Medical Politics and Canadian Medicare: Professional Response to the Canada Health Act

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MEDICAL POLITICS IN CANADA, BY WHICH WE MEAN the political activity of members of the medical profession—and relations between the profession, governments, and other political actors—have been characterized by regular and escalating conflict since the beginnings of universal government health insurance in the 1960s. Such conflict has focused on the medical profession's defense of its corporate autonomy in the face of what it has viewed as unwarranted government intrusion in medical affairs. At issue have been the profession's claims of dominance and control of the health care delivery system as opposed to government's desire to guarantee as a social right reasonable access to health care for all Canadians.

In this article medical politics in Canada in the aftermath of the Canada Health Act of 1984 (Government of Canada 1984) is examined. Intended by the federal government as a means of counteracting a perceived erosion of public access to medical care due to the willingness of some provinces to allow charges to patients for physician and hospital services over and above those insured under the federal-provincial health insurance program (Medicare), the act served as a lightning rod for profession-government conflict, and touched off a doctors' strike in Canada's largest province, Ontario, lasting 25 days.

In this article data from a 1987 representative national survey of

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Canadian physicians is used to investigate the most recent cycle of conflict between physicians and government over control of the health care system. The contours of professional response to a range of issues at the center of the political debate over the Canada Health Act are documented, and the implications for the future course of medical politics in Canada are assessed. We argue that the profession's response must be understood (1) in terms of the ideological commitments and solidarity of members of the profession who are in opposition to Medicare; (2) by variations in the manner in which provincial health insurance programs are administered, and, particularly, in the extent to which such programs are perceived by physicians to intrude upon areas of professional interest; and (3) by the internal dynamics of leadership and participation in the organized medical associations that play a major role in articulating the political interests of the medical profession.

The first section of the article provides an introduction to the historical development of the federal-provincial health insurance system in Canada and to the political issues and conflicts accompanying it. The second section gives details of the 1987 physicians' survey from which the data used in this article are derived, and specifies hypotheses guiding the empirical analysis. The third section presents the responses of physicians in all Canadian provinces to questions concerning the operations and financing of Medicare, and strategies open to the profession in pursuing its political goals. In a fourth section we focus on the recent physicians' strike in Ontario, investigating the extent to which physician involvement in this most extreme manifestation of conflict over Canadian Medicare confirms our hypotheses about the ways in which professional response is grounded in ideology and professional organization. Finally, in section five we present our conclusions about the nature of medical politics in Canada and about their implications for the future development of Canadian Medicare.

Historical Development

After government health insurance was forced onto the political agenda by the massive social and economic dislocation of the Depression, the Canadian Medical Association, articulating the collective national interest of physicians, insisted in 1934 that any such program be administered

so as to guarantee the dominance and autonomy of the profession within the health care delivery system. Such dominance and autonomy was justified in the association's view, not simply by the self-interests of physicians, but by the congruence of professional and public interests, "because what is best for the medical profession must be best for the public" (Taylor 1978, 24). This insistence reflected the profession's belief that physicians, due to their mastery of a complex diagnostic and curative technology, were best able to make decisions concerning the health of Canadians, including those in the political sphere (Naylor 1986, 245; Taylor 1960, 125).

When draft federal legislation for a national health insurance program was presented in 1943, it essentially accommodated the profession's key demands. This included a guarantee of professional representation on commissions administering public health insurance, remuneration for the provision of medical services by methods selected by the profession, complete control by the organized profession in each province of fee schedules, and a guarantee that no economic barrier would be imposed between doctor and patient. Under these circumstances the Canadian Medical Association (CMA) (1943, 31) endorsed the principle of government health insurance, stating its readiness "to render any assistance" toward "the solution of one of the country's most important problems." The proposed legislation foundered, however, as a result of federal-provincial disagreements over postwar financial arrangements, and in 1949 the CMA backtracked from its earlier position. It now declared that government involvement in health insurance should be restricted to paying into voluntary private insurance plans part or all of the premium of those unable to pay (Taylor 1978, 108).

This reiteration of the profession's historical opposition to government-controlled health insurance reflected two developments. First, in the vacuum created by the collapse of the federal initiative, the profession had moved to establish its own physician-controlled health insurance plans. By 1949 seven such plans existed offering coverage to Canadians in all regions of the country (Taylor, Stevenson, and Williams 1984, 3; Shillington 1972, 40–45). Second, in 1947 the social-democratic, Co-operative Commonwealth Federation government of Saskatchewan, one of the smallest and poorest of the Canadian provinces, and one especially hard hit by the Depression, introduced its own program of compulsory hospital insurance. Similar initiatives in other provinces followed, as well as a federal program of conditional grants for hospital

construction, disease control, and medical research (Weller and Manga 1983, 227). If these developments quickened the pace of evolution toward a national health insurance system in Canada, they also clarified the essential point of political conflict in that evolution—the question of public or private control.

Nevertheless, overt political conflict over the federal government's Hospital Insurance and Diagnostic Services Act of 1957 was minimized by the fact that this legislation subsidized the institutional facilities in which the most costly of physicians' services were provided, without affecting the greater range of medical services provided through private offices. Professional opposition escalated rapidly, however, when the success of hospital insurance and the proliferation of the profession-controlled plans stimulated further government initiatives to provide more comprehensive and universal medical care insurance (Taylor 1978, 170–75).

In 1962 the social-democratic government of Saskatchewan extended its health insurance program to cover the costs of virtually all physicians' services, whether or not they were provided in an institutional setting. This action was met by a month-long strike in which physicians in the province withdrew all but emergency services. The outcome was a compromise which, on the one hand, acknowledged the right of government to introduce and operate a public health insurance program, but which, on the other, permitted physicians to practice outside of the program and to "extra bill" patients at more than government-insured rates (Badgley and Wolfe 1967, 70).

Although this compromise between public and private control was reproduced on a national scale through the subsequent federal Medical Care Insurance Act of 1966 which led to the establishment of government health insurance programs in all ten provinces, the new national initiative was strenuously opposed by professional association spokesmen appearing before the Royal Commission and parliamentary committees involved (Taylor 1978, chap. 6). Direct physician obstruction of the national program was checked, however, by the continued dominance and autonomy of the profession as a result of the entrenchment of the fee-for-service payment system and the retention of fee schedules previously established by medical associations for the physician-sponsored insurance plans. Physician compliance was further assured by the windfall professional income gains realized in the early years of Medicare's

operation resulting from the fact that physicians were now virtually guaranteed payment for every service provided (Coburn, Torrance, and Kaufert 1983, table 2. Naylor, 1986: 248).

Even if physicians, at least initially, fared well economically under government health insurance, there was an inevitable tension between a profession jealous of its corporate autonomy and governments jealous of their treasuries, especially in times of fiscal crisis (Touhy 1976, 192–94). In spite of the entrenchment of fee-for-service payment, governments proved unwilling to serve simply as disbursement agencies (Soderstom 1980, 225–26). Their attempts to impose some constraint upon escalating health care costs intensified professional opposition to Medicare, leading to the 1970 strike of Quebec specialists, and, after 1970, to the increasing resort by individual physicians to extra billing above insured fee schedules.

Pressures for controlling health costs increased in the mid-1970s. Federal wage and price controls introduced in 1975, and the abandonment of plans for review and expansion of the social welfare system, marked a national shift away from the tenets of Keynesianism to fiscal restraint and monetarist policies. Assisted by the provincial governments' interest in restoring their own initiative in the health policy field, the 1977 Federal-Provincial Fiscal Arrangements and Established Programs Financing Act fixed the federal share of health program costs to the rate of growth of the gross national product. While providing a framework for greater provincial flexibility and efficiency in the management of health insurance plans, the legislation effectively capped federal contributions to health care and created conditions for the progressive Balkanization and privatization of the Canadian health care system (Weller and Manga 1983, 233–35).

Faced by the twin facts of escalating health care costs, and limited revenues, Medicare premiums were increased in three provinces that required them. In addition, some provinces permitted direct user charges for hospital services, and others tacitly approved the practice of extra billing by physicians. These developments increased the costs to individuals of medical services and prompted widespread public concern that the principle of access seen to underly Medicare was being threatened (Weller and Manga 1983, 239). Such concern led to the establishment of a federal Royal Commission of inquiry in 1979 that reaffirmed the principle of access, and in 1984 to the

introduction by the federal government of the Canada Health Act that levied financial penalties upon provinces permitting user fees and extra billing.

This move against extra billing was viewed by the medical profession as a direct assault on its autonomy despite the fact that the practice had already been banned in two provinces—Quebec and British Columbia—prior to 1984, was of little or no consequence in two other provinces—Newfoundland and Prince Edward Island—and was ended by government-profession agreement at or about the time of the act in three additional provinces—Nova Scotia, Manitoba, and Saskatchewan (Heiber and Deber 1987). In the face of survey evidence showing that the great majority of Canadians opposed extra billing and that public support for Medicare was overwhelming (Heiber and Deber 1987, 66) physicians and their professional organizations condemned the act as an unwarranted intrusion on professional freedom that reduced the profession to public service. The Canadian Medical Association criticized the legislation as turning doctors into "a type of state employee," with a "loss of professional independence," arguing that the benefits realized under a medical system "manned (sic) by volunteers" would not result from a system "manned by demoralized conscripts" (Geekie 1984; Montgomery 1984).

The high-water mark of conflict was the Ontario doctors' strike of 1986. A history of relatively nonconflictual relations between government and the medical profession in Canada's largest and wealthiest province was altered a year earlier by the election of a Liberal minority government supported in power by the social-democratic New Democratic Party (NDP) which demanded the end of extra billing. Pressured by the federal financial penalties of the Canada Health Act, by public concern over a perceived erosion of access, and by the need to maintain NDP support, the province introduced legislation forcing physicians to accept fees insured under Medicare as full payment for their services.

In this action the provincial government faced the Ontario Medical Association (OMA), the most powerful of the professional associations in Canada, representing a constituency in which fee-for-service, solo practioners were proportionately more numerous than in any other province (Williams, Stevenson, and Vayda 1987). The OMA responded initially by calling for a two-day strike (May 29–30) supported by an estimated 60 to 75 percent of doctors in the province (Toronto Globe and Mail, May 30: A1). When this show of muscle had no

effect, the OMA Council, in an "almost unanimous" decision, called for an unlimited strike to begin on June 12, asking doctors to provide only emergency services and cancel elective surgery, and asking all hospital chiefs-of-staff and -services to resign (Silversides and McMonagle 1986).

The Ontario strike lasted 25 days, just longer than the Saskatchewan strike a quarter century earlier. As in that earlier instance, the strike failed in its fundamental political objective—the obstruction of government's resolve to extend its control over health insurance. In one sense, therefore, the Ontario strike suggests a political naiveté, weakness, or inability to learn from experience on the part of the profession. On the other hand, the strike mobilized a large proportion of the profession in opposition to government and may have stimulated a substantial measure of political solidarity even among those who did not strike. Such strengths, real or imagined, may limit future elaboration of government health insurance in ways opposed by the profession.

It is in this latter connection that the Canadian literature has tended simply to assume that the medical profession is monolithically committed to the defense of its professional autonomy and dominance in the health care system, that it maintains a substantial power if not absolute veto over the formulation of health policy, and that the scope of future reforms is, therefore, severely limited. In the view of expert observers, "physicians collectively carry more political weight than any other group in health care. Their access to the headlines, and their degree of organization and commitment, assures that their concerns will remain at or near the top of the public policy agenda" (Barer, Evans, and Labelle 1988).

Although not directly challenging these conclusions, our aim is to qualify them by suggesting that "the degree of organization and commitment" of the medical profession is less than is commonly assumed, and that the political weight of the profession is greater than it need be because governments and other political actors hold exaggerated assumptions about its organization and commitment. In developing this argument, we touch on three general aspects of medical politics in Canada. Two of them, already referred to as organization and commitment, concern the ideological commitments and solidarity of members of the profession and the internal dynamics of leadership and participation in the medical associations that articulate its collective political interests. A third aspect of medical politics, also touched

upon, has to do with the activities of governments in the administration of the health care system, and relations between governments and professional organizations.

Data and Hypotheses

Our national survey of Canadian physicians was conducted between November 1986 and May 1987 at the Institute for Social Research, York University. The survey was designed as a follow-up to an earlier one conducted in 1982 prior to the introduction of the Canada Health Act (Taylor, Stevenson, Williams 1984). Self-administered questionnaires were mailed to all 2,100 respondents to the 1982 survey, and to another 2,000 physicians randomly selected to ensure the national representativeness of the new sample. Initial mail contacts were followed by a series of reminder cards, letters, and additional questionnaires, and, finally, by personal telephone calls to nonrespondents, producing a total of 2,397 completions. After adjustment for ineligible respondents (physicians no longer in medical practice) and "dead addresses" (physicians deceased, moved out of the country, or otherwise not reachable by phone or mail), this number represented an effective response rate of 67 percent.

The central objective of the survey was to document professional attitudes and behavior following the Canada Health Act. The survey, therefore, included questions which asked physicians about (a) different aspects of Canadian Medicare in principle and practice; (b) various existing and proposed policies regarding physicians' incomes and the financing of health services; and (c) political strategies open to the profession in responding to government policies perceived to impinge upon professional autonomy. Our analysis of professional ideology, organization, and government-profession relations is based upon physician response in these areas. Our operational hypotheses are as follows.

Ideological Conflict

We are concerned, first, with the extent to which the medical profession is ideologically monolithic in its defense of professional dominance and autonomy, and, by extension, in its opposition to the banning by provincial governments of extra billing following the Canada Health

Act. We have argued elsewhere (Stevenson and Williams 1985) that physicians' attitudes toward health policy issues are ideologically structured, that they tend to be systematically organized in terms of the intensity of support for the principles of professional dominance and autonomy rather than objective differences in professional background and experience. In this article, we want to modify that argument, indicating a more complex organization of physicians' attitudes. Rather than focusing on a single dimension of ideology, with contrasting positions for and against Medicare, we hypothesize that there are three relatively distinct ideological positions taken by physicians.

First, there is a small but significant group of physicians who systematically support government health insurance in principle and in practice, accepting public regulation and financing of health as a means of guaranteeing equitable access as a social right for all citizens. Second, there is a larger and more influential group in systematic opposition to government health insurance. These physicians ground their opposition in an ideological criticism of social welfare "rights," and of government interventions in social and economic life securing these rights, favoring rather the principles of laissez-faire liberalism and a return to free-market medicine.

Between these polar positions lies a middle ground occupied by the majority. As in the wider political universe, so in the medical profession this middle ground is defined by a mixed appropriation of the ideas articulated on the left and right. In the case of medical ideology, the essential logic of the mix involves opposition to government control of the health care system and confirmation of medical dominance, but support for state licensing of the monopolistic powers of the profession and public financing of its activities.

For physicians occupying the middle ground, therefore, the ideological justification of professional dominance does not stem from a principled opposition to state intervention in free markets as such, but from a desire to ensure that such intervention serves medicine's interests. Without resort to ideological principles other than self-interest, this majority position may be less coherent and unified than conventional interpretations of the solidarity of the medical profession would suggest, subject to the competing appeals of the ideologically more consistent positions to the right and left. On the other hand, physicians in this middle category may articulate an equally coherent but more pragmatic conception of medical dominance, recognizing that "only in rhetoric

is there a conflict between state control and private organization of medical practice; in reality 'private versus public' debates are over who shall direct the power of the state in regulating the health care market" (Evans 1984, 69).

Internal Dynamics of Professional Organizations

We are interested, secondly, in the ways in which professional associations mobilize opposition to Medicare. In this connection we will examine differences in the policy attitudes of medical association leaders, activist members, nonactive members, and nonmembers. There are three hypothetical scenarios that might describe the internal politics of the medical profession. First, the extent of solidarity within the profession over the issues raised by government initiatives in health policy during the 1980s may be such that there is no significant division between medical association leaders and the rank and file in the profession. Alternatively, the "logic of collective action" may force professional association leaders to engage in ideological mobilization of a membership otherwise loosely involved in medical politics. Medical association executives may therefore "lead" their memberships in opposition to legislation like the Canada Health Act, and we may expect a greater degree of opposition to recent changes in Medicare on the part of leaders as compared to the rank and file. Finally, as opposed to this latter top-down mobilization, a minority of activist members who are more rigid ideologues of professional autonomy may "push" their associations, rather than being led by them. The supposition in this case is that relatively moderate political stances on the part of medical association executives could stem from a greater awareness of the practical need to engage in conciliation and bargaining with government. If this scenario is the most accurate of the three, a different style of medical politics could be anticipated if the professional associations can be captured by the "quiet majorities" rather than by the militant minorities among their members.

Public Administration

We are concerned, finally, with the general question of the extent to which differences in the operations of provincial health insurance programs influence the political attitudes of physicians. Differences

in provincial government, policy priorities, and political culture may have critical mediating effects upon the professional response to government health insurance.

In Quebec, where there has been a more pronounced historical commitment to social welfare expansion and a more collectivist political culture, we might expect less professional opposition to Medicare in principle. In the Maritime provinces, where conditions of regional economic underdevelopment have increased the need for welfare state programs, and where such programs have been more strongly supported in public opinion, we expect a similarly more approving professional opinion on Medicare. Greater delegated authority to the profession in the administration of provincial health plans, as in Nova Scotia, may also encourage greater professional support for Medicare. Conversely, in the Western provinces where there have been, in varying degrees, strong attacks on the welfare state, we expect greater ideological commitment by physicians to their professional autonomy against perceived intrusions by government.

We might also expect a priori that professional opposition to Medicare will be greater with greater conflict between government and professional associations. In a number of cases, this effect and the political culture effect discussed in the last paragraph run in opposite directions. In Quebec, for example, where we expect the highest support for Medicare as a result of the influence of the wider political environment, income negotiations between the province and profession have been conflictual and physicians may be less rather than more supportive of Medicare as a result of their experience of the lowest rate of increase in incomes. In Alberta, to take the opposite interaction, ideological hostility to Medicare, reflecting the local political culture, may be tempered by a history of nonconflictual relations between the provincial medical association and government, and by a record of much better than average income settlements. It may also be the case that direct profession-government confrontation over questions of medical autonomy could lead to a recognition within the profession of the limitations of its position vis-à-vis the entrenched political support for Medicare. Militant action by professional associations has to date not been particularly effective in securing the political objectives of physician or in advancing the political influence of medical associations. Accordingly, physicians in Saskatchewan, Manitoba, and Ontario, to take the cases of the greatest recent conflict between government and associations, may be

more rather than less disposed to accept recent changes in health policy.

Findings

Medicare in Principle and in Practice. The 1982 survey found that Canadian physicians were more critical of the principle of government involvement in health insurance than of the actual operation and effects of their provincial programs (Taylor, Stevenson, and Williams 1984). The 1986 data confirm this general finding and reaffirm the extent of ideologically based criticism among physicians of government's presence in the health care field.

Almost 50 percent of physicians agree—but 31 percent disagree—that "Medicare has resulted in a direct loss of physician control over medical decisions" (table 1). While there are grounds to argue that by institutionalizing fee-for-service medicine, Canadian Medicare has reinforced rather than undermined critical aspects of economic and clinical autonomy, a plurality of physicians feel that government health insurance constrains their professional practice. They justify this primarily by the charge that the Canadian health care system is "underfunded," and that as a result equipment and facilities necessary for the full exercise of professional competence are not readily available. Note, however, that a recent special inquiry commissioned by the Canadian Medical Association (1986, 115–16) was unable to substantiate this charge.

Three-quarters (74 percent) of physicians believe that Medicare has reduced "the individual's personal sense of responsibility for health" (table 1). This reflects a common concern of the profession that free access to medical care leads to an increase in the volume of trivial demands for service and overutilization. As a result physicians believe that their capacity to provide necessary care is undermined (Canadian Medical Association 1986, 105).

The next two items in table 1 concern the consequences of public and bureaucratic administration of the health care system. Despite the fact that administrative costs as a percentage of total health care costs are an estimated four to eight times greater in the private medical marketplace of the United State than they are in Canada (Himmelstein and Woolhandler 1986; Weller 1986, 612), one-half of the physicians surveyed disagree—and only 19 percent agree—that "compared to

TABLE 1
Attitudes to Medicare by Province and Medical Association Membership

Statement	Response	Province									Association status				All respondents
		P.E.I. Nfld.	N.S.	N.B.	P.Q.	Ont.	Man.	Sask.	Alta.	B.C.	Exec. member	Active member	Member	Non-member	
a. Direct loss of physician control	Disagree	32.4%	40.8%	16.2%	41.5%	25.6%	24.1%	19.2%	27.3%	26.3%	28.3%	21.9%	33.7%	38.3%	30.9%
	Neutral	35.3	18.5	24.3	22.9	17.9	11.5	21.9	21.3	20.4	19.7	20.1	19.6	21.5	19.9
	Agree	32.4	40.8	59.5	35.6	56.5	64.4	58.9	51.3	53.3	52.0	58.0	46.7	40.2	49.3
b. Reduced individual responsibility for health	Disagree	14.3	14.6	5.3	23.5	11.9	11.6	5.5	12.0	12.6	13.4	11.9	16.0	21.1	15.3
	Neutral	17.1	6.9	5.3	16.3	8.7	11.6	9.6	6.0	8.0	10.7	9.9	10.1	13.1	10.4
	Agree	68.6	78.5	89.5	60.2	79.4	76.7	84.9	82.0	79.4	75.9	78.3	73.9	65.7	74.3
c. Lower administrative overhead	Disagree	44.1	33.1	37.8	52.0	54.3	36.3	48.5	56.3	43.4	52.3	54.4	48.6	44.1	49.9
	Neutral	38.2	40.5	35.1	27.7	28.0	37.5	26.5	23.9	40.4	27.6	27.8	31.7	35.3	30.7
	Agree	17.6	26.4	27.0	20.3	17.7	26.3	25.0	19.7	16.2	20.1	17.8	19.7	20.6	19.4
d. Centralized planning necessary	Disagree	23.5	13.8	31.6	32.1	29.7	34.9	25.4	28.2	27.0	24.1	35.2	28.0	27.9	29.2
	Neutral	32.4	25.4	23.7	27.4	25.4	19.8	33.8	29.5	25.3	27.2	28.3	26.4	21.9	26.5
	Agree	44.1	60.8	44.7	40.5	44.9	45.3	40.8	42.3	47.8	48.7	36.6	45.6	50.2	44.3
e. Positively influenced health status	Disagree	8.6	9.9	21.1	10.5	26.0	19.8	19.2	26.0	17.0	19.1	20.8	17.5	21.0	18.8
	Neutral	28.6	18.3	21.1	19.1	21.6	22.1	21.9	30.7	14.9	19.6	23.0	20.6	16.4	20.6
	Agree	62.9	71.8	57.9	70.4	52.4	58.1	58.9	43.3	68.2	61.3	56.2	61.9	62.6	60.6
f. Satisfaction in practice	Satisfied	64.7	67.4	71.1	65.4	56.4	52.8	51.4	60.8	60.5	61.4	57.5	61.8	62.6	60.9
	Neutral	17.6	18.2	10.5	13.3	16.2	19.1	19.4	17.6	16.8	15.2	15.8	16.8	10.0	15.8
	Dissatisfied	17.6	14.4	18.4	21.3	27.4	28.1	29.2	21.6	22.7	23.3	26.7	21.3	27.5	23.4
g. Overall assessment of program	Excellent	20.0	57.1	21.6	22.6	33.8	20.9	28.8	34.7	29.2	31.6	28.3	31.0	31.5	30.5
	Good	37.1	33.1	54.1	43.8	36.5	24.2	37.0	36.0	35.8	39.6	37.9	37.6	40.7	38.2
	Poor	42.9	9.8	24.3	33.6	29.7	54.9	34.2	29.3	35.1	28.9	33.9	31.4	27.8	31.3

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		P.E.I. Nfld.	N.S.	N.B.	P.Q.	Ont.	Man.	Sask.	Alta.	B.C.	Exec. member	Active member	Member	Non-member	
h. Quality change over 10 years	Better	52.9	53.8	54.1	19.6	24.6	25.0	25.0	31.3	24.4	30.5	25.2	26.0	25.1	26.2
	Same	17.6	34.8	29.7	35.6	38.2	35.7	45.8	43.1	38.9	29.1	35.8	39.6	37.4	37.4
	Worse	29.4	11.4	16.2	44.8	37.3	39.3	29.2	25.7	36.7	40.4	39.0	34.4	37.4	36.4
Number of physicians		35	133	39	617	786	91	73	150	290	225	510	1233	219	2214

Exact item wordings are as follows:

a. "Medicare has resulted in a direct loss of physician control over medical decisions."

b. "Medicare has reduced the individual's personal sense of responsibility for health."

c. "Compared to private insurance programs, under Medicare a lower percentage of the health care dollar is allocated to administrative overhead."

d. "Centralized planning of health care is necessary to determine an optimal distribution of health care services and facilities."

e. "By providing greater access to medical care, government health insurance has positively influenced the health status of Canadians."

f. "How satisfied or dissatisfied are you in the practice of medicine at the present time?"

g. "What is your overall assessment of the functioning of the medical and hospital care plan in your province?"

h. "During the past ten years, would you say that the general quality of health care in this province has become better, become worse, or remained the same.

private health insurance programs, under Medicare a lower percentage of the health care dollar is allocated to administrative overhead." Nevertheless, 44 percent agree that "centralized planning of health care is necessary" to ensure that resources are optimally distributed. While arguing that *government* administration of health care is undesirable, there is, therefore, less opposition to the principle of centralized, bureaucratic administration.

Given the extent of physicians' antipathy toward government, it is significant that almost 61 percent agree—and only 19 percent disagree—that Medicare "has positively influenced the health status of Canadians" by improving access to medical services. Improved access was a central objective of Canadian Medicare (Taylor 1978) which, the majority of physicians acknowledge, has been met. The question for the profession, however, is to what extent this objective could have been met without government involvement, through the physician-sponsored plans that predated Medicare. Comments appended by physicians to their questionnaires restate the profession's historical position that the role of government should have been limited to financing the private health insurance premiums of those who could not otherwise afford them.

Just over 60 percent of physicians are satisfied "in the practice of medicine" under Medicare and only 24 percent are dissatisfied. While a positive endorsement of government health insurance in practice, this is a limited endorsement since about equal thirds of respondents rate provincial medical and hospital care programs as "excellent," "good," and "poor." Further, about two-thirds of physicians believe that the quality of care under provincial programs has either failed to improve or has actually deteriorated over the past decade, and only 26 percent believe it has gotten better. These results suggest that physicians make a distinction between their own practices and the medical care system as a whole, deriving satisfaction from the former, but remaining unconvinced of the values and effects of the latter.

Provincial breakdowns in table 1 show that Nova Scotia physicians are less critical of Medicare than their colleagues in other provinces. While almost one-half of all physicians surveyed agree that Medicare reduces physician control over medical decisions, 41 percent of those in Nova Scotia do so, and an equal number explicitly disagree. Similarly, greater than average proportions of physicians in Nova Scotia agree that administrative costs are lower under Medicare, that centralized

planning is necessary, and that Medicare has positively influenced health status. Nova Scotia physicians are also more likely to assess the provincial program as very good to excellent, to state that they are satisfied in practice, and that the quality of care in their province has improved. A more qualified recommendation is given by Quebec physicians. Although they are less likely to agree that Medicare has undercut medical decisions or decreased personal responsibility for health, most feel that the quality of care has deteriorated.

Physicians in western provinces are more critical of Medicare. In Saskatchewan, 59 percent feel that the program undermines physician control over medical decisions, and 85 percent believe it reduces personal responsibility for health. In Manitoba, 55 percent rate the provincial program as "poor," and 28 percent say they are "dissatisfied" in practice. In Alberta, 56 percent of physicians disagree that administrative costs are lower under Medicare.

These breakdowns initially appear to confirm the hypothesis that differences in medical ideology correspond to differences in provincial political cultures. Physician opposition to Medicare in provinces such as Nova Scotia may be muted because control over health policy is, or is perceived to be, more in the hands of the profession (Heiber and Deber 1987). On the other hand, the relatively mild criticism of Medicare in Ontario, where provincial legislation to end extra billing precipitated the closing of doctors' offices and hospital emergency wards in 1986, clearly modifies the hypothesis of greater physician opposition to Medicare, the greater the conflict between government and medical association.

When responses are examined by medical association membership status it appears that professional association leaders may be responding to the pressure of militant activists. The survey asked, "Which of the following best characterizes your current involvement in the medical association in your province? Are you . a member of the executive, committees, or district councils . . an active member who attends meetings, votes in elections, and so on . . . a member but not otherwise active . . . a nonmember"? While the date show that greater proportions of association executives as compared to nominal members and association nonmembers, state negative evaluations of Medicare, active members are somewhat more likely than the executives to do so. For example, 58 percent of active members but only 52 percent of executives agree that Medicare has undermined physicians' control

over medical decisions. Similar differences are found in responses to the other items in table 1.

Income and Financial Arrangements. The confrontation over the Canada Health Act centers on the prohibition of extra billing and user fees, and on related problems of the private or patient financing of health services. The source of professional concern in this area is shown in the first line of table 2. Three-quarters of medical practitioners believe that compared to other occupational groups, they are "losing ground" economically. This concern reflects the fact that in 1959 physicians' incomes were 3.7 times the average national industrial wage in Canada, a ratio which increased to 4.9 in 1970, peaked at 5.4 in 1971 after the entry of Quebec into medicare, but declined by 1978 to 3.4 (Naylor 1986, 248; cf. the similar index of "physicians" relative incomes" in Evans 1984, 14–15). Instead of acknowledging the initial economic gains due to the introduction of Medicare, physicians focus instead on the relative decline after 1971.

In this context, extra billing—the practice of charging fees for service in excess of those covered under provincial health insurance programs—has been viewed by the profession as a way of allowing individual physicians to increase their incomes while avoiding the most serious threats to professional autonomy posed by "a single paymaster." Again, extra billing was a concession won by Saskatchewan physicians in their 1962 strike. The practice continues to be regarded by the profession as a principal way of maintaining medical autonomy in the face of increasing government control. Extra billing also serves as a reference point for the "market value" of physicians' services in fee schedule negotiations between government and professional associations.

A majority of physicians surveyed (52 percent) favor reestablishing extra billing. It is significant, however, that 29 percent explicitly oppose this practice. Together with the over 19 percent who are neutral, this suggests that despite the official militancy of opposition, the Canada Health Act stimulated real opposition among only a bare majority of physicians.

In addition to arguing for extra billing on the grounds of threats to medical autonomy, and of the chronic "underfunding" of the health care system, spokesmen for the profession have also argued for a greater degree of "reprivatization." This includes policy changes which would assess costs directly to the consumers of medical services, increase

TABLE 2
Attitudes to Reprivatization Policies by Province and Medical Association Membership

Policy	Response	Province									Association status				All respondents
		P.E.I. Nfld.	N.S.	N.B.	P.Q.	Ont.	Man.	Sask.	Alta.	B.C.	Exec. member	Active member	Member	Non-member	
a. Physicians losing economic ground	Disagree	0.0%	9.0%	7.9%	3.9%	9.9%	7.8%	9.6%	11.4%	8.0%	4.5%	6.2%	8.3%	10.6%	7.6%
	Neutral	11.4	10.5	13.2	6.7	12.9	6.7	6.8	16.1	14.9	8.0	15.9	11.8	16.2	10.8
	Agree	88.6	80.5	78.9	89.4	77.2	85.6	83.6	72.5	77.2	87.5	86.4	79.9	73.1	81.6
b. Reestablish right to extra-bill	Disapprove	42.9	29.0	22.2	36.4	23.5	29.1	18.6	23.3	31.7	25.7	21.9	30.2	41.2	28.9
	Neutral	11.4	21.4	25.0	25.3	14.8	18.6	14.3	14.7	22.1	16.7	19.1	20.6	15.7	19.3
	Approve	45.7	49.6	52.8	38.2	61.6	52.3	67.1	62.0	46.2	57.7	59.0	49.3	43.1	51.8
c. Hospital user fees	Disapprove	25.7	20.6	27.0	34.0	24.9	24.1	22.9	24.2	23.3	26.3	19.8	28.0	38.6	27.0
	Neutral	5.7	13.0	5.4	14.1	9.2	13.8	11.4	9.4	11.1	4.5	12.3	11.2	13.5	11.0
	Approve	68.6	66.4	67.6	51.9	65.9	62.1	65.7	66.4	65.6	69.2	67.9	60.8	47.9	62.0
d. Private medical care insurance	Disapprove	32.4	33.8	35.1	27.9	21.8	19.8	27.1	20.0	26.3	22.1	22.2	25.8	32.7	25.2
	Neutral	11.8	13.8	13.5	19.9	11.7	23.3	14.3	10.0	19.7	15.8	13.9	16.2	16.4	15.6
	Approve	55.9	52.3	51.4	52.1	66.5	57.0	58.6	70.0	54.0	62.2	63.9	58.1	50.9	59.1
e. Annual family deductibles of $1,200	Disapprove	17.6	27.6	25.0	27.9	22.3	27.9	14.5	21.2	20.5	22.9	20.6	24.0	31.1	23.8
	Neutral	29.4	39.0	25.0	35.1	31.6	18.6	23.2	21.9	24.7	27.5	29.2	31.8	28.7	30.4
	Approve	52.9	33.3	50.0	37.0	46.1	53.5	62.3	56.8	54.8	49.5	50.2	44.2	40.2	45.7

f. For-profit hospital	Disapprove	45.7	50.8	43.2	31.8	40.3	45.3	45.7	34.0	48.8	34.7	37.6	40.2	44.4	39.5
mgmt.	Neutral	20.0	21.9	24.3	20.5	19.9	10.5	21.4	18.0	22.0	20.7	21.1	20.2	17.1	20.1
	Approve	34.3	27.3	32.4	47.7	39.8	44.2	32.9	48.0	29.3	44.6	41.2	39.6	38.4	40.4
g. Return to volun-	Disapprove	74.3	65.2	54.1	56.8	45.9	44.3	53.5	43.9	57.9	50.2	45.3	54.6	58.3	52.3
tary and commercial	Neutral	5.7	19.7	24.3	22.1	18.7	26.1	22.5	21.6	21.4	22.4	24.1	19.3	17.1	20.6
control	Approve	20.0	15.2	21.6	21.1	35.4	29.5	23.9	34.5	20.7	27.4	30.6	26.1	24.6	27.1
h. Market forces	Disagree	58.8	63.1	52.6	55.6	52.8	57.1	48.6	44.3	58.5	55.6	47.7	56.0	60.0	54.4
should determine	Neutral	17.6	23.1	21.1	22.8	21.9	20.2	26.4	29.5	22.0	25.1	24.4	22.3	18.1	22.7
	Agree	23.5	13.8	26.3	21.6	25.3	22.6	25.0	26.2	19.5	19.3	27.9	21.7	21.9	22.9
Number of physicians		35	133	39	617	786	91	73	150	290	225	510	1233	219	2214

Exact item wordings are as follows:

a. Do you think that physicians are 'losing ground' economically, that the incomes of other occupational groups are rising at a significantly faster pace?

b. Do you support "reestablishing the physicians' right to 'extra-bill' in provinces where the practice has been ended"

c. Do you support "establishing or increasing user fees for hospital services"

d. Do you support "allowing private insurance carriers to cover services now covered by Medicare"

e. Do you support "establishing annual family deductibles of $200 for provincial Medicare programs"

f. Do you support "permitting hospital management by private for-profit management firms"

g. Do you support "the Medicare system should be returned to voluntary and commercial control"

h. Do you support "market forces alone should determine the mix and distribution of health care services and facilities"

private control over health care, and correspondingly decrease government's control in the field (Weller 1986; Weller and Manga 1983). As Weller points out, "if reprivatization were to take place and extra-billing and user fees were allowed then (government's) monopoly would be partially broken and there would be extra money in the system to allow for increased incomes" (Weller 1986, 613). The data in table 2 show widespread support among Canadian physicians for these arguments.

Sixty-two percent of the survey respondents approve of "establishing or increasing user fees for hospital services," while 27 percent disapprove and 11 percent are neutral. On another proposal for greater private funding of the health care system, about 46 percent of physicians approve of "annual family deductibles of $200.00 for provincial Medicare programs," while 30 percent are neutral, and 24 percent disapprove. Almost 60 percent of physicians approve and only 25 percent disapprove of the proposal "to allow private insurance carriers to cover services now covered by Medicare." This finding is consistent with the profession's historical stance in favor of a private health insurance system financed in part by government-paid premiums. Even if not physician-controlled, a private system involving multiple carriers would reduce the perceived threat to incomes connected with a "single paymaster" and relatively increase the profession's bargaining power.

Responses to the last three items in table 2, however, suggest that there are important limits to Canadian physicians' ideological support for an unregulated medical marketplace. Presumably because it implies the reduction of physician control over institutional care, a majority of physicians do not support the idea of "hospital management by private, for-profit management firms"; only 40 percent approve, while an equal percentage disapprove. Further, 52 percent of respondents disapprove of the proposal that "the Medicare system should be returned to voluntary and commercial control," and an even greater proportion (54 percent) disagree with the statement that "market forces alone should determine the mix and distribution of health care services and facilities." Although reduced government control is desired by physicians, only one-quarter of them desire full-blown competition in a private market. At the very least this constitutes an indirect acknowledgment by physicians of their advantages under Medicare (including guaranteed payment for virtually every service performed). This is also consistent with the view that medical dominance of Medicare, and not a return

to the free market, is the preferred position of the Canadian profession (Coburn, Torrance, and Kaufert 1983; Hamowy 1985; Naylor 1986).

Provincial differences in response to these items may be briefly summarized. Relatively large numbers of physicians in Saskatchewan (62 percent), Alberta (57 percent), and British Columbia (55 percent) approve of the establishment of annual family deductibles for provincial health insurance programs. Alberta physicians also give strong support of for-profit hospital management, voluntary and commercial control of medical insurance, and coinsurance of medical services. Quebec physicians, though relatively more likely than those in other provinces to complain about "losing ground economically," are much less likely to endorse user fees, coinsurance, or family deductibles. Finally, physicians practising in the Atlantic provinces are less likely to approve of a return to a voluntary and commercial system in which the market determines the mix of health care services and facilities. These data also reaffirm that the activist members are slightly more opposed to Medicare than the medical association executives, and that both these groups are more consistently opposed than the majority of physicians.

Political Strategies. If Canadian physicians are concerned with issues of professional control and dominance in the face of government intrustion in the health care field, what strategies are preferred as a means of reinforcing the profession's position?

One strategy, part of the history of government-profession relations in Canada, is the doctors' strike. Table 3 records that 60 percent of physicians disapprove and only one-quarter approve of "the withdrawal of nonemergency services" in support of income demands. While not necessarily an accurate indication of the proportion of physicians who would or who actually take part in job action of this type, the result does measure widespread reluctance among Canadian physicians to leave their practices. This is true even in Ontario where 59 percent disapprove of strike action in spite of—or perhaps because of—their recent experiences involving the withdrawal of services. Such reluctance may stem from a concern on the part of physicians for the welfare of their patients. It may also stem from the fact that physicians' strikes have proved to be more successful in mobilizing public opinion against the medical profession than in winning physicians' economic demands. Nevertheless, physicians in Saskatchewan, the site of the first doctors' strike in 1962, are more likely than those in other provinces to approve of strike action.

TABLE 3
Attitudes to Income Policies by Province and Medical Association Membership

Policy	Response	Province									Association status				All respondents
		P.E.I. Nfld.	N.S.	N.B.	P.Q.	Ont.	Man	Sask.	Alta.	B.C.	Exec. member	Active member	Member	Non-member	
a. Withdrawal of services	Disapprove	55.9%	73.1%	68.4%	55.7%	58.6%	60.7%	45.1%	62.7%	72.4%	52.5%	51.0%	63.5%	73.6%	60.4%
	Neutral	14.7	13.8	18.4	14.0	12.8	15.7	12.7	12.7	10.8	12.1	17.5	12.0	11.3	13.2
	Approve	29.4	13.1	13.2	30.4	28.6	23.6	42.3	24.7	16.8	35.4	31.5	24.5	15.1	26.3
b. Medical association as labor unions	Disapprove	65.7	72.3	63.2	30.4	52.6	73.6	33.8	56.4	66.9	46.2	48.6	51.5	56.4	50.8
	Neutral	17.1	13.8	21.1	26.9	18.6	5.7	23.9	22.1	18.5	21.1	21.3	19.4	22.7	20.3
	Approve	17.1	13.8	15.8	42.6	28.8	20.7	42.3	21.5	14.6	32.7	30.1	29.1	20.9	28.9
c. Binding arbitration	Disapprove	8.6	3.9	13.2	13.2	11.9	10.1	12.7	4.1	12.9	13.8	13.4	9.5	12.3	11.2
	Neutral	2.9	11.6	15.8	17.5	14.2	9.0	12.7	10.8	18.2	12.5	12.8	15.4	17.5	14.7
	Approve	88.6	84.5	71.1	69.4	73.9	80.9	74.6	85.1	68.9	73.7	73.8	75.1	70.1	74.2
d. Excellence funds	Disapprove	34.3	38.8	32.4	25.2	53.3	41.6	31.9	37.2	41.9	38.9	44.6	39.5	38.3	40.5
	Neutral	28.6	29.5	29.7	23.5	17.9	24.7	22.2	24.3	23.6	21.3	20.5	23.2	20.1	22.1
	Approve	37.1	31.8	37.8	51.3	28.8	33.7	45.8	38.5	34.5	39.8	34.9	37.3	41.6	37.4
e. Salaried system for physicians	Disapprove	51.4	41.7	45.9	37.6	45.5	41.6	43.1	45.3	47.2	50.4	48.3	41.3	35.8	43.3
	Neutral	14.3	24.2	13.5	16.8	18.2	21.3	22.2	21.3	19.7	14.3	17.5	20.1	17.2	18.6
	Approve	34.3	34.1	40.5	45.6	36.3	37.1	34.7	33.3	33.1	35.3	34.2	38.6	47.0	38.1
Number of physicians		35	133	39	617	786	91	73	150	290	225	510	1233	219	2214

Exact item wordings are as follows:

a. Do you support "withdrawal of nonemergency services by physicians in the event of inadequate income settlements."

b. Do you support "reconstitution of medical associations as labour unions under provincial labour laws."

c. Do you support "binding arbitration in the event of deadlock in the negotiations with government."

d. Do you support "establishment by provincial health insurance programs of special funds to reward excellence."

e. Do you support "a salaried system for all physicians in hospital or group practice which included such benefits as pensions and vacation and overtime payment."

A majority (51 percent) of physicians disapprove of the proposition that medical associations should be reconstituted "as labor unions under provincial labor laws." In comments attached to questionnaires, many respondents expressed discomfort both with strike action and unionization. Concerns include the undermining of medicine's prestige as an autonomous, self-governing profession, both from the public's viewpoint, and as a result of government's regulation of labor codes.

Another option, adopted in Manitoba, Saskatchewan, and Alberta, is binding arbitration in the event of deadlock with governments over fee negotiations. Physicians apparently believe in the legitimacy of their income expectations, a belief strengthened by the fact that arbitrated settlements have been favorable to the profession. Three-quarters of the survey respondents approve of arbitration, and only 11 percent explictly oppose it. In spite of the Manitoba government's initial repudiation and attempted roll-back of an arbitrated settlement in 1986, the eventual acceptance of the award is likely a factor leading 81 percent of Manitoba physicians to approve of arbitration.

A number of other related strategies have been publicly discussed. Special funds to "reward excellence in practice" were proposed by the government of Ontario as a response to the profession's assertion that extra billing constituted a mechanism through which superior medical qualifications and experience were recognized. Sensing the potential dangers inherent in any program which would involve evaluating the credentials and performance of individual physicians, however, a government-established fund to reward excellence in practice was rejected by provincial medical association leaders. Our data show that almost equal proportions of physicians nationally disapprove and approve of the establishment of "special funds to reward excellence"; an additional 22 percent are neutral. In Ontario, where the provincial association explicitly rejected the establishment of such funds, only 29 percent approve them.

Finally, 43 percent of respondents disapprove of "a salaried system for all physicians in hospital or group practice," including such benefits as pension and vacation and overtime payments, but 38 percent support this proposal. This distribution reflects the extent of debate within the profession over salaries that would provide practitioners stable incomes but also transform them from small entrepreneurs, to semi-autonomous employees with limited economic discretion. A key issue, not specified in our question, is at what level salaries would be set.

Data from a recent survey show that, if assured that their incomes would remain unchanged (i.e., not drop), close to two-thirds of physicians in the province of Quebec would accept salaries (Pineault, Contandriopolous, and Fournier 1985, 422). As on other issues, therefore, there may be more flexibility within the profession on this basic question than is normally assumed.

Ideology and Medical Politics: The Ontario Strike

Our discussion of physicians' attitudes to questions raised in the political struggle over the Canada Health Act has suggested that the opinions of most doctors are consistent with an underlying ideology of medical dominance and professional autonomy. In these terms, a majority of physicians defend professional autonomy in the determination of incomes, support various privatization policies, and agree that Medicare has resulted in a direct loss of physician control over medical decisions. The ideological solidarity of the profession is, however, far from complete. A majority of physicians oppose a return to commercial insurance; almost one-half favor some form of centralized planning of health care services; and a majority agree that the effects of Medicare on health status have been positive despite perceptions of bureaucratic inefficiency.

There are, therefore, divisions within the medical profession over how to translate the general commitment to medical dominance and professional autonomy into appropriate public policy. These divisions relate both to political objectives and to political strategy. There is no overwhelming commitment to "free-market" rather than "socialized" medicine, and there is substantial resistance to the most militant forms of professional organization against contentious legislation. How, then, can these observations be reconciled with the public record of militant professional opposition to the Canada Health Act?

The answer may be in the more extreme ideological orientations of the most active members of the medical associations, who pressure the executive leadership into more hard-line positions than they might otherwise take. In order to test this hypothesis with more precision, we employed factor analysis to construct multiple-item scales tapping physicians' responses to questions of health care policy (see appendix A for details), expecting to see a relation between professional association

activism and ideological opposition to Medicare, particularly in Ontario where opposition to the Canada Health Act was most extreme.

Table 4 records the relationship between these complex measures of ideological orientation and physicians' involvement in medical associations. The data to the left of the table pertain to Canada as a whole and indicate that activist members of medical associations tend to be among the most strident critics of public health insurance and the most committed to free-market medicine. For instance, the mean level of support among activist members for the principle of professional economic autonomy (3.7) is higher than that for executive leaders of the associations (3.6), for ordinary members (3.4), and for nonmembers (3.2). Similarly, activists score highest on the items measuring approval of the concept of user pay and support for the privatization of health services, and they score lowest on the item measuring approval of Medicare in principle. Activist members also have distinct views regarding modes of health delivery and the content of professional education.

Despite the consistency of these differences at the national level, they are not marked. The modest nature of the relation between ideology and medical association membership is measured by the magnitude of the eta coefficients: while the coefficients are statistically significant, they are small. The nation-wide results, then, are suggestive of, rather than conclusive evidence for, a situation in which a minority of ideologically committed activist members "pushes" association leaders and a passive rank and file into active opposition to government.

We get stronger support for our hypothesis in Ontario. The data to the right of table 4 suggest, first of all, that Ontario physicians, as expected, are somewhat more critical of Medicare than are all physicians, and slightly more supportive of economic autonomy, the principle of user pay, and privatization. More important, the eta coefficients indicate that the relation between association membership and ideology is much stronger in Ontario than it is nationally. For example, the eta coefficient summarizing the relation between medical association status and attitudes toward user pay rises from .17 nationally to .27 in Ontario. Five of the other seven eta coefficients show a similar increase in magnitude. The mean scores demonstrate that association activists most strongly articulate positions in support of professional dominance and autonomy. In addition, the standard deviations of the ideological measures are smallest among association

TABLE 4
Ideological Variable Means and Standard Deviations by Medical Association Membership for All Physicians and for Ontario Physicians Only

		Canada						Ontario					
Ideological variable	Statistic	Executive member	Active member	Nominal member	Non-member	All physicians	Eta	Executive member	Active member	Nominal member	Non-member	All Ont. physicians	Eta
Approve Medicare	Mean	2.7	2.6	2.8	2.9	2.8	.12**	2.3	2.3	2.6	2.9	2.6	.22**
	(S.D.)	(.81)	(.78)	(.81)	(.97)	(.82)		(.84)	(.70)	(.85)	(1.0)	(.86)	
Satisfaction with Medicare	Mean	3.1	3.0	3.1	3.1	3.1	.06	3.1	3.0	3.1	3.1	3.1	.09
	(S.D.)	(.77)	(.76)	(.75)	(.83)	(.76)		(.78)	(.79)	(.75)	(.90)	(.76)	
Support economic autonomy	Mean	3.6	3.7	3.4	3.2	3.5	.16**	3.8	4.0	3.6	3.2	3.6	.24**
	(S.D.)	(.86)	(.88)	(.91)	(1.0)	(.92)		(.96)	(.81)	(.95)	(1.1)	(.97)	
Approve user pay	Mean	3.5	3.6	3.3	3.0	3.3	.17**	3.8	3.8	3.4	2.7	3.5	.27**
	(S.D.)	(.96)	(.88)	(.91)	(1.1)	(.94)		(1.0)	(.80)	(.94)	(1.1)	(.97)	
Approve privatization	Mean	3.0	3.1	2.9	2.7	2.9	.11*	3.2	3.3	3.0	2.7	3.0	.21**
	(S.D.)	(.87)	(.89)	(.88)	(.99)	(.90)		(.93)	(.90)	(.91)	(1.1)	(.95)	
Approve unions, strikes	Mean	2.7	2.7	2.5	2.2	2.6	.14**	2.8	3.0	2.4	2.2	2.6	.25**
	(S.D.)	(1.1)	(1.0)	(1.0)	(8.8)	(1.0)		(1.1)	(1.0)	(.99)	(.89)	(1.0)	
Approve alternative organization	Mean	2.2	2.3	2.5	2.7	2.4	.16**	2.5	2.3	2.6	3.0	2.6	.20**
	(S.D.)	(.88)	(.83)	(.87)	(.96)	(.88)		(.92)	(.79)	(.87)	(.86)	(.87)	
Approve biomedicine	Mean	2.9	3.0	2.9	2.8	2.9	.10**	2.8	3.0	2.9	2.8	2.9	.12**
	(S.D.)	(.68)	(.65)	(.62)	(.61)	(.64)		(.66)	(.61)	(.62)	(.66)	(.63)	
Number of physicians		225	510	1233	219	2187		68	164	459	87	778	

** Significant at .01.

TABLE 5
Strike Participation in Ontario by Medical Association Membership.

Strike participation	Medical association membership				
	Executive member	Active member	Nominal member	Non-member	All physicians
Nonparticipant	31.1%	22.3%	53.3%	81.0%	48.0%
Participant	68.9	77.7	46.7	19.0	52.0
Number of physicians	68	164	459	87	778

activists indicating that they are not only more ideologically extreme but also more ideologically cohesive.

To demonstrate the political significance of the linkages between association activism and ideological orientations, we now examine their concrete expression in the choices of Ontario physicians to participate or not in the 1986 strike.

Estimates of strike support are highly contentious. For instance, the Ontario Medical Association (OMA) claimed that 75 percent of doctors participated in the two-day strike called at the end of May, while a newspaper poll put the figure at approximately 60 percent (Silversides, Douglas, Ingram 1986). Dr. Earl Myers, president of the OMA, predicted that the full strike would get more than 75 percent support, but newspaper polls indicated that not more than 50 percent of physicians would strike on the day it was called, that 45 percent were on strike after one day, and that only 11 percent were on strike after a month (*Toronto Globe and Mail* 1986; Douglas and Balsara 1986; Kingwell and Masse 1986). Our survey data, presented in table 5, indicate that 52 percent of Ontario physicians withdrew their services from the general public, while 46 percent withdrew services from their own patients, *at any time* during 1986.

The data in table 5 reveal a marked correlation between strike participation and medical association involvement. Of executive members of the provincial association, close to 70 percent withdrew their services for some period. This proportion is predictably high, but indicates that the "nearly unanimous decision" of the OMA council may have been opposed by a significant group of professional leaders pursuing a corporatist accommodation with government in the management of

a publicly funded health care system. It is clear, secondly, that the nonexecutive but active members of the association were even more strongly committed to strike action. If they did not "push" their leadership along this path, the commitment to strike action by 80 percent of active members may have encouraged the leadership to overestimate the strength of support among physicians in general, and to maintain a militant course of action after it was perhaps politically unwise to have done so. This latter speculation is prompted, thirdly, by the evidence that only 47 percent of the ordinary members and less than 20 percent of the nonmembers participated in the strike. One might argue that more may have supported the strike, although they were unable for one reason or another to participate. But this latter possibility seems unlikely given the data reported earlier to the effect that 59 percent of Ontario physicians disapproved of strike action.

Consistent with our earlier arguments about the ideological grounding of professional response to Medicare, the data in table 6 indicate that strikers in Ontario are an ideologically more homogeneous and politically right-wing group than nonstrikers. The standard deviations of their scores on the ideological variables are lower than those of nonstrikers and the mean values of those scores indicate significantly less support for Medicare in principle, or satisfaction with Medicare in practice, and significantly greater support for professional autonomy, user pay, and privatization in the funding of the health care system. The results of multivariate analysis, not shown, indicate that 21 percent of the observed variation in strike participation can be accounted for by scores on the first five of the ideological variables in table 6. When medical association involvement is statistically controlled, these five ideological variables still account for 11 percent of the variance, indicating that, while correlated with medical association involvement, ideology has a unique, direct influence on strike participation in Ontario.

The extent to which professional ideology, organization, and political response are grounded in economic self-interest is demonstrated by patterns of differences in the professional characteristics of strikers and nonstrikers in Ontario. On the one hand, the data in table 7 indicate that many of the variables widely supposed to have affected strike participation did not in fact do so. Sex and specialization, for example, have no measurable impact. Geographic location also played no significant role, even though a somewhat larger proportion of physicians in

TABLE 6
Ideological Variable Means and Standard Deviations by Strike Participation for Ontario Physicians Only

Ideological variable	Statistic	Strike participation: Nonparticipant	Strike participation: Participant	All Ontario physicians	Eta
Approve Medicare	Mean	2.9	2.3	2.6	
	(S.D.)	(.92)	(.67)	(.86)	.37**
Satisfaction with Medicare	Mean	3.3	2.9	3.1	
	(S.D.)	(.76)	(.78)	(.77)	.23**
Support economic autonomy	Mean	3.2	4.1	3.6	
	(S.D.)	(.98)	(.77)	(.98)	.44**
Approve user pay	Mean	3.1	3.8	3.5	
	(S.D.)	(.99)	(.78)	(.89)	.38**
Approve privatization	Mean	2.7	3.4	3.0	
	(S.D.)	(.98)	(.79)	(.95)	.36**
Approve unions, strikes	Mean	2.1	2.9	2.6	
	(S.D.)	(.92)	(.98)	(1.0)	.38**
Approve alternative org.	Mean	2.8	2.4	2.6	
	(S.D.)	(.86)	(.86)	(.88)	.22**
Approve biomedicine	Mean	2.9	2.9	2.9	
	(S.D.)	(.65)	(.60)	(.62)	.06
Number of physicians		374	404	778	

** Significant at .01.

TABLE 7
Practice Characteristics of Strike Nonparticipants and Participants in Ontario

Practice characteristic		Strike participation		Number of physicians	X^2
		Nonparticipant	Participant		
Sex	Male	47.4%	52.6%	716	
	Female	54.3	45.7	103	1.5
Year of graduation	1926–53	65.8	34.2	170	
	1954–60	47.7	52.3	151	
	1961–68	46.2	53.8	178	
	1969–74	40.4	59.6	166	
	1975–83	40.4	59.6	153	25.7**
Practice Type	Private	39.2	60.8	528	
	Hospital	73.1	26.9	141	
	Mixed	60.3	39.7	150	52.5**
Specialization	GP	46.1	53.9	429	
	Specialist	50.7	49.3	390	1.4
Payment mechanism	>66% FFS	39.2	60.8	654	
	34–65% FFS	90.0	10.0	56	
	<33% FFS	87.3	12.7	85	101.5**

Net income 1985	<$65,000	58.8	41.2	150	
	$66–85,000	53.0	47.0	146	
	$86–100,000	51.8	48.2	153	
	$101–130,000	40.2	59.8	125	
	>$131,000	38.3	61.7	170	17.1**
Extra-billed?	Yes	23.4	76.6	169	
	No	54.4	45.6	597	46.2**
Patient visits per week	<48	68.6	31.4	158	
	49–100	54.4	45.6	212	
	101–150	36.1	63.9	171	
	>151	28.6	71.4	177	59.9**
Location	Toronto	45.1	54.9	315	
	Other	50.2	49.8	504	1.6

** Significant at .01
* Significant at .05

Toronto, as opposed to those elsewhere, participated in the strike. These data also show, however, that it was the most well-off who tended to support the strike: 62 percent of those earning more than $131,000 participated, as compared to 41 percent of those in the lowest income group. Physicians who had previously participated in extra billing were also much more likely than those who had never done so (77 versus 46 percent) to withdraw their services. The 25 percent of Ontario physicians with the largest patient loads, and correspondingly with the highest incomes, were much more likely to strike than those with the smallest loads (71 versus 31 percent); and 61 percent of physicians remunerated primarily through fee-for-service payment, as opposed to 13 percent of physicians who were primarily salaried, participated in the strike. These findings suggest that the Ontario strike was seen primarily as a means of securing the latitude available before the Canada Health Act for physicians autonomously to determine their incomes. Although the end of extra billing did nothing to interfere with clinical practice, it did constitute an affront to physicians, especially those within the most privileged strata of the profession, accustomed to manipulating the economic machinery of Medicare to their own best advantage.

The Ontario case study, therefore, supports our argument that professional opposition to the Canada Health Act was based in an ideological defense of professional dominance and autonomy, and that such opposition was "pushed" by the ideologically more extreme minority of activist members of the OMA. It also supports the thesis that medical ideology and the defense of professional autonomy are expressions of the economic interests of physicians. It is this fact that accounts for the contradictions inherent in the tendency of many physicians to seek, on the one hand, to limit government control over health care insurance, while, on the other, calling for the extension of government health care funding. Nevertheless, these contradictions, while perhaps consistent with the logic of self-interest, must ultimately create confusion within the profession about the extent to which it should attempt to enter into accommodations with governments over the operations of Canadian Medicare.

Discussion and Conclusions

In this article we suggest some new lines of interpretation and speculation about medical politics in the wake of the Canada Health Act. Our

analysis of the attitudes of practicing physicians indicates that opposition to Medicare by the organized medical profession is characterized by a paradoxical strength and weakness. This paradox is apparent in each of the dimensions of the conflict surrounding the recent legislation that we have considered: attitudes toward Medicare in principle; attitudes toward the reprivatization of funding for physician and other medical services; and attitudes toward political strategies available for the pursuit of professional interests.

The paradox is rooted in the coexistence of a widespread ideological commitment to professional autonomy and dominance coupled with internally contradictory or at least divided attitudes toward the proper ways of regulating and financing health care services, and protecting professional dominance. Our data show that physicians react negatively to the perceived threat to their autonomy posed by government health insurance; that there is widespread agreement among physicians that they have experienced a loss of autonomy and economic status as a result of Medicare; and that physicians are reluctant to attribute to Medicare any improvements in the quality of health services while arguing that extra billing and hospital user fees should not have been eliminated as a result of the Canada Health Act. At the same time, however, about one-half of physicians accept the need for a nationally regulated health care system, oppose the return of the current system to voluntary and commercial control, and report fundamental satisfaction with their personal experience in practice under medicare. Ideological militance in defence of professional autonomy on issues like extra billing is not duplicated in support for militant strategies such as a strike.

All ideologies, however, admit a large measure of vagueness and inconsistency, and it cannot be assumed that the lack of universal agreement on all issues, or perfect consistency in the structure of medical ideology, weakens its uses in defending medical dominance against the interventions of public authorities. There are, however, a number of potential weaknesses in the medical profession's capacity for political organization.

No more than one-fourth of the profession is consistently committed ideologically to opposition to a government health insurance system, and about the same proportion are consistently ideologically committed to its support. Between these polarized positions lies the majority, who should not be considered a priori to be more amenable to the influence of their colleagues who strongly oppose Medicare in future

debates over health care policy, even though the majority position is grounded ideologically in defense of medical dominance of the health care system. "Moderates" among leaders of the profession and government may so far have overestimated the homogeneity of professional opinion and the influence of those ideologically most opposed to Medicare, failing as a result to articulate a defense of the system that is convincing to the majority of the ideologically less-rigid members of the profession.

Our analysis of provincial differences in physician attitudes suggests also that direct confrontation by government with the profession does not strengthen the solidarity of the profession in its opposition to Medicare. In the most extreme case of confrontation between government and profession over the implementation of the Canada Health Act, the doctors' strike in Ontario, it does not appear that professional opposition to Medicare was raised above the norm for the rest of Canada. Ontario physicians are, if anything, somewhat more supportive of the principles of Medicare, and somewhat less supportive of the merits of the most militant forms of professional opposition to government than their colleagues in provinces that have taken a much less confrontational position vis-à-vis government.

The pattern of East-West regional variation in physician attitudes suggests that physicians reflect the political culture in the provinces where they are located. Public opinion and professional attitudes in Quebec and the Maritimes are somewhat more supportive of social welfare policy and Medicare than is the case in the West. Given the depth of public support for Medicare in Canada, this suggests that professional resistance to future government initiatives that maintain or increase public financing and regulation of the system may be considerably less effective than has been supposed, depending upon the care and skill with which governments articulate the justification for such initiatives and mobilize public support for them.

This last comment is connected to our discussion of the interest group politics of the medical associations. Traditions of solo practice and professional independence, as well as relatively high work loads and a more narrow range of social interaction on the job as compared with other professions are likely to limit the political information and activism of physicians. Oligarchic leadership and appeals to ideological solidarity may tend, therefore, to dominate the internal politics of the professional associations. Our analysis has suggested that the relatively narrow circles of activist participation in these associations include leaders and active members who are significantly more ideologically

opposed to Medicare and more militant in defense of professional autonomy than the majority of members of the profession.

These observations further illustrate the political weaknesses of the profession. Though it is unlikely that the less active and more moderate members will organize to elect less militant leaders, the limits to which the associations can respond primarily to militant minorities of their membership are particularly evident in the minority approval of strike action. Such limits may become even more apparent as the agenda for health policy debate shifts from problems of accessibility (and the associated questions of extra billing and user fees) to the much more intractable issues of cost effectiveness and quality. The issues of accessibility addressed by the Canada Health Act directly confronted the symbolic cornerstone of the doctrine of medical autonomy (control over income), and gave maximum scope to the associations' mobilization of professional solidarity. The issues of cost effectiveness and quality have the potential of stimulating greater internal division within the profession, according to experience, proficiency, and styles of practice. Under such circumstances, the associations would have greater difficulty promoting the interests of the ideologically militant defenders of medical dominance.

While public authorities may be encouraged by these findings to undertake further policy changes opposed by the professional associations, our purpose has been to suggest that it is politically possible, as well as desirable, to develop initiatives that move beyond the confrontation between professional control over the delivery of health care and public control over financing, to "develop and expand avenues of communication between political and professional authorities, on the understanding that neither one is going to, or should, go away" (Evans 1984, 347–48). Our analysis suggests that medicine is not monolithic, and that there are political grounds for expecting that such change can be undertaken without escalating conflict and confrontation. The challenge will be to establish an agenda and lines of communication that break out of the institutionalized conflict that has characterized the relations between governments and organized medicine thus far.

Appendix A: Multiple-item Variable Construction

The multiple-item variables used in this article were constructed by first selecting groups of related questionnaire items in relevant areas

and then confirming their unidimensionality by use of factor analysis. Groups of items were considered to comprise acceptable variables if variance estimates for the first principal components exceeded 50 percent. In some cases the response scales were reversed so as to be consistent with the "direction" of other items. Variable scores were computed by simply summing and averaging the values of the component items. The consensus in the methodological literature is that unless component items differ appreciably in variance, the simple sum approximates the reliability of a score computed using factor weights. These simple scores have the advantage of greater intelligibility since the original response scales can be conserved, and they are considerably easier to compute. Presented below are the exact wordings of the questionnaire items used to construct the multiple-item variables.

1. Approve Medicare
   ". . . please indicate your position on each of the following statements concerning government health insurance:
   a. Medicare has resulted in a direct loss of physician control over medical decisions;
   b. Medicare has reduced the individual's personal sense of responsibility for health;
   c. By providing greater access to medical care, government health insurance has positively influenced the health status of Canadians."
2. Satisfaction with Medicare
   a. ". . . how satisfied or dissatisfied are you in the practice of medicine at the present time?
   b. What is you your overall assessment of the functioning of the medical and hospital care plan in your province?
   c. During the past ten years, would you say that the general quality of health care in this province has become better, become worse, or remained about the same?"
3. Support Economic Autonomy
   a. ". . . please indicate your position on . the following statement concerning government health insurance: . . . The ban on extra-billing in most provinces has resulted in a deterioration in the quality of care.
   b. Please indicate now strongly you approve or disapprove of the following possible change to the Medicare system: . . .

reestablishing the physician's right to 'extra-bill' in provinces where the practice has been ended.

c. Do you think that physicians are 'losing ground' economically, that the incomes of other occupational groups are rising at a significantly faster pace?"

4. Approve User Pay

"Please indicate how strongly you approve or disapprove of the following possible changes to the Medicare system:

a. reestablishing the physician's right to 'extra-bill' in provinces where the practice has been ended;

b. establishing or increasing user fees for hospital services;

c. establishing annual family deductibles of $200 for provincial Medicare programs."

5. Approve Privatization

The root question is the same as for the preceding variable:

a. "allowing private insurance carriers to cover services now covered by Medicare;

b. permitting hospital management by private, for-profit management firms.

Please indicate your position on each of the following statements concerning government health insurance:

c. Market forces alone should determine the mix and distribution of health care services and facilities.

d. The Medicare system should be returned to voluntary and commercial control."

6. Approve Unions, Strikes

"Do you approve or disapprove of the following proposals concerning professional incomes?

a. withdrawal of non-emergency services by physicians in the event of inadequate income settlements;

b. reconstitution of medical associations as labour unions under provincial labour laws."

7. Approve Alternative Organization

The root question is the same as for variable #4:

a. "licensing of midwives to conduct uncomplicated births in hospital settings;

b. changes to Medicare regulations allowing nurse practitioners and midwives to be paid on a fee-for-service basis;

c. establishing of a government-operated health centre in your hospital district."

8. Approve Biomedicine
   Assuming that the length of time spent in medical school would not change, should more or less emphasis be placed on training physicians in the following areas?
   a. transplant technology;
   b. cancer research;
   c. diagnostic technology."

References

Badgely, R.F., and S. Wolfe. 1967. *Doctor's Strike.* Toronto: Macmillan.

Barer, M.L., R.G. Evans, and R.J. Labelle. 1988. Fee Controls and the Cost of Medical Care in the Frozen North. *Milbank Quarterly* 66(1):1–00.

———. 1986. *Task Force on the Allocation of Health Care Resources.* Ottawa.

Coburn, D.G., M. Torrance, and J.M. Kaufert. 1983. Medical Dominance in Canada in Historical Perspective: The Rise and Fall of Canadian medicine? *International Journal of Health* 13:407–32.

Douglas, J., and N. Balsara. 1986. 55 Percent of GPs Reject Call Walkout. *Toronto Globe and Mail,* June 13.

Evans, R.G. 1984. *Strained Mercy: The Economics of Canadian Health Care.* Toronto: Butterworth.

Geekie, D.A. 1984. Ottawa Using the Health Stick to Tame Its Foes, Doctors Feel. *Toronto Globe and Mail,* January 27.

Government of Canada. 1984. Bill C-3, The Canada Health Act, Second Session, 32nd Parliament.

Hamowy, R. 1984. *Canadian Medicine: A Study in Restricted Entry.* Vancouver: Fraser Institute.

Heiber, S., and R. Deber. 1987. Banning Extra-Billing in Canada: Just What the Doctor Didn't Order. *Canadian Public Policy* 13(1):62–74.

Himmelstein, D.U., and S. Woolhandler. 1986. Socialized Medicine: A Solution to the Cost Crisis in Health Care in the United States. *New England Journal of Medicine* 314(7):441–45.

Kingwell, M., and L. Masse. 1986. Specialists More Likely Than GPs to Strike, Globe Surveys Indicate. *Toronto Globe and Mail,* June 12.

Montgomery, C. 1984. M.D.s to Seek Right to Strike if Extra-billing Banned. *Toronto Globe and Mail,* February 17.

Naylor, D. 1986. *Private Practice, Public Payment.* Montreal: McGill-Queen's University Press.

Pineault, R., A.P. Contandriopolous, and M.A. Fournier. 1985. Physicians' Acceptance of an Alternative to Fee-for-service Payment: A Possible Source of Change in Quebec medicine. *International Journal of Health Services* 15(3):419–30.

Shillington, H.C. 1972. *The Road to Medicare in Canada.* Toronto: Del Graphics.

Silversides, A., J. Douglas, and M. Ingram. 1986. OMA Threatens to Escalate Protest: Many Doctors Balk at Walking Out. *Toronto Globe and Mail,* May 30.

Silversides, A., and D. McMonagle. 1986. Open-ended Doctors' Strike Called in Ontario Fight over Extra-billing. *Toronto Globe and Mail,* June 10.

Soderstom, L. 1980. The Canadian Experience. In *Regulating Health Care,* ed. Levin, 224–38. Montpelier, Vt.: Capital City Press.

Stevenson, H.M., and A.P. Williams. 1985. Physicians and Medicare: Professional Ideology and Canadian Health Care Policy. *Canadian Public Policy* 11(3):504–21.

Taylor, M.G. 1960. The Role of the Medical Profession in the Formation and Execution of Public Policy. *Canadian Journal of Economics and Political Science* 26(1):108–27.

———. 1978. *Health Insurance and Canadian Public Policy: The Seven Decisions That Created the Canadian Health Insurance System.* Montreal: McGill-Queen's University Press.

Taylor, M.G., H.M. Stevenson, and A.P. Williams. 1984. *Medical Perspectives on Canadian Medicare.* Toronto: Institute for Social Research, York University.

Toronto Globe and Mail. 1986. Most MDs Giving Patients Full Service. July 5.

Touhy, C.J. 1976. Medical Politics after Medicare: The Ontario case. *Canadian Public Policy* 2(2):192–210.

Weller, G.R. 1986. Common Problems, Alternative Solutions: A Comparison of the Canadian and American health systems. *Policy Studies Journal* 14(4):604–20.

Weller, G.R., and P. Manga. 1983. The Development of Health Policy in Canada. In Michael Atkinson and Marsha Chandler (eds.) *The Politics of Canadian Public Policy,* ed. M. Atkinson and M. Chandler, 223–46. Toronto: University of Toronto Press.

Williams, A.P., H.M. Stevenson, and E. Vayda. 1987. The Organization of Medical Practice in Canada: Policy Implications of a Trend toward Private Group Practice. York University. (Unpublished.)

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