MRG NEWSLETTER

MEDICAL REFORM GROUP OF ONTARIO P.O. Box 366, STATION "J" TORONTO, ONTARIO M4J 4Y8

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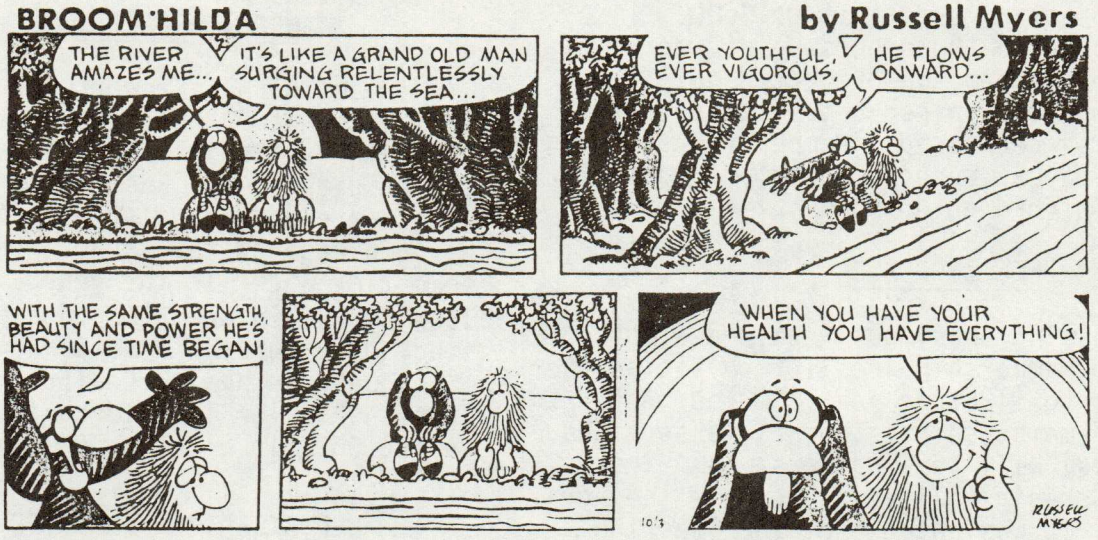


General Meeting Report

The Medical Reform Group's Spring General Meeting took place in Toronto on April 26 and 27. Friday evening featured a talk by June Callwood on the topic of Violence and Women's Health.

HEALTH SERVICES FOR WOMEN

On Saturday morning, the meeting opened with a panel discussion on the subject "How Can We Improve Health Services for Women?" Speakers were Dr. Miriam Garfinkle, a family physician and MRG member, Mary Lou McPhedran, a lawyer at Toronto City Hall who several years ago was involved in an attempt to set up a women's health centre, and Julie Brickman, a psychologist.

The panel discussion was followed by three workshops, on the subjects:

1) Women in Medicine/The Support Function of the MRG;
2) The Medicalisation of Women's Problems;
3) Fragmentation of Care.

FINANCIAL REPORT

The business portion of the meeting heard a financial report from Ulli Diemer which showed that from October 1, 1984 to March 31, 1985, the MRG showed a surplus of $4,689. By comparison, there was a surplus of $2,614 over the same period last year. (It should be noted, however, that $1,037 of this year's surplus goes to cover last year's eventual deficit, and also that the first portion of the year shows a surplus because that is when most of the revenue comes in.) The projection of the financial report is that there will be a small deficit of about $600 on the whole fiscal year. In giving a background to the financial report, Ulli noted that MRG revenue from memberships has not been enough to cover expenses for the past two or three years. Two years ago, there was about $3,600 in "special income", such as speakers fee, which made up the gap in revenue. In 1983-84, however, these special sources of income dried up, while

General Meeting Report

membership revenue remained almost exactly the same. The result was a deficit of $2,000. This year, membership revenues are up by about $2,000, partly because there are a number of new members and partly because more members paid at supporting membership rates. Because expenses have risen, we are still projecting a deficit of $600. In connection with the proposed fee increase, it was noted that the projected gain in revenue could be wiped out if supporting memberships decreased. Members were strongly urged to pay at supporting member rates if they can afford to do so.

FEE INCREASE

The meeting unanimously passed a motion that "MRG Membership fees for physicians be increased to $125 per year." Other categories of membership (students, associates, affiliates) will remain the same. First-year membership will still be half the normal fee. It was noted that the Steering Committee still has the discretion to reduce fees on an individual basis for members who cannot afford the full fee.

CHAPTER REPORTS

Hamilton reported on two recent events: a meeting on the Hamilton Health and Safety Centre, and a meeting on the role of work and well-being, and unemployment and health.

Toronto reported on two meetings: one on community health centres and HSO's, and another on obstetrics and midwifery. Toronto chapter will be pursuing the health professions topic over the next six to 12 months.

HEALTH COALITIONS

Michael Rachlis reported that the Canadian Health Coalition has been working on the pharmaceuticals issue, trying to influence the results of the Eastman Commission with briefs, telegrams, etc. The CHC is planning a conference on the Canada Health Act for some time later in the year. The CHC is also looking for information on a privatization study done for the federal government.

The Ontario Health Coalition has prepared fact sheets for local organizations to use in the Ontario election campaign.

NEW STEERING COMMITTEE MEMBER

Claire Payne was elected to the Steering Committee. Clyde Hertzman, who is moving to Vancouver, was thanked for his contributions to the Steering Committee.

DEATH PENALTY

The following motion was passed unanimously: "Be it resolved that the MRG oppose the restoration of the death penalty in Canada."

From the Steering Committee

Steering Committee Report: Philip Berger presented the Steering Committee Report. The Steering Committee held seven regular meetings since the last general meeting in October, and held one special meeting in January which dealt with media relations and steering committee functioning. Each meeting deals with regular items such as a financial report, reports from the chapters, tracking down members who are tardy in paying their memberships, communications, administrative decisions and the newsletter. The steering committee currently sends representatives to four organizations: the Canadian Health Coalition, the Ontario Health Coalition, the Coalition against the Death Penalty, and the Ontario Coalition for Abortion Clinics (liaison rather than formal representatives to the latter two).

Steering Committee members together with members-at-large have been working on a variety of other issues--some high-profile, some not, all equally important--over the past months. These include:

Joel Lexchin and Bob Frankford prepared an exhaustive brief on the pharmaceuticals/patent law issue and submitted it to the federal Eastman Commission. Joel along with others is co-ordinating the MRG response to the release of the Commission Report.

Clyde Hertzman, Don Woodside, Bob Frankford, Paul Rosenberg, and Brian Hutchison have been the members of the working group dealing with health professions legislation review. Their work has included meetings with the Registered Nurses Association of Ontario and the Midwives Coalition.

Gord Guyatt has drafted three "generic" presentations on MRG policies on health care issues. These are intended to be usable by MRG members who are called upon to speak to other organizations or public meetings. The steering committee intends to develop a speakers' list on various topics, to enable the MRG to respond more easily to requests for speakers. Gord recently tested one of his presenatations under somewhat trying circumstances, in a talk to the P.C. student club at York University.

The MRG's pamphlet, "A Guide to the Ontario Health Care System" is now in the final stages of preparation. The Ontario Public Service Employees Union (OPSEU) has undertaken to print the pamphlet and distribute copies of it to its local union officials.

The University of Toronto course--a proposal for a course on social and economic issues in medicine, to be taught by MRG members to University of Toronto medical students--did not happen, because funding for the course did not come through. It is still possible that the course may happen next year.

Preparation for MRG general meetings always begins well in advance. Preparation for this meeting began in November 1984 and included Miriam Garfinkle, Fred Freedman, Fran Scott, Michael Rachlis, Mimi Divinsky, and Gary Burrows.

The MRG has been well represented at conferences discussing women and health. As well as individual MRG members acting as resource people for the University of Toronto conference "Murmurs of the Heart", Fran Scott spoke as an official MRG representative at a meeting of the Ontario Advisory Council on the Status of Women and at an NDP-sponsored conference on Women and Health.

The MRG continues to be active in supporting choice on abortion, and in supporting medically insured free standing abortion clinics. Mimi Divinsky co-ordinated MRG participation in the never held Morgentaler benefit in co-operation with the Law Union of Ontario. The MRG participated in the "Day of Action" at the Morgentaler Clinic on April 24, 1985. In January 1985, the MRG held a press conference with Debby Copes, Miriam Garfinkle, Bob James, and John Frank in which the dangers of delayed abortions were pointed out and the MRG's support for medically insured free standing clinics was stated.

Jim McDermid, a student writing his thesis on the MRG, received permission to send a questionnaire to the membership after careful consideration by the steering committee.

The appropriate strategy for dealing with the abortion issue provoked some sharply differing perspectives within the steering committee but eventually a decision was arrived at.

The steering committee spent some energy dealing with questions relating to the internal functioning of the steering committee. A special meeting in January dealt partly with how to deal most effectively with the press (two outside resource people were invited) and partly with ways of restructuring steering committee time. In the course of this discussion, different political perspectives were acknowledged, stated, and let be. It was decided to delegate some simple routine decisions to one steering committee member (Gord Guyatt) to decide together with Ulli Diemer, the Executive Secretary. These decisions are

reported back to the steering committee, but time does not have to be spent in discussing them at meetings. The purpose of this change, and a related attempt to move through the agenda more efficiently, was to allow more time at meetings for philosophical and strategy discussions. The steering committee also decided to invite MRG members who are involved with different issues to come to meetings and discuss these issues with the steering committee. Steering committee meetings are open to members.

The presentation of the Steering Committee report was followed with a discussion of the MRG's support for the "Day of Action" on abortion on April 24, 1985. Some members felt that the MRG's statement, while appreciated, did not go far enough in supporting the Day of Action. They wanted to know why more explicit support and endorsation for the Day of Action was not given. Some other members expressed their reservations about the Morgentaler clinic, particularily the issue of non-coverage by OHIP, and stated that the objective had been to find ways of giving support without compromising the MRG's emphasis on the OHIP issue. Some members felt that this is a critical time for the pro-choice movement, and that support should have been given without equivocation or "fence-sitting".

The Steering Committee Report was adopted.

Report: Health Disciplines Review

There was a discussion of the work of the MRG's working group on Health Professions Legislation Review.

The experience of the working group was reviewed, as described in Bob Frankford's outline in the last Newsletter. The meeting was clearly interested in pursuing the process energetically.

There was general agreement that we need a more concrete vision of our goal of integrated primary care. We need to grapple with the constraints on innovation that a fully funded health centre model may produce, but also acknowledge that the Centres themselves may be innovative while we as physicians may find our roles more constricted.

There was comment on the conflict between our oppostion to free standing, fee for service midwives and nurses, and our own enjoyment of the same style of practice. Our third principle of equally valuable contributions of health workers has received only token attention so far. When the rights of groups of health workers conflict with quality care, which do we support? Our working group on this subject expired without reaching any conclusions, why? Perhaps the question of quality of care will more more answerable in this context. The question of the structure of integrated primary care is a large one, though, perhaps too large for us to deal with usefully.

The Legislation Review has divorced funding from legislation, a division which makes it impossible to develop health policy in Ontario.

There may be a virtue in extending rights to many 'medical' procedures to non-medical professionals, but this may not objectively improve health care. What are out outcome criteria? eg. health outcomes, utilization by social class or age, or sense of mastery over health care?

There are many innovations in the U.S. both because of the free market chasing wealthy people and because some traditional forms of health care are too expensive for poor people. Some innovations, like free standing abortion clinics which avoid hospital charges, are money savers; are they preferable for us too?

Following this discussion of issues, the meeting focussed on support of the midwives, for whom this Review is a crisis. Strong sentiments were expressed in favour of supporting them. Three possible roles for them were suggested: Midwives assisting obstetricians in institutions; midwives in free-standing fee for service practice; and midwives working with family physicians in integrated primary

obstetrical care. The last named seemed to be a clear winner. If we support home births as well what criteria would we have for physician and emergency support? Do we support birthing centres?

Are birthing centres a legitimate specialized facility or do they lead to fragmentation? Can they be integrated into good primary care with a concept of linkage which is looser than a single administrative unit?

A set of questions also arises as to the relation between nursing and midwifery, in education, practice, and regulation.

After this short but stimulating discussion the working group was given a mandate to bring forward a resolution with respect to support of midwifery at the Fall '85 general meeting. Should the Legislation Review process be accelerated, they may take a position before that general meeting after presenting it to Toronto and Hamilton chapters and obtaining the support of the Provincial Steering Committee.

New energy will be brought to the group by Pat Smith, Catherine Oliver, John Frank, Steve Hirschfeld, joining Bob Frankford, Don Woodside, Paul Rosenberg, and chaired by Brian Hutchison, as Don Woodside will be away for six months from September on.

--Report on Health Professions discussion by Don Woodside

REX MORGAN M.D.

MRG PRESS RELEASE ON ABORTION CLINICS

The MRG issued the following press release on April 24, 1985:

"Medical Reform Group Calls for Medically-Insured Free-Standing Abortion Clinics

The Medical Reform Group, a group of 150 physicians in Ontario, takes this opportunity, on this 'Day of Action' to restate our support for the establishment of medically-insured free-standing abortion clinics in Ontario. Such clinics, which are currently operating in the province of Quebec, have an excellent safety record and actually reduce the overall risks to women, by allowing women to have an abortion earlier in their pregnancies.

We ask the Ontario government to stop its 'head in the sand' approach on the question of abortion: to stop the prosecution of Dr. Morgentaler who has been acquitted by jury four times in this country, and establish government-sponsored medically insured clinics which would vastly improve the health care of women in this province."

MRG MEMBERSHIP

Do you know of someone who ought to be an MRG member, but isn't? Let them know about the MRG, or ask Ulli Diemer (416-920-4513; 416-960-3903) to send them a basic information kit about the Medical Reform Group.

MRG NEWSLETTER

If you have information or opinions which you think would be of interest to other MRGers, then put them in the Newsletter. Write to P.O. Box 366, Station J, Toronto M4J 4Y8 or call Ulli Diemer at 416-920-4513 or 416-960-3903. Book reviews and other short, readable submissions are particularily welcomed. The fact that items are published in the MRG Newsletter does not necessarily imply MRG endorsement of any particular group, activity, or opinion.

Notices & Announcements

PARTNER SOUGHT

Nikki Colodny, G.P. and Psychotherapist, would like to announce an amicable separation with her partners. I am therefore looking for a like-minded practitioner with whom to share offices at 425 Queen St. East, Toronto, beginning this summer or fall. Call 364-3982.

LOCUM AVAILABLE

Locum needed to work in general practitioner group practice in downtown Toronto. January to June, 1986. For more information contact Miriam Garfinkle at 928-0920.

WRITER(S) SOUGHT

Borderlines Magazine, a Toronto-based magazine on culture and politics, is looking for people to write about medicine, health and science. Call Alex Wilson at 469-3223.

PHYSICIAN WANTED

South Riverdale Community Health Centre is looking for a G.P./family physician to act as a locum every fourth weekend. This means being on call from Friday evening to Monday morning (including making house-calls if necessary to patients within out geographical area) and staffing the Saturday clinic from 10 am to 1 pm. Remuneration is $275 per weekend. We would prefer someone with one or two years experience beyond residency.

If you are interested, please send your c.v. to Liz Feltes, Administrator, South Riverdale Community Health Centre, 126 Pape Avenue, Toronto, Ontario M4M 2V8. Phone 461-3577 if you have further questions.

LOCUM TENENS: GENERAL PRACTITIONER

Klinic, Inc. Community Health Centre in Winnipeg requires a general practitioner with a minimum 3 months post-grad Obstetrics required, to work in a community health centre in conjunction with another physician, nurse practitioners, registered nurse, and professional and para-professional social service staff. The program requires an innovative individual with experience, who is interested in health maintenance and who has a commitment to a team approach to health care. For further information call Ellen Kruger at 204-786-6943.

ONTARIO PUBLIC HEALTH ASSOCIATION MEETING

The Ontario Public Health Association is holding its annual Educational and Scientific Meeting in Toronto on September 22 - 25, 1985. The theme of this year's meeting is "Working Together: Building Coalitions for Public Health." There will be three theme days for the conference, Social Health, Environmental Health, and Personal Health. For more information about the conference contact Dr. Trevor Hancock, 64 Merton St., Toronto or Ms. Irene Korecz, 791-9400 (Brampton).

A CALL FROM SOUTH AFRICAN HEALTH WORKERS

"The National Committee of Health Organisations is a group of progressive health workers formed to oppose the World Medical Association's Assembly to be held in Cape Town, South Africa during October 1985 and to expose the WMA's collaboration with apartheid...

We are concerned that the WMA Assembly will be used to give credibility to the apartheid policy, the Tricameral System, and weaken the forces which are struggling for democracy and social justice....

It is for these reasons that we make this call to:

-all health professionals and medical organisations not to attend the Assembly

-persuade your national medical associations to stay away

-undertake activities aimed at popularizing our call and strengthening our struggle

-support us and our member groups to eliminate all forms of racism and exploitation from our society

-and to endorse the WHO/Brazzaville Declaration aimed at eradicating apartheid and its effect on health."

For more information contact National Committee of Health Organisations, P.O. Box 17160, Congella 4013, South Africa.

MRG INTRODUCES "GENERIC" SPEECHES

Gordon Guyatt has prepared a series of "blueprints" or packaged talks for MRG members who are speaking in public around health care issues or debating the OMA or other groups with differing viewpoints. The topics include the history of the Canadian medical system, the arguments against user fees and opting out, and a discussion of the claims made by those who would "privatize" the health care system. The documents are designed not only for MRG speakers, but as information packages for interested members.

Gord recently had a chance to try out the new armaentarium when he represented the MRG in a panel duscussion on opting out at a Conservative Campus Association policy meeting at York University prior to the election. The other panelists were Gail Peach (president of the Registered Nurses Association of Ontario) and Hugh Scully, a cardiovascular surgeon and Treasurer of the Ontario Medical Association and chief negotiator for the OMA in the fee schedule negotiation with the provincial government. Gord found the experience interesting, and despite the somewhat frightening red neck opionions of those who asked questions at the end of the talks he had the impression that most of the audience was open to the MRG message. This impression was subsequently strengthened when we found that the audience had voted Gord as the day's best speaker.

If you wish to receive one or more of the information packages, please write or call the MRG's executive secretary, Ulli Diemer, at the following address or phone numbers: MRG, P.O. Box 366, Station J, Toronto, Ont. M4J 4Y8; 416-920-4513; 416-960-3903.

FORUM DISCUSSES NURSING REPORT

The University Departments of Nursing and the Ontario Nurses Association are spearheading a drive toward the "professionalization" of nursing. The plans seems to be to have all nurses graduating with a Bachelor of Science (BScN) with elimination of the two year nursing training program now run out of community colleges. It has further been suggested that most Head Nurses should have a Masters Degree. Association with this campaign has been a move to eliminate Registered Nursing Assistants (RNAs) from hospitals. Presumably, their jobs would be taken by RNs with only two years of training. The Ontario Association of Registered Nursing Assistants is naturally concerned and commissioned a study by Woods Gordon Consultants to examine the issue. Woods Gordon's recommendations included a suggestion that research into the effect of all-RN staffing in hospitals be conducted; that increased educational opportunities be available to RNAs; and that the levels of employment available to RNAs be monitored by the Ontario Ministry of Health.

An open forum to discuss this report was recently held in Hamilton by the Ontario Association of Registered Nursing Assistants. Speakers included the President of the Association, representatives from nursing homes and from CUPE, Anne Coy, President of the Patients Rights Association, and Gordon Guyatt representing the Medical Reform Group. A summary of Ms. Coy's talk appears below, Gord felt somewhat constrainted in that the MRG of course has no official position on this issue. However, he did point out that the Registered Nurses Assistants should try and organize to get their voice heard, both in hospitals and nursing homes and that they should demand research demonstrating that changes in staffing are in fact beneficial before such changes are implemented as policy.

--Submitted by Gord Guyatt

ANNE COY ON OARNA REVIEW

You will understand that, as a patient advocate, our association approached this report from a different perspective--that of the user of the health care system--the person the care giver is going to do it to or for, as the case may be. True to our form we wanted to know, first of all, who the consultants consulted. This information we found in Exhibit One.

True to the form of such examining committees, patients or their representatives were not included in the list. It is a sign of the changing times, however, that a patient advocate has, at least on this occasion, been asked to participate in the discussion.

As in any other situation, all of those who are going to be affected by a change in a rule or a system should have a part in the decision-making. Otherwise we have foxes making rules for chickens--and the chickens don't like it.

Now to the Report. From our reading of it, three points seem to be made:

1) Complete RN staffing will cost a lot more.

2) Complete RN staffing could lead to a decreased level of professional satisfaction and to boredom.

3) Complete RN staffing will not necessarily improve the quality of care.

Not one of these three points would tend to improve the situation for the RN or the RNA, who would be out as a result, or indeed for the patient, the person on the receiving end. No one, it seems, would benefit if the trend to complete RN staffing continues. As a matter of fact, very serious adverse effects could follow for all.

We should look seriously, then, at the adverse effects of this project as Woods Gordon sees them.

In raising the education requirements for RNs the purpose was to raise the professional standard of those aspiring to enter the profession. The graduates would be able to assume greater responsibility and, instead of being in the traditional role of the "Doctor's handmaid" s/he could take a proper place as part of the professional team. The question is, would elimination of the RNA further this concept or be an obstacle? Will the RN be able to find time to perform as a full-fledged professional or will she have to make beds?

The RNA, who now provides the basic routine needs of the patient and who, we supposed, was being educated to do that, is now seen to be the victim of an inadequate education system which has not kept up with the needs of the patient. Should this, if true, result in the elimination of the RNA and the down-grading of the functions of the university educated RN or should proper educational standards be introduced?

Could one result of all RN staffing, which could ignore the RN's desire to aspire to a more responsible role, and the elimination of the educated RNA entirely, be the eventual hiring of nursing aides, totally untrained personnel? The temptation to follow this route could be strong for employers who want to reduce the routine procedures from the work load of the professionals and also to balance the budget.

Would it be shown, eventually, that the up-grading of the educational requirements of the RN was a bad move? After the increased investment of time and money, would s/he, on graduation, find himself or herself spending a lot of time making beds, bringing bed pans, feeding patients and taking temperatures? Would there be enough time to assume the increasing number of sanctioned medical acts which would improve his/her skills and upgrade his/her position by adding greater responsibility? Is this what is wanted by anyone in the health care system? Is this in the best interests of the nurse or the patient?

The report finds that a "mix" is to be desired. We must agree with that, emphasizing that the mix must be of those care givers who are adequately educated to do the job that needs to be done. As we see it in reading the report, the patient is caught between an over-qualified care giver and an under-qualified care giver. It is apparent, then, that the educational requirements for all jobs must be examined.

One further point which must be made on the "mix" is that it should include male

care-givers. No particular effort has been made, as far as we can see, to recruit men to what is traditionally a female occupation. Male patients are at a disadvantage and, in fact, are discriminated against as a result. A female patient does not have to submit to having her very personal needs attended to by a male care-giver but, under the present system, a male patient has no choice. This should be corrected.

In conclusion I will return to the three points the report seems to make and the questions which must be asked:

1) The increased cost--will the money be well spent?

2) Less professional satisfaction for the RN--will re-introducing routine duties occupy the university-educated RN to her/his full potential?

3) Will the quality of care improve? The answer Woods Gordon gives to all three is "No".

The simple question put to the patient, "What is important to you as a patient or resident" would likely have brought some simple answers.

Would the educational standing of the care giver be No. 1? Would the letters RN or RNA be No. 1?

Or,

Would "Attitude, Kindness, Understanding, Gentleness, Patience, Interest, Consideration for the concerns and anxieties of my family members" be No. 1?

This aspect has not been dealt with.

Any further study must include participation and input from all of those who will be affected by any contremplated change, including the user of the health care system.

Whatever is being planned and whoever is planning it, an outside consultant or the profession itself, the outcome must reflect the best interests of the patient, without whom the health care system would not be necessary.

--Anne Coy, President,
Patients Rights Association

MRG PRESS RELEASE ON ELECTION/OPTING OUT

Shortly before voting day in the Ontario provincial election, the MRG Steering Committee, responding to a letter sent out by Premier Miller and to an interview with him in the Globe and Mail, decided to hold a press conference regarding the Premier's stand on opting out. The following press release was prepared:

"DOCTORS' GROUP DEMANDS CLARIFICATION FROM MILLER REGARDING OPTING OUT

The Medical Reform Group of Ontario, a group of 150 pro-medicare physicians, today demanded that Premier Miller clarify his stand on opting out. Miller sent individual letters to Ontario doctors on April 22 saying, 'My position is clear. Doctors are not civil servants. The right to opt out is a symbolic principle even for the doctors who choose to take part in OHIP.'

However, Miller responded to a question from the Globe and Mail on April 27th by saying, 'I can't say whether we will or will not be continuing with OHIP extra billing.'

We are concerned the Premier is telling doctors what they want to hear and the people of Ontario something else. At present, because of the Canada Health Act, Ottawa is withholding $50 million from Ontario as a penalty for extra billing."

In the event, the press conference was not held because initial reaction from some press contacts indicated that it would not be well covered by the media. Nevertheless, the story did receive some play (see Clippings) and the MRG was quoted in the stories dealing with the issue.

MRG STEERING COMMITTEE MEETINGS

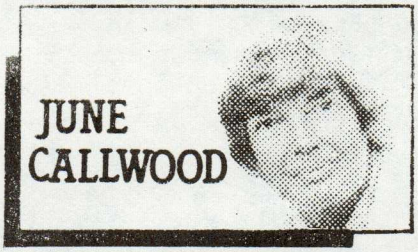
MRG members are welcome to attend Steering Committee meetings. Meetings are usually held the last Thursday of each month. If you are interested in attending, call Ulli Diemer at 416-920-4513 or 416-960-3903 for information about where the meeting will be. Meetings alternate between Hamilton and Toronto.

Globe and Mail
25/4/1985

The doctors who care

IT WAS MIDNIGHT and lights were burning everywhere in the Victorian pile which houses Nellie's, a women's hostel in Toronto. A middle-aged woman who had arrived with a bad cough and all her belongings in a green garbage bag was shouting in the halls. While other women cringed in their beds and tried not to listen, she screamed curses and spoke of terrible danger.

The staff person, Elizabeth Greaves, called a doctor. Not many physicians are willing to make a middle-of-the-night house call to talk to a schizophrenic, but Nellie's and all

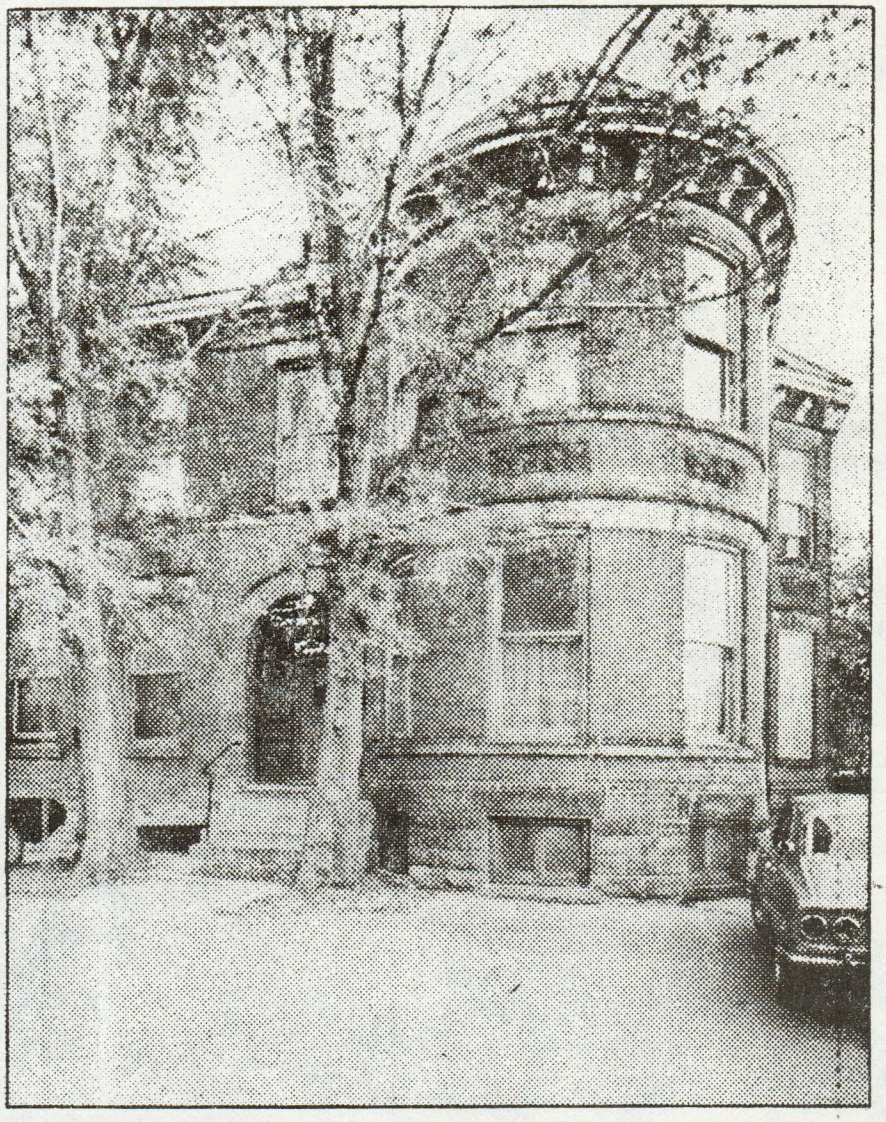


other shelters for people in crisis couldn't function without knowing at least one who will come when called, no questions asked.

Dr. Michael Rachlis rang the bell minutes later. He was carrying a doctor's little black bag but all resemblance to a dignified establishment doctor ended with the satchel. He's 33, a small spectacled man with wildly red hair and the face of a schoolboy. This night he was wearing a sweatshirt, jeans and sneakers.

The woman stopped shrieking to stare. The doctor asked her about her cough in a way that left no doubt of his professionalism. She answered sensibly. They talked for an hour, during which he assured her she was safe at Nellie's and that the staff knew how to protect her. When he left, the house was dark and still, every woman asleep.

Dr. Rachlis is one of the founding members of an organization of about 150 Toronto doctors known as the Medical Reform Group. They hold a number of views which are not shared by most of their medical colleagues, among which, predominantly, is the group's rejection of extra-billing. Because they don't charge fees higher than the Government's fixed rate, and sometimes don't charge at all, and because they take almost twice as much time with patients — four in an hour as compared to the usual seven or eight — they tend to have the smallest incomes of any physicians in the country — about half the national average, in fact.



Nellie's women's hostel relies on the Medical Reform Group.

They have some other positions that make them unusual in their profession. On the abortion issue, they support freedom of choice and are asking for medically insured free-standing abortion clinics. They also believe health services should be located in non-hierarchical community clinics where doctors would work collectively with others delivering health and social services.

Their most conspicuous activities relate to the knowledge they have acquired treating low-income people. As doctors, they have reached a documented opinion that poverty is not good for a person's health.

Dr. Fran Scott, 31, another member of the Medical Reform Group, is a blonde with a delicate face. She's in public health and lately has been studying the effects of pollution on people who live among the industries in Toronto's notorious Junction Triangle. She is struck by the correlation between poor health and low income.

The doctors who care

"Poor people die of the same diseases that other people do, but they die sooner," she observed. "It's like tuberculosis at the turn of the century — if you were poor you likely died of it, if you were rich, you didn't. Poor people have shorter lives by about seven years, and they have 20 more years of disability than other social classes do."

Another member of the group, Dr. Debby Copes, 37, a tall, friendly general practitioner whose baby is due this week, spoke of the respiratory infections common among people who have poor nutrition and live in crowded housing. "We see a lot of strep throat," she said, "a *lot* of strep throats. Also, gastroenteritis is more common and more severe. Children of the poor are likely to need hospitalization more often than other children and to stay in hospitals longer."

The young doctors take the position that their profession has a responsibility to be active in all matters which contribute to ill-health, whether or not it is politically popular. Their interpretation of medical ethics is similar to that of clergymen who believe in social gospel, which inevitably takes them down political pathways.

They protest against scarce and inadequate housing for low-income people and family allowances that are below the poverty line. They are the descendants of doctors who pioneered in public hygiene more than a century ago, in the days when excrement was dumped in gutters, babies were delivered by people with dirty hands, and milk wasn't pasteurized.

The glamor side of medicine today is in such achievements as heart transplants, but the nuts and bolts that keep a nation healthy are sewage-treatment plants, uncontaminated water and safe housing. The young doctors say medical schools pay little attention to such issues.

"The course on public health is a soft subject," Dr. Copes explained. "It's not like cardiology. You almost could fail it and still get your degree."

The young doctors came to be nonconformists by a process of observation, empathy and reflection. It began for some when they were in residency programs in hospitals where cleaning staffs complained about low wages and poor working conditions. They put themselves solidly on the side of the cleaners.

Since then, the spunky organization has been lobbying for better housing and increased family allowances for the poor, and for the establishment of egalitarian community-based clinics.

"We aren't the Ontario Medical Association, that's for sure," grinned Dr. Miriam Garfinkle, a family physician, 31 this week, and a woman with a thoughtful, calm manner.

The young doctors worry about other matters rarely found on the agenda of medical conventions. Although two-thirds of the Medical Reform Group are men, all members are pondering the question of whether women patients are better treated by women doctors.

"Some of us say that we should look at it as people serving people and stay out of questions of gender," commented Dr. Scott. "That's true, of course, but women doctors do have something different to offer women patients. We're also looking at how to give women doctors more support. We're not like other doctors for two reasons: one, that we're women and the majority of doctors aren't, and, two, that most women doctors are progressive."

The Medical Reform Group represents only a small fraction of doctors in practice. Executive meetings fit nicely into one tiny livingroom without anyone having to sit on the floor. So far, they have almost no political clout. All they have is the right priorities. Ask anyone at Nellie's.

Group calls for end to opting out of OHIP

Hamilton Spectator
May 7, 1985

APPROXIMATELY 20 Hamilton doctors are calling for legislation to prevent doctors from opting out of OHIP.

The doctors are part of the 150-member Medical Reform Group which today renewed its call for the provincial government to end opting out.

Dr. Gordon Guyatt, a physician with St. Joseph's Hospital, said the provincial election, which returned a minority Conservative goverment, was a factor in the group's demand.

"Both the NDP and the Liberals have called for an end to opting out. We feel the Conservative government is really out on a limb in rejecting an end to opting out," said Dr. Guyatt.

He said it has been long established that opting out — where Ontario physicians charge their patients directly instead of charging the provincial health insurance plan — unfairly penalizes the poor, the sick and the elderly.

"It delays people going to their physicians, and that is mostly the poor and the elderly," he said.

Dr. Guyatt also said Ontario is losing $50 million a year in transfer payments from the federal government as a result of opting out. Under the Canada Health Act, which was introduced last summer, provincial governments lose one dollar of their federal medicare grants for every dollar which patients have to pay out of their own pockets to doctors or hospitals.

In effect, said Dr. Guyatt this means that Ontario taxpayers are spending $50 million to subsidize opting out physicians, who he said are among the most highly paid doctors in the province.

Dr. Guyatt said that when the Canada Health Act was passed a year ago, the federal Conservatives joined Parliament in giving unanimous support to the act. He said it is unacceptable for the provincial government to ignore the wishes of the electorate and the majority of legislators and allow the practice of opting out to continue.

Dr. Guyatt said the Medical Reform Group also wants OHIP premiums to be abolished.

"They are a regressive form of taxation because everyone pays the same amount irrespective of their income," he said.

Extra-billing costs Ontario $44 million

By CAITLIN KELLY

Extra-billing by Ontario doctors has cost the province more than $44-million since the Canada Health Act came into effect on July 1, 1984, but politicians who campaigned on the promise of ending it say making good that promise may be more difficult than expected.

Ottawa withholds $1 for every $1 billed above the fee schedule negotiated by provincial medical associations and governments. The money is held in trust and will be repaid if a province ends extra-billing before April 1, 1987.

"The potential for conflict or confrontation is generally there but I'm not sure that this is the issue that will bring the Government down," said Liberal health critic John Sweeney.

Peter Mosher, a spokesman for the New Democratic Party, said: "It will certainly be put to the Government."

Ontario is currently receiving $170,921,000 a month instead of $175,365,000, said Dr. Luc Goudreault, a spokesman for the Department of Health and Welfare in Ottawa.

Reducing the urgency for the province, however, is the fact that an unexpected jump in general revenues has softened the potential blow.

"Some revenue sources produce and others don't produce," said Peter Sadlier-Brown, assistant deputy minister of the office of the budget. Thanks to a rise in corporate tax and sales tax from increased consumer spending, Ontario has $238-million more than it expected even after absorbing the federal penalty for extra-billing.

"We don't reduce health-care spending because of this (penalty). We're committed to spending what the Government has decided it will spend."

The NDP and the Liberals promised in their campaigns to end extra-billing and members of both parties say they plan to stand by their promises.

But first they must find a way to address physicians' concerns, Mr. Sweeney said.

The Liberals have yet to come up with alternative proposals so that they and the NDP can effectively propose terminating the present system, Mr. Sweeney said.

The Ontario Medical Association, which has been negotiating with the province for several months to set new fees, has no stated position on the issue, said spokesman Lynn Beckett.

The OMA says it has no strategy ready if the Government changes its position, a change of heart many observers are predicting — and one hinted at last week by Health Minister Alan Pope.

"We were extremely vocal during the (introduction of) the Canada Health Act," said the OMA spokesman. "We tried to point out that extra-billing was a smokescreen and that underfunding was the issue."

Of the 13 per cent of physicians who are opted out of OHIP, only 6 per cent extra-bill, the OMA said.

That 6 per cent is costing Ontario $4,444,000 every month.

(The figure is an estimate agreed on by the province and the federal Government. It was reviewed in April and will remain constant, Dr. Goudreault said.)

A letter sent by Ontario Premier Frank Miller on April 22 to several hundred Ontario doctors revealed that he was solidly supporting the concept of extra-billing.

"My position is clear. Doctors are not civil servants. The right to opt out is a symbolic principle . . . ." the letter read.

Spokesmen for both opposition parties said the issue was raised repeatedly by concerned voters during the final days of the campaign but that it has less impact than the more visible effects of underfinancing in general — crowded wards, cancelled surgery, obsolete equipment.

"Everywhere we went we were hearing these stories," Mr. Sweeney said. "(Hospital underfinancing) was one of the key issues of the campaign."

The Ontario Hospital Association, which said in April it needs $96-million in addition to the Government's increase of 2.7 per cent to maintain standards, has yet to feel the loss, said spokesman Peter Wood.

"A shortage of dollars (as a result of extra-billing) may not be very visible (yet) but it shows up down the line. What we're seeing now is 140 of 185 hospitals saying they can't make ends meet," he said.

"Extra-billing has never been an issue to grab people, because people don't understand how the system works" said Dr. Philip Berger, spokesman for the Medical Reform Group, an organization of doctors committed to revising Ontario's health-care system.

If the dollar-for-dollar impact of the Canada Health Act has yet to make an impact on the public, Ontario patients still expect affordable, quality health care, he said.

"Medicare is the most popular social service in Canada and Frank Miller will look foolish trying to say no to the ending of extra billing."

Globe and Mail, May 1985

Premier writes doctors supporting extra billing

By ROSS HOWARD

Conservative Party Leader Frank Miller's indefinite public stance on the controversial issue of extra billing for medical services is not matched by what he is telling doctors in private.

In a letter mailed to several hundred Ontario doctors during the campaign, Mr. Miller bluntly declares his support for extra billing.

During the election campaign, Mr. Miller has vaguely defended the Government policy of allowing doctors to charge extra fees beyond the publicly subsidized rate but has left the impression that the policy could be changed soon.

The penalty of almost $1-million a week imposed by the federal Government on Ontario for allowing extra billing is being "negotiated" with Ottawa, Mr. Miller has told campaign audiences, suggesting Ottawa might be more lenient or that Ontario might amend its policy.

In an interview with The Globe and Mail on April 27, Mr. Miller said, referring to the negotiations and their progress over the next few months: "I can't say whether we will or will not be continuing with OHIP (Ontario Health Insurance Plan) extra billing."

Recent public-opinion surveys show the majority of Ontario residents is opposed to extra billing and both the Liberal and New Democratic parties have campaigned to end the practice.

In his letter to the doctors, Mr. Miller says: "My position is clear. Doctors are not civil servants," echoing the medical establishment's own argument. "The right to opt out (to extra bill) is a symbolic principle even for doctors who chose to take part in OHIP."

The letter, dated April 22 under a letterhead that reads "Frank S. Miller, Premier of Ontario," thus implying it comes from Mr. Miller in his Government rather than candidate role, says the $50-million federal penalty is not harmful to the provincial medical-health system.

"We have not forced out doctors to work within OHIP," the letter adds. "Since the start of medicare in Ontaro, the Provincial Government has followed a course of negotiation rather than confrontation."

The letter — paid for by the Conservative Party, campaign spokesman John Tory said yesterday — concludes by asking the recipient doctor to support the local Progressive Conservative candidate in the May 2 election to ensure a continuation of the current policy of allowing extra billing.

One of the doctors who received the letter was a member of the Medical Reform Group of Ontario, an organization of about 150 physicians who oppose extra billing.

Dr. Michael Rachlis, a spokesman for the group, said yesterday that Mr. Miller is "highly contradictory, telling doctors what they want to hear and the people of Ontario somethi g else."

Globe and Mail
May 1, 1985

Extra-billing avoided as big election issue

By MURRAY CAMPBELL

Every working day, the federal Government gets about $200,000 richer because Ontario's Conservative Government refuses to stop doctors from charging more than the fees allowed under their contract.

But most days in the Ontario election campaign, there is relative silence on the issue.

Liberals and New Democrats say the issue of extra-billing — doctors charging more than the Ontario Health Insurance Plan schedule — is important, but not sexy enough to attract hordes of voters.

Both New Democrat Leader Bob Rae and Liberal Leader David Peterson outlined early in the campaign for the May 2 election their opposition to extra-billing and to the Ontario Government's defiance of federal legislation that prohibits it.

Since last July, Ontario has lost $4.4-million a month in transfer payments under the Canada Health Act, which allows Ottawa to withhold $1 in medicare grants for every $1 patients pay out of their own pockets.

About 13 per cent of Ontario's doctors have opted out of OHIP (down from 15.4 per cent in 1982). The province does not collect data on how much of the total gross OHIP billing of $2.149-billion relates to extra-billing, so the federal Government set the $4.4-million figure.

The money would be repaid if Ontario banned extra-billing by April 1, 1987.

Premier Frank Miller said recently that his Government had no intention of banning extra-billing by doctors, but that he is trying to work out a deal with Ottawa which would allow the practice to continue without a financial penalty.

The issue seems tailor-made for the opposition parties, but don't expect it to be given much prominence in the last two weeks of the campaign.

The subject received little attention in the March, 1981, election, but then it was only the NDP that took an official stand against extra-billing. At the time, the Liberals could not find a position that pleased all caucus members.

This time, however, the Liberals have joined the NDP in condemning extra-billing, primarily because it is now against federal law.

Liberal campaign manager Ross McGregor says it is a matter of priorities. The party continues to emphasize health care in its literature, but "there are only so many issues you can talk about in 37 days."

John Sweeney, the Liberals' health critic, says he has passed on to Mr. Peterson his finding that unease about the state of Ontario's health-care system is "far and away the single biggest issue in my area."

Mary-Ellen McQuay, co-chairman of the NDP campaign, says that Mr. Rae will continue to raise the subject of extra-billing and Ottawa's financial penalty, but that no specific events or television commercials are planned on the health-care issue.

David Cooke, the party's health critic, laments the fact that the state of the health-care system has not caught on, because he says more than 70 per cent of Ontario voters are opposed to extra-billing. But, he says, "they're not angry enough to change their voting patterns."

Mr. Cooke's regret is equalled by that of the Medical Reform Group, which represents 150 doctors and other health-care workers. Group members have spoken out against extra-billing since it became a political issue more than five years ago.

Globe and Mail
April 18, 1985

Five MDs learning with Morgentaler

Five Ontario doctors are learning how to perform abortions in Dr. Henry Morgentaler's Toronto clinic, and say they could take over the operations if Dr. Morgentaler or his partners are unable to work. The doctors — all general practitioners or family physicians — are Evan Collins, Nikki Colodny, Christina Mills and Catherine Oliver of Toronto and Pat Smith of Hamilton. "We believe that every woman has the right to a safe medically ensured abortion when she needs one," Dr. Colodny told a news conference at the Harbord Street clinic yesterday. "Women cannot be in control of their lives if they are not in control of their bodies."

Globe and Mail
April 25, 1985

32 The Toronto Sun, Thursday April 25, 1985

TRESPASSING CHARGES

Abortion foes cite historic law

The unborn child's right to life was enshrined more than a century ago, says a lawyer for 14 people charged with trespassing at a Toronto abortion clinic.

The anti-abortionists have pleaded not guilty to the charges, laid Dec. 13 and 19 after they congregated on steps leading into Dr. Henry Morgentaler's clinic at 85 Harbord St.

The six-foot-wide steps are shared by 85 and 87 Harbord St., and 87 owns one foot, 10 inches of the stairway while the clinic owns the rest, provincial court was told.

Defence lawyer Angela Costigan said eight of the 14 accused were only on 87's section of the steps and should not be prosecuted.

In her final submission, which will continue today, Costigan went back to 1861 to explain her other clients' "defence of necessity."

They were forced to break the law in an effort to stop the greater crime of murder, she said.

The 1861 Offences Against the Person Act in Britain was imported to Canada in 1869 as the then Criminal Code, she said, and it specified "the rights of the unborn child exist in criminal law."

The trial continues.

Meanwhile, five physicians are training to become abortionists at the Harbord St. clinic.

The doctors — Evan Collins, Nikki Colodny, Christina Mills, Catherine Oliver, all of Toronto; and Pat Smith of Hamilton — say their work there will begin "if the need arises."

The physicians called on other medical experts to join them in forming an organization called "Doctors for Choice."

"Women are in desperate need of better access to abortions (and) the government has refused to meet this need," said Colodny, who was with 13 female and seven male pro-abortion doctors at a press conference at the clinic.

Dr. Robert Scott is the only doctor currently performing abortions at the clinic, which marked 16 consecutive weeks of operation yesterday. Morgentaler hasn't worked there since January.

Colodny, a family physician in Toronto, said she and the other doctors don't expect their caseloads to be affected by their stance.

"My patients are quite supportive," she said.

She said "it's extremely unlikely" the doctors will lose their licences because of the stance.

Outside the clinic, a handful of people demonstrated.

5 doctors get abortion training at Morgentaler's Toronto clinic

By Robert Sutton Toronto Star

Five doctors say they are training in abortion techniques at Dr. Henry Morgentaler's Harbord St. clinic.

"We are preparing ourselves to staff the clinic in the future, if the need arises," Nikki Colodny, a Toronto family physician, told a news conference yesterday.

With her were doctors Evan Collins, Christina Mills and Catherine Oliver, all of Toronto, and Pat Smith of Hamilton.

Group formed

The five are training under Dr. Robert Scott of the clinic staff. They said the program involves observation, assisting in abortions and performing them with and without supervision.

There are "no plans at the moment" to open another clinic, Colodny said.

She announced the formation of Doctors for Choice and urged physicians to join the group, which believes that an expectant mother has the right to end an unwanted pregnancy.

Dr. Joel Lexchin of the Medical Reform Group urged the Ontario government to drop its "head-in-the-sand" approach to abortion and stop persecuting Morgentaler, who has been acquitted by four juries. Lexchin's organization claims a membership of 150 Ontario physicians.

'Courageous choice'

More than 20 young doctors attended the news conference to show their support for the five.

The physicians made a "courageous choice," according to Judy Rebick, spokesman for the Ontario Coalition for Abortion Clinics. "We believe there are many more prepared to make that choice, even in the face of government attacks," she said.

Such demonstrations of support could influence the outcome of an Ontario government appeal of Morgentaler's acquittal last Nov. 8 on abortion-related charges, she added.

Toronto Star
April 25, 1985

Doctors looking south face familiar problems

By CAITLIN KELLY

Ontario doctors thinking of moving to the United States if extra-billing is outlawed may be in for a surprise.

For years, the move south has been a threat held out by doctors if extra-billing is banned. The ban now appears likely under an agreement between Ontario Liberals and New Democrats.

But the United States is having the same problems with physicians as Canada is — an oversupply of certain specialties, too-heavy concentrations in urban areas and an influx of graduates from foreign schools, said Dr. Frederick Merchant, a retired surgeon on a three-year medical manpower study sponsored by the American Medical Association.

As a result, some U.S. schools have cut their enrolments by as much as 5 per cent in the past year, he said.

"We have no shortage of doctors." Working in the United States "is as easy or difficult as the individual state boards make it.

"It isn't as though you can walk across the border and hang out a shingle," said Dr. Merchant, who is executive secretary of the licencing board of the Federation of State Medical Boards.

Canadian physicians who want to practice in a given state must pass that state's examinations. Historically, though, Americans and Canadians have routinely crossed the border to study and train.

"There has always been some type of easy flow between American and Canadian medicine," said Dr. Merchant, who trained at the Royal Victoria Hospital in Montreal 45 years ago.

Accreditation of Canadian medical schools and hospitals is the same as those in the United States and Canadian doctors are generally considered of equal calibre, he said.

An official of the U.S. Consulate in Toronto said that Canadian doctors wanting to emigrate face the same restrictions as anyone else in obtaining an immigrant visa. Those married to a U.S. citizen would find it slightly easier but there are no preferential categories for doctors.

The Medical Reform Group, Ontario doctors committed to changing the medical system, are "relieved and happy" that extra-billing will end, said spokesman Dr. Philip Berger.

"This was a long-standing platform of the NDP and a recent but strong position of the Liberals so we're not surprised," he said.

Patients needing specialists — anesthetists, gynecologists and psychiatrists in particular — have regularly had to pay rates higher than those set by the province.

More anesthetists — 58.7 per cent — extra-bill than any other specialist, according to figures collected by the Ministry of Health. Opthalmologists are the second-largest group (40.9 per cent) and urologists the third-largest (36.5). Thirty-five per cent of obstretricians and gynecologists and 29 per cent of psychiatrists charge more than OHIP rates.

The lowest rates are those charged by dermatologists (3.1 per cent), pediatricians (2.4) and neurologists (3.6).

No hematologists, or specialists in clinical immunology or nuclear medicine extra-bill.

General practitioners extra-bill at a much lower rate than most specialists, according to ministry figures.

In Metro Toronto, 6.7 per cent of general practitioners extra-bill compared with 36 per cent of specialists. In Middlesex County, which includes London, the rate is 3.1 per cent for general practitioners and 21.2 per cent for specialists. Niagara County, which includes St. Catharines, has extra-billing rates of 7 per cent and 22 per cent.

There is no relationship between extra charging and the quality of care, said Dr. Berger.

"It's offensive conceptually for the Ontario Medical Association, or anyone else, to say that opted-out doctors are better," he said. Most staff physicians at the major teaching hospitals do not extra-bill.

In a speech to a group of the OMA that met this week in Toronto, William Freamo, secretary-general of the Canadian Medical Association, said the CMA plans to take the federal Government to court to challenge the Canada Health Act, in effect since July 1, 1984.

Under the terms of the act, the federal Government witholds $1 from its federal per-capita transfer payments for each $1 extra-billed; Ontario has so far lost about $50-million.

Globe and Mail
May 30, 1985

Health care a key election issue

Opposition parties woo the voter with vows to end MDs' extra fees while PCs say key is 'co-operation'

By Marilyn Dunlop Toronto Star

Ontario votes 85

THE ISSUES

The way to a voter's heart may be through Ontario's health care system. Or so the three main political parties appear to believe.

Prescribing remedies and promising cures for ills in the system are key points in the provincial election campaign. Each party hopes issues involving health care may be as good as pacemakers at putting people's heartbeats in tune with its particular political drummer.

If it raises your blood pressure to know that some doctors still charge patients fees higher than the Ontario Health Insurance Plan sets, you may agree with the diagnosis of the New Democratic Party or the Liberals.

Launched campaign

NDP leader Bob Rae launched his campaign with an attack on the Progressive Conservatives for wasting $50 million a year in penalties that the federal government imposes on the province for allowing doctors to extra-bill.

In Ontario doctors may charge a patient more than the amount the health plan will reimburse. But if they do, they must present the full bill to the patient, who then claims from the plan up to the amount covered by the approved fee schedule.

Under the Canada Health Act, introduced last April by then-health minister Monique Begin, Ontario forgoes one dollar in federal funding for every dollar that doctors bill patients beyond the amounts the health insurance plan pays. In Ontario, 12.9 per cent of doctors extra-bill.

Rae says the province is throwing out the window federal money that could be used for health care that is not now covered by the provincial health plan. He cites payments for wheelchairs and artificial limbs for patients over 19 among items that are not covered.

Disgraceful waste

"Where is the compassion, the social justice," he says, "when the government can't find money to pay for wheelchairs in a budget that can throw away $50 million?"

Liberal leader David Peterson agrees with Rae. He calls it a disgraceful waste of money, and accuses the government of kowtowing to a powerful doctors' lobby by failing to ban extra-billing.

But Health Minister Alan Pope says, "Kicking doctors in the teeth is not how the health care system was built in this province. It was built with co-operation and negotiations."

Pope has been meeting with federal Health Minister Jake Epp and with representatives of the Ontario Medical Association seeking a solution whereby the province would not be penalized under the health act but would not enrage doctors to the point where some of the best would pack up and leave.

Ontario has a number of medical specialists recognized internationally as tops, Pope says. The only way they can be paid more than the greenest of doctors in the same specialties is by permitting them to levy higher fees.

"We've advised the federal government that payment for our world-class doctors is one of the issues," he says.

Funds retrieved

The Ontario government "is concerned about the holdback" of $50 million a year by Ottawa, he says, but contrary to the accusations of waste levelled by the other parties, the money is not gone for good. Ontario may lose no more than interest on the $50 million.

Under the act, the provinces have until 1987 to get rid of extra-billing by doctors. Funds withheld by Ottawa can be retrieved if charges to patients are eliminated by that time.

Furthermore, Pope says, Ontario has challenged the $50 million figure, the amount Ottawa estimates that patients pay Ontario doctors. Doctors are not obliged to inform the health plan of the size of the fee charged a patient. Nobody knows whether patients are paying doctors as much as $50 million.

Ottawa based its estimate on 1983 provincial figures showing that patients pay something extra on 7 per cent of medical services provided. But, Pope says, extra-billing has decreased and is now down to 5 per cent.

Pope is to meet with Epp again later this month and says both governments want the matter settled this year. He refuses to predict the solution. "There are three or four options," he says.

Chopped little

Hospitals present a rash of other problems. If Premier Frank Miller has any regrets about his political career, it may be that he is sorry he was health minister when the government attempted to close some hospitals. As health minister, he was the hatchet man. As it turned out, he chopped little. Public protests intervened.

Nevertheless, bruised feelings remain. Miller will apply soothing balm later this week when he makes public a package of new government plans on health care. Among them will be assurances to small communities, worried about the future of their hospitals, that small hospitals are not an endangered species.

Miller's package will also contain an improved deal in health care for Northern Ontario. Liberals and New Democrats may say Miller has stolen their thunder. Both parties have outlined gaps and inequalities in health services in the north.

Expanded services

The NDP has called for more long-term care beds and expanded homecare services in northern communities so that seniors can stay in their home towns. Rae says community health and social service centres in all parts of the province could counsel people of all ages on lifestyles and nutrition, helping people to stay healthy. That could cut the workload — and the costs — of hospitals.

Miller's health policy package will encompass a wide-ranging plan for care for the elderly, designed to keep them from requiring care in nursing homes and hospitals by providing health services in homes and neighborhoods.

But that won't make life easier this year for hospital managers, who say they can't make ends meet. The Ontario Hospital Association has predicted a majority of the more than 200 hospitals in the province will go into the red this year because the increase in the hospital budget won't cover rising costs of salaries and supplies.

David Peterson says he'd give hospitals more money instead of providing a tax break for small business, as Miller has promised, estimated to be worth $975 million.

Rae says no hospitals should be closed, but he argues that demand for hospital beds could be cut by the provision of more preventive care, including reducing occupational and environmental health hazards.

Health-care dilemma: The opposition wants to ban extra-billing by Ontario doctors but the Tories say the only way to pay top specialists what they're worth is by permitting them to levy higher fees.

Hospital association officials predict that rising costs will force some hospitals to take beds out of service, reduce staff or stop providing some kinds of treatment. But Pope says, "Costs will not rise as much as the hospital association predicts. I think our predictions are accurate. Last year we predicted inflation would be 5 per cent. It was 4.5. This year we predict it will be below 3 per cent."

The hospitals got a 6.7 per cent increase ($260 million), but the hospital association says only 2.8 per cent will be left to cover inflation. It says the rest is eaten up by 1984 wage settlements, new hospitals and as adjustments in the budgets of hospitals treating more patients than before.

In dire straits

Pope says that, in his travels around the province and speaking with hospital authorities, he finds few who tell him they are in dire straits. An individual hospital in economic trouble that asks for help from the ministry can have an audit team on its doorstep the same day to assist in assessing and solving the difficulties, he says.

The three parties disagree on where money for health care should come from. Liberals and New Democrats want to get rid of health plan premiums, which now raise $1.6 billion annually. Families pay $59.50 a month and individuals $29.75. Only three provinces collect premiums, and Ontario rates are higher than those in Alberta and British Columbia — $28 and $34 respectively for family coverage.

Peterson would abolish premiums over a five-year period. He's made getting rid of premiums an election promise. The lost revenue, he says, would be recouped through higher income and corporate taxes.

Eliminate premiums

But, Pope counters, "Over half of individuals and families are covered by group plans with employer contributions. Eliminating premiums would take costs off the corporate sector and put it on individuals."

Personal income tax would have to be raised by a third, he says, or sales tax increased by 3 per cent to 10 per cent. "You couldn't make up the difference of $1.6 billion by increasing corporate taxes."

The province pays full or part of health insurance premiums for 20 per cent of the population, including seniors and people on welfare and families with low incomes who apply for help.

The victims are families with modest incomes who do not qualify for government subsidies, Rae says.

Toronto Star
April 25, 1985

Toronto Star
May 23, 1985

Increase prices of drugs to pay for research inquiry urges

TOR STAR
23 May 85
P-A1

By Joel Ruimy
Toronto Star

OTTAWA — Canadians should pay more for prescription drugs to stimulate pharmaceutical research in this country, a royal commission has recommended.

The commission's report, released yesterday, also says the 85 per cent of Canadians who now get drugs free through provincial or private health plans should have to pay part of the cost to encourage comparison shopping for drugs.

But the commission also strongly endorsed a 16-year-old law that has enabled smaller Canadian drug firms — the so-called generics — to copy medicines developed by big multinational firms and sell them at massive discounts.

The increased prices consumers would pay for drugs — an average of 2 per cent and in some cases as much as 10 per cent — would be placed in a federal government fund and paid to multinational companies in proportion to the research and development they do.

Consumer Affairs Minister Michel Cote, the man responsible for the report, tried to distance himself from the recommended price hikes yesterday, saying he considers price increases a last resort.

In any case, Cote added, the report was commissioned by the old Liberal government and, while "useful," does not commit the Progressive Conservative government to any action.

Meanwhile, the two opposition parties, Canada's largest consumer group and a medical association welcomed the report, expressing only minor reservations about the proposed price increases.

The generic firms, who currently can copy drugs developed by the multinationals on payment of a 4 per cent royalty, said yesterday they were generally pleased with the report, although they oppose the proposed price increase.

Cote

But a spokesman for the multinationals, who had been lobbying hard to eliminate the copycat law, said the recommendations "are not sufficient to encourage (big firms) to maintain and expand their hi-tech research and development programs."

The report also recommended:

- ☐ There be guarantees that multinational drug firms be given four years exclusive rights to any new drug they develop before the generics can copy it. No time limit exists at present;
- ☐ That the royalties now paid by generic manufacturers to their bigger counterparts be raised from the current 4 per cent to a maximum 14 per cent and that the additional revenues be paid to the multinationals doing the most work on discovering new drugs;
- ☐ That people who now get free medicine should be made to pay an unspecified amount of the cost themselves so as to encourage them to shop around for cheaper generic products;
- ☐ That the federal government speed up the amount of time it takes to grant approvals for the marketing of new drugs;
- ☐ That pharmacies be allowed to advertise prescription drug prices.

Canadians now spend $1.6 bil-

Higher prices for drugs could help research: report

Continued from page A1

lion a year on prescriptions, but most of that is absorbed by private drug insurance plans, covering 65 per cent of all Canadians, and provincial health plans, which cover another 20 per cent — those over 65 or on welfare.

Eastman estimates his proposals would add between $26.6 million and $30.6 million to the country's total drug bill, but Cote said yesterday that he was "concerned about the effect the (higher) royalties could have on consumer prices."

A possible "alternative," he said, could be to leave the royalties unchanged at 4 per cent, but guarantee the multinationals more than the four years of exclusivity proposed by Eastman.

However, that proposal came under fire from Luciano Calenti, president of the Canadian Drug Manufacturers Association, which represents the generic drug makers.

"We have not calculated yet what four years of exclusivity would cost," he said, but preliminary statistics compiled by his organization show each year of "monopoly" boosts prices by hundreds of millions of dollars.

No competition

Calenti also denounced what he called the "colonial and captive market" that existed before the international drug firms, "motivated by greed," were faced with competitition from the generics starting in 1969.

Gordon Postlewaite of the Pharmaceutical Manufacturers Association of Canada, representing the multinationals, would not comment directly but, instead, read a brief statement from association president John Zabriskie.

"Growth of research funding has slowed in the past 16 years" as the bigger firms saw their work copied by the generics, Zabriskie said. "Many companies restricted their research activities in Canada. Many others postponed or cancelled expansion plans while others curtailed or ceased production.

Average costs and prices for drugs

	Patent firm	Generic firm
Research and Development costs	$ 4	$ 2
Active ingredients	18	9
Other materials	6	4
Factory costs	6	5
Other costs	16	12
Promotion	17	2
Profit	13	6
Total (sales price)	**$80**	**$40**

Source: Eastman report

Little impact

"The recommendations in the report are not sufficient to encourage PMAC members to maintain and expand their hi-tech research and development programs."

But Doug Frith (L—Sudbury) said Eastman did "a Solomon's job of threading his way through the minefield of the two interests" and that the proposed price increases would have a "minor impact on consumer prices."

David Orlikow (NDP—Winnipeg North) added that "if the higher prices to consumers . . . went into a fund which would really be used for research and development, I think the consumers could live with that.

Bob Best, a spokesman for the 160,000-member Consumers Association of Canada, told The Star he is pleased the report found generic drugs had saved consumers $211 million in 1983 alone.

"We had only estimated between $100 million and $182 million."

The report also says the 1969 law which brought the generic industry into being "did all those things without any discernable impact" on profits of the established multinationals, which the report found had profits that were more stable than the rest of the Canadian economy.

"We certainly expect the federal government to follow through with these recommendations," said Dr. Michael Rachlis, a spokesman for the Medical Reform Group of Ontario.

Cheaper price

But he had reservations about the comparison-shopping proposal, saying it would force the elderly "to walk another mile to find a cheaper price."

People taking several different kinds of medication, especially the aged or those on welfare, would be hard-put to do adequate comparison shopping and, in any case, could not afford to pay part of the costs of some costlier drugs themselves.

The 474-page report, which took a year and $1.1 million to prepare, also found little evidence to support the multinationals' contention they were losing their markets to copies of drugs they had developed.

The big firms enjoyed a 79 per cent share of the market on all sales of the copied drugs, or about $171 million, while the generics accounted for the remaining 21 per cent, worth $46 million.

The generics also sell other drugs they haven't copied from the big firms and, all told, they account for just 8 per cent of the $1.6 billion prescription market, leaving the bigger firms with a lion's share of 92 per cent.

Ease drug ad laws, report urges

OTTAWA (CP) — Canadians should be able to comparison shop for their prescription drugs, but lack both the opportunity and the incentive, says the royal commission report released yesterday by Consumer and Corporate Affairs Minister Michel Cote.

To correct the situation, it recommends provincial governments remove all restrictions against advertising drug prices and dispensing fees and regulations be changed to allow pharmacists to provide information on drug prices over the telephone.

And to provide an incentive to comparison shop, consumers should have to pay for part of their drug costs, even if they get drugs free through provincial or private health plans, the report recommends.

Health News Briefs

NO ABORTION IN 20% OF ELIGIBLE HOSPITALS

No abortions were performed in almost 20% of the Canadians hospitals with therapeutic abortion committees in 1983, according to a federal report. Of the 257 hospitals with committees, about 50 reported that abortions had not been performed all year. Fewer than one-third of Canada's 860 general hospitals have set up therapeutic abortion committees. The report, from Statistics Canada, shows that just 38 hospitals performed 73% of the 61,800 abortions reported in 1983, the most recent year for which data are available.

LIBERALS PROMISE ABORTION ACCESS EQUALITY

Liberal leader David Peterson said during the recent provincial election campaign that a Liberal government would ask district health councils to ensure equal access to abortions across Ontario. He said that he does not favour the establishment of abortion committees outside of hospitals, but that abortions in hospitals must be available equally across Ontario. In situations where it was necessary for a woman to travel to a hospital outside her area for an abortion, he said a Liberal government would pay for travel costs, as for the travel costs for other medically necessary treatment.

SASKATCHEWAN ABORTION BILL

A private members bill in the Saskatchewan legislature to restrict access to abortion is receiving support from the government, including Premier Grant Devine. The legislature has referred the proposed bill to the Saskatchewan Court of Appeal for an opinion on its legality. The bill, introduced by Progressive Conservative MLA and anti-abortion crusader Gay Caswell, would require all women requesting abortions, and their husbands and parents when involved, to receive information detailing "the probable, questionable age of the unborn child at the time the abortion would be performed; a detailed description on the probable physiological and anatomical characteristics of the unborn child... including appearance, mobility, responses to stimuli, presence of organs and members, and brain and heart functions." The information, to come in person from a hospital abortion committee or one of its members, would include details of the medical risks of abortion and a "printed description of the public and private agencies" in Saskatchewan available to assist the woman to carry her child to term. The bill would require a married woman to get her husband's consent for an abortion, and a woman under 18 or financially dependent on her parents would require their consent for the procedure. The bill has the support of both Premier Grant Devine and Health Minister Graham Taylor. Since taking office in 1982, the Progressive has taken a strong anti-abortion stand, giving more than $50,000 a year to "right-to-life" groups.

GLOBE POLL FINDS MAJORITY SUPPORT CHOICE

A poll commissioned by the Globe and Mail has found that a majority of Canadians support choice on abortion. 53% of poll respondents agreed with the statement that "Every woman who wants an abortion should be able to have one", while 41% disagreed. 78% agreed with an abortion being performed if approved by a therapeutic abortion committee, while only 16% disagreed. 87% agreed an abortion should be performed if a woman's health is endangered, while only 8% disagreed. 93% agreed with an abortion if a woman's life is endangered, while 4% disagreed. 58% of men agreed that every woman who wants an abortion should be able to have one, while 49% of women agreed. The poll shows Roman Catholics to be evenly split on the issue, with 47% favouring freedom of choice and 48% being opposed to abortion being available simply by a woman's choice.

STUDY CATALOGUES TOXIC POLLUTANTS

Nine sewage treatment plants in Ontario are contaminating the lower Great Lakes and several tributary rivers with 272 organic chemicals, according to a study which the provincial Ministry of the Environment refuses to release. Many of the chemicals are toxic and some might cause cancer in humans. The three-year study, which looked at municipal waste treatment plants in Cornwall, Toronto (two), Hamilton, Burlington, Stratford, Kitchener, Goderich, and Sarnia, was the first attempt by the province to analyse and quantify the sophisticated chemicals coming out of sewage treatment plants. The authors found that the sewage facilities emit as much pollution as 10 large chemical plants and oil refineries in the Sarnia area. The study is being "kept as an internal report" according to the Ministry, but details of its contents found their way to the Globe and Mail. According to Dr. Douglas Hallett, a biologist who said he wondered why the study had not been made public and why no action was being taken on it, the study clearly illustrates that hazardous industrial wastes containing persistent toxic substances have to be treated differently from human wastes. Sewage treatment plants are not designed to handle sophisticated dry-cleaning solvents, plasticizers and toxic chlorianted compounds being dumped in the sewers by industries, he said.

MINISTRY WASTE BRANCH BEING DISMANTLED

The Ontario Ministry of the Environment has begun dismantling its recently created Hazardous Contaminants and Standards Branch, although the arrival of a new government may yet reverse that decision. Senior staff has been transferred or have left, and have not been replaced, and, according to ministry employees, a decision was made to quietly wind down the branch. An analysis of the philosophy underlying the move, leaked to the Globe and Mail, said that "•If the branch is disbanded no new standards will be set.
•If no standards are set there is no obligation to search for contaminants and measure them.
•If you don't look for contaminants, you don't find them.
•If you don't find contaminants you don't cause trouble for the Government."

POLLUTION SAID PROBLEM IN SCHOOLS

Lead pollution, oil-based paints and cleaning fluids in Toronto schools are affecting the ability of some children to learn, according to a study done for the Toronto Board of Education.

RIGHT TO LEGAL COUNSEL BEING DENIED

Involuntary psychiatric patients in Ontario hospitals are being deprived of their right to legal counsel--to which they became entitled more than a year ago--because of bureaucratic wrangling at Queen's Park. The Ministries of Health and Attorney General and Ontario's Legal Aid Plan have not resolved the issue of how to comply with the legislation. Legal Aid has been refusing to process applications from committed patients. "Something is very badly needed, because most involuntary patients are not aware of their rights," Carla McKague, a Toronto mental health lawyer, said. "I've had two situations in which an involuntary patient was refused permission to contact legal aid and another was refused the application form to appeal the commital."

PSYCHIATRIC HOSPITAL PLANS ELECTRONIC TRACKING OF PATIENTS

A psychiatric hospital in St. Thomas plans to start testing electronic tracking equipment on patients. Involuntary patients would wear a tag or bracelet containing an electronic chip that will alert a computer when the patient leaves the area to which s/he is assigned. The Ministry of Health has given its approval to the project, but mental health advocates are worried that electronic monitoring is a violation of civil liberties.

WOMAN HELD 9 MONTHS OVER BUS FARE DISPUTE

A Toronto woman charged with refusing to pay bus fare was held in a maximum security psychiatric hospital for nine months--longer than the toughest sentence she could have received if convicted. The charge of mischief against the woman was dropped before coming to court. Lawyers have attacked the woman's detention as an example of the abuses that occur in the system that allows people to be detained indefinitely on a Lieutenant-Governor's warrant. Michael Berman, the lawyer appointed by Legal Aid to represent the woman, described her as non-communicative but said her behaviour was not enough to get a civil committal to a psychiatric hospital because she posed no danger to herself or to others. The court took her behaviour as a sign she was unfit to stand trial and ordered her into custody under a Lieutenant-Governor's warrant, under which she could be detained indefinitely until she was judged fit to stand trial.

EVIDENCE GUIDELINES SOUGHT

Police should be prohibited from administering drugs to suspects or ordering X-rays or surgery such as the removal of a bullet, the Law Reform Commissior of Canada has recommended. Other procedures which the Commission wants to ban include pumping stomachs, probing body cavities, removing concealed objects from within a subject's body and taking hair samples and fingernail scrapings. The Commission says that as far as it knows such methods are rarely practised in Canada, but it feels that guidelines should be established before they do arrive in Canada. Police in California, for example, have used stomach pumps on prisoners. The commission says that some procedures should be permitted, but only upon judicial authorization. These would include being compelled to submit to examination for identifying features such as tattoos or scars, taking of hair clippings, or making of dental impressions. These should be permitted, the Commission says, only where the offense in question is punishable by imprisonment of five years or more, where there are reasonable grounds to believe that the proposed procedure will provide evidence of the offence and where there are no less intrusive means for obtaining evidence.

SHOCK TREATMENT AUTHORIZED

A 22-year-old psychiatric patient was given two sessions of electro-convulsive therapy even though a review board was considering the patient's and his family's refusal to consent to the treatment. The board made the interim order in a telephone conversation with the patient's psychiatrist even though it was to resume hearing evidence on the case the following week. Under Ontario's Mental Health Act, ECT cannot be administered to involuntary psychiatric patients without their consent. But a physician who feels the treatment is necessary can apply to a review board for permission to administer the electroshock.

LIBERAL/NDP PACT FOR LIBERAL GOVERNMENT

The pact between the Liberals and the NDP which paves the way for a provincial Liberal goverment contains the following references related to health care:

- Banning extra-billing by doctors.
- Introduce reforms to the Occupational Health and Safety Act including toxic substances designation and regulations to give workers the right to know about work-place hazards.
- Provide full coverage of medically necessary travel under the Ontario Health Insurance Plan for residents of Northern Ontario.
- Workers compensation reform.
- Proclaim the sections of the Environmental Protection Act dealing with spills.

The Liberal/NDP agreement did not mention eliminating OHIP premiums, but both parties campaigned against them in the election campaign.

ALBERTA COLLEGE CONSIDERS PATIENT LIMITS

The Alberta College of Physicians and Surgeons is considering placing a limit on the number of patients a doctor may see each day, college president Dr. Peter Seland says. Concerns have been raised recently about doctors' high incomes due to heavy patient loads. Some doctors have reported seeing more than 100 patients a day and Seland is concerned about the kind of care the patients are receiving.

OMA HINTS AT DOCTORS STRIKE

Ontario's doctors could end up striking if a Liberal government attempts to enact a promise to ban extra billing, according to Dr. Edward Moran, general secretary of the Ontario Medical Association. "If we think we're abused, we'll look at ways of retaliating and we've got some pretty inventive minds,"he said. According to Dr. Moran, it "intensely deprofessionalizing" for a doctor not to be allowed to extra bill.

B.C. BILLING NUMBER RESTRICTIONS

The British Columbia Social Credit government has passes new legislation to restrict the location of doctors in the province, replacing the previous law which was declared invalid by the courts. The law allows the provincial Medical Services Commission to restrict the issuing of new doctors' billing numbers and attach conditions, such as geographical location. Doctors need billing numbers so they can bill the provincial medicare program. The B.C. Medical Association has said that it will fight the new legislation in court. Their challenge to the previous legislation was successful when the B.C. Supreme Court ruled in their favour earlier this spring.

B.C. BAN ON 'BALANCE BILLING' UPHELD

British Columbia doctors have lost in their legal battle to preserve extra billing in the province. The Supreme Court of Canada turned down a request from the B.C. Medical Association for leave to appeal lower court rulings against 'balance billing'. Balance billing was banned by the provincial legislature in April 1981. Under balance billing, doctors would bill the provincial medicare plan for the amounts listed in the approved fee schedule, and then bill patients directly for an additional amount.

SASK. DOCTORS AGREE TO END EXTRA-BILLING

The Saskatchewan government has reached an agreement with the province's doctors to end extra billing. Under the agreement, doctors have the choice of being in or out of the provincial medicare plan. Those in will not be able to extra bill, and the patients of those who opt out will not be able to receive any reimbursement from the government. According to the president of the Saskatchewan Medical Association, physicians will not become government employees but will negotiate a contract with the province.

MANITOBA MOVES TO END EXTRA BILLING

The government of Manitoba has introduced legislation to end extra billing in the province.

DEFICIT TO TAKE PRIORITY OVER HEALTH $

Reducing Canada's deficit will have to take priority over increases in health-care financing, federal Health Minister Jake Epp told a meeting of 1,200 hospital administrators in Ottawa on June 13. "Canadians have to generate more wealth...not only to maintain the health-care system but to allow it to adjust." He warned repeatedly that "adjustments" will be necessary, but did not specifiy what those might be.

HOSPITALS SAY THEY NEED MORE MONEY

An "overwhelming majority" of Ontario hospitals will not be able to make ends meet this year unless the provincial health ministry gives more money, according to the Ontario Hospital Association. At a meeting of 350 chief officers from 185 hospitals, "most reported they are hurting badly," according to Peter Wood, OHA spokesman.

NUMBER TWO

David Jones, the chairman of Humana Inc., the American hospital chain, was paid $18,120,000 last year by his appreciative employers. Every silver lining has its dark cloud, however, and in Mr. Jones' case it is the fact that even at that rate of pay, he only ranks second on the pay ladder among American corporate executives. Up front, leaving Mr. Jones choking in the dust, was T. Boone Pickens of Mesa Petroleum, who received $22.8 million (U.S.).

EXTRA COSTS SEEN IN DECLINE OF RNAs

A management consultant's study commissioned by the Ontario Association of Registered Nursing Assistants says Ontario's health care system will be paying out $39 million extra in 1985-86 because of a continuing trend toward replacing registered nursing assistants in hospitals with registered nurses whose salaries are 39 to 53 per cent higher. The study was commissioned because the ORNA became alarmed last fall over the loss of RNA positions and an apparent move toward establishing all-RN nursing staff in hospitals. The report also says that a survey of recent research does not substantiate previous claims that all-RN staffing increases the quality of patient care or the claims that it can be done without increasing cost. It recommends independent research on the proposal for all-RN staffing in hospitals.

CALL TO LIMIT MEDICAL SCHOOL ENROLMENT

Enrolment in Canadian medical schools should be limited, says B.C. Freamo, the secretary-general of the Canadian Medical Association. According to Mr. Freamo, the oversupply of general practitioners is the most serious problem facing Canada's health care system. He attributed much of the oversupply problem to the number of foreign medical school graduates entering the country. In 1985, Canadian medical schools will produce about 1,800 doctors, he said, and an additional 500 to 600 graduates of foreign medical schools will enter the system.

NEW HEALTH MINISTER

Philip Andrewes is Ontario's new minister of health, although his term is expected to be a short one, with his Progressive Conservative government about to be replaced by a Liberal one. Mr. Andrewes is the third man to hold the post in 1985. He replaces Alan Pope, who replaced Keith Norton.

BLINDED WORKER GETS $350,000

A chemical manufacturer and distributor have been found partly responsible for the blinding of a worker in an industrial accident because their labelling of a dangerous chemical and warning instructions were insufficient. According to Justice Donald Steele of the Supreme Court of Ontario, the manufacturer and seller of the chemical, used in rock excavations, should have provided more information about the seriousness of the inuries that could be incurred and about proper treatment in case of an accident. The ruling is believed to be the first in Canada to establish a duty to show how to treat an accident caused by a company's chemical product. Nevertheless, the victim, Emmanuel Meilleur, was found to be 75% responsible for his own injury.

IUD MANUFACTURER SET TO PAY CLAIMS

The manufacturer of the Dalkon Shield intrauterine contraceptive has set up a $615 million fund to pay claims resulting from use of the device, taken off the market in 1974 amid reports of injuries to users. The company still has thousands of outstanding lawsuits from women who claim they were injured by the Dalkon Shield.

Of Interest...

HOME OR HOSPITAL?

In Britain today, only one woman in every 100 gives birth in her own home, but many more would like to, if medical opinion supported them. A survey of the 8,856 home births in England and Wales in 1979 shows how safe home delivery can be. Two thirds of the 8,856 had been planned as home births and their perinatal mortality was 4.1 per 1,000. The remaining third included women who were booked for hospital delivery, but did not get there for one reason or another, and a minority of 12 per cent who had not made any plans--and in whom the perinatal mortality was an appalling 197/1,000.

Argument continues about the relative safety of home and hospital deliver; what this survey proves without question is that, when women are carefully selected for home delivery, the results show no evidence of risk to either mother or child.

--Submitted by Robert Frankford

AMNESTYINTERNATIONAL ANNIVERSARY POSTER

Amnesty International

Toronto Arts Group for Human Rights on behalf of Amnesty International is pleased to announce the publication of three limited edition posters. Produced, as a fundraising project, the posters commemorate the tenth anniversary of Amnesty International Canadian Section (English Speaking).

Graham Coughtry

Canadian artists Derek Caines, Graham Coughtry and Wiesia Pikula-Sickle were chosen for their bold depiction of Amnesty's concerns. Each poster is printed in a limited edition of 500 on Rising Stonehenge rag paper (size 22" x 30"). The posters are signed and numbered by the artists.

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Amnesty International is a worldwide human rights movement which is independent of any government, political action, ideology, economic interest or creed. It works for the release of men and women imprisoned anywherer for their beliefs, colour, ethnic origin, sex, or religion provided they have neither used or advocated violence. Amnesty International opposes torture and capital punishment in all cases without reservation. It advocates fair and early trials for all political prisoners and works on behalf of persons detained without charge or without trial and those detained after expiry of their sentences. Amnesty International has consultative status with the United Nations, the Council of Europe, the Organization of American States and the Organization of African Unity

-- THE GLOBE AND MAIL, THURSDAY, APRIL 25, 1985 7

Shaving costs of medical care by toning up the system

BY CYNTHIA CARVER

Dr. Carver is the author of Patient Beware. She lives in Regina.

THE DISCUSSION of the problem of rising medical-care costs has so far centred on finding more money to throw into the system. User fees, higher premiums and co-insurance have all been suggested and, in some cases, used as panaceas. But they are regressive and simplistic solutions to a complex problem and they are solutions that tend to hurt the poor, the sick and the elderly.

The medical-care system itself merits careful scrutiny. The bulk of medical-care payments go to physicians (about 25 per cent) and to hospitals (50 per cent). Yet little effort is expended in making these components of the system efficient and cost-effective. There is no incentive for practitioners to seek ways of decreasing costs. Hospitals responding to budget restraints tend simply to close beds and lay off staff.

Physicians, working on a fee-for-service basis, are the key to our medical-care system. Not only are they paid for each patient they see, but they generate the costs involved in laboratory tests and hospital admissions. Few, if any, mechanisms are in place to monitor these activities.

If a general practitioner with 3,000 patients decides that more income is required, he or she can suggest an extra follow-up visit to each patient. At an average of $15 a visit, gross income is boosted by up to $45,000 a year. The doctor can handle the load by working a longer day or by booking shorter visits.

No way to check

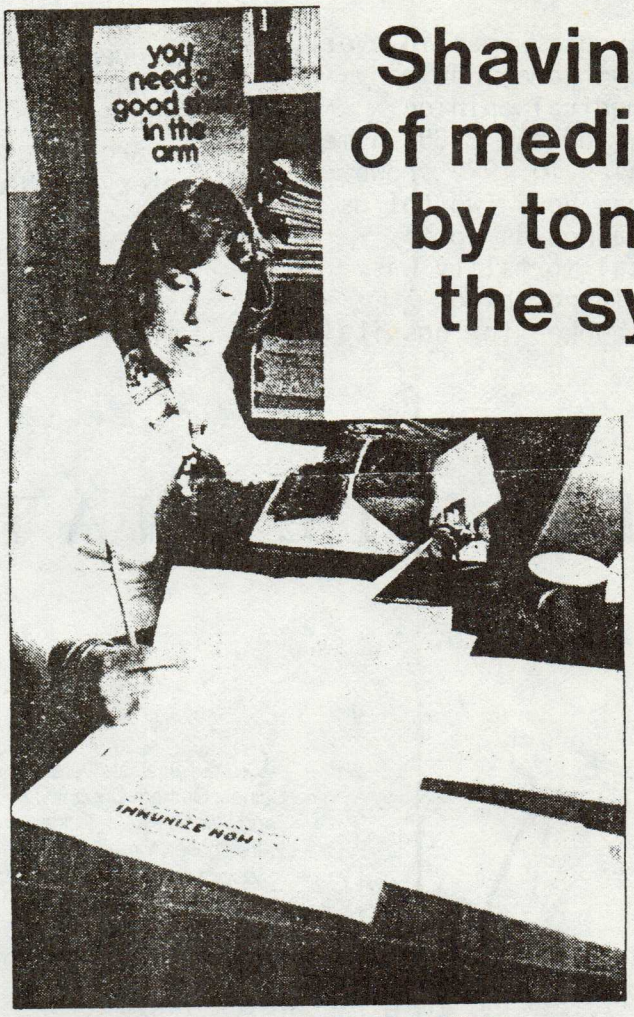
At present, there is virtually no way to identify this, let alone control it. The only doctors who seem to be investigated by provincial medical colleges or billing plans are those whose gross incomes vastly exceed the norm.

Yet physician profiles can be used by medical regulatory bodies to look at practice patterns. How many patients do doctors see a day? How do the referral rates, prescription rates, testing rates and revisit rates compare for doctors who book eight patients an hour instead of three or four? What are the average annual visit rates for patients of general practitioners or specialists?

Experimenting with alternative payment systems also has potential. Consider capitation. In capitation, the doctor receives an annual fee for the care of a patient. The general practitioner with 3,000 patients might receive a yearly average of $60 a patient to provide primary-care services, and would earn $180,000. With 45 per cent overhead, the doctor gets $99,000 in pre-tax income. Not too bad.

With capitation there is no incentive to increase patient visits. Quite the contrary, since the same income is received whether 10 or 100 patients are seen in a day. But the guaranteed income provides an opportunity for doctors to embark on programs of patient education and preventive medicine. Doctors can offer patients information that can enable them to deal with illness more effectively themselves. Doctors can also be freed to provide periodic assessments — screening, early detection of disease, health-promotion counselling and other manoeuvres to reduce the incidence or severity of disease. Explaining disease processes and counselling on behavior can lead to fewer repeat visits and lower rates of prescription, referral and hospitalization.

The use of non-physician practitioners can also decrease costs. Canadian studies have shown that nurse practitioners can competently perform about 85 per cent of the activities of the family practitioner. She can do routine physicals, counselling and patient education, diagnosis and treatment of such minor (but common) ailments as colds, flu, strains and sprains, and can monitor patients with such chronic diseases as high blood pressure and diabetes. A doctor might consider taking on another 1,000 patients — for an increase of $60,000 — out of which the nurse practitioner, a part-time nutritionist and the increased overhead could be paid.



Shirley Wheatley was Ontario's first nurse practitioner.

Midwives, banned from practice in Canada, should provide prenatal care and be the birth attendant for virtually all normal pregnant women. A peculiarity of our system is that we permit a general practitioner who has delivered five babies during training to attend births, but bar midwives who have delivered hundreds of babies. Countries which make extensive use of midwives have birth statistics as good as or better than ours.

Obstetrician/gynecologists, who train for at least four years after medical school and earn generally more than $100,000 a year pre-tax, really ought to be performing specialist functions. They should not be attending normal births, doing routine pap smears, dispensing birth control and performing D and Cs (dilation and curettage) and abortions.

We use very highly trained and highly paid specialists to perform tasks that far less well-paid practitioners can do just as well, and in some cases better. And the public has become convinced that only top-flight specialists will suffice, even for routine medical matters. Why do pediatricians look after normal children and internists do physicals on business executives, when general or nurse practitioners could do these exams? Why do family practitioners do family and marital counselling when social workers are better trained for it? Using $100,000 practitioners for work done as well by $35,000 professionals, aside from the high cost of physician training, is not cost-effective.

The federal Government should establish experimental delivery systems that could reduce costs without decreasing quality. Projects must be adequately financed, however, since short-changing them (as has been done at times) assures that nothing will be learned or achieved, and, while pilot projects must be subjected to rigorous evaluation and monitoring, they must not be swamped by paperwork. Savings associated with high-quality comprehensive care are often deferred and may be largely in the form of reduced hospitalization rates.

The multi-professional group practice financed either by capitation or an overall budget (funds available to a practice, allocated by the members of the practice), is a system that should be explored. A few of these have been set up in Canadian cities, but they tend to be in low-income areas, are usually underfinanced, do not have a full complement of practitioners and are inadequately evaluated.

Several such multi-professional centres should be set up in each province, each with a different set of practitioners. They might incorporate general/family practitioners already in practice or new ones, nurse practitioners, social workers, midwives and nutritionists/dieticians. Such centres could lead to reduced referral and hospitalization rates; fewer visits per patient per year; patient and practitioner satisfaction, and of course, death and illness rates at least as good as in other provinces. The cost to the whole system per patient per year should then be compared to the cost of traditional practices.

In the area of hospital utilization and costs, there are a number of avenues to pursue. Since surgery accounts for about half of hospital admissions, we should look carefully at surgical rates. Studies have shown large variations in operating rates that do not seem to be related to disease in the community. The over-all rate of surgery in Canada, although lower than in the United States, has been shown to be about 60 per cent higher than in England, and these rates do not seem to be related to health status. U.S. studies have shown that salaried surgeons do less surgery — are they lazy, or are the fee-for-service surgeons over-zealous? Not known, but worth a look.

Second-opinion programs are controversial, but just recently New York State's public-employee health plan found hysterectomies down 17 per cent, knee surgery down 36 per cent and prostate surgery down 19 per cent following a requirement for a second opinion in six common surgical procedures.

Produces a saving

Length of hospital stay could also be examined. After childbirth, the norm in Canada is four or five days; in the United States, two or three days is common. Several early discharge programs have been tried here, in which nurses visit the mother and baby at home. More home care and shorter hospital stays for various procedures could produce savings.

Out-of-hospital centres for surgery and birth flourish in the United States and seem cost-effective and safe. Birth centres exist in several states, some midwife-run, others run by GPs or obstetricians. Similarly, abortion clinics are commonly out-of-hospital in the United States.

Surgical centres in the United States are performing an increasing proportion of minor surgery. Their per-patient costs are lower than those for in-hospital surgery, even when overnight stays are not considered. Studies have shown that for minor procedures (tonsillectomy, hernia repair and tubal ligation, among others) surgi-centres are safe, cost-effective and are acceptable to both doctors and patients. Although many Canadian hospitals provide ambulatory, short stays for some kinds of surgery, the use of hospital staff, space and operating room is more costly than using non-hospital facilities.

Finally, more expenditure on home care, chronic-care facilities and nursing-home beds would enable patients now occupying acute-care beds to leave hospitals. More generous financing of research into non-surgical, lifestyle-oriented treatment might enable surgical rates to decline. More research into preventive programs holds the most potential for reducing disease and medical-care costs.

Although a few such projects have been attempted, they have tended to have far from full support from the powers that be. They have also been poorly monitored for per-patient costs, per-doctor costs and their effects on health.

The federal Government appears to recognize the need for investment and support in the business sector to achieve future returns. Perhaps it can begin to support innovative, well-thought-out, carefully evaluated experiments in health care. Nationwide experiments could lower costs and improve health on a large scale. One can only hope.

Cynthia Carver is a member of the Medical Reform Group.