse, we just could not in good conscience accept the offer," said Dr. Tandan. In fact, he added that unilateral action has been punitive towards doctors, pointing to the fact that in the government's imposed settlement the 1.4% one-time funding increase in the third year had been removed. "Still, uniformly, the message I'm hearing from physicians is that we did the right thing."

The cutting room floor

A summary of the slashed rates and revoked premiums imposed by the Ontario government in this recent round of cuts.

Fee-for-service: As of Feb. 1, payments for all doctors have been reduced by 2.65%.

Continuing medical education: Funding will be eliminated, but all doctors are still obligated to attend courses and events to stay up-to-date on CME requirements.

Condition-specific premiums: Some specialists, including nephrologists, gastroenterologists, cardiologists and internists, will no longer receive a 50% premium on fees for assessing certain diagnoses.

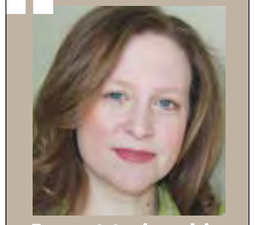
Weekend and holiday rates: Fees for family physicians working holidays and weekends will be reduced.

Healthy patient premiums: Premiums for accepting healthy patients will be eliminated. Doctors who accept complex patients will continue to receive these premiums.

Income stabilization payments: Doctors working in over-serviced areas will no longer be eligible for these payments.

On-call program: Funding for the Hospital On-Call Coverage program will be frozen at the current level for the forseeable future.

Icons: iStockphoto



> **"I want to be able to bring on some more patients, but I can't overburden my staff in the process."**
>
> *—Dr. Lisa Habermehl*

Physician voices

Dr. Whatley, the FP in Mount Albert, Ont., is a physician blogger. He began his blog in 2013 writing about emergency department processes, but after the Ontario negotiations collapsed, the topic took over his postings. He began to explore some of the finer points of physician billings, offering rough comparisons between physician fees and the services a vet, mechanic or plumber might charge. He highlighted and analyzed the contentious portions of the Winkler report, and penned a didactic parable about a king who couldn't pay his bakery bill as a metaphor for Ontario's health-care system.

"I don't want people to feel sorry for doctors," Dr. Whatley said. "We are going to recover and weather the storm." However, doctors have been drawn into a "big scrum" with the government, he added, where MDs have been "bullied," "slandered" and "maligned." Now, according to Dr. Whatley, they'll need to work harder, longer and faster to reduce the impact of the cuts, and future generations of doctors will, in many ways, be left with a weaker system. Still, Dr. Whatley maintains the real victims are vulnerable patients, such as the elderly, the medically complex or those who can't advocate for themselves.

To illustrate his point, Dr. Whatley refers to an entry on his blog, which outlines how a relatively simple procedure at his clinic was suspended due to the last round of cuts. Prior to 2012, a physician could bill about $5 (a low fee even then) to draw blood in the clinic. When the fee dropped to $3.54, it became impossible for Dr. Whatley to make a financial case for the service, given the cost of kits, bands, tubes, needles, storage and staff. Now, the elderly patients who previously came in once a week for the service must drive 30 minutes away to the nearest lab, a circumstance Dr. Whatley finds "absurd."

Though it would be hard to argue Dr. Whatley's blog—which features pronouncements like "doctors just want to work hard seeing patients"—is not slanted towards those in his profession, it has nevertheless spurred important discussion. One commenter observed that, "if the cuts were a simple 3% fee cut across the board the effects would be minimal." Instead, he suggested that most of the money the government is saving would be coming from more damaging cuts to rostering bonuses, which are paid out depending on patient complexity. These allow physicians to schedule longer visits for more complicated patients, without packing their schedule to ensure fee-for-service pay-

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2 negotiations. The timeline, the players

2012 February When the OMA and government sides sit down for the first time in a boardroom at the OMA's white office tower on Bloor St. in Toronto to negotiate a 2012 fee deal, government negotiators hand the OMA a white binder. That binder contains government objectives, approved by Premier **Dalton McGuinty**'s cabinet, calling for four years of zero growth in total payments to physicians. However, because utilization (number of fees per doctor plus the rise in number of doctors) is increasing 3.7% annually, that means the government is asking for a deal where the fee schedule will fall by about 3% annually.

2012 April With talks at a standstill, the government walks away from the table.

2012 May Then Health Minister **Deb Matthews** imposes a number of fee cuts, but she specifically targets "highly paid" specialists such as ophthalmologists and diagnostic radiologists.

2012 September Fee talks restart.

2012 November New deal reached undoing some fee cuts, but every doctor sees across-the-board 0.5% cut. Deal formalizes process if negotiations break down in future talks.

2012 November OMA members ratify new deal in highest voter turnout in OMA's history (54% of eligible doctors) with 81% supporting the new deal.

2014 January Two sides begin talks for 2014 deal. Matthews has been promoted to president of the Treasury Board, where she overseas the government's bid to return to budgetary balance by 2017/18. **Dr. Eric Hoskins** is now health minister.

2014 September With no progress, talks enter the facilitation stage (as outlined in the 2012 agreement on process). **Dr. David Naylor**, former president of U of T, is the facilitator, but no progress is reached.

2014 November Next stage in agreed process starts: Conciliation is led by **Justice Warren Winkler,** former chief justice of Ontario.

2014 December After conciliation fails to reach an agreement, Winkler urges the OMA to "consider" the government offer. OMA president **Dr. Ved Tandan** and more than 150 doctors meet in Toronto on Dec. 20. The offer is rejected.

2014 January OMA board meet and formally reject the government's offer. Dr. Hoskins announces, effective Feb. 1, revisions to doctor compensation including a 2.65% cut to all fee-for-service physician payments.—*Colin Leslie*

CP Images

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ments cover salary and costs.

Just below this comment, on the same post, a radiologist left a note explaining that she does a lot of work she isn't paid for, like reviewing charts for upwards of one hour before seeing a patient. "At the end of the day, I enjoy my profession—yes. But it can be an all-consuming role," she wrote. "I firmly believe that, in Ontario, doctors are not overpaid."

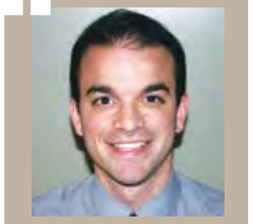
READ MORE ON THE TABLET!

For a bonus chart showing overhead costs by specialty, see this month's tablet edition of the *Medical Post*.

Tracking true earnings

Physician earnings always come under scrutiny during fee deal negotiations, but in light of this second round of cuts (after Ontario slashed fees in 2012) and the OMA's warnings about the impact on patient care, the discussion has taken on newfound importance.

Dr. Mario Elia, a family physician in London, Ont., said he believes the inflated gross payment figures often quoted in the press make doctors an easy target for cuts. "How can you argue that the average physician should be paid over $300,000 a year without sounding greedy?" he asked. Moreover, he acknowledged that trying to convince patients that physician salaries should be high because of overhead costs, no pension and no benefits, doesn't often work. "I think the way the OMA has responded is a fairly neat way of arguing, because the idea that doctors are overpaid is difficult to counter, but focusing on the idea of service and access has had some traction, I think."



How can you argue that the average physician should be paid over $300,000 a year without sounding greedy?

—Dr. Mario Elia

Despite this, Dr. Elia didn't seem particularly incensed by the deal itself. (Although, as he wrote in a web editorial on CanadianHealthcareNetwork.ca, the online home of the *Medical Post*, he was "infinitely more irritated" by the spin Dr. Eric Hoskins has put on the situation.)

"Myself, day to day, I don't know if it's going to change a whole lot," Dr. Elia said, adding that he can't speak for other physicians who may experience more lasting effects. "I think the fair deal was the freeze. If they want to let us eat the cost of inflation moving forward, I think that's a fair deal."

The hardest-hit doctors

While most agree the conversation about physician earnings is an important one, in a way, it's also a moot point. Even if Dr. Hoskins could successfully argue that doctors are overpaid, trimming fees and eliminating premiums makes it difficult for physicians to keep up with the expanding needs of Ontario patients. This is especially true for patients living in the province's rural areas, where, traditionally, greater incentives have been required to draw physicians to more remote areas.

Dr. Lisa Habermehl is a family physician working in Kenora, a town 30 minutes from the Manitoba border and about six hours away from Thunder Bay. Though Winnipeg is closer, Dr. Habermehl said patients are more often sent to Thunder Bay for advanced care because of "difficulties in cross-provincial funding."

The area has a listed population of 15,000, but Dr. Habermehl said that surrounding communities, First Nations populations and summer cottagers put the primary health-care catchment at well over 25,000. Still, patients requiring cardiac surgery need to travel to Ottawa, Toronto or Hamilton, and though every eight to 12 weeks specialists open visiting clinics, waits for those clinics can run up to six months.

According to Dr. Habermehl there are still "many, many patients" without a family doctor, a fact that's particularly discouraging since the clinic where she works was originally built to accommodate more practitioners and more patients, neither of whom materialized in light of cuts in the last five years. "My plans to expand my own practice and take on more patients also becomes less straightforward," she said. "I want to be able to bring on some more patients, but I can't overburden my staff in the process." And without new staff willing to come into the area to build a career, she won't be able to take on those patients without compromising the quality of care for her current patients.

While the government has maintained that certain payment incentives, such as income stabilization (supplementary payments offered to new doctors while they build their practice) will remain in effect for "under-serviced areas," it's unclear whether Kenora would qualify. Without these sorts of incentives, Dr. Habermehl said she's not hopeful any new doctors will show up at the clinic's doorstep.

Indeed, many anticipate that these new doctors will be the ones most significantly affected by the cuts. Some estimates suggest that Ontario will require 700 new doctors every year to meet the needs of existing patients and the 900,000 who are still without a family physician. However, given the two consecutive rounds of cuts (2012 and just this month) and the uncertainty surrounding the sustainability of the current system, there may be less of a financial incentive for young doctors to practise in Ontario.

Take income stabilization, for example. Unless these young doctors are willing to locate to a provincially designated under-serviced area, they'll no longer be eligible to receive payments which could account for over 30% of their income. On Dr. Whatley's blog, this topic generated noticeable chatter, with some commenters voicing concerns that new doctors may choose to work as locums in walk-in clinics or emergency rooms, or in the fee-for-service models their education has been steering them away from.

Some medical students who would have gone into family medicine are now also choosing other specialties, and many residents who have already chosen family medicine are either moving into "factory-style family practice"—treating more patients, more quickly and, as a result, less effectively—or moving out of province.

The U.S. option: recruiting salaries

ALL FIGURES IN U.S. DOLLARS

When Canadian doctors become unhappy with their compensation, they traditionally look south. Here are the most recent incomes offered in 2013/14 for key specialties according to U.S. recruiter Merritt Hawkins' 2014 annual report on recruiting incentives.

	Low	Average	High
Family medicine	$140,000	$199,000	$293,000
Internal medicine	$145,000	$198,000	$360,000
Hospitalist	$145,000	$229,000	$350,000
Psychiatry	$150,000	$217,000	$350,000
Pediatrics	$130,000	$188,000	$240,000
Emergency medicine	$220,000	$311,000	$400,000
Ob/gyn	$215,000	$288,000	$380,000
Neurology	$180,000	$262,000	$400,000
General surgery	$270,000	$354,000	$515,000
Orthopedic surgery	$350,000	$488,000	$700,000
Gastroenterology	$240,000	$454,000	$560,000
Hematology/oncology	$315,000	$377,000	$450,000
Otolaryngology	$250,000	$372,000	$500,000
Cardiology (non-invasive)	$400,000	$442,000	$500,000
Cardiology (invasive)	$350,000	$454,000	$550,000
Urology	$430,000	$504,000	$625,000
Neurosurgery	$450,000	$591,000	$700,000
Pulmonology	$230,000	$358,000	$425,000

Source: Merritt Hawkins

Dealing with uncertainty and the way forward

The night of the fee deal collapse, Dr. Hoskins took to Twitter to respond directly to those who had criticized the government's plan. He claimed physician salaries had been on the rise since 2003, and shot back at angry users who seemed to be goading him into a fight, arguing that block fees and tax splitting were other ways for physicians to make and save money. He responded to tweets late into the night. Early the next morning in his interview with CBC Radio One, he made it clear that the government would not sway from its course of action.

Dr. Fullerton

Dr. Merrilee Fullerton was one of many Twitter users voicing concern about the current deal that night. A health-care communicator (and former family physician) from Ottawa, Dr. Fullerton has been involved in medical politics and patient advocacy for over 25 years. During an interview with the *Medical Post*, she explained that, as the government "lurches" back and forth, pouring more funding into the system and then choking it off, it costs taxpayers more money and creates greater uncertainty. However, according to Dr. Fullerton, many administrations go ahead with new programs anyway to save face in the public eye.

"We have these long-term issues because governments will throw money at problems to try to appease the public," she explained. "Sometimes it doesn't accomplish anything, but the government goes back to the OMA and claims the new initiatives are costing too much, and then it's up to the OMA to find some savings." However, according to Dr. Fullerton, a major problem is that the organization cannot account for the funding that will be required to accommodate new technologies, procedures or unforeseen pressures on the health-care system, such as pandemics.

Dr. Fullerton argued the best solution to these uncertainties might be a public-private funding model. Though the concept is taboo in any Canadian health-care negotiation, Dr. Fullerton argued it would offer the flexibility the system needs to absorb rising costs—both unanticipated and expected.

During an Empire Club speech delivered on Feb. 2, Dr. Hoskins did touch on this proposal, but maintained that a two-tier system simply wasn't an option. As he laid out his strategy for the future of care in the province, he talked about a system that would be evidence-based and patient-centred, with home and community care supports that were flexible, affordable and reliable. There was no mention of Winkler's concerns about sustainability, nor of the cuts that had been imposed only one day before.

Currently, the discussion is slowly beginning to slide out of the spotlight. The OMA's Twitter feed is still pumping out messages in their #CareNotCuts campaign and Dr. Tandan remains confident that the message is finding a home among the public.

Perhaps most hopeful, both Dr. Tandan and Dr. Whatley pointed out that the physicians of Ontario are a sizeable group and, in and of themselves, may be capable of effecting change. "Doctors will continue caring for patients," Dr. Whatley wrote in a comment on a CanadianHealthcareNetwork.ca article. "Physicians will continue to be envied for the incomes they generate. Things will not change until large groups of the public stand together and demand change. Could 35,000 physicians in Ontario be that group?" **MP**

Putting physician income into perspective

By Dr. Shawn Whatley

FINANCIALLY SPEAKING, hard-working physicians and surgeons can do quite well. Unfortunately, that's what makes them easy targets. Politicians can win instant support by publishing gross billings and calling them "doctor incomes."

Dr. Whatley

Physicians will never move public opinion by justifying their salaries, but if MDs can shift the discussion from gross incomes to individual services, it will allow people to decide for themselves whether doctors are paid too much for the care they provide.

Here are a few Ontario-specific examples that list what doctors charge compared to some everyday services people pay for daily (note these figures represent pre-fee-cut amounts):

What doctors charge

1. Intermediate assessment (e.g., an appointment for pneumonia), A007, 15 to 20 minutes; 10 minutes if really rushed = $33.70
Compared with:
- Eye exam checkup, 20 minutes = $85
- Dental cleaning and exam, 30 minutes = $90

2. Adult periodic health exam (aka, "annual physical"), K131, 30 to 40 minutes = $50
Compared with:
- Massage, 1 hour = $125
- Accountant, review taxes, 1 hour = $200

3. Skin biopsy with sutures, Z166 + E542. Tray fee (sutures, needles, anesthetic, antiseptic, sterile equipment, etc.) = $29.60 (Z166) + $11.15 (E542) = $40.75
Compared with:
- Haircut, female, 30 min, starting at $65

4. Breast lump excision, human, R111 (partial mastectomy) = $269.40
Compared with:
- Breast lump excision, dog = $849 per hour

5. Immunization, G840 = $4.50. With examination at visit = $4.50 + 33.70 = $38.20
Compared with:
- Immunization, Black Labrador retriever, with exam at visit = $85.43

6. Fecal disimpaction, Z756 = $36.80
Compared with:
- Drain cleaning = $93

7. Cost of family practice per person in Ontario = $0.78 per day
Compared with:
- Tim Hortons coffee = $1.57 medium, $1.71 large, $1.90 extra-large per day

Bonus tablet content