MEDICAL REFORM GROUP OF ONTARIO

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CANADA HEALTH ACT

The new Canada Health Act was introduced in mid-December by federal Health Minister Monique Begin. The proposed Act would subject provinces allowing extra-billing and user charges to financial penalties. In order for a provincial health program to be fully eligible for federal funding, it must be (a) comprehensive: covering all necessary hospital and medical services; (b) universal: 100 per cent of residents must be entitled to insured health services; (c) portable from province to province; and (d) accessible: "reasonable access to insured health services is not to be precluded or impeded, either directly or indirectly, by charge or other mechanisms".

The Act was expected to have a rough ride, with opposition to it anticipated from provincial Ministers of Health, the Canadian Medical Association, and the Progressive Conservative opposition (the PC's surprised many observers by coming out in favour of the Act, thereby defusing it as a potential election issue). The MRG considered it important to take a public stand in favour of the principles incorporated in the Act, to make it clear that the medical profession is not unanimously opposed to the proposed legislation. A news conference was organized in Toronto on very short notice (special thanks to Michael Rachlis!) with the result that the MRG's position was being stated while media interest was at its peak. The news conference resulted in widespread coverage on television and radio, and in newspapers, including national and local television news and articles in the Globe and Mail and the Toronto Star. In addition, former steering committee member Bob James was interviewed on CBC radio, while Cynthia Carver wrote an 'op-ed' article in the Globe and Mail.

The MRG's press release, and samples of the press coverage, are attached.

A series of meetings on the issues at stake is being organized across Ontario by the Ontario Health Coalition. MRG members are closely involved in organizing these meetings and speaking at them.

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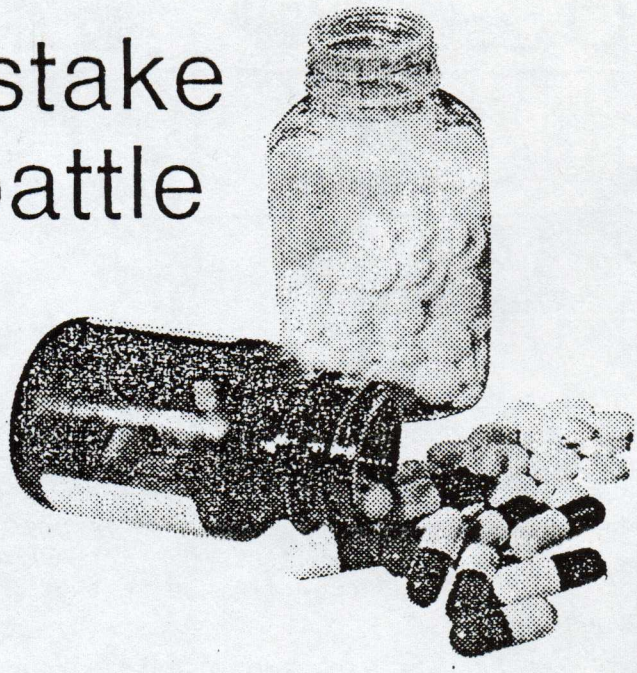
Globe + Mail, Aug 18/1983

Drug costs at stake in patent law battle



By CHARLOTTE MONTGOMERY
Globe and Mail Reporter

OTTAWA — One of Ottawa's most obscure laws has inadvertently become a battleground for the two giants of public policy — high technology and health.

The unlikely subject — federal Government proposals to change the Patent Act — has spawned an emotional debate, with the promotion of economic growth and corporate profits on one side and social concerns and consumer rights on the other.

At issue is a 13-year-old section of the Patent Act which is credited with making inexpensive generic drugs available to Canadians.

Ottawa would like to alter the legislation in some way which would please multinational drug companies, who are bitterly opposed to it, in an effort to persuade them to expand their research and development investment in Canada.

But the debate over the amendments has unexpectedly become focused on medicare, the costs of health care and the propriety of extra charges to consumers.

Those opposed to changing the Patent Act argue that Canadians' access to low-cost drugs is threatened, that provincial drug plans for the poor and elderly might be endangered and that a dozen Canadian companies who have recently begun to carve a spot for themselves in the country's billion-dollar drug industry could face sharply diminished growth or even extinction.

But those in favor of the changes reply that corporate investment in research programs is not respected by the law, that the law has an anti-business bias and that universities and hospitals might gain valuable additions to research investment if changes are made.

The passions of the argument are so polarized and uncompromising that a Cabinet decision on changes to the act has been put off and surprised federal officials are searching for some common ground between the two sides.

Those lobbying on either side were to have prepared a report on the issue for Cabinet by the end of September so that a decision could be made. But that deadline has come and gone and George Post, deputy minister of Consumer and Corporate Affairs, is making no further estimates of how long it will take to settle the question.

Companies feel generic drugs violate their patent privileges

"There is so much controversy that it's going to be hard for the Cabinet," Mr. Post said in an interview.

"It's more difficult than I had anticipated to get people to take a medium- and longer-range view," Mr. Post said. "This is a higher-tech industry than most, I would have thought that a longer view would be taken by some. It turns out that most people are thinking in the immediate term."

The polarity of the conflict is reflected in the position in which provincial governments find themselves as they tardily begin to submit the recommendations Ottawa had wanted from them by the end of summer.

As large-scale buyers of drugs through their prescription drug plans, the governments react strongly to any move which might lessen competition and drive up prices, Mr. Post said. But at the same time, some see industrial development prospects in the drug industry, although any increase in research and development by drug companies is expected to favor central Canada.

Aside from the industry, social and consumer groups have checked in with strong views on what the Government should do.

The Patent Act was changed in 1969 to introduce compulsory licencing, a measure that sprang from controversy about high drug prices. That provision allows companies operating in Canada to produce generic copies of name-brand drugs if they pay a 4 per cent royalty to the company that developed the drug and holds a patent on it.

Since compulsory licencing was established, manufacturers of name-brand drugs have angrily charged that they spend years and millions to develop drugs which then profit companies which shared none of the risk or expense. They want a 17-year patent to recognize their investment.

Provincial government officials have said that they have saved millions of dollars by using lower-priced generic drugs in their public drug plans and that they doubt Ottawa will devise any effective way of monitoring prices if compulsory licencing removes much of the price competition.

"The drug business is seen by a lot of people as an integral part of health care costs, which already was a debate," Mr. Post said. "I think we've been caught up more in the immediacy of that debate than I would have thought."

One option for Ottawa has always been to leave the act as it is. But that, said Mr. Post, would leave unresolved the "sense of irritation the multinational drug companies feel towards Canada" and might eliminate the country from competition for drug research.

MEDICAL REFORM GROUP OF ONTARIO

December 13, 1983

FOR IMMEDIATE RELEASE

Four years ago physicians concerned about the erosion of Canada's medicare system founded the Medical Reform Group of Ontario. The Medical Reform Group has a membership of approximately 150, most of whom are practising physicians.

We applaud Monique Begin's introduction of the Canada Health Act, because it reasserts the original principles of medicare, in particular universality of coverage and reasonable access to services without financial impediments. We are pleased that the Act provides for financial penalties for provinces which allow hospital user fees and physician extra billing.

However, we are worried that some provinces will decide to accept the proposed penalties rather than eliminate these destructive practices. If the provinces follow this course, Canadians will continue to experience barriers to necessary care, while the public money available to provide for health services will decrease. We therefore call upon the provincial governments and physicians to abide by the wishes of the overwhelming majority of Canadians and follow the spirit as well as the letter of this new Act.

As practising physicians we have encountered patients in Ontario who are without insurance coverage because they cannot afford OHIP premiums or are unable to wend their way through the premium assistance maze. We have found it difficult to find opted-in specialists for patients in some specialties and geographic areas, including metropolitan Toronto. We believe health care cannot be treated as a commodity to be bought and sold on the open market. It is time for all Canadians to reconfirm that health care is a right, not a privilege.

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XTRA-BILLING A PITFALL

Globe + Mail, Dec. 22/1983

The danger of travelling the U.S. route on medicare

BY CYNTHIA CARVER

Dr. Carver is a Toronto physician.

ONE YEAR in the United States, formally as a student of public health, and informally as a student of the U.S. medical care system, has brought me back to Canada convinced that to allow our system to go the way of the one south of the border would be disastrous.

The largely private nature of U.S. medical care means virtually no control er rising costs, a totally different kind and quality of care for rich and poor, a great measure of control over physicians and consumers by insurance companies, little in the way of quality assurance, and, on top of this, a level of health inferior to that in Canada, England and most Western European countries.

Are we in danger of going the way of the United States? I think we are. The small step leading in that direction is extra-billing. The giant step likely to follow — and already advocated by many — is the introduction of private medical insurance to bridge the gap between what is covered by medicare and what physicians and hospitals choose to bill for services.

When I first established my general practice in downtown Toronto 10 years ago, I sought consultants in almost every specialty who were top-notch doctors and opted-in. This meant my patients could have all necessary medical attention, preventive and curative, without fear of receiving bills they could not affort.

As the years went by, I observed two related phenomena which forced me to change my referral patterns: first, some of the specialists opted out of medicare and began billing extra, and second, those remaining in the plan became so amped that the personalized kind of ...edical care I desired for my patients disappeared. A related point was that the extra-billing amounts rose from a few dollars a visit to $20, $30 or more, and for technical procedures, surgery or obstetrics, began to amount to hundreds.

For a while, either my secretary or I phoned ahead to opted-out specialists to ask whether they would see a particular patient at the Ontario Health Insurance Plan rate. The specialists nearly always agreed, but in some cases they or their secretaries suggested we send our patient to hospital clinics. In a few instances, despite prior agreement, patients were accidentally extra-billed, and an embarrassing time was had by all. Finally, these phone calls simply took so much time that I resorted to telling my patients that, if they were to plead poverty, specialists would not bill them extra. Patients then began to say they would rather go to clinics than be known as charity cases. This is a two-tier system of medical care, and it can only get worse.

The Government of Canada in the 1957 Federal Hospital Insurance Diagnostic Services Act and the 1966 Medical Care Act committed itself to the concept that health care, like education, was vital to individuals and the nation, and should be available to all without financial penalty.

When I first established my general practice in downtown Toronto 10 years ago, I sought consultants in almost every specialty who were top-notch doctors and opted-in. This meant my patients could have all necessary medical attention, preventive and curative, without fear of receiving bills they could not affort.

As the years went by, I observed two related phenomena which forced me to change my referral patterns: first, some of the specialists opted out of medicare and began billing extra, and second, those remaining in the plan became so swamped that the personalized kind of medical care I desired for my patients disappeared. A related point was that the extra-billing amounts rose from a few dollars a visit to $20, $30 or more, and for technical procedures, surgery or obstetrics, began to amount to hundreds.

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The Government of Canada in the 1957 Federal Hospital Insurance Diagnostic Services Act and the 1966 Medical Care Act committed itself to the concept that health care, like education, was vital to individuals and the nation, and should be available to all without financial penalty.

In particular, taxing illness was repugnant.

In reality, the benefits are comprehensive and accessible on paper, but not in practice. For example, most private psychiatrists in Toronto extra bill at a rate of $25 to $40 per session. How many people on marginal incomes can obtain psychiatric care for the weeks or months usually needed? Many obstetricians bill $200 to $500 above the insured rates for obstetrical care. How many single mothers, pregnant teens or low-income women can afford that? And these are the high-risk groups.

Universality of coverage is problematic in the three provinces with premiums, Alberta, Ontario and British Columbia. Workers not covered by union contracts, part-time employees, transients, the self-employed and those who alternate between employment and unemployment are often not insured. These are people who tend to be at relatively high risk for illness. Single mothers with low-paying jobs are frequently in this situation: they may delay preventive services for themselves or their children, taking a "let's wait and see" attitude. Soon someone is going to wait and see too long.

Non-use of preventive health services because of cost, deferral of surgery and testing, opted-in specialists forced to compromise their quality of care, increasing referrals of the poor to hospital clinics to receive care from interns and residents who are there one month and gone the next — these were not the intent of medicare.

In Ontario there is no binding fee scheduled for doctors. OHIP has one schedule, binding only for opted-in physicians; the Ontario Medical Association has another fee schedule recommended, but binding for no one. In effect, opted-out physicians can bill what the traffic will bear. Right now what the traffic will bear is limited to some extent: but if private insurers are permitted to offer coverage to bridge the gap between what OHIP covers and what doctors bill, the sky becomes the limit.

A recent U.S. study reported that "21 to 27 million Americans had no health insurance last year — the majority were working people". It also said "300,000 Americans say members of their families were denied medical treatment." Privately owned profit-making hospitals were re-

BY CYNTHIA CARVER

Continued

ported turning away patients with no insurance or with only Government insurance (for the elderly, disabled and welfare recipients).

In the United States, I was offered a Blue Cross-Blue Shield non-group insurance plan, which was advertised as highly comprehensive and would have cost me $1,840.92 a year. It had a $100 deductible provision, covered only 80 per cent of physicians' (50 per cent of psychiatrists') "reasonable charges" and "reasonable" was determined by BCBS.

Items not covered by this insurance included: hospital admissions primarily for diagnosis or physical therapy; routine care such as physical examinations, well-baby care and immunizations; allergy testing; routine vision and hearing examinations or foot care; blood transfusions; experimental or investigative services; treatment of illness or injury resulting from an act of war. Treatment for any illness or condition, diagnosed or not, that was present before this insurance became effective might not be covered by the policy. (Cancer and heart disease, two major causes of death in North America, are usually present long before they are diagnosed.) Finally, a catch-all of exclusions: "for services, supplies or charges not judged medically necessary by BCBS".

Is this what we want? Doctors say they do not want government telling them how to practice medicine. Would they prefer insurance companies?

The Canada Health Act is before Parliament. It should be passed promptly, and then provincial governments and health providers together should work on problems in the delivery system. Innovative programs using different physician payment systems, non-physician health workers (nurse practitioners, midwives and paramedics), home care and outpatient surgery can reduce costs and free up hosptial beds and doctors' time. There are ways of controlling costs and yet not penalizing the sick — let's try them.

Begin's move backed by reform MD group

Globe + Mail, Dec 14/83

While the medical establishment rails against the proposed Canada Health Act, a small group of reform-minded doctors has come to the defence of federal Health Minister Monique Begin.

The 150-member Medical Reform Group of Ontario says federal legislation aimed at eliminating hospital user fees and extra-billing by doctors "reasserts the original principles of medicare, in particular universality of coverage and reasonable access to service without financial impediments."

Six members gathered at a press conference in Toronto to throw the group's weight behind Mrs. Begin's bill. "It's important that this act is passed so we can preserve what we have" in the face of an erosion of the principle of access, said Dr. Michael Rachlis.

Dr. Cynthia Carver said that with many specialists in Toronto now practicing outside medicare, "we are having great difficulty" finding doctors for patients who cannot afford to pay for treatment. They said there is a severe shortage of anesthetists, obstetricians and psychiatrists.

The reform group is worried that Ontario may regard the penalties in the federal bill as just a licence fee for the right to allow doctors to opt out of the Ontario Health Insurance Plan. If that happens, "the health system and the taxpayers will be poorer for it," Dr. Rachlis said.

Dr. Philip Berger said it is important to distinguish the leadership of the medical profession from the bulk of doctors. "The leadership is out of touch . . . there's tremendous pressure to conform," he said; adding that a schism may occur if the leadership responds too drastically to the federal bill.

Dr. Fred Freedman said doctors, like everyone else, would like to earn more money, but "it has to be bargained like other labor negotiations in society," and settled by contract so that doctors don't "stick another 30 per cent on it."

He said a doctors' strike over the federal proposals is unlikely. "You're talking about a whole profession going on strike for the sake of the 15 per cent who are using this privilege (extra-billing), and that's why I don't think a strike will come off."

Most doctors want to stay in OHIP rebel MD says

Toronto Star, Dec 14/83

By Hamlin Grange Toronto Star

The leadership of Ontario's medical association is "out of touch with reality" and represents only a minority of physicians who want to opt out of the provincial medicare plan, a Metro doctor says.

Speaking in support of the federal government's proposed new Canada Health Act, Dr. Philip Berger, a member of the Medical Reform Group, said most physicians participate in the Ontario Health Insurance Plan and are satisfied with their salaries.

The new health act, given its first reading in the Commons Monday, would penalize provinces — dollar for dollar — that charge extra for health services or allow doctors to extra-bill. The OMA is opposed to the bill.

Carver

"Most doctors are kind, care about their patients and are satisfied with their salaries; it's just that there are tremendous pressures on the rank and file to follow the leadership (of the OMA)," Berger said.

But Gene O'Keefe, spokesman for the OMA, called Berger's allegations "nonsense."

"The board of directors and the council of the OMA represents 15,900 physicians and interns. It's a voluntary organization and they aren't forced to join."

Dr. Cynthia Carver, one of the reform group doctors, interpreted this to mean that Ontario is willing to allow physicians to opt out and will view the federal penalities — which may cost Ontario taxpayers $50 million annually — as a "license for opting out."

Medicare penalties need more teeth, advocacy group says

By ROBERT STEPHENS

The proposed Canada Health Act does not go far enough in penalizing provinces that allow extra-billing by doctors, the Ontario Health Coalition says.

Michele Harding, executive director of the advocacy organization, told reporters yesterday at Queen's Park that the proposed penalties may not deter wealthier provinces from allowing extra-billing and hospital user fees. She said stiffer sanctions are needed.

Under the act, provinces will lose a dollar of federal transfer payments for every dollar that hospitals charge in user fees or physicians bill in excess of medicare rates. Mrs. Harding said the penalties should rise each year so there is "increased pressure on the provinces."

She said the federal Government, for example, could reduce a province's health care payments by $1.50 for every dollar of direct billing in the second year and by $2 in the third year. She said Ontario, British Columbia and Alberta may not move to ban extra-billing without the threat of "incremental sanctions."

Ontario will lose about $50-million a year of federal funds if it is penalized on a dollar-for-dollar basis. Mrs. Harding said the province may decide to forgo that amount of money rather than face a showdown with doctors and attempt to make up the difference in higher provincial taxes.

"If (Ontario Treasurer) Larry Grossman ups our taxes, he'd better be able to prove that the additional money is spent on improved health services and not on increased incomes for doctors," Mrs. Harding said.

Dr. John Frank, a member of the coalition and an official with the Medical Reform Group, said doctors should be content to negotiate their fees "the same as any other public service worker" and should not be allowed to arbitrarily charge some patients more than medicare rates.

Wally Majesky, president of the Labor Council of Metro Toronto and also a member of the coalition, agreed that doctors should abide by the fee schedules negotiated under medicare. "And they should have the right to withdraw their services," he said.

Dr. Frank said there is no evidence to suggest that large numbers of doctors would leave provinces that banned extra-billing. He also argued that hospital user fees do nothing to improve the efficency of the health care system.

Although members of the coalition are generally pleased with the act and welcome the public debate that has ensued since its introduction, they say one major shortcoming is a failure to include mental health in the legislation.

Mr. Majesky said universal access to health care must be preserved, and extra-billing threatens to create a two-tier system that would deny basic services to the poor. "Health is not for profit, it is for people," he said. "Health should be a right, not a medical racket."

Canadian Health Coalition
Press Conference - December 14, 1983

The Canadian Health Coalition welcomes the introduction in Parliament of Canada Health Act legislation. This legislation is meant to strengthen Canada's hospital and medical insurance plans by more clearly defining the principles of Medicare and by establishing clear and effective compliance mechanisms to address violations.

The Canadian Health Coalition supports the Canada Health Act in principle. We fully support the right of the federal government to establish standards and conditions of payment and to enforce those standards by holding back the cash portion of the federal contributiuon to offending provinces. According to the funding agreements established between the federal and provincial governments, the federal government shares the cost of provincial health services on condition that the basic principles - universality, accessibility, comprehensiveness, portability and public administration - are adhered to. When these principles are violated, as by allowing extra-billing and/or user fees, the federal government has the right and the obligation to impose penalties. Federal money is public money and when the rights of the public are violated the government must act to defend those rights.

We also support the broadening of the principle of Universality to include 100% of residents entitled to insured health services. In practise, this must mean that entitlement to insured services cannot depend on the payment of health care premiums.

Despite this support, the Canadian Health Coalition has grave concern that the non-discretionary sanctions for extra-billing and user fee violations are not strict enough. We are not convinced that the dollar-for-dollar penalty over a three year period will actually motivate provinces to eliminate extra-billing and user fees. We propose, instead, that a stricter penalty be enforced, namely, that, after a clear warning from the federal government, the province allowing extra-billing or user fees is given one year to eliminate these abuses or else lose the total federal cash contribution annually given to that province.

We are also gravely concerned that the principle of comprehensiveness of services is not expanded to include mental health as well as health promotion, community health centres, nursing services and other cost-effective alternatives to the present health care system.

With respect to other parts of the legislation, we have questions that require further study. We are hoping to have an opportunity to suggest other specific amendments when, after the second reading, the legislation is in committee and public hearings are held.

Presented by
Richard Haughian
President Canadian Health Coalition
at National Press Gallery

Medicare system envied in U.S.

By PAUL TAYLOR

Federal and provincial officials are currently locked in a bitter struggle over escalating health costs, but there are people in the United States who look to the Canadian medicare system with admiration — and even a touch of envy.

Repeated studies have shown that the Canadian health care system has resulted in lower medical expenses for both individuals and large corporations than the U.S. system.

"Your medicare program may not be perfect, but I'd rather be in your shoes than have to contend with our health care system," Patrick Killeen, a Detroit-based health care consultant, told the United Auto Workers union.

U.S. residents do not have a comprehensive national health care insurance program. As a result, many unionized workers have sought health care protection by getting employers to pay part, or all, of the premiums in private insurance plans.

According to various estimates, U.S. corporations will pay between $80-billion and $100-billion (U.S.) this year in health insurance premiums for their employees, retired workers and their dependents.

And industry officials say these massive bills are eroding the competitive position of U.S. companies in international — and even domestic — markets.

William Winters, a spokesman for General Motors Corp. of Detroit, said his company's health care tab amounted to $1.9-billion in 1982 — $483 for every car and truck GM made in the United States last year.

"We paid out more in health care premiums than we made in total world-wide profits last year," he said. "And we estimate that our health care costs will double every five years unless something is done to stop the upward spiral."

It is difficult to make a direct comparison between the health care benefits paid by employers in Canada and the United States. But in the auto industry — where benefits are about equal on both sides of the border — the costs in Canada run about half those in the United States.

U.S. corporations are worried about the dramatic rise in health care costs, and some are trying to wriggle out of commitments to pay health care bills.

For their part, labor unions are resisting what they see as a regressive move on the part of management.

The result has sometimes been bitter and lengthy strikes. Earlier this year, for example, unionized employees of Caterpillar Tractor Co. of Peoria, Ill., went on a 205-day strike to maintain their medical benefits.

There are, of course, many reasons for skyrocketing health costs. New and costly equipment has pushed up hospital bills; an aging population has put greater demands on the medical profession; and abuses of the system — such as overuse of laboratory tests and unnecessary surgery — have added to costs.

However, Canada seems to have done a much better job at keeping health costs under control.

In 1967, the year before medicare came into effect in most provinces, Canada spent 6.4 per cent of its gross national product on health services. In the same year, 6.2 per cent of the U.S. GNP went for health care.

By 1982, the United States was spending 10.5 per cent of its GNP on health services, while Canada was spending only 8.4 per cent.

Health care analysts believe Canada's universal medicare system has been partly responsible.

"The Canadian Government has some power to keep a lid on costs because it is the one that ultimately pays the bills," said Lee Soderstrom, an economist at McGill University in Montreal. "But in the United States, there is no single authority that can oversee the system."

Instead, financing comes from a myriad of private and public insurance plans, plus individual payments for services. Some plans are paid for by companies and others by individuals.

In the case of the elderly and the poor, government agencies often pick up part, or all, of the tab.

However, under this system, "no one is a big enough player to negotiate fee schedules with all doctors or put hospitals on a budget," Mr. Soderstrom said.

This view is echoed by senior executives in U.S. industry. As David Collier, a vice-president of General Motors, put it: "Doctors and hospitals have enjoyed what amounts to a blank cheque when it comes to treatment and reimbursement."

Canada may have escaped the big increase in health costs that has hit the United States, but analysts warn that its medicare program, and the Government's ability to hold down costs, is being eroded by the introduction of user fees and overbilling by some physicians.

In a bid to safeguard the system, federal Health Minister Monique Begin has introduced legislation that would impose financial penalties on provinces that permit hospital user fees and extra billing by doctors. The legislation has been criticized by some provincial health ministers, who say it does not deal with the main problem facing medicare: a lack of funds.

Many observers think the Canadian system is at a crossroads and they are uncertain about whether costs can be contained in future and about who will end up paying.

"Canadian corporations would have to be pretty naive if they thought they wouldn't be picking up part of the higher costs," said Robert Evans, a professor of economics at the University of British Columbia.

So far, only three provinces — Ontario, Alberta and British Columbia — actually charge health insurance premiums, paid by employers and employees, that cover a portion of the costs. The rest of the money comes from general tax revenue.

Many companies are also able to trim their tax bills by various write-offs and deductions.

This has led some economists to conclude that the burden of Canada's health care costs is unfairly borne by individual taxpayers rather than corporations.

And some reform-minded doctors — such as Michael Rachlis, a director of the Ontario Health Coalition — believe that the threat of higher health costs will eventually persuade corporate interests to rally to the support of the medicare system.