MRG NEWSLETTER

Medical Reform Group of Ontario P.O. Box 366, Stn. J Toronto, Ontario M4J 4Y8 (416) 920-4513

VOLUME 6, NUMBER 3 JUNE-JULY 1986

But Hamilton's Dr. Gordon Guyatt, a spokesman for the Medical Reform Group, which opposes the strike, said "I think it's going to become evident the government is going to pass the legislation and the actions by the OMA are essentially an act of futility."

Dr. Guyatt said the city's four academic family practice units — which handle "a few thousand" patients each and train family doctors — are operating as usual and the five-doctor kidney unit at St. Joseph's hospital is operating normally.

"Whatever way you look at it, there's a substantial number of doctors working," he said. "If they go further with a longer strike, there would be increasing damage to the patients and real problems with increasing distrust of the medical profession."

Dr. Guyatt said Hamilton doctors — who voted 72 per cent against a strike in a poll earlier — would be unlikely to ... stepped-up job actions.

Dr. Mimi Divinsky becomes visibly angry when discussing the arguments in favour of extra billing made by other doctors. A family physician who practices with three other women in Cabbagetown, Divinsky belongs to the Medical Reform Group of Ontario, a group of about 150 physicians and medical students who support the banning of extra billing in opposition to the stand of the OMA. "I know most doctors support the OMA's stand, but I'm not sure if they will go to the wall for it. I have trouble understanding why they are so upset."

Divinsky dismisses most of the arguments in favour of extra billing as "absurd," saying that the public's right of access to medical services outweighs any right to extra bill.

... favor of a strike but does ... an Ontario-wide vote ... turn out.

Dr. Gordon Guyatt, Hamilton spokesman for the Medical Reform Group of Ontario, hailed the results as a significant victory in the fight to ban extra billing.

"I think it's really great. It restores some of my faith in physicians. At least in Hamilton, physicians are not willing to put their fight for extra billing before their patients."

Many of those who do oppose a ban would never consider taking action that could jeopardize the health of their patients, he said.

A new realism

While Dr. Berger agrees the image of doctors may be at an all-time low, the sudden appearance over the past 10 years of patient advocacy groups, and an influx of health economists into medicine, have contributed to the fall. "Times have changed," he observes, "and I feel badly the profession these days. They're ... queered and are retiring."

Dr. Philip Berger, a spokesman for the 150-member Medical Reform Group of Ontario, said he expects a majority of the province's doctors to take part in the walkout but "fewer participating in cities and more in rural areas."

'No measure'

Berger, whose group supports the government's proposed legislation banning extra-billing, said he believes many uncommitted physicians will take part in a two-day strike "just to show solidarity to the (medical) association."

"A two-day strike is no real measure of the level of doctors' support for this battle," Berger said, adding that he's confident most physicians will take extraordinary steps to ensure their patients are safe during the walkout.

Several doctors' leaders downplayed the impact the strike will have ...

However, the Medical Reform Group of Ontario urged area doctors to ignore the "ideal medicine" tactic, saying patients will be upset if they don't know if they're being kept in hospital for medical or political reasons.

The group represents about 160 Ontario doctors who agree with the government's move to ban physicians from charging fees above those set out by the OHIP schedule.

In that sense, the profession may be contributing to its own fall from grace.

Doctors, Dr. Berger notes, have to accept that the public has become more knowledgeable and more questioning. "It's very sad if doctors are threatened by that and don't get enjoyment out of their work because of it," he says, but it is now a fact of life.

And while the profession has slipped a notch in the public's eyes, Dr. Berger doesn't see it as a major tumbling. "I don't think," he says, "they've come crashing down."

Usually poles apart philosophically from Berger, Dr. Joan Ch...

Hamilton psychiatrist Dr. Donald Woodside summed up the feelings of a minority of doctors who want their colleagues to focus on "more important medical issues," such as improved care for senior citizens.

"There are many grievous concerns in the world and I am very sad that the Ontario Medical Association chooses to mobilize and to focus its energies on this particular issue," he said.

... doctors have begun discharging their patients from hospitals to protest against the government's plans to end extra-billing, an executive of the Ontario ...

However, not all doctors agree with this latest tactic by the OMA. Dr. Philip Berger, a spokesman for the Medical Reform Group of Ontario, criticized it as reckless, irresponsible and an insult to the entire medical profession.

"This is just another example of the (OMA) leadership's unethical behavior. It's the way they've conducted themselves from the ..."

Fears recalled

Philip Berger of the Medical Reform Group said the elderly have "vivid memories" about doctors' protests when medicare was introduced in the 1960s.

"The strife between the government and the doctors only raises these memories and fears," he told the committee.

"It is not fair that the blood of an all-out war be shed by the most vulnerable people in our society."

Berger, representing 160 practising doctors and medical students, said he makes house calls on many old people and "I don't consider it a joke when people in their '80s wonder if I'm going to come back again."

The group supports a ban on extra-billing. But doctors and the government must reach "a just compromise," he said.

... Berger, a spokesman ... member Medical Reform ... which supports a ban on extra-billing, said yesterday that the ... psychiatrists' move to close offices is irresponsible.

General Meeting Report

The following is a synopsis of the MRG's semi-annual general meeting which took place on May 3, 1986, with about 30 members in attendance:

John Frank introduced the opening discussion on Health, Politics, Health Care: Lessons from the Third World.

Doug Sider discussed his four years as a GP in Mozambique; Don Woodside discussed his experience in Lesotho; Roseanne Pelizzari described her experiences in Lima, Peru; and Don Boudreau his experiences in two years in Nicaragua.

In the business part of the meeting, Bob Frankford gave the Steering Committee report, mentioning:

-activities around the extra billing controversy;

-challenges to the MRG's stated membership figures;

-the discussion of MRG involvement in the CMA's lawsuit regarding the legality of extra billing and the Canada Health Act;

-the College of Family Physicians involving itself in the extra billing controversy, and the challenge of some MRG members to this;

-contacts with the National Medical and Dental Association in South Africa, leading to the question of developing further links with other progressive physician groups.

Trudy and Everett Baker, the insurance agents who have worked on developing a disability insurance plan for MRG members, arrived at the meeting just before lunch and were introduced.

Stan Gray, Ruth St. Amant, John Chong, Debbie Honickman, Shawna Perlin, and Ted Haines were present to speak to members over lunch about the Workers' Health clinics.

Chapter reports: Toronto: Fred Freedman reported on three recent Toronto chapter meetings, with pharmacist Bill Crothers; with two representatives from the College of Physicians and Surgeons; on the extra billing issue and about how MRG members felt about how the controversy has been unfolding.

Chapter reports: Hamilton: Roseanne Pellizari reported on three meetings, on community health centres with Jonathan Lomas; on company doctors; and on women and the peace movement (co-sponsored with Physicians for Social Responsbility).

Media co-ordinator's report: Michael Rachlis gave a rundown on what has been happening in the extra billing battle and how the MRG has responded publicly to it.

Steering Committee elections: Steering Committee elections take place at the fall general meeting, but steering committee member Clare Pain resigned from the committee and Steve Hirshfeld was approved for membership on the committee.

Outrageous Quote Contest: The winning quote in the most outrageous quote contest was submitted by Don Woodside, who submitted the following from Dr. Geoff Issac, the former head of the Ontario Medical Association. It comes from a talk given to a group of medical students: "Because you are a carefully selected group with IQ's and memory capacity in the top one per cent of the population, you will spend your days not with your peers, but with patients who are your intellectual subordinates."

Pharmaceutical Marketing: After a video and a discussion, a resolution on pharmaceutical marketing was passed. The resolution is on page of this newsletter.

MRG INSURANCE PLAN

Trudy Baker reports applications are coming in well but we still have several more to go before the full discount becomes applicable. Apparently, several members insured through the College of Family Physicians have been interviewd and Trudy says the MRG plan is not only better but is guaranteed. The Citadel plan (CFP) is not guaranteed and because the company has not been very successful in the disability insurance field the plan may and can be discontinued (check your policy). Finally, the MRG disability plan in a modified form can be extended to MRG doctors's support staff. Presently unemployment insurance will cover our employees for 15 weeks only at 60% of their insured earnings.

--Gary Burrows

[See also enclosed questionnaire]

But this doctor talking medicine, not politics

By BRIAN PORTER
The Spectator May 27/86

IT WILL be business as usual for the Cross Street Medical Associates in Dundas next week when thousands of Ontario doctors go on strike.

"We're not going to participate in any strike or job action over this issue," says Dr. Robert James, a seven-year veteran of the family practice clinic which has posted a sign advising patients there will be no disruption in service by its three physicians.

"We have discussed it with some of our patients who have raised it," says Dr. James. "But we don't raise it with them because they're not here to talk politics, they're here to talk medicine."

Dr. James says the majority of his patients sympathize with his objections to the Ontario Medical Assocation's position on extra-billing.

The OMA has unanimously approved a province-wide physicians' strike on Thursday and Friday to protest the proposed legislation which would end the practice.

But most patients are more concerned about what will happen to them if they require the services of a striking specialist.

"One woman, who is 37 weeks pregnant, expressed concern about what would happen when it comes time for her to deliver and whether her obstetrician will be available," says Dr. James, a member of Ontario's Medical Reform Group which opposes extra-billing.

"In theory, I would not say that doctors should never strike," he adds, "I just don't think this issue is one to go on strike for.

"I believe extra-billing should have been outlawed 20 years ago and this particular law is not a bad law. I think the government is bargaining in good faith and the OMA is doing it in bad faith."

While Dr. James has experienced no animosity from his colleagues who plan to walk out next week, he believes the issue could damage professional relations.

Dr. Robert James: no strike

Doctor defends government on extra billing issue

Dundas Star Journal
May 14, 1986

I feel obliged to respond to the letter in your May 7th edition, from Donald Kemp in Renfrew, Ontario. I wonder why your paper is going as far as the Ottawa valley to get letters for the Opinions page.

In the Dundas area, there are no physicians who extra-bill; in Hamilton, only a small percentage of physicians do so. It is not something which directly affects the majority of your readers. However, I understand that you feel an obligation to take part in this debate.

I would hope that you would also seek to look at the facts of the issue. Dr. Kemp's statements are occasionally inaccurate, and often misleading.

He cites Quebec as an example of the negative effects of government control. I practiced medicine in that province for three years before coming to Dundas. It is worth pointing out that the Quebec government is one of the few in Canada which has had the courage to address the question of distribution of physicians. People living in small communities, or remote areas, have often had restricted access to health care because of a lack of doctors. Quebec, at least, is attempting to deal with this. Such a move does not hurt patients, but in fact helps the population at large.

He talks about a restriction on doctor's income, but does not spell out what is entailed in this; it is worth pointing out that this restriction prevents any single physician from earning more than $100,000 every three months. I don't feel this is unreasonable.

He mentions Britain as a "bad example". I agree that it is a bad example, but not of government control. Britain spends roughly half the amount per capita on health care that we spend in Canada. Mrs. Thatcher's Conservative government has allowed privately-controlled medicine to gain a foothold, and this profit-seeking medical system has withdrawn needed funds from the public sector. It has resulted in a decrease in health-care accessibility to the general population. However, this "starving" of public medical care has come about because of private-controlled medicine, and will not be solved by more private control.

Scandinavia is also noted as a bad example. It is worth mentioning that in Scandinavia, the infant mortality rate is the lowest of any western European or North American country. It is also worth mentioning that, in general, the health status of Scandinavians has been shown to be better than that of Canadians. One need only refer to previous Health Minister Lalonde's study done in the 1970's to verify this.

As a doctor, I am confident that no government in Canada would be foolish enough to try to interfere with what goes on in my office. What Bill 94 will change is the so-called right of physicians to levy a fee - over and above the OHIP rates - on patients who come to seek care. This practice has been shown, in three separate studies in two different provinces, to adversely affect health care.

The forces who defend extra-billing are correct in their contention that there are other issues related to health-care accessibility which need attention. There are faults with the Bill. However, it does address one problem of accessibility to medical care - the question of extra-billing. It deserves support.

R.A. James, M.D., C.C.F.P.

MRG IN THE MEDIA

The prominence given to the extra billing controversy over the last several months has brought a good deal of media attention to the Medical Reform Group and a number of its members. Some of the newspaper and magazines articles which have resulted are reprinted elsewhere in this newsletter. Some of the other coverage is mentioned below, although this represents only a fraction of the total media appearances by MRG spokespeople:

Bob James was interviewed on radio on Sunday April 13 and then was involved in a debate with an Ottawa physician on April 17. Both of these appearances were on CJBC, the French language Radio Canada station. Other events were in the aftermath of the OMA's press conference which was held on Saturday April 19. Don Woodside appeared on CFTO TV as well as being responsible for reports of MRG positions which were broadcast on CKOC adn CHML radio. Gord Guyatt was on the 6 pm and 11 pm news on CHCH TV on Sunday April 20 as well as being on CKCO radio from Kitchener on the Saturday and the Sunday of that week.

After the Hamilton Academy of Medicine voted not to support a strike, Don Woodside appeared on CHCH News, while Bob James appeared on Metro Morning and on Global News, and Gord Guyatt appeared on CKOC, CHML, and CHAM.

After the OMA strike was announced, Gord Guyatt and Don Woodside appeared several times on CKOC, CHML, CKDS, and CHAM radio and on CHCH TV. In addition, they also facilitated media contacts with non-MRG physicians opposed to the strike and in favour of the legislation. Specifically, Dr. William Goldberg, former chief of medicine at St. Joseph's Hospital in Hamilton appeared on CHCH TV expressing his opposition to the strike.

During the OMA strike, Bob James appeared on CBC national radio programs twice during the week.

--submitted by Gord Guyatt

NATIONAL MEDICAL AND DENTAL ASSOCIATION (SOUTH AFRICA)

The MRG steering committee has been in contact with the National Medical and Dental Association of South Africa, an anti-apartheid group. The NAMDA has sent copies of its newsletters, resolutions, and goals. These are available to MRG members who wish to see them through MRG Secretary Ulli Diemer.

The NAMDA is asking for publicity, protests and support is response to the detention and repression of doctors and health workers in South Africa. It has sent us a list of individuals who are being detained; this too is available through Ulli Diemer.

HEALTH PROBE

Health Probe is a new organization whose purpose is to develop, advocate and have implemented public policies that result in improving the health and well-being of Canadians. For more information, contact Neville Chenoy at 222-1101, or write to Health Probe, 511 the West Mall, Suite 1711, Etobicoke M9C 1G5.

THE DIRTY DOZEN

The Dirty Dozen Campaign is a public education effort organized by the Pesticide Action Network (PAN) International, a global coalition of citizen's groups. It targets 12 particularily hazardous pesticides for international regulatory action. It urges that citizen groups monitor production, marketing and distribution and usage of pesticides and publicize evidence of harmful impacts; aim education campaigns at consumers, farmers and other pesticdie users; organize conferences and demonstrations of support for the objectives of the Dirty Dozen campaign; and be active in PAN International. In Canada, PAN can be reached through World InterAction Mondiale, P.O. Box 2484, Station D, Ottawa, K1P 5W6, or phone (613) 238-4659.

DOCTORS AND THE W.C.B.

A conference on the Workers' Compensation Board policy and practice in the use of the medical profession in the adjudication of claims has been scheduled for October 2 and 3 at Ryerson Polytechnical Institute in Toronto. For information contact Injured Workers" Consultants, #402, 815 Danforth Ave., Toronto.

Of Interest...

PARENTS OF ENVIRONMENTALLY SENSITIVE

Parents of Environmentally Sensitive is an organizations whose aims are to:

1. Promote formation of support systems for the environmentally ill and their families;
2. Provide for development and dissemination of educational resources;
3. Promote basic and clinical research of environmental illness. The group publishes a newsletter, and can be reached at Parents of the Environmentally Sensitive, Box 434, Station R, Toronto, Ontario M4G 4C3.

MIDWIFERY TASK FORCE

The Government of Ontario has established a Task Force on the Implementation of Midwifery in Ontario. The Task Force is inviting written submissions. Submissions may be addressed to and further information obtained from:

Linda S. Bohnen
Executive Director
Task Force on the Implementation of
Midwifery in Ontario
14th floor, 700 Bay St.
Toronto, Ontario
M5G 1Z6
(416) 965-5094

KNOW YOUR RIGHTS

The Patients' Rights Association has published a pamphlet, Know Your Rights: A Guide for In-Patients in Ontario. The pamphlet is available from the Patients' Rights Association, 40 Homewood Ave., #315, Toronto, Ont., M4Y 2K2, (416) 923-9629.

MRG NEWSLETTER

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

Group's claims on health care are disputed

March 25, 1986

By Denise Harrington
Toronto Star

The Ontario Medical Association is misleading the public and its own members with claims that the province's health system is inadequately financed, says a group of doctors who support a ban on extra-billing.

The 160-member Medical Reform Group, in a statement prepared for a news conference today, asks the medical association "to provide accurate information and to accept the proposed ban on extra-billing."

In the statement, the group slams a medical association advertising campaign saying that doctors oppose the proposed ban partly because they need to keep their independence to criticize government about problems in the health-care system.

The reform group also charges that the medical association refused to distribute to members copies of a report by the Canadian Medical Association on the financing of the health-care system because the conclusions contradicted its own.

"We're concerned that the association has started this misleading advertising campaign and its own national association spent $500,000 studying this issue and came up with findings that were contradictory," Dr. Michael Rachlis, president of the reform group, said in an interview.

The group says a five-member panel appointed by the national association reported in 1984 that "given the health-care system's existing inefficiencies, there was no evidence for the . . . claim that there was 'dangerous underfunding'."

CANADIAN DOCTOR, MAY, 1986

Treating the person, not the purse?

Ontario MDs against extra-billing contend the sole issue in this debate is money

by Steven Rauchman, a Toronto-based freelance writer.

Although only 12 per cent of doctors in Ontario extra-bill, there has been a massive and bitter outcry from these and other practitioners alleging that the pernicious effects of the Health Care Accessibility Act (Bill 94) on doctors' rights have even more severe implications for the future. But doctors who take the opposing stance maintain that those who support extra-billing are more concerned with running an especially lucrative practice than with assuring their patients – regardless of income – equal and first-rate health care.

Dr. Philip Berger, a family practitioner in Toronto and a member of the Ontario Medical Reform Group, is adamant that, "It is unquestionable that the aged, welfare recipients, and the low income groups in the province are forced to bear additional out-of-pocket charges in order to receive medical attention." As a result, he says, people in these groups – who together number in the millions – often do not go in for needed treatment, and when they do, tend to avoid recommended follow-up visits.

Dr. Berger points out a number of examinations of extra-billing performed over the years, which legitimize these claims with their consistency. Two of the most recent were 1984 studies conducted in Alberta – one of the three remaining provinces which still sanctions extra-billing (*along with Ontario and New Brunswick*). Receiving much public attention was a study conducted by the Alberta College of Physicians and Surgeons, which revealed that 800 Alberta doctors extra-billed patients who were on welfare. Another report, made under the guidance of Alberta government economist Richard Plains, showed no significant difference in billing patterns between the extra-billing of the well-to-do and the poor. The argument put forward by pro-billing doctors, that they are discerning in who they extra-bill, was deflated by both these studies.

In the same vein, the Woodward and Stoddard study, conducted at McMaster University in 1980 for that year's health system review by Justice Emmett Hall, looked at four different counties in Ontario where there were high rates of opting out. They found that over a third of the poor were extra-billed, that nearly 20 per cent of all patients had reduced their use of medical services because of fear of extra-billing, and nearly five per cent of the poor said they had not sought medical attention for a sick child for fear of being extra-billed. In his summation, Justice Hall concluded that, "Not only does extra-billing deny access to the poor, but it also attacks sick persons who, besides paying premiums, are already paying the major costs to the system with their taxes."

The statement is echoed in the sentiments of Dr. Gordon Guyatt, an internist and epidemiologist practising in Hamilton, Ontario. "The issue," he says, "is simply that it [extra-billing] compromises accessibility to health care for the poor and the elderly, and those in fixed incomes. I suppose another way of looking at it is the sick have to pay twice. They have to pay like the rest of us out of their income taxes and provincial taxes, and they have to pay out of their premiums. And *then* they have to pay again at a time when they're sick, often when they can least afford it. So it's really an extra tax for the sick."

Dr. Guyatt laments that the Ontario Medical Association "has successfully persuaded physicians that the issue is not really extra-billing, but government control and all the things that government might do in the future. But in fact, the *sole* issue is extra-billing. If extra-billing should later threaten to affect curbs to professional freedom, those issues can be dealt with as they come up. But those speculations are a blind to the only immediate issue contained in Bill 94 – which is extra-billing."

Dr. Berger, who besides being a member of the Medical Reform Group's steering committee is also a founding member of the Canadian Centre for the Investigation and Prevention of Torture, has a long-standing involvement in government interference and control of medicine – in this and other countries. Why, then, does he not protest the government's push to ban extra-billing?

"I think that in a democratic society with a democratically elected government, the government has a responsibility – in fact, a duty – to protect the public interest. Protecting the public interest means ensuring *equal*

access to the health care system for all the citizens. I think that the freedom of doctors to bill what they want has to be weighed against the right of access to the health care system. I think the latter is far greater, and outweighs the right of doctors to bill extra if they want to.

"Further, while some of them [doctors] say they want to work independently of the government, that becomes a hollow argument because they're so dependent on the government for their hospitals, laboratory services, education, and for the monopoly they have to practise medicine, all of which are quite important."

Dr. Don Woodside, a psychiatrist practising in Hamilton, feels that "the focus of the medical profession on retaining their small business role as entrepreneurs through retaining the right to opt out is kind of a tragic blind alley. There's lots of causes in health care that they could be putting their energy into. With this one, you have to ask, how can they be so out of touch with the whole rest of the population, with a parliament that was unanimously in favor of the Canada Health Act, tremendous support at the Gallup polls – where are they coming from?"

Partly in answer to this, he then points out the air of intellectual superiority that has, in the past, characterized the medical community, and effectively set them apart from the rest of the population. But with the public's greatly increased level of both general and specialized education, fewer individuals buy into the sense of unapproachable – and un*re*proachable – grandeur with which they once viewed their physicians. They are therefore less accepting of the limitless fee structure that has been an intrinsic part of the medical monopoly.

"And I think that's a change that is very hard for the medical profession to accept," says Dr. Woodside. "But I think doctors cling very hard to the concept of professional independence, which often is not in the best interests of the patient's clinical management. Today, if the doctor doesn't listen carefully to what others have to say, then the patient's interests are not well-served."

Dr. Antony Holliday-Rhodes, who has a rural family practice in Minden, Ontario and surrounding areas, says the people there cannot afford to be extra-billed. "The people in this area, in particular Minden, are extremely poor," he says.

"I would like to see all the energy that doctors are channelling into their fight against extra-billing directed instead towards negotiations for more hospitals, more hospital equipment, better medical service in general, and more research money to improve the medical service standard in Ontario, which appears to be on the decline. The ever-increasing elderly population is causing bed shortages so that some specialized services are not meeting the increased demand."

Dr. Holliday-Rhodes, working closely with patients who sometimes require more specialized medical care than they can comfortably afford, harbors strong feelings against those physicians whose highest priority is to occupy the highest medical income bracket. "I took up medicine as a vocation first, and as a means of earning a living as a necessary but secondary consideration. I feel that those doctors who are interested primarily in a well above average income should never have entered medicine. They should have entered the business world, a field that does not involve caring for the sick.

"Ontario can afford to lose a few doctors to the U.S.," he continues. "It occurs to me that the doctors who are leading the fight against extra-billing could and should perhaps re-locate to the U.S. if they so desire, where the system sounds as if it may be more suited to them. There are plenty of European doctors out of work who are of high calibre in countries where there's a surplus, many of whom would welcome an opportunity to come to Ontario should there be a lack of doctors at any time."

Dr. Barbara Lent, in family practice in London, Ontario, believes the OMA's suggestion to devise a special numerical code or card system would be ineffectual in attempting to pigeon-hole patients who can afford to be extra-billed from those who cannot. "People can't always predict what their financial situation is going to be," she says. "If you have unexpected medical costs, it can pose a sudden hardship for you and your family. Changes in finances or in health would change your status dramatically under a system like that.

"The basic thing is, we shouldn't be making decisions about whether or not it's appropriate to go to the doctor based on the amount of money in our pockets. If my kid is sick, and has been screaming through the night, I want to be able to take him to the doctor the next day and not wait until payday."

Dr. Philip Berger, speaking only on behalf of members of the Medical Reform Group, makes the final point that "The MRG does not view health care services as a commodity.

"It's an essential service. *Because* it's an essential service the government has a duty to ensure equal and public access to the service. And extra-billing charges, which impede access to the health care system, are contrary to the view of health care as being valuable and indispensable." ■

Philip Berger, Gordon Guyatt, Barbara Lent, and Don Woodside are all members of the Medical Reform Group.

Lesson for Ontario doctors in two western facedowns

THE GLOBE AND MAIL, THURSDAY, MAY 29, 1986

BY GABOR MATE
Dr. Mate is a Vancouver family physician and freelance writer.

VANCOUVER

AS ONTARIO physicians launch their work stoppage today, they would do well to consider the lessons of two previous confrontations between doctors and governments in Canada: the Saskatchewan doctors' strike in 1962 and the conflict over extra-billing in British Columbia in 1981.

From neither did the medical profession emerge victorious, and both left the doctors' moral image more than a little tarnished.

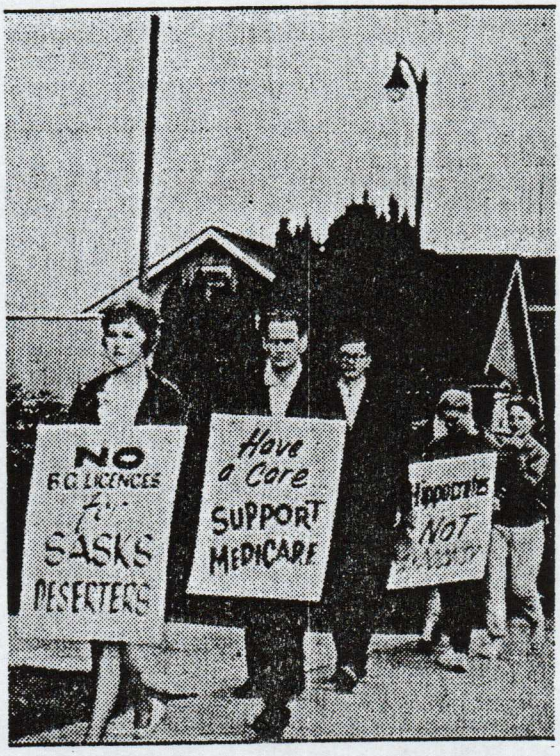
At issue in Saskatchewan was the intention of the CCF (Co-operative Commonwealth Federation) Government, led originally by Tommy Douglas and later by Woodrow Lloyd, to pioneer the first government-sponsored universal medical plan in North America. As early as 1944, Saskatchewan doctors had expressed concern that government health insurance programs might violate "our rights, our liberty, or our well being."

Eighteen years later, many of them remained unequivocally opposed to universal health care under governmental aegis, although existing private and physician-sponsored plans had left more than one-third of the population without health coverage. As The Globe and Mail predicted on June 21, 1962: "The battle being waged is merely the opening round in a war over government medical insurance which may spread to the entire continent."

The Saskatchewan physicians called their three-week work stoppage a "withdrawal of services," but everyone else called it a strike.

Lord Taylor, the British doctor and Labor peer who helped negotiate the end to the walkout, explained later that at the root of the doctors' opposition had been the fear that "they were to be forcibly enrolled as civil servants."

The strike, which began on July 1, 1962, did succeed in wringing some concessions from the Government, but not in preventing the establishment of a universal health-care scheme in Saskatchewan, nor indeed in the rest of Canada. When a federal royal commission on health services, under Mr. Justice Emmett Hall, presented its recommendations two years later, they were modelled closely on the Saskatchewan precedent. And contrary to the predictions of medical spokesmen and despite the early departures of some doctors from the province, within two years of the strike the physician/population ratio in Saskatchewan reached its highest level ever.



Moral reaction outside Saskatchewan to the unprecedented sight of doctors leaving patients unattended in the pursuit of political objectives was epitomized by Dr. Albert Sabin, discoverer of the oral polio vaccine. He called the strike "contrary to everything the practice of medicine stands for."

Nearly 20 years after Canada's first doctors' strike, the British Columbia Medical Association found itself embroiled in conflict with its provincial Government. Under the banner of individual liberty, the medical association fought what it feared would be a reduction of doctors to civil service status and campaigned in favor of extra-billing, which it raised to the level of moral principle. In a burst of rhetoric similar to the current Ontario debate, the president of the B.C. Medical Association, Dr. Alex Mandeville, likened the situation of B.C. doctors to that of the embattled workers of the Solidarity trade union in Poland.

During the course of fee negotiations for 1981, the BCMA suddenly announced that it would unilaterally introduce extra-billing. It sent packets to doctors' offices with information on how to apply for Visa and MasterCard usage, and offered medical practi-

tioners the services of consultants who would help institute extra-billing smoothly and efficiently. Thus did the BCMA attempt to present the Government with a *fait accompli* of extra-billing.

To its chagrin, the doctors learned that a government painted into a corner can batter the wall down and create its own exit. The B.C. Government promptly legislated a ban on extra-billing. Even today, the BCMA continues to fight a protracted court action against this legislation, but its members have not evinced much willingness to man the barricades in favor of extra-billing.

The Ontario Medical Association has used the spectre of the B.C. example to help stir its troops into the fray. The OMA, too, sees the banning of extra-billing as tantamount to giving "politicians total control over health care in Ontario." Dr. Edward Moran, general secretary of the OMA, has argued that recent government moves in British Columbia to limit the number of doctors by restricting the issuance of billing numbers is but a further example of how the banning of extra-billing is itself merely the thin edge of a wedge of government control.

Dr. Moran is apparently unaware of the irony of this argument. If making extra-billing illegal reduces doctors to the level of civil servants, why, five years later, must the B.C. Government strive to reduce the influx of doctors into the province?

B.C. doctors continue to practice autonomously and independently of any government control over such matters as where they practice, with whom they practice, what field of medicine they choose to pursue, how many and which patients they wish to treat, how much or how little they wish to work, when to take their vacations, when they elect to retire, or, if indeed, they wish to retire. No civil servant can claim such privileges.

The threat of government controls is no more likely to materialize in Ontario than it has in Saskatchewan or British Columbia — and the reputation of Ontario physicians may well become the principal casualty of the extra-billing conflict.

Ontario doctors could take as applying to themselves the words of Montreal's Le Devoir during the 1962 strike: "What the doctors of Saskatchewan win from the Legislature — if they win — they will pay for dearly in prestige and moral authority."

'The sick will be ones who suffer'

Toronto Sun, April 20, 1986

By ANITA ELASH
Staff Writer

Chaos will plague emergency wards and illnesses will go undiagnosed if doctors withdraw services, a group of physicians says.

"There is no way a strike action can do anything but hurt the patients," Dr. Gordon Guyatt, member of the Medical Reform Group of Ontario, said yesterday.

He made the statement after a nearly unanimous decision by the Ontario Medical Association council to withdraw services if necessary to protest against Bill 94, which would outlaw extra-billing by doctors.

Guyatt, whose association represents 160 doctors and medical students, said the danger to patients would depend on which services doctors withdraw.

If doctors closed their offices and offered only emergency services, patients and hospitals alike would suffer from the strain.

"People may have to wait for hours to see a doctor and under such circumstances doctors could make mistakes," Guyatt said.

However, physicians who voted in favor of the job action said patients would be protected since emergency wards would still be open to anyone who needed to see a doctor.

And emergency ward staff would probably be doubled, they said.

"The doctors who will back us up will be working twice as hard and twice as long to ensure no one will get hurt," said Dr. Ian Graham, a Toronto psychiatrist.

"Patients will get first-class care," said Dr. Marshall Redhill, chief of obstetrics at Scarboro Centenary Hospital. "They may have to sit with their sniffle for an hour or two. They'll be inconvenienced, but they will get looked after."

Doctors interviewed called government offers degrading and said they are convinced Premier David Peterson intends to push the law through during the legislative session that begins next week.

"They have made no serious offers. They have offered candies," Redhill said.

"We have no choice. This is the only way we'll get the government's attention."

MD remains at work; cites more serious challenge

BY ANN SILVERSIDES
The Globe and Mail

Dr. Michael Gordon is at work today.

The prominent geriatrician, who works at Toronto's Mount Sinai Hospital and the Baycrest Centre for the elderly, is a long-standing and active member of the Ontario Medical Association.

He believes that the province insulted the medical profession when it included fines of up to $10,000 in legislation introduced to ban extra-billing. Naming the proposed law the Health Care Accessibility Act was also an affront, since access to care is a much broader issue, he said.

But Dr. Gordon has chosen not to participate in the OMA's withdrawal of services today and tommorrow, a walkout that is part of a campaign to protest against the Ontario Government's plans.

"I do not feel that the end to extra-billing really threatens the medical profession," he said in an interview yesterday. "I'd have to be pushed much harder to take things out on my patients."

In his view, doctors will probably soon face extremely serious challenges to their professional independence. Their ability to face those hurdles, however, may well be diminished because they are "putting so much energy and vigor into fighting on the wrong issue."

Dr. Gordon's views are not unique among Ontario doctors. What is rare is that he expressed them publicly. Several others share his views, and, like him, are not members of the outspoken Medical Reform Group. But they will speak to reporters only off the record because of a perceived need to close ranks with the medical fraternity.

One other exception is Dr. Charles Hollenberg, vice-provost of health sciences at the University of Toronto medical school. Last month, Dr. Hollenberg publicly criticized the OMA for basing "the freedom of the profession on one funding tool," which can be abolished with a stroke of the Government's pen.

He further argued that the function of extra-billing is to increase the income of a "self-selected group of doctors," and not to protect professional freedom.

Dr. Gordon said the two-day walkout that begins today "is, in a sense, like an extended, unexpected weekend."

A group of doctors who are ambivalent about the extra-billing battle will probably not work today, he said. They will probably argue that cancelling elective surgery "is, at most, an inconvenience for patients, that such surgery is often cancelled out of necessity.

"But there can be a great deal of emotional inconvenience and anxiety for patients, say, for a woman scheduled to have a breast biopsy. . . . Doctors can say to themselves that cancellations happen all the time, but, the fact is, this is different, the cancellations are deliberate."

Dr. Gordon said he would have preferred if the OMA used negotiations over the proposed ban on extra-billing as a pivot to tackle issues that could seriously limit the control doctors now have over the practice of medicine.

"The truth of the matter is I do understand why so many of my colleagues feel so threatened that they are prepared to take an action they find abhorrent. . . . People are going along (with the walkout) because they think this is, perhaps, the last battle, like the Alamo. That they have to go to the wall."

But the OMA could have bargained a quid pro quo — it could have forfeited extra-billing in exchange for guarantees that the Government would not begin to dictate where doctors can practice and how many services they can perform, he said. (Doctors in some other parts of Canada are already subject to such limitations.)

"On issues like those, the support of the profession would have been much greater and more justified. . . . The public, too, might have seen these are professional issues, and not perceived the battle to be about money, which is what they think.

Dr. Michael Gordon

"Maybe, too, we could have worked something out about court cases and settlements, so we don't end up like the doctors in the United States who work under constant fear of lawsuits and have to practice defensive medicine."

The OMA also might have done well to negotiate so that family doctors receive a premium for caring for older patients, Dr. Gordon said, acknowledging his bias since he works with the elderly.

It takes considerably longer to diagnose and treat elderly patients, yet doctors are paid no more than for treating younger patients, he said.

It is not just the walkout that Dr. Gordon takes issue with. Calls from the OMA to delay the discharge of patients from hospital are irresponsible, he said.

"All of us constantly have to weigh the benefit of getting someone into hospital quickly, against any cost of discharge which might be, say, a day earlier than ideal. But you have to think of both patients. Hospitals are just not places where you can lie around until you feel terrific."

If he is defying the OMA by working today, Dr. Gordon is not doing so in a defiant fashion. "I may be wrong, of course. . . . Maybe I'll look back some day and decide that I missed the Alamo."

Globe and Mail,
May 29, 1986

Health News Briefs

IMPROVE ABORTION ACCESS, CCLA SAYS

If Ontario is to conform with the equality provisions of the Charter of Rights and Freedoms, it must improve access to therapeutic abortions, the Canadian Civil Liberties Association has told a committee of the Ontario Legislature. "Suppose the federal law prohibited gall bladder operations except when a certain committee approves them. And suppose those committees were confined to a few larger communities. The unacceptability of the situation becomes clear," CCLA general counsel Alan Borovoy said.
[Globe and Mail, Feb. 6, 1986]

PANEL FINDS ABORTION LAW IN CONTEMPT

In an attempt to turn the tables on the legal system, pro-choice groups have been convening a series of tribunals to judge Canada's abortion laws. A tribunal in Toronto, sponsored by the Ontario Coalition for Abortion Clinics, found Canada's abortion laws "in contempt of women". The tribunal heard from nine women who had direct experiences with the abortion system.[Toronto Star, March 3]

NEW CLINIC TO OPEN IN TORONTO

Despite government warnings of prosecution, Toronto abortionist Dr. Robert Scott is opening a second free-standing abortion clinic on Gerrard St. in Toronto, Dr. Scott previously worked at the Morgentaler clinic, and together with Dr. Morgentaler was acquitted of abortion-related charges last year. The province is appealing the acquittal.
[Globe and Mail, May 14, 1986]

POLICE ACCUSED OF HARASSING PATIENTS

Staff at the Morgentaler Clinic in Toronto have accused Metro Toronto Police of harassing patients who leave the clinic. Police admit that they follow and interrogate patients who leave the clinic, but maintain that this is necessary to obtain evidence. One of the doctors who works at the clinic told a news conference that police do not need evidence that abortions are being performed. "It is no secret abortions have been performed in our clinic," Dr. Nikki Colodny said. "I have been performing abortions there since January. I'm prepared to state that anywhere, any time." [Toronto Star, June 12, 1986]

LABOUR MINISTRY INSPECTORS BLAST SUPERIORS

Ontario's Ministry of Labour is allowing companies to get away with gross violations of health and safety laws that have led to deaths and injuries among workers, the ministry's own inspectors allege. Ministry officials turn a "blind eye" to outright contraventions of the Occupational Health and Safety Act and are "in consort" with employers, the inspectors say in a report obtained by the Toronto Star. Among the practices alleged in the report are "intentional thwarting" of prosecutions against employers; pressuring inspectors to rescind health and safety orders; inspectors being ordered to stop regular inspections of some workplaces; refusal to allocate sufficient resources to improve workplace inspections. "There is little encouragement from the ministry's administration to enforce the act vigorously. In fact, experience shows that inspectors are actually being discouraged by front-line managers and the legal branch from enforcing the act," the inspectors say in the report.
[Toronto Star, May 21, 1986]

Mock trial finds abortion laws unjust

BY ERIKA ROSENFELD
The Globe and Mail

Limited access to therapeutic abortions and long, health-threatening delays in obtaining them make Canadian abortion laws unacceptable, say proponents of free-standing abortion clinics.

Before a jury of politicians, students and abortion rights advocates at a mock trial Saturday, doctors, social workers and women who have had abortions in Canada described shortcomings in the law that legalizes abortion under limited conditions.

"We are here to put an end to the suffering, the humiliation and the pain caused by an unjust law," Sandi Ross, acting as a prosecutor, told an audience of about 500 people at the mock trial sponsored by the Ontario Coalition for Abortion Clinics.

Saying the law is "in contempt of women," she introduced witness after witness who said they had dealt with misogynistic hospital gynecologists, impersonal therapeutic abortion committees and long, arbitrary delays that resulted in more complex and risky abortion procedures than if they had been treated immediately. Several also said they had been required to pay before their abortions.

Dr. Nikki Colodny, who performs abortions at the Morgentaler clinic in Toronto, said Canadian abortion laws are criminal because they establish "a medical delivery system of abortion services that is unnecessarily dangerous.

"The law ... institutionalizes unsafe medical practices.

"Because of the committee system and the lack of reasonable access to abortion services, women in Canada wait an average of eight weeks between their first appointment and the procedure itself," she said, adding that the incidence of medical complications increases by at least 20 per cent for each week of delay.

Becaus of delays, Canada has the second-highest rate of mid-trimester abortions of all industrialized countries, she said, noting that mid-trimester abortions are more dangerous and more emotionally difficult than first-trimester abortions.

"All delays are more difficult emotionally and unsafe medically, yet delays are exactly the consequences of this unjust law."

Dr. Colodny said studies show clinic abortions to be safer than those performed in hospitals, because the clinics use superior equipment and techniques.

"We know that not using a general anesthetic lowers risk factors," she said, pointing out that hospitals use general anesthetics while clinics do not.

"The current abortion law treats women as if we were throwaways, disposables; our pain, our injuries, our well-being and our rights just don't count. This law perpetrates injury — physical and emotional injury — on the women of Canada and Quebec."

Susan Seagrove, in the role of the defence lawyer, described the Criminal Code's abortion provisions as "part of the very foundation of our society."

Many speakers called the law discriminatory, saying it denies women access to abortion on the basis of wealth, geography, race and education.

Juror and Metro Toronto councillor Jack Layton said both statements are probably true and that "the foundation of our society needs changing in some very fundamental ways.

"When I came to this jury this afternoon, I was already convinced that the law was unjust, but I now am absolutely convinced that this law is a crime."

In delivering his verdict, Dr. David Carr, a member of the therapeutic abortion committee at Chedoke-McMaster Hospital in Hamilton, said such committees present the only instance in which a woman has doctors who are not of her choice reviewing her private records and passing judgment on her health care.

"Therapeutic abortion clinics are quasi-judicial bodies run by people with no legal training, giving a medical decision on women with whom they have no professional relationship. These committees are an abomination.

'Doctors resist needed reform'

By KEN POLE

OTTAWA—Two York University researchers, Michael Stevenson and Paul Williams, say that doctors' "ideological resistance" to government intervention in the health-care system continues to constrain the need for basic reform of the system. They also suggest there's little government can do about it.

"The extent of this resistance is demonstrated by physicians' opposition to medicare in principle, their qualified approval of Canadian medicare programs in practice, their strong support for user pay and extra-billing and their resistance to regulation of the conditions of medical practice."

Their views, based on a survey of 2,087 randomly selected Canadian doctors, are contained in a report published in the latest issue of *Canadian Public Policy*, a monthly publication edited by Anthony Scott at the University of British Columbia's economics department but whose editorial board is a blue-chip national cross-section of the economics community. The survey was underwritten by a grant from Health and Welfare Canada.

Stevenson and Williams, with the department of political science and Institute for Social Research at the Toronto university, say the perceived ideological constraint on reform stems from doctors' complaints about health-care bureaucracies. "Only a minority of physicians have serious complaints," they say, but "the frequency of such complaints is very strongly associated with the intensity of opposition to medicare." They contend that the complaints take on a greater significance—when seen "through the lens of medical ideology"—than most doctors might feel is warranted.

Continued...

...:Continued

Complaint

They say although this kind of complaint might prompt bureaucracy to streamline its administration, it is doubtful whether this would reduce the profession's opposition to government control of health insurance. "In the same way, there is little guarantee that increases by governments in insured fee schedules would do anything to dispel the widely held perception of physicians that they are 'losing ground' economically if, as our analysis suggests, this perception reflects concern not just about absolute income levels but about government restrictions on the right of physicians to determine them."

Stevenson and Williams explain that some aspects of their survey indicate doctors do come around "at least to some degree" on government policies they initially oppose. They cite a less militant extra-billing posture of doctors in British Columbia and Quebec, where the practice is prohibited. This leads them to conclude doctors' opposition to the Act logically should diminish once they adapt to the legislation or rearrange their workload. The growing number of doctors in salaried or institutional practice might help to moderate opposition.

"It should be clear," they add, "that these findings and speculations only qualify, and do not substantially alter, the strength of the fundamental professional consensus against government involvement in the health-care field. Given this . . . it seems unlikely that governments can produce any substantial prospects for reform of medicare which will not be resisted by the medical profession."

They also warn that the profession's insistence on autonomy, pitted against fiscal and public pressure for rationalization of the system, leaves policy-makers little room to manoeuvre.

Drug industry warns new bill could cost Ontario 2,000 jobs

February 21, 1986

By Denise Harrington
Toronto Star

Ontario could lose 2,000 drug research and manufacturing jobs if the province does not change proposed legislation that would cut costs to a drug plan for seniors and welfare recipients, industry officials say.

Legislation, which would make pharmacists substitute cheaper generic drugs for higher-priced brand name drugs under the plan, would save the government money, spokesmen for the Pharmaceutical Manufacturers Association of Canada said yesterday.

But it would be at the expense of companies that create jobs here.

Stuart Alexander, chairman of the association's Ontario committee, predicted "a very definite brain drain" of highly-educated researchers from Ontario to the U.S. unless the legislation, now before a legislative committee, is changed.

Patent changes

Some 43 companies in Ontario spend millions on drug research and innovation, he told a news conference. But the legislation is giving business "to the companies that are not paying taxes and not employing people."

The association wants changes in federal patent laws that now let some companies produce generic versions of drugs within a few years of other companies spending millions of dollars to develop the original product.

Generic companies, without the research expenses, can sell the drugs much more cheaply and could drive innovative manufacturers out of business because of the preferential treatment, Alexander said.

"Let's not have the provincial government jumping on the bandwagon just because of some bad federal legislation.

"This legislation is going to take away the opportunity for jobs and the opportunity for industry in the province of Ontario."

Syntex Inc. president Howard Jeffery told reporters his company spent $100 million developing an anti-arthritic drug called Naprosyn. In the 10 years it has been on the market, a generic version, developed for $50,000, has matched its sales.

The Liberals proposed the legislation last fall to eliminate "price spreading" in the Ontario Drug Benefit Plan, which reimburses pharmacists for dispensing prescriptions free to seniors and welfare recipients.

The government now pays pharmacists a dispensing fee and a wholesale price for the drug quoted to the province by the manufacturer. But manufacturers were actually charging pharmacists substantially discounted prices — as much as $19 million less than the province reimbursed, Health Minister Murray Elston claimed.

Won't work

Yesterday, association officials said the government's intention was good but would not eliminate the price spread. The government intends to set its own price list by monitoring company records and prices in other provinces.

But as soon as it sets a price, a company will charge a lower one and price speading will start again, said Lester Gagnon, president of McNeil Pharmaceuticals Canada Ltd.

The preference for generic brands shown in the legislation will give away $200 million to two major generic manufacturers, he added.

"It's like handing it to them on a silver platter," Gagnon said.

Choice's new face

By SUSAN G. COLE

When physician Nikki Colodny decided to perform abortions at the Morgentaler clinic, she knew she had made a decision that might put her career and personal safety in serious jeopardy. Now the gravity of her decision has hit home — literally. Since last week, anti-choice pickets have staked out territory outside her house in Riverdale, harassing her household, including her two children who have to navigate the lines to get into their own home.

The neighbours have been affected too, but according to Colodny, they have been wholly supportive. "I've received notes that have said specifically 'keep on going,' 'don't stop what you're doing.' So if the anti-choice pickets thought they were going to pit the neighbours against me, they haven't succeeded."

For the first female physician to court national notoriety via the route of the intrepid Henry Morgentaler, a little noise and confusion even in the front yard isn't likely to be intimidating. But while anti-choice arrows have a new target, feminists are riding high on Colodny's boldness. Her breeze into the operating room at the hounded and harassed clinic feels like movement magic, and it's brushing fresh energy and enthusiasm into a pro-choice campaign bogged in legal intricacies. Already the changes are showing - from the re-casting of the clinic's structure to the upscale tempo of the new pro-choice political offensive.

Story stream

"I went into medicine to provide a service," Colodny says. "I knew the situation was grim, but when I got there and heard the stream of stories, I felt it was grimmer still and I just had to speak out."

When she does, she is thoughtful and absolutely effective. She doesn't come across as a romantic and furious radical, just a committed one. She has the important facility of remaining open, in spite of her strongly held views, so when people talk, she listens. When she listens to clinic patients, she doesn't like what she hears.

"Young women, 17 and 18 years old, are so afraid to tell their parents that they're pregnant," she says. "One woman felt so relieved after her procedure and, remember, she had to get through the pickets outside the clinic. This woman had cut herself on the inside of her thigh so that her mother would think she was menstruating. You can see how fear can turn to self-mutilation."

Colodny's decision to become involved with the clinic was no doubt aided by her family's activist background. All four of her grandparents were involved in the union movement of the 20s and 30s. Her merging of her medical and feminist political practice is helping to re-style clinic life. The staff is more closely involved in decision-making and has made a point of trying to network with other community health groups to avoid the clinic's isolation from other services. The Ontario Coalition for Abortion Clinics (OCAC), which spawned the clinic, now has a strong bond with organized midwives and the coalition has had a high profile participation in the extra billing battle. There are also plans to establish a board of directors with membership from the community so that the clinic can be situated within the context of a large progressive movement.

Outside the clinic, Colodny works furiously to get more doctors involved in pro-choice activities. To that end, she is helping to organize the annual meeting of the Canadian Abortion Rights Action League scheduled for this Saturday (May 3) at Ryerson. The meeting - open to all CARAL members and pro-choice supporters - features the ubiquitous Henry Morgentaler in the morning and in the afternoon Kate Michaelman, executive director of the (U.S.) National Abortion Rights Action League (NARAL). Last March, NARAL sponsored the huge demonstration in Washington for reproductive freedom, in which 500,000 pro-choice Americans and at least one Canadian, Colodny, participated.

Involving doctors

But the key for Colodny is the late afternoon session, which includes a panel of physicians for choice from all over the country. Doctors Pat Smith from Hamilton, Sally Mahood from Regina and Lucie Lemieux from Quebec will be there, and Colodny is very pleased about it. "It's important for the public to perceive that there is more than one doctor willing to take the risk. Even the medical journals are discussing the problems women are having when they don't have access to abortion."

"In my case, it's not only one more doctor, it's a feminist doctor. There has always been a contradiction there when men speak for women's reproductive rights; I'm a feminist doctor and another spokesperson for the movement. Women tell me it is very empowering to see a woman challenging the male protective syndrome."

If Colodny and the members of CARAL and OCAC can take the focus off Morgentaler by making it plain that other doctors are prepared to stand up for women's reproductive rights, it's more likely that the rest of the tired pro-choice movement will be ready to stand with them for a few more rounds.

Last month, when the courts heard arguments from the crown and from Morgentaler's lawyer as to whether the second charge laid against Morgentaler in Toronto ought to proceed, the judge said no, he'd wait for the Supreme Court decision on the earlier charge. After the session, attorney general Ian Scott told anti-choice protesters the crown was "prepared to proceed." His decision to talk to the pickets and the fact that Morgentaler has already been acquitted four times in this country indicate that the court cases could drag on for years.

"The clinic was opened to provide women with the medical services they needed, not to take the issue into court," Colodny says. "The fact that the clinic has been operating for 15 months is more than we could have hoped for. But all of these court actions demobilize the movement and we have to attend to the health of the coalition and the movement to keep the clinic safe."

Coalition health

In other words, now that the clinic is still open, and in spite of the continuing court battles, politics and political organizing are more important than ever. Both CARAL and OCAC have sprung into action

to galvanize the political support required for the movement's - and women's - safety. CARAL, for example, sponsored a series of tribunals in Canadian cities over the winter and early spring. The bottom line in most of the testimony was that women suffer deeply because of a discriminatory - "criminal," Colodny calls it - abortion law.

The tribunals spanned from Vancouver to Halifax, creating a national presence for pro-choice forces. OCAC is also determined to hammer out and participate in a national strategy and is going full-tilt to connect with a burgeoning coalition for reproductive freedom in Quebec. The Quebec coalition for Abortion on Demand - consisting of over 100 organizations - is laying the political groundwork designed to make it impossible for the new Liberal government to enforce the abortion law. Plans are underway for a major political action for the fall, possibly in Ottawa, that will combine the forces of both the Ontario and Quebec coalitions.

"We're only as safe as long as the movement is strong," Colodny warns. "It's a process thing, not a finished product."

This doctor supports ban and refuses to stop working

By PAUL BENEDETTI
The Spectator

THERE IS a sign in Dr. Mark Cornfield's office that reads, "We are not on strike. We support the ban on extra-billing."

He worked yesterday and he will work today. And if there is another strike he will work through it.

"There was never any question that I would go on strike," said Dr. Cornfield from his King Street East office.

For him the choice was clear and he did not waver. He has always supported the ban on extra billing.

"I know I'm out of step with the majority of my colleagues," said the 40-year-old McMaster University Medical School graduate.

He's not sure how other doctors feel about him and he doesn't feel like a strike-breaker. He said he can only imagine what other people think about his stand, but he does not feel any pressure from fellow doctors.

No pressure

"No, the only pressure is entirely an imagining of what people are saying," he said.

"I can only speak for my side, but I frankly don't resent the people on strike. I don't feel any rift with them."

Although a member of the Medical Reform Group — a group that opposes the strike — Dr. Cornfield says he has never been a high-profile member and has not had to deal with criticism from his peers. "I don't feel threatened by other doctors."

The striking doctors are good doctors and good people, he said, but Dr. Cornfield said he cannot accept the Ontario Medical Association's stance on the issue.

"They (the OMA) see it as an issue of freedom. I see it as an issue of power," he said. He said he feels the extra-billing issue is being used by the OMA as a "bargaining chip" in their dealings with the provincial government, but he wishes they had chosen a different chip — one that doesn't harm anyone.

Concerned

His resistance to what he terms "the party line" may make him a radical in some doctors' eyes, but he doesn't consider himself one.

"I think that in medicine it is very easy to be left wing. If you grow a beard and take off your tie, you're a radical," he said. "It's such a conservative group, it's easy to be a radical."

Dr. Cornfield said there should have been more open debate on the issue, more alternatives considered, before the OMA established a policy position. "I guess I just wish that either they had chosen a different route, or polled their members more ..."

In his own practice, Dr. Cornfield has not allowed the issue to come between him and his patients.

Not appropriate

"I do not raise it — I feel it's not appropriate," he said. He feels the strike will not in itself harm doctor-patient relationships, but, "It tarnishes their image in the eyes of the public," he said, and eventually, along with other problems, will contribute to "a souring of the view of doctors."

Despite this, he feels most patients like their own doctor, whatever their view of the profession as a whole.

How would he like the dispute settled? "They (the OMA) have backed themselves into a corner and need to find a way out. I'd like the OMA leadership to cut their losses ... and really look at how doctors can use their power to protect their own position and use it for the good of the people of Ontario."

16

NESTLINGS

Doctor criticizes OMA for extra-billing stand

Globe and Mail April 9/86

By ANN SILVERSIDES
Globe and Mail

Extra-billing is designed to increase the income of a self-selected group of doctors, not to protect professional freedom, the vice-provost of health sciences at the University of Toronto's medical school said last night.

Dr. Charles Hollenberg told more than 200 people at a panel discussion on medicine and the state that the Ontario Medical Association has chosen to fight the province "very publicly on the very slender reed of extra-billing."

He told the audience, mostly made up of doctors, that he would have more respect for the OMA if it were to address the practical concerns about some of the health care issues it has identified.

The OMA would have been far better advised over the years to look at its fee schedule and make changes to reward and encourage doctors who work with the elderly and the disabled, said Dr. Hollenberg, who is also director of the Banting and Best Diabetes Centre in Toronto.

"We have to look at the needs on our doorstep . . . the unmet needs of the community," he said during the discussion, which was sponsored by Wellesley Hospital.

Fellow panelist Dr. Hugh Scully, chairman of the OMA board, acknowledged that the OMA has not done much to reward those who work with the elderly, but argued it is not the OMA alone that is responsible for such policy changes.

The OMA is actively working on key health issues, Dr. Scully argued. Dr. Hollenberg replied: "I'm sure members of the profession are working assiduously. I'm not so sure about the executive of the association."

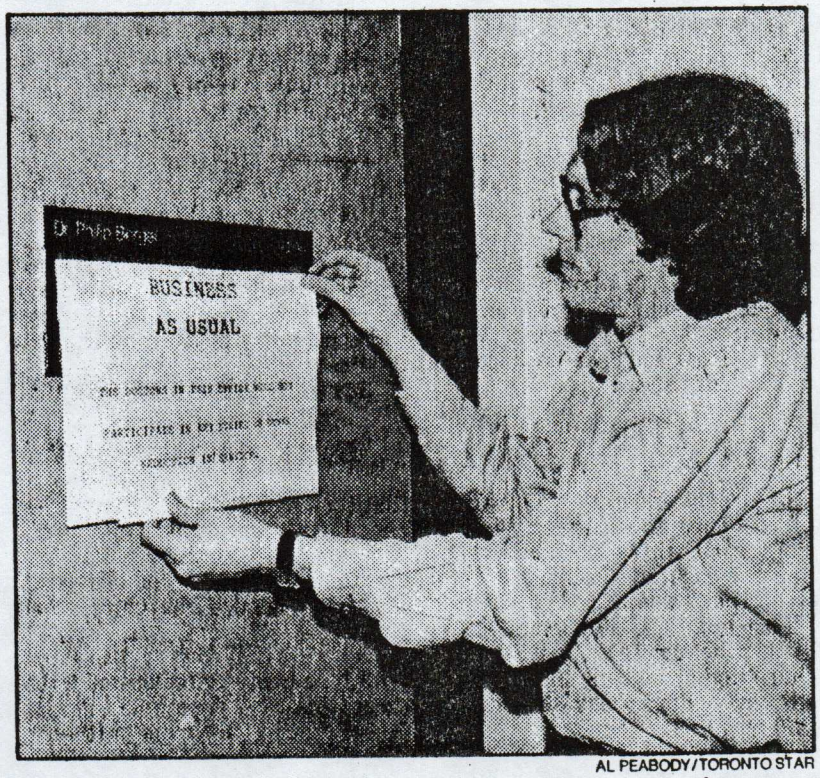
The third panelist was Health Minister Murray Elston, who sat silently through the exchange between the two doctors.

The whole energies of the OMA have become wrapped up in the extra-billing issue and the association has chosen to "base the freedom of the profession on one funding tool," Dr. Hollenberg told reporters after the panel.

He said it will take only "one stroke of the pen" by the province to abolish extra-billing.

Dr. Hollenberg also told the audience that he strongly disagrees with the OMA's strategy of trying to win patients over to the association's view on extra-billing.

If a doctor wants to deliver a political lecture, he should rent a church basement, Dr. Hollenberg told reporters. "A patient comes to a doctor to get medical help," he said, the patient should not be brought into a fight between the medical profession and the Government.



AL PEABODY/TORONTO STAR

The other side: Dr. Philip Berger's sign at his office on Parliament St. represents the dissenting view among doctors. He says support for the association's strike "is collapsing."

Toronto Star, June 12, 1986

THE BURLINGTON POST May 28, 1986

Reformers question OMA tactics

By ALEX MATHESON

The 'worst' in a series of 'ethically questionable tactics' recommended by the Ontario Medical Association is the way a Hamilton physician describes the recent call to keep patients in hospital longer.

Dr. Gordon Guyatt, a member of the steering committee of the Reform Group of Physicians, said that the recommendation is coming under the term practising 'ideal medicine'.

"I have never discharged a patient from hospital prematurely and I don't know of any other physicians in Hamilton who have," said Dr. Guyatt.

If patients are now kept in hospital longer, he said, they will wonder whether it is for political or health reasons. It will damage the trust physicians have had and all will be 'tarred with the same brush' whether they kept patients in longer or not, he suggested.

In addition, he said this tactic can jeopardize the health of patients. Risk of catching further infection in hospitals is significant and the the longer the stay the greater the risk, he said. This 'iatrogenic illness', he said, is illness due to medical intervention.

Not only is it cost-ineffective to keep people in hospital as long as possible, they are also healthier and happier out of the institution, said Guyatt.

But Lynne Beckett, communications co-ordinator with the OMA, said physicians have been feeling uncomfortable about letting patients out a day earlier than they would like.

Keeping them in a day longer, she said, is in the interests of 'ideal medicine'. By following this course, she said, physicians are saying they will not cover up for underfunding of the health system in the province.

Beckett said the physicians have been practising responsible medicine, but would like to allow a

see HEALTH pg. 13

Health considerations

continued from pg. 1

day longer in hospital. They will "stop shaving the margin of safety when it comes to discharging a patient," she said.

She said it has been a constant problem to get people into hospital, but denied that keeping patients in hospital would compound the problem of backlog.

The practice of keeping patients in longer "is not going to make any difference to this backlog," Beckett said. She said she doesn't know why 'ideal medicine' was not practised in the past if it didn't affect backlog to get a bed in the hospital.

Physicians, said Beckett, have been trying to make "all kinds of accommodations in the past and have put missing links in the system where there were not enough to make it work. They won't work around them anymore," she added.

However, she said: "It has nothing to do with money in their pockets."

She said it is irresponsible to suggest that political decisions and not health considerations would be paramount in determining a length of stay in hospital. "Accountability is at the top of the list", she pointed out.

Dr. Tom Dixon, a member of the OMA board of directors and a member of its political committee, said the backlog to get into hospital will increase as a result of physicians' actions.

However, he said it will not be allowed to affect those needing emergency treatment. Those wishing elective surgery will have to wait longer, he added.

Dr. Dixon said that using this as a sanction will hurt patients, but no emergency patient will be jeopardized.

Physicians are at a disadvantage in conducting labor activities because patients are at the centre, he said.

He conceded that this action of keeping patients in hospital longer has the potential for a loss of trust. Patients, he added, don't know when they should be going home.

Doctor opposed to strike says it 'victimized' one patient

By KEVIN VON APPEN
EMILIA CASELLA AND
LOUIS SMIRLIS

A LABORER who needs surgery to repair his collapsed hip has been victimized by the Ontario doctors' strike against the ban on extra billing, his Hamilton doctor says.

Dr. Dave Ludwin, who opposes the strike, said yesterday the laborer waited two weeks in hospital for the surgery, only to have his operation cancelled by the doctors' job action. "He has some pain and this will also affect his abillity to get back to his job," said Dr. Ludwin, director of the renal transplant unit at St. Joseph's Hospital and McMaster University Medical Centre.

"He's definitely affected by (the strike). Is his health affected? No. Is he inconvenienced? Yes."

As the doctors' strike entered its second day, about two-thirds of routine elective surgery across the city had been cancelled, according to a "very rough estimate" by Dr. Donald Rosenthal, vice-president of the Hamilton Academy of Medicine.

Most of those operations will be rescheduled within the next two weeks, says Dr. Earl Meyers, president of the 17,000-member Ontario Medical Association.

But Dr. Ludwin says in the case of his patient — a 28-year-old Niagara Peninsula resident whose hip collapsed as a result of side effects from a drug — rescheduling the four-hour operation may take months.

He said that kind of elective surgery at the best of times takes four to five months to book.

The man was brought in on a "semi-emergency basis" for a two-week hospital stay to speed up the booking, Dr. Ludwin said. When the operation was cancelled, the patient was sent home.

"He's very upset, but fatalistic," said Dr. Ludwin, who declined to reveal the name of the patient, or the surgeon involved. "As he said to me, what can you do?"

Area emergency wards stayed quiet yesterday, but how many doctors are supporting the strike was unknown.

Officials of the Hamilton Academy of Medicine estimated support among their 850 members at 60 to 70 per cent, but said they would not be polling the doctors.

A random and unscientific telephone poll taken by The Hamilton Spectator showed that of 25 doctors polled, 15 were on strike and 10 were seeing patients as usual.

Whether patients can renew prescriptions today depends on their doctor, said Dorothy Cooper, office manager at the Wilson Medical Centre, who said some doctors at the centre would do it and some would not.

Dr. Gordon Guyatt of the Medical Reform Group, which opposes the strike, said every member of the department of family practice at McMaster University Medical Centre and every member of the department of medicine at McMaster — except for Dr. Rosenthal — stayed on the job yesterday.

"There is a great deal of disillusionment with the OMA," Dr. Guyatt said. "If they go further with a longer strike, there would be increasing damage to the patients and real problems with increasing distrust of the medical profession."

Dr. Ned Gagic, president of the academy, noted the usual daily load of 60 to 70 operations at Henderson General Hospital had been cut to 15 and the dozen doctors of the Mountain Medical Centre were off.

Hamilton Spectator
May 30, 1986

David Ludwin is a member of the MRG.

MEDICAL REFORM GROUP

Resolution approved at Semi-annual meeting May 3rd 1986

WHEREAS the aggressive marketing in developing countries of ineffective overpriced and even contra-indicated drugs has been clearly documented and is a major constraint on the provision of appropriate primary care

AND the World Health Organisation has been addressing concerns about the marketing of various substances (including infant formula, pharmaceuticals and tobacco), has adopted an International Code of Marketing of Breast Milk Substitutes and is now considering guidelines for pharmaceutical marketing in line with their rational use of drugs programme and the adoption of limited drug lists

AND the medical and pharmaceutical professions in Canada lack the resources, including independent sources of information for the rational use of pharmaceuticals, appliances and other industrial products, leading to frequent irrational prescribing

AND governments have an obligation to ensure the appropriate allocation of resources within the health care system

BE IT THEREFORE RESOLVED THAT

The Medical Reform Group calls upon the Government of Canada to actively support a program for the rational use of pharmaceuticals by the World Health Organisation and take steps to implement it within Canada and expresses its support for programs and legislation in other countries that support this aim.

All levels of government in Canada actively implement decisions of the World Health Organisation that will lead to the above aims, noting in particular the Code of Marketing of Breast Milk Substitutes.

The medical and pharmaceutical professions co-operate in ensuring that treatment is rational and that there are no inherent conflicts of interest through marketing and promotion. In particular :

i. Drug treatment be based on a consensus of expert opinion.

ii. Substantial restrictions be placed on pharmaceutical advertising, only allowing objective information including price, comparative indications and toxicities etc.

iii. Sources of funding independent of industry be developed for information on prescribing.

Medical Reform Group of Ontario

P.O. Box 366, Stn. J
Toronto, Ontario M4J 4Y8
(416) 920-4513

The following is a summary of the brief presented by the Medical Reform Group to the Legislature Standing Committee on Social Development on Bill 94, on March 4, 1986

The Medical Reform Group supports bill 94 which would ban physician extra billing. The group is convinced that extra billing does compromise accessibility to our health care system. Numerous studies have shown that the most vulnerable people in our society, the poor and the elderly decrease their utilization of medical services in response to small user charges. These studies also demonstrate that these people are extra billed by Ontario physicians.

The Ontario Medical Association has expounded a number of incorrect arguments in their opposition to the proposed legislation. In summary:

*The OMA, not the government, is largely responsible for the OHIP fee schedule failure to reward excellence or experience.

*There is no evidence that opted out doctors are better physicians.

*There is evidence that there is little difference in practice styles between opted in and opted out doctors.

*It is very unlikely there will be an exodus of physicians after the legislature passes bill 94.

*Bill 94 will not make doctors into civil servants. Opted in doctors will continue to have clinical freedom.

*Public opinion massively supports an end to extra billing.

*The legislation will not directly lead to capping of incomes, restrictions of OHIP billing numbers, or controls on utilization. However, these are possible responses to legitimate problems affecting the health care system and the OMA should develop meaningful alternatives if they wish to avoid these "blunt" policy instruments.

*Physicians will continue to have effective bargaining tools without extra billing.

The Medical Reform Group acknowledges that a ban on extra billing infringes on the economic rights of physicians but feels that this must be judged against the rights of the public to access to health services without financial barriers. Also, the other economic benefits which society confers on physicians must be recognized. There are many characteristics of the health care system which make it unlike any other market. In fact most Canadian health care economists have pointed out that our health system should not be analyzed only in traditional economic terms.

There are many other pressing issues affecting the health care system. The Ontario Medical Association has claimed that bill 94 is a "smokescreen" for the real issue which is underfunding of the system. The Medical Reform Group reaffirms that extra billing is a real issue that affects hundreds of people every day. The group also points out the Canadian Medical Association Task Force on Funding which reported in 1984 found no evidence of overall underfunding of the system.

Recommendations

1. The government and the OMA should develop a fair fee negotiation process. This should involve a grievance procedure which would cover all issues related to physician remuneration including income capping and utilization restrictions. There should be provision for binding arbitration with a ban on a legislative veto.

2. The government should establish a Royal Commission on the financing of the health care system. It should provide facilities and funds for the public and non-profit organizations to become involved in the process. The commisssion should investigate alternatives to traditional delivery systems such as community health centres, and health service organizations. It should also examine the distribution of physicians and resources.

3. The government should take some simple steps to make medical practice easier. Plastic OHIP cards would facilitate the completion of forms. The Province of Quebec has provided these for a number of years. Better public information on health service organizations would make it easier for physicians who wish to pursue this alternative.

4. Bill 94 should be amended so that patients should not have to pay an opted out physician until he or she is reimbursed by OHIP.

EXTRA BILLING

The following background paper on extra billing was written by MRG Steering Committee member Dr. Gordon Guyatt.

One of the most controversial issues in health care in Canada today is whether physicians should be allowed to charge their patients more than is covered by the provincial health insurance plan--in Ontario, the Ontario Health Insurance Plan, or OHIP. Controversy over extra-billing has reached a fever pitch in Ontario with the introduction of the Health Care Accessibility Act and the OMA's frenzied opposition to the legislation. To understand this issue requires some knowledge of how the problem developed in the first place, and I shall briefly review the story.

When the national health insurance program was introduced in 1969 the requirement for provincial participation (and thus eligibility for federal transfer payments) included making the plan available to all provincial residents on uniform terms and conditions (universality) with reasonable access to insured services. All provinces eventually joined the plan, and all set up schedules of reimbursement for physician services. One difficulty facing the provinces was how to deal with physicians who did not want to participate in the plan, or who were dissatisfied with the stipulated fee schedule. The provinces addressed the problem quite differently. Quebec constructed its plan to prevent physicians from charging patients more than the provincial plan would reimburse. In Quebec any physician who is part of the plan cannot charge more than the stipulated fee, and if a physician is not in the plan and extra bills then neither physician nor patient gets reimbursed for the physician services. That is, if a patient visits an opted out physician who extra bills that patient must pay the entire fee with no help from the provincial government. Such a situation is unacceptable to most patients, and as a result there are virtually no opted out physicians in Quebec.

At the other extreme is Alberta which allows what is called balance billing. Physicians obtain reimbursement from the provincial insurance fund irrespective of what they charge patients, and are permitted to obtain as much extra money from patients as they like. Between these two options is the Ontario situation (prior to the passage of the Health Care Accessibility Act). While balance billing is not permitted, physicians can opt out. If they do, they are not permitted to charge OHIP; rather, they charge the patient, who pays them directly. The patient, however, can then obtain reimbursement equal to the OHIP fee for whatever service or procedure was performed. This half-way measure makes opting out administratively more difficult for the physician than Alberta's policy of balance billing (and, to the extent that it involves more cash on the table, more difficult for the patient as well).

For the first several years after OHIP was introduced the OHIP schedule of fees (which stipulates what doctors get paid for any individual service) was set at 90% of the value of the Ontario Medical Association fee schedule. The only opted out physicians were those who objected to the principle of the national health insurance plan. However, by 1978 the Ontario Medical Association (OMA) was no longer satisfied with the outcome of its negotiations with the government and since that time the OMA fee schedule has been higher than the OHIP schedule (now approximately 25 to 30% higher than the OHIP version). Approximately 12% of Ontario physicians are presently opted out, and most charge at OMA rates (although they are permitted to charge even more if they wish to).

The federal government saw opting out, and other forms of user fees (that is, fees that are paid by people who are ill in addition to the taxes and premiums they pay for their health care) as a threat to our national health care system. The basic premise of our system, the reason it was set up in the first place, is to guarantee high quality medical care to all citizens irrespective of their ability to pay. User fees clearly undermine this principle. In response to the threat, the late Liberal government introduced the Canada Health Act which, in 1984, was passed by a unanimous vote in the federal parliament.

Constitutionally, health is a provincial matter. Therefore, the federal government is limited in how it can intervene in this area. Because of this, the only way the federal government could exert pressure on the provinces to deal with user fees was to penalize them financially. Thus, the Canada Health Act stipulates that for every dollar of user fees charged to provincial residents the federal government will withhold a dollar of the transfer payments that would otherwise be given to the province to pay their health costs. In Ontario, this amounts to approximately 50 million dollars a year, almost all resulting from extra fees charged by opted out physicians.

The provincial government was thus faced with a major dilemma: do something to stop opting out, or forfeit 50 million dollars, money which then needs to be raised in other ways. The government has chosen to end extra-billing, and thus regain the full transfer payments from Ottawa. In doing so, however, they have brought down upon themselves the wrath of a substantial proportion of Ontario's physicians.

The advocates of extra-billing raise two major sorts of arguments. The first is that opting out, because of its economic effects, is actually beneficial. The second is that banning opting out would be an infringement on the rights of the medical profession. I shall examine these arguments in turn.

Under the present system of unimpeded access, it is argued, patients make unnecessary visits to the doctor, resulting in extra costs to the system which could be avoided. By instituting user fees such as opting out one deters these unnecessary visits and lowers health care costs. Given the present magnitude of health costs, which almost everyone agrees is a problem, it seems only sensible to lower costs if one can do so without having medical care suffer. User fees, according to this argument, are a sensible way of helping to bring runaway medical costs under control.

The first question that one might ask when examining this argument is whether user fees such as opting out actually deter utilization. The answer is yes, they do. Evidence for this comes from a number of sources. In April, 1968 in Saskatchewan, the newly elected government of Ross Thatcher (yes, if you're wondering, father of the politician who gained infamy by murdering his ex-wife) which had recently defeated the New Democrats, introduced a program of user fees. It turned out that this resulted in certain groups making fewer trips to the doctors. Who these groups were is a matter we will return to subsequently.

A second major source of information about the effects of user fees on health care utilization comes from a large study conducted in the United States by the Rand Corporation. In this study people were randomized to

receive different levels of co-insurance. Some had all their costs covered, some had to pay a portion of their health costs, others had to pay almost the whole thing. The result of this study was that the more you had to pay, the less services you used. So far, then, the data appears to support those who would argue in favour of user fees and opting out.

The data changes, however, when one examines the pattern of total costs rather than just physician utilization by groups who respond to financial deterrents. In Saskatchewan, though the poor and elderly decreased their utilization by 18%, the total amount of physician services used was identical before and after the introduction of user fees. This was because the amount of services used by younger, higher income people actually increased after user fees were introduced. This finding is not surprising when one considers that a substantial proportion of patient visits are initiated by the physician and not the patient (things like the number of followup appointments after an episode of illness such as a urinary tract infection or a pneumonia, the frequency with which a chronic illness such as high blood pressure is monitored, or the number of pre-term visits during a pregnancy, are all determined primarily by the physician). It appears that Saskatchewan physicians responded to the decrease in visits by the poor and elderly by increasing the number of physician-initiated visits for the more affluent.

Another point that should be kept in mind when one considers cost is that we are trying to decrease total expenditures on health, not just expenditures in the public sector. To decrease total costs the decreased utilization as a result of opting out would have to begin by compensating for the increased cost of each individual visit. For example, the OMA fee schedule is 30% higher than OHIP's. For health care costs to simply break even patient visits would have to decrease by 30% in a system in which extra-billing was universal. It is almost certain, then, that total health care costs are actually increased as a result of physicians' extra-billing.

The fact that allowing user fees isn't likely to decrease health costs for the society as a whole is brought home in a striking way when one looks at the United States. There user fees are widespread, and the poor and indigent do indeed use less services as a result. However, while Canada spends about 8.5% of its gross national product on health, the United States uses over 10.5%, both because individual services cost more and because of increased utilization by the affluent.

In summary, it is clear that the argument that money will be saved through opting out and other user fees is bogus.

Perhaps because of the failure of the evidence to sustain the argument that opting out can decrease health costs the Canadian Medical Association (CMA) has turned to an alternative economic argument. They contend that the health system in Canada is underfunded and that user fees, and extra-billing in particular, should be used to generate additional income for health care. It is obvious from the start that this argument is exactly the opposite of the first; opting out clearly cannot save money and increase funds for the health care system at the same time. Nevertheless, it is not unusual to see two different spokesmen for organized medicine (if not the same individual) bringing forth both arguments to bolster their views. This suggests that the real motive for advocating opting out is neither to save money nor to generate additional money for an underfunded system, but to supplement physician incomes.

Indeed, this hypothesis about the true motivation receives further support when one examines the underfunding issue more closely. Determining the amount of health services that are appropriate is a difficult issue. Certainly, in urban Ontario centres situations arise in which all the beds in a hospital are full and patients require transfer to another hospital.

A substantial number of hospital medical beds are filled by patients waiting to be placed in more appropriate nursing home or chronic care beds which are simply not available. Whether these situations represent underfunding or inefficient use of resources is a moot point. What is relevant is that extra-billing will not result in a single additional hospital, or nursing home, or chronic care bed; in fact, it will not expand health services in any way whatsoever. Rather, services will remain more or less identical, and physician incomes will rise. When examined in this light the underfunding argument is revealed as simply another attempt to dress the true motivation, increasing physician incomes, in more attractive garb.

So much for the economic arguments supporting opting out. I would now like to turn to the second major sort of argument adduced by advocates of extra-billing: these have to do with the consequences of banning extra-billing not on the public or the economy, but on the medical profession. Ontario physicians have contended that abolishing extra-billing will end the only available method of rewarding excellence in physicians. This contention raises the image of a small number of physicians in each area or specialty, chosen by their colleagues, who are allowed to extra-bill. The reality is very different. It is the physician himself who decides to opt out; he doesn't have to ask his colleagues' permission. Opting out is heavily concentrated in certain specialties: psychiatry, obstetrics and gynaecology, orthopedics, and anaesthesiology, and in certain geographic areas. It is not true, for example, that all the psychiatrists in Toronto (the majority of whom extra-bill) are superb physicians, while all the general practitioners and specialists in internal medicine (almost all of whom are opted in) are a mediocre lot. Rather, the psychiatrists (including the junior and the less skilled) are responding to an economic milieu that allows them to get away with extra-billing.

What qualifications are required to opt out and extra-bill? Any doctor, however junior, however questionable his reputation among his colleagues, can extra-bill. The only requirement is a willingness to risk imposing a financial burden on one's patients. Top quality physicians who believe in universal access to health care without financial disincentives will not extra-bill.

As it turns out, most of the very best Ontario physicians--those who are chosen to teach medical students and physicians in training, and who have international reputations--are members of medical faculties, and full time university employees. These physicians do not extra-bill.

It is clear that extra-billing is not a mechanism for rewarding excellence--but are there any such mechanisms? Few people realize that while the mean level of fee increases for the Ontario Hospital Insurance Plan (OHIP) schedule of benefits are negotiated between the Ontario Medical Association and the provincial government, it is the OMA alone that decides how these increases are divided among physicians. It is fully within the OMA's power to allocate funds so that senior physicians are paid more for the same service. It is also possible for the OMA to establish mechanisms for identifying superior physicians and to then specify that these physicians will receive more per service or procedure than their colleagues.

In fact, the provincial government has informally approached the OMA, encouraging them to consider such merit-rewarding policies. No doubt it would be extremely difficult to establish schemes of physician evaluation that all would consider fair and just. Nevertheless, it is clear that if the OMA is sincerely concerned about providing financial rewards for excellence, there is plenty of opportunity to do so within the constraints of the government's legislation.

Advocates of extra-billing raise the spectre of a mass exodus of top quality physicians should the practice be banned. One of the reasons this will not happen follows from what has been said about who extra-bills: a majority of top quality physicians are opted in and thus would not be directly effected by a ban on extra-billing. All provinces except Alberta and New Brunswick already have legislation or agreements with the medical profession which effectively eliminate extra-billing and have not suffered a physician exodus. Canadian physicians have much keeping them here, including family and personal ties, and established practices.

Finally, it is becoming increasingly clear that even if a physician wanted to leave, he would have great difficulty finding an attractive alternative. The United States has more doctors per capita than Canada and all the desirable practice locations are taken. In Canada physicians are able to order diagnostic tests and prescribe treatment without worrying whether a patient is able to pay. For even the more pecuniarily oriented physicians, the American situation in which one cannot provide optimal care for the poor would be distressing. An additional factor is that the U.S. is rapidly becoming a progressively less attractive place to practice. Large corporations are taking over the practice of medicine, and 30 per cent of physicians are employees. They are sometimes told how many lab tests to order and when their patients should leave hospital. In Ontario, opted-in doctors have freedom to practice with almost no government involvement.

Some physicians suggest that extra-billing is actually beneficial. By providing physicians with larger reimbursement per patient it allows them to spend more time with each patient and prevents "revolving door medicine". However, the evidence shows little difference in practice style between opted-in and opted-out doctors. Professors Alan Wolfson and Carolyn Tuohy of the University of Toronto conducted an exhaustive survey of opting-out which was published by the Ontario Economic Council in 1980. They found no difference between opted-in and opted-out practices in patient load, hours of work, or waiting times for appointments. There is no good evidence that, on average, opted-out doctors spend more time with their patients.

There are another set of issues which have to do with basic questions about physicians' role in society. Physicians who view themselves as independent businessmen see any attempt to limit extra-billing as an intolerable assault on their professional freedom. This argument has a different sort of character than that of the economic argument which could be dispensed with on the grounds of appealing to the available evidence. The discussion about physicians' rights involves moral and ethical, rather than empirical issues.

In many ways physicians are not, and cannot be, independent businessmen. First, it is public funds that pay almost all of the costs of their medical education. Second, they are granted a monopoly on the practice of medicine by the state. Nurses, physiotherapists, chiropracters, and the like, cannot set out their shingle as physicians. Third, public funds pay for the hospitals, and many of the laboratory facilities, that physicians rely on in their

practice. Doctors do not pay rent to the government for their use of these facilities. Fourth, physicians are paid out of public funds. The public health insurance program virtually assures physicians of an excellent income by guaranteeing that any service the doctor deems necessary is reimbursed. Fifth, if physicians were independent businessmen, they would be rapidly indicted for price fixing and limiting advertising. There is no real competition among physicians, reflecting the fact that health care is not a conventional market.

Sixth, and most important, health care is an essential service. If health care were simply another commodity like the shoes one buys at the store or another service like the haircut one obtains at the local barber shop, physicians' outrage at billing constraints would be quite appropriate. However, because health care is an essential service, the government assumes a responsibility for public access to the service. Viewed in this regard, health care becomes analagous to education, or to the services of the fire department, and physicians assume a responsibility quite different from that of the shoe salesman or the barber. While it might be nice for them if school teachers could charge parents an extra fee per student in addition to their salary from the board of education, or if opted out firemen could charge the householder a user fee for every fire put out, such charges would be contrary to our view that education and fire control are indispensible public services.

Almost every civilized country in the world has decreed outright or introduced legislation and programs that make it clear it views health care as an essential service (the United States being a notable exception, or not among the ranks of civilized countries, depending on one's point of view). It is clear that by the very nature of the practice of medicine, physicians have special privileges and special responsibilities that make banning extra-billing appropriate and necessary, rather than the undemocratic affront to physician freedom that the Ontario Medical Association claims. As Justice Emmett Hall wrote in the report of Canada's 1965 Royal Commission of Health Service, "When the state grants a monopoly to an exclusive group to render an indispensible service, it automatically becomes involved in whether those services are available and on what terms and conditions." Physicians must accept the responsibilities that go along with providing an essential service. One of those responsibilities is to ensure that their services are available to all without financial deterrents.

Essential service or not, one might argue, what is so terrible about allowing physicians to opt out and charge user fees. The rationale here is that opting out really doesn't act as a deterrent at all. This is simply false. Although it is true that during the last few years only 12 to 18% of Ontario physicians have been opted out, opted out doctors are concentrated in certain specialties and geographic areas. A large proportion of orthopedic surgeons, obstetricians and gynaecologists, anaesthetists, and psychiatrists are opted out. Therefore, the impact of opting out is much greater than the 12 to 18% figure might lead one to conclude.

There is also more direct evidence that opting out effects utilization. I have alluded to the data from the Rand health insurance study, and from Saskatchewan during the period of extra-billing when utilization of physician services by the poor and the elderly decreased. Two epidemiologists from McMaster University, Greg Stoddart and Chris Woodward, conducted a survey to determine how people in four Ontario counties with high rates of opting out reacted to user fees in the form of extra charges by opted out physicians. Eighteen percent of the poor reported the cost of seeing an opted out physician had resulted in delay in seeking medical attention or resulted in their staying away from the doctor altogether, versus only four percent of the

non poor. In addition to these studies are the personal experiences of primary care physicians who work in poorer areas. These physicians know that their patients will avoid seeking a needed consultation because of the financial consequences. As a result, the more conscientious seek agreements with specialists that their patients will not be extra-billed.

Physicians often argue that the patient who is really unable to pay is never extra-billed, that all a patient has to do to avoid user fees in the physician's office is to point out that direct charges would be a hardship. There are two problems with this. First, many people find that requesting a physician to waive his usual fees is a humiliation; they would rather pay or simply not visit the physician at all. Second, the claim that physicians consistently screen patients and don't extra-bill those who cannot pay is bogus. Stoddart and Woodward, in their survey of the effects of opting out, found that of 135 poor households who had dealt with opted out doctors in the previous two years, 107 had been extra-billed. In 1984 Richard Plain, analyzing Alberta billing data, examined the incidence and amount, by age and income class, of extra-billing. His data suggested that in fact there were few differences between the degree of extra-billing applied to the poor versus the non poor, and he concluded as follows: "It is an unquestionable fact that the aged, welfare recipients and the lowest income groups in the province are forced to bear additional out-of-pocket charges in order to receive medical attention." Finally, in 1985, the Alberta College of Physicians and Surgeons presented data showing that 800 Alberta physicians had extra-billed patients who were on welfare. As to the argument that patients are deterred only from unnecessary or unwarranted services, Chris Woodward found that physicians, when presented with a range of scenarios involving situations of questionable necessity that charges to patients are supposed to eliminate, could not agree on which visits were unwarranted.

In summary, there is no doubt that extra-billing adversely effects health care utilization by the poor.

When considering the impact of opting out, there are two additional points to keep in mind. One is that, as Emmett Hall wrote in his 1980 review of health care in Canada, "Not only does extra-billing deny access by the poor but it also taxes sick persons who, besides paying premiums, are already paying the major cost of the system through their taxes." One should also remember that there is still a very substantial relation between socioeconomic status and health in this country: the poor are significantly sicker than are the well off. Therefore, extra-billing decreases health care utilization by those who need it most.

Another argument adduced by proponents of opting out is that even if the poor do decrease their utilization of physician services as a result of opting out or extra-billing it will not effect their health status. As support for this statement, they point to the results of the Rand Health Insurance Study which found that on their general measures of health status there were no differences between those receiving free care and those subject to cost-sharing. However, these findings should not be interpreted as indicating that, in general, user fees will not adversely influence health status. First, several of the groups most likely to be effected, including the very young, the disabled, and the elderly, were excluded from participation in the Rand study. Second, the global measures of health status used were almost certainly insensitive or unresponsive to small but important differences in health status. For example, differences between the free care and co-insurance groups in control of hypertension and in visual acuity were found. In addition, the low but not the high income patients in the co-insurance

groups ended up presenting to physicians more often with serious problems, suggesting that the financial penalties led to delay in seeking needed care among the poorer participants. Recently, Shapiro and colleagues have demonstrated an adverse impact of termination of health care benefits on health status in the very poor in California. In summary, the decreased utilization by the poor and elderly which results from user fees almost certainly has an adverse effect on health status, and hinders access to both the curing and the caring aspects of medical care.

A final argument is based on fear of physician reprisals. Physicians are already antagonistic toward the provincial and federal governments, they have already conducted one rotating strike in Ontario and they threaten major sanctions (including civil disobedience) in response to the Health Care Accessibility Act. No one likes to see confrontations between the government and the province's doctors; a physicians' strike is a frightening and disturbing event. Perhaps it is worth $50 million to keep the provinces' physicians pacified.

What is one trading off if one makes this choice? Physicians are already the highest paid professionals in the province. Depending on how one makes the computation their average net income after expenses but before taxes is well over $80,000 and may be approaching $100,000. Not only that, but as I mentioned earlier it is primarily certain specialties in which opting out is rampant, and these specialties are among the highest paid.

Finally, one of the assumptions which tend to be made by those who argue that we should retain opting out as an "escape valve" for dissatisfied physicians is that physicians have suffered financially as a result of national health insurance. This is not the case. In the late 1950's before the introduction of any sort of health insurance the mean income for physicians was 3.8 times that of the mean industrial wage. Physician income rose with the introduction of health insurance, and at its peak in the early 1970's was over 5.5 times the mean industrial wage. Although the relative position of physician incomes has dropped somewhat over the last 10 years, physician incomes are still greater than 4 times the mean industrial wage. Economically, physicians are better off as a result of national health insurance, not worse off.

There is no doubt that the public at large desires an end to extra-billing. The Canada Health Act is one of the very few pieces of legislation which passed through the House of Commons unanimously. Public opinion polls have consistently shown 70-80 per cent of Ontario residents oppose extra-billing. The Liberals and New Democrats garnered nearly two-thirds of the votes in the last provincial election with a ban on extra-billing in their platforms. Public groups, including the Ontario Health Coalition, the Ontario Coalition of Senior Citizens Organizations, and the Ontario Federation of Labour, representing hundreds of thousands of Ontario citizens, are publicly campaigning against extra-billing and in favour of the Health Care Accessibility Act.

As a society we have to decide whether we will allow ourselves to be coerced by physicians angry at the prospect of losing the right to decide what their services are worth and charge accordingly, or whether we will protect the access of the poor and disadvantaged to high quality health care. There is little doubt as to which choice we should make.