

Sexually transmitted diseases in Ontario

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Introduction

Canada is a federal union of 10 provinces and two territories. It is an independent community within the British Commonwealth of Nations. The constitution still rests on the British North America Act of 1867 and, despite repeated attempts to agree to a new constitution, little progress has been made. The population of Canada in 1977 was 22 191 000, of whom eight million were of British origin, five and half million of French origin, and one million of German origin. An increasing number of immigrants from Asia and the Pacific is now being reported.

The Federal Government and the Parliament in Ottawa control foreign policy, major economic affairs, and general home policies. The provincial governments have full sovereignty in all local matters. Responsibility for the provision of health care in Canada is vested in the provincial governments.

In the 1950s and 1960s the Federal Government gave direction and help to the provincial governments to establish health insurance schemes. There were differences of detail in each province, but the general guidelines were: (a) that all Canadian citizens should be eligible for benefits without any exception; (b) that care should be easily accessible to all; and (c) that schemes should be run on a non-profit-making basis and should be transferable between provinces.

At first the Federal Government shared the costs with the provinces but it has recently transferred the major financial responsibility to the provinces. It is estimated that the schemes cost about 7.1% of the gross national product.

Ontario Health Insurance Plan

Ontario is one of the most densely populated provinces situated close to the great lakes. It is an industrialised province with a population of about 7 700 000 people. Toronto is the principal town and

major administrative centre, with highly developed industries, important banking and publishing interests, and a large port.

Until 1969 health care covered only hospital expenses. In 1969 the Ontario Health Services Plan started to cover outpatient service costs. The current Ontario Health Insurance Plan (OHIP) now provides cover for doctors' fees, laboratory and radiological investigations, occupational therapy, chiropody, optometry, chiropractice, osteopathy (up to \$125 a year), ambulance services, and some home nursing.

The scheme does not cover the cost of drugs, dental care, spectacles, false teeth, hearing aids, nor cosmetic surgery. There is a drug benefit scheme for old-age pensioners and those receiving social security. About three-quarters of those who are not eligible for free drugs belong to private insurance schemes, which are often part of fringe benefits negotiated with employers.

The subscription to the OHIP is \$19 a month or \$38 for family cover. People over 65 are exempt and the scheme is optional for the self-employed and those in small firms.

DOCTORS' FEES

There are 16 500 licensed doctors in Ontario. They are paid on an item-of-service basis. When a patient consults a doctor or goes to a medical institution a form is filled in at each visit. This includes the patient's name, address, date of birth, the OHIP registration number, and the doctor's name, number, and address. The date of examination and the diagnosis, together with the scheduled fee, is recorded, as is the type of service provided—such as office or home or hospital consultation.

It is estimated that about 12 000 of the 16 500 licensed doctors regularly submit claims to the OHIP. Some doctors opt out of the scheme and negotiate their fees directly with their patients. The patients can claim back the standard fee for the service on the OHIP schedule but have to pay the difference between the two fee scales.

Over six million claims are dealt with each month and there is a clerical staff of over 2000 employees. The administrative costs are estimated to be between 5% and 6% of the one billion dollars paid out each year in claims. Everyone in the scheme must have an

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Received for publication 24 January 1979

OHIP number which is given only to the heads of households. When they are 21 years of age, or when they marry young, people are given an independent number but otherwise they must use their father's number.

Fee schedules are negotiated annually with the Ontario Ministry of Health by the Ontario Medical Association. The fee for an office visit to a family physician is at present \$8.75 and for a specialist \$30-60 under OHIP. In the private sector an office visit costs about \$12 for a family physician and significantly more for a specialist consultation.

DOCTORS' CLAIMS AND INCOMES

Claims submitted by doctors to the OHIP are all carefully monitored by the Professional Services Monitoring Board of the Health Insurance Division of the Ontario Ministry of Health, using a computer which checks the accuracy of the claims and arranges payments. The computer also produces a picture of each doctor's professional habits and compares them with those of his colleagues in similar specialties. It can note any divergence from the practices of his colleagues and records the use of laboratory and radiological services.

Medical incomes in Canada are high and the average earnings of family doctors in 1977 were about \$46 000, or £24 000 before tax. Incomes of specialists are substantially higher. The paperwork in submitting claims for fees to the OHIP is tedious and onerous, occupying about one hour a day for each doctor. The fee-for-service system is open to obvious abuse by both doctors and patients. All OHIP employees are legally bound not to divulge medical information to a third party but computerised information makes real confidentiality difficult, and there appears to be greater access to medical information than would be allowed in the United Kingdom.

Sexually transmitted diseases

Patients who suspect that they may have a sexually transmitted disease (STD) usually go to a family or private physician and not to a specialised clinic. It is estimated that between 70 and 80% of these patients either attend their own physician or go to see another physician in his office. Only about one patient in five attends a Department of Health venereal diseases clinic. The fee for consultation is \$8.75 and can be claimed from the OHIP. Laboratory fees are about \$4 but darkground microscopy is \$9. Serological tests for syphilis are free and are carried out by the public health laboratories.

STD CLINICS

The STD clinics are organised by the senior medical

consultant and principal programme adviser on STD to the Ontario Ministry of Health. The Venereal Diseases Prevention Act of 1918 states that all hospitals have the right to establish STD clinics provided the medical officer of health agrees to the arrangements. Contacts of known patients who are suspected of being infected can be compelled by law to be examined and treated. In the clinics all examinations, investigations, and treatments are free. The patients are not asked to prove that they are covered by the OHIP scheme.

There are 32 clinics for patients with STD in Ontario serving a population of 7.7 million people. About 80% of the population of Ontario live in urban areas and there are 12 clinics in Toronto, one in Ottawa, one each in London, Hamilton, and Kingston, and others in smaller centres. Of the 32 clinics, only 16 are in hospitals, the remainder being situated in health units away from the hospitals. All the clinics are open only part-time each day.

FINANCE

The total cost of the clinics is paid by the Department of Health. The clinics are under the general direction of the local medical officer of health and the doctors who work in them all have major interests in other fields, such as dermatology, gynaecology, urology, or family medicine. There is no such person as a pure venereologist. Doctors are paid a fee of \$8.75 for each patient seen in the clinics, whether they are new patients or those attending for follow-up examinations.

The estimated cost of each patient-visit is about \$32 and, in addition to the funds from the Department of Health, the hospital or health unit contributes an extra sum of \$8 per patient towards clinic expenses. The clinical nurses are paid by the hospital or health unit and the public health nurses, who do the contact-tracing, by the medical officer of health. In some clinics there are laboratory technicians who are paid \$3.84 for every stained microscope slide examined.

CLINIC ATTENDANCES

The total number of attendances of all patients at the 32 clinics was 165 000 in 1977. It is recommended that the ideal patient flow in clinics should be of the order of seven to eight patients per hour for each physician.

TEACHING

Medical students have some lectures on STD at most medical schools but no clinical experience with patients. In some schools the subject is only mentioned in lectures on gynaecology and urology, and there is no planned teaching of the subject. Even

a very modern medical school like McMaster University Medical School in Hamilton has no planned course of teaching about the diseases. Thus the students' only opportunity to learn about the subject is if they choose it as an elective subject, but unfortunately few do this. Opportunities for postgraduate study are few and, where they do exist, take the form of lectures.

NOTIFICATIONS

All family doctors, specialists, and private physicians are required by law to notify all cases of STD to the local medical officer of health. Records of all cases are then forwarded to the director of public health services in Toronto. As is usual with such a system there is considerable under-reporting. For example, in 1977 the total number of reported cases of gonorrhoea was about 20 000 and, of syphilis, 2200. It is estimated that the actual true totals should be nearer 60 000 cases of gonorrhoea and 2500-3000 cases of syphilis. The incidence of all the other sexually transmitted diseases is unknown.

CONTROL PROGRAMMES

Ontario, Quebec, and British Columbia are the only three provinces which have developing programmes for the control of sexually transmitted diseases, and it is reasonable to conclude that the prevalence and economic importance of the diseases are completely unknown in the other provinces and territories.

Discussion

The methods developed in Ontario for the control and prevention of sexually transmitted diseases are closer to the system used in the United States than to the British system. Essentially they are based on a series of programmes which are initiated and controlled by the Public Health Service through the senior medical consultant and principal programme adviser on STD to the Ontario Ministry of Health. As in the United States about 80% of patients are seen by their family physicians or by private doctors and only about 20% attend the clinics. Unfortunately, very few family or private physicians have been taught anything about the management of patients with STD at their medical schools, and postgraduate teaching in the subject is still rudimentary. As a result standards of diagnosis and treatment are very variable and contact-tracing is often omitted.

The clinics themselves are frequently not part of hospitals but are relatively isolated units, and the doctors working in the clinics are not fully committed to the specialty and usually have another major interest such as family medicine, dermatology,

urology, or gynaecology. There is no equivalent of the British consultant physician, who has had postgraduate training in general medicine and three to four years of specialist training in STD at a large clinic in a teaching hospital.

Some of the clinics in Ontario treat only patients with statutory venereal diseases. This makes the work limited and unattractive and leads to difficulties in recruiting high-quality doctors. A broader concept of the subject—including a wide variety of diseases of the genitourinary systems—could well improve recruitment and even persuade some doctors to make a career in the subject.

As is the case all over the world the standards of the premises are very variable. The best clinics are well equipped and are housed in reasonable departments, in some cases in university hospitals. Other clinics are overcrowded and in unattractive surroundings, often outside the main hospital, and are unlikely to attract either patients or well-trained physicians and nurses. Because of the shortage of doctors, nurse assistants are widely used and they carry out many of the duties which have traditionally been the responsibility of doctors. The public health nurses who undertake the contact-tracing have no formal training in the subject at present but they perform their duties with enthusiasm and considerable success.

Conclusions

The Ontario Ministry of Health recognises that the sexually transmitted diseases constitute an important problem in the province. Through their senior medical consultant in STD they are taking active steps to develop a service for patients and plans to try to control the incidence of the diseases.

University hospitals do not provide adequate undergraduate teaching about sexually transmitted diseases and many of them do not have a clinic. As a result medical students rarely have opportunities for clinical teaching on patients. It is something of a paradox that most infected patients are treated by family and private physicians who have had no training in the subject. Furthermore, if medical students do not receive adequate teaching—including clinical experience with patients—recruitment to the specialty will remain poor and the best students will not consider the specialty as a career.

There are great opportunities for the development of a high-quality service in Ontario. The essential step is to establish the subject in all the university hospitals and to ensure that medical students receive both theoretical teaching and practical experience with patients. One of the initial difficulties will be to

find suitable people to do the teaching and this can only be achieved in the long run by establishing university hospital clinics and providing a career structure in the specialty. Most other improvements will follow such as attractive clinics, higher standards of clinical practice, better teaching and research, and the improved training of nurses, social workers, and other ancillary workers.

Meanwhile, during the transition period—before the benefits of this policy become apparent—a major attempt could be made to educate practising physicians and to keep them up to date with recent developments in the subject. This could take the form of postgraduate seminars, workshops, incentives, the circulation of recommended diagnostic procedures, and treatment schedules, and

the formation of a group of public health workers who could be available to physicians to help with the management of their patients and the tracing of contacts. Experience in the United States has shown that this approach has its limitations. Education and clinical experience during the formative years are more effective than attempts to change unsatisfactory habits acquired through lack of guidance and instruction.

Ultimately the establishment of a high-quality service for the control of sexually transmitted diseases could have important consequences for the health of the community. It could be shown to be very cost-effective in preventing the complications of the diseases, which often result in repeated periods of hospitalisation and prolonged ill-health.