MRG Newsletter

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

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MRG October General Meeting

The Medical Reform Group's semi-annual meeting began on Friday night, October 24, with a speech by Ontario Health Minister Murray Elston. Mr. Elston's presence marked the first time that a Minister of Health has come to a meeting of the MRG. Mr. Elston gave an overview of what he saw as some of the key issues facing ther health care system in Ontario, and then answered questions from members.

Saturday's meeting began with reports from MRG working groups and represenatives. A prominent item was a report on and discussion of the recent extra billing controversy and doctors' strike, and the MRG's role in these events. Members of the steering committee were thanked for their hard work during the extra billing battle.

Steering committee member Mimi Divinsky than gave a report on the continuing issue of extra charges which have become much more prominent since the strike. She noted that the legislation only covers insured services, and that doctors are now finding ways of charging for a variety of uninsured services. Some of these fees have been prominently reported in the media. The steering committee has been collecting letters about these charges in order to accumulate evidence for further action. One suggested course of action was for patients subjected to these charges to file complaints with the College of Physicians and Surgeons.

Bob James suggested that the argument made by the physicians who charge these fees, that they have expenses which are not covered by OHIP, could be a double-edged one which could lead logically to the conclusion that doctors ought to be on salary.

One member wondered if MD's were allowed to sell items such as gowns if they didn't have a retail sales license.

Irving Brown argued with what seemed to be broad agreement that the MRG's position should be that there should be no uninsured services at all.

Don Woodside said that he was in basic sympathy with this position, but raised the issue of innovative forms of treatment which are not covered (yet) by OHIP. If there were no extra charges allowed under any circumstances, then physicians would be detered from using innovative therapies.

Michael Rachlis reported on the Ontario Health Coalition. The OHC is currently in a period of low activity. Michael asked if someone else were willing to join him in representing the MRG at the OHC; Roseanne Pellizzari volunteered.

Joel Lexchin reported that the Canadian Health Coalition has been spending the bulk of its time recently on the pharmaceuticals issue.

Joel reviewed the patent law legislation which the federal government was intending to introduce (the legislation has since been introduced). It provides for 10 years without competition for each new drug which is introduced into the marketplace. Joel Lexchin and Robert Frankford met with the Minister, Harvie Andre, to present their, and the MRG's, opposition to the legislation. Joel noted that he thought the legislation would be widely unpopular.

There was a report on the Evans Review of the Health Care System in Ontario. This review was initiated by the Liberal government last spring in an effort to win support from the Ontario Medical Association. After the OMA said it would not co-operate with the Review, it went into limbo, but is now proceeding with the participation of the OMA. Atthis point its terms of reference are not clear, but it seems that it will be a fairly quick process rather than one with public hearings. The MRG had taken the position that a broad type of enquiry is needed into the health care system, but the MRG will make a submission to the Evans Review.

Michael Rachlis and Gord Guyatt reported on the Ontario Legislature's Select Committee on Privatization (in health care and social services). The MRG will likely make a submission to this Committee when its focus is more clearly established.

Mimi Divinsky reported on developments in the abortion issue. The Morgentaler trial is before the Supreme Court, and it could be 6, 8, 10, or 12 months before a decision is

Editorial Note

This issue marks the beginning of a new phase for the MRG Newsletter. At its October 1986 meeting the MRG Steering Committee decided to invite submissions from members of original articles for publication in the newsletter. These articles will be in addition to the usual announcements, newspaper clippings and copies of MRG briefs/ correspondence.

Publication of articles does not imply endorsement of the authors' analysis or opinions. The articles are meant to stimulate discussion on current issues and to provide an opportunity for members at large to express viewpoints on subjects of their particular interest. The first article is by Dr. Ralph Sutherland.

The new MRG Newsletter committee is composed of two Steering Committee members, Dr. Gordon Guyatt and Dr. Haresh Kirpalani, and one past Steering Committee member, Dr. Philip Berger. The committee welcomes letters to the editor and encourages all members to submit articles for publication.

We hope the newsletter will serve as a forum for free and open debate.

Philip B. Berger
on behalf of the Newsletter Committee

General Meeting Report

reached. The defence put forward two basic lines of argument in the Supreme Court hearing. The first is the defence of necessity for breaking the law; the impression was that most of the justices were not receptive to this line of argument. The second line of argument was that the law is discriminatory because it restricts access on the basis of geographic distribution, age, income level, and ethnic group; this line of reasoning seemed to be pursued more favourably by the justices.

Nikki Colodny reported on the Morgentaler Clinic and on Marion Powell's forthcoming report on abortion access. Apparently Powell was told in her terms of reference that her recommendations could not include free-standing clinics.

Nikke Colodny also appealed for MRG member physicians to consider joining the clinic on a part-time basis.

Catherine Oliver reported that she and Brian Hutchison have completed work on a brief on midwifery which was presented to the Committee on the Implementation of Midwifery in Ontario a few days before the general meeting.(Copies of the brief are available from the MRG at $4 each: MRG, P.O. Box 366, Station J, Toronto, Ontario M4J 4Y8.) The committee is still accepting submissions until the end of December.

Philip Berger gave the Steering Committee report. He reported that the extra billing issue had been the single key issue with which the steering committee had dealt in the last six months. Its involvement included almost-daily contacts with the government and the media, including a meeting with Murray Elston in early May. Lines of communication with senior people in the OMA and the College were kept open.

The Steering Committee also concerned itself with a whole range of other issues in the same time period, including abortion, pharmaceuticals and midwifery.

After the steering committee report, the meeting discussed a motion introduced by Don Woodside and seconded by Philip Berger on the question of administrative fees. The following motion was adopted in principle, with an instruction to the Steering Committee to tighten up and improve the wording. (Time constraints made it impossible to arrive at a final formulation, but members were satisfied that the motion essentially conveyed their position.)

Be it resolved that:

1. The MRG opposes the charging of general administrative fees by physicians;
2. Physicians be prohibited from charging fees for services which flow directly from insured services;
3. The government institute a registration and monitoring system for any direct charges by physicians.

Steering Committee elections: It was announced that Philip Berger and John Frank are leaving the steering committee after several years of service. Fran Scott and Michael Rachlis praised their contributions, and both were presented with tokens of appreciation by the Steering Committee.

Three new members were elected to the Steering Committee: Catherine Oliver, Bob James, and Haresh Kirpalani. The Steering Committee now consists of the following members:

Mimi Divinsky
Robert Frankford
Gord Guyatt
Steve Hirshfeld
Bob James
Haresh Kirpalani
Catherine Oliver
Shawna Perlin
Michael Rachlis
Fran Scott
Don Woodside

Steve Hirshfeld announced the formation of a new health group: Coalition for Toronto Persons with Aids. The group needs money, and space for meetings.

Bob James reported on the fundraising campaign to raise money to rebuild the Hamilton Family Planning Clinic, which was destroyed by fire. He will ask for approval to do a mailing to the MRG membership for the clinic.

Gary Burrows reported on the MRG Insurance Plan. The MRG has been granted an extension to the end of February to get members to sign up and qualify for the discount. If the required number of members sign up then several MRG members who currently can't get insurance will be able to sign up as well. Gord Guyatt suggested that even members who already have insurance could take out a small additional amount with the MRG plan to help get the numbers up.

The afternoon session of the General Meeting was devoted to a panel discussion on the topic: The College of Physicians and Surgeons: Its Role with Respect to Society, the Profession, and Government. The speakers were Dr. Peter Granger, the Past President of the College of Physicians and Surgeons; Carolyn Tuohy, of the Department of Political Science at the University of Toronto, and author of publications on the professions, public policy, and the role of the College; Gail Donner, Executive Director of the Registered Nurses Association of Ontario; and Daphne Wagner, a lawyer working with the Schwartz Commission reviewing health disciplines in Ontario.

Dr. Granger began by giving a history of the College, which was estsblished in 1865 with the mandate to govern the practice of medicine in Ontario. He noted that the government has the power to proclaim regulations for the College to enforce without the College's consent; this power was not used during the extra billing strike. About 1000 members of the College are complained against each year.

One important area of concern for the College is fitness to practise. The Fitness to Practise Committee is concerned to maintain competence, and has to wrestle with the problem of how best to handle this. The experience is that most physicians with problems in this area can be re-educated; the College is trying to set up a program for them.

Gail Donner explained that the RNAO is a voluntary professional association with about 50,000 members (there are about 100,000 nurses in the province). The Association does not support the fee for service system.

The RNAO's position on self-regulation is that it is a public trust which has been transferred to the profession, but not holus-bolus. There is and must continue to be a trust between the provider and the consumer (citizen). Self-regulation is not an exclusive right of the profession; for this reason there are members of the public on the professional governing bodies.

General Meeting Report

Nurses are for the most part employees, so they have a different view of what professional freedom is than doctors do.

Ms Donner identified as a key question "how do you protect the vested interest and the public interest at the same time?" She argued that where the two come into conflict, the public interest should be paramount. She posed the question of what impact this has on delegated medical acts, and what this says about the right to strike.

Daphne Wagner gave a history of the Health Professions Legislation Review. The Review began in the summer of 1983. There are a number of disputes between professions which have to be addressed (eg."turf" questions). It is also looking at the question of how to deal with professions which are outside the Health Disciplines Act. How does one define scope of practice and entry standards?

The Review is addressing itself to four tasks: 1. Identify the professions which are to be regulated; 2. Update procedures and determine who is to be regulated; 3. Develop structures for regulation; 4. Develop ways of resolving disputes.

The Review will not do a report as such; it will just write legislation. The Review was approached by 75 professions; 25 professions will be self-regulating. They intend to only regulate activities which present a risk of harm.

Ms Wagner enumerated the balances which are inherent in self-government: 1. There are lay members appointed by the government; 2. for some professions, the Minister appoints all or some of the professional members; 3. the government can impose regulations; 4. the public can appeal to the courts; 5. Procedural precedents are protected by common law.

She also noted that without compliance from practitioners, self-regulation does not work.

What Ms Wagner hoped would emerge from the Review's work was that the system will be made more flexible; common procedural codes will be developed; accountability will be increased; existing monitoring bodies will be strengthened; public represenation will be increased, to ⅓; mechanisms for continuing competence assurance will be developed.

Carolyn Tuohy identified what she thought the stakes and limits of professional self-regulation are: Control over the volume, mix, and price of medical services. For the medical profession as a profession, its interest is in volume and mix, clinical discretion, and professional norms of quality. There are also financial interests, especially in fee for service.

The mandate of the College of Physicians and Surgeons is volume and mix: what services at what standard? The College is in an "agency" relationship: the College acts as 'agent' of the public or government; it acts the way they would act if they had the information. The College is concerned to protect those levers from the government; it will trade off some economic interests to keep autonomy. Because of this, the College may have antagonized the "entrepreneurial majority" of the profession.

The College is not mandated to deal with job actions, wages and prices, or the mix between the professions. The efficient distribution of health care cannot be done through the College structure. Prof. Tuohy warned that one should not expect too much of the self-regulation system. It is very good at doing what it does, but is not suited to deal with many other kinds of problems which require different organizational and financial mechanisms and changes.

In the discussion which following the speakers' presentations, Dr. Granger noted on the question of continuing competence that "if we don't do it, the government will".

Gail Donner noted a concern about lay members regarding how they are appointed and whether they represent the public or the government. And how does one do competence evaluation for 72,000 working nurses?

Carolyn Tuohy raised the question of how does one define the public interest. Without knowing the answer to this, how can one appoint someone to represent the public interest? Should allied professionals be represented on governing boards?

Doug Sider argued that the College's complaints procedure is little known and has no reprersentation of the person making the complaints. This makes for an inherent protect-the-physician bias.

Daphne Wagner said that we require governing bodies to be more active. One idea proposed is that every health professional should post a sign in their offfice indicating scope of practise and where to complain.

Gail Donner said that "we need the structures, but we need more than the structures. We are talking about social change."

Letter to Premier Peterson

The Medical Reform Group of Ontario, a group which is composed mostly of physicians and medical students, is writing you in regard to Bill 7.

We know that the quality of health care is jeopardized when patients do not feel that they can freely discuss all aspects of their emotional, physical, and social well-being, including their sexual orientation with their health care provider. A physician may not be able to offer appropriate help because of lack of awareness of certain stresses that the patient is experiencing; stresses which may be producing the patient's symptoms. A physician may make an incorrect diagnosis of the patient's symptoms because he or she is not aware that the patient is in a high risk group for certain illnesses.

The reluctance of the patient to disclose his or her sexual orientation and all relevant related aspects of this to his or her health care provider may seriously compromise the patient's health. The lack of protection from discrimination on the grounds of sexual orientation in the Ontario Human Rights Code encourages and supports this reluctance regarding disclosure.

We encourage the government to take the long overdue steps that are necessary to change the climate which causes this reluctance. We therefore strongly urge you to include sexual orientation as a grounds on which discrimination is prohibited in the Ontario Human Rights Code.

Yours truly,
Gord Guyatt, M.D.
Don Woodside, M.D.
for the Medical Reform Group of Ontario

Notices & Announcements

Hamilton Chapter Meeting

The Hamilton Chapter of the Medical Reform Group are having a meeting on "Tobacco: The Social Cost of Production" on Tuesday January 20 at 7 p.m. at 17 Chilton Place, Hamilton.
For more information contact Roseanne Pellizzari at 529-6010.

Toronto Chapter Activities

To all Toronto chapter members: Recently, a group of us--Fred Freedman, Mimi Divinksy, Gary Burrows and Doug Sider--have constituted a working Steering Committee for the Chapter. We'd like to put more organizational energies into a programme for the next six months, especially the planning of a series of educationals for the membership. We hope that with much prior notification and an interesting and varied set of issues some of the fitful participation of the past can be reversed, and that once again we can use these forums for learning, exchange and recruiting. The plans are to begin our programme in early January. If any of you have ideas and/or energies, we definitely have a place for you! Contact Doug Sider, (W) 537-2455; (H) 532-3273.

Toronto People With AIDS Coalition

On August 28, 1986, People With AIDS (PWA's) formed the Toronto PWA Coalition to join the battle against Aquired Immune Deficiency Syndrome, (AIDS). Our top priority is to do everything possible to eradicate this world wide health threat.

People with AIDS are affected by their illness in countless ways: physically, emotionally, socially and economically. Every area of a person's life is dramatically altered.

Medical research has provided some answers, but still has a long way to go before the cure is here.

Your donation will help us:
1) to be supportive to each other in self-help discussion groups,
2) to participate in experimental medical research,
3) to reach out to those still isolated in their communities
4) to provide low-cost housing and meeting facilities, and
5) to ease financial emergencies and help

People With AIDS (continued)

meet costs of prescribed medications to treat AIDS related infections.

Please keep in mind that most people with AIDS are unable to work and thus they are not able to pursue many life prolonging programs due completely to a lack of funds.

AIDS is not just an urgent medical challenge, but a challenge posed to all humanity--those with whom we share this planet. Let this challenge not go without response. Meet the challenge; please give your donation and support today.

Please help us help!

Sincerely,
The Toronto PWA Coalition
Box 1065, Station Q,
Toronto, Ontario M4T 2P2

Adverse Effects

The International Organization of Consumers Unions announces the publication of "Adverse Effects: Women and the Pharmaceutical Industry", edited by Kathleen McDonnell. Focusing on the particular problems faced by women in relation to the drug industry, Adverse Effects is an anthology of articles from both the Third and First World. It covers drugs used in population control programs, mood modifiers, hormone manipulation, DES and EP drugs. Adverse Effects is available from IOCU, P.O. Box 1045, 10830 Penang, Malaysia for $7.95 U.S.

CUSO seeks health workers

Need a challenge? Would you like the challenge of working at a remote health centre in the highlands of Papua New Guinea? CUSO, the Canadian international development organization which has been placing health workers on a two-year posting in the Third World for 25 years, is seeking a registered medical practitioner with at least two years' Canadian experience to take on the duties of medical officer for the Ialibu health centre.

"In addition to curative work, there is a research aspect concerning provincial medical problems and some extension work involved', says CUSO's health officer Linda Cobb. "The focus is on community health but some aid post orderly stations in the area are vacant due to lack of community interest in making the necessary repairs. The communities need encouragement and motivation."

continued....

Notices & Announcements

In addition to the medical officer, the health centre has nurses, nurse aides and orderlies. There is an outpatient clinic, as well as casualty and in-patient wards, and the centre carries out immunization and community health programs.

Some experience in community health care is particularily important for applicants. If you are interested, send a curriculum vitae (and that of your partner if applicable) to CUSO's regional office at 815 Danforth Ave., Suite 411, Toronto, Ontario M4J 1L2, or to the CUSO office in your area. CUSO pays travel costs and housing is provided, along with a good benefits package. Salary is low by Canadian standards but adequate for a reasonable lifestyle. Job satisfaction should be high!

EGALE

Human rights are taken for granted in Canada. Two years ago, the Charter of Rights proclaimed equality for all--all, that is, except significant invisible minorities.

One year ago, an all-party Parliamentary committee strongly recommended that this omission be rectified. In particular, it recommended the amending of the Human Rights Act to prohibit discrimination on the basis of sexual orientation.

Last March, in response to the Committee's Equality for All report, the justice minister said that the federal government would take "whatever measures are necessary" to ensure sexual orientation is a prohibited ground for discrimination in all areas of federal jurisdiction.

These words, however, have not yet led to concrete action. Although gay men and lesbians were initially encouraged by the positive statements of the government, the lack of follow-up Parliamentary action has prompted the formation of a major lobbying effort.

EGALE (Equality for Gays and Lesbians Everywhere, in English, "Equal" in French) consists of a core group of about three dozen men and women in Ottawa which maintains contact with two hundred gay groups across the country, and other organizations and individuals.

Letter writing is an important function of this campaign. An informed public can effect vital legislative change that will make social equality a reality. We invite further enquiries and idalogue. Please contact: EGALE, Public Relations Committee, P.O.Box 2891, Station D, Ottawa, Ontario K1P 5W9.

Community Health Centres Conference

The Community Health Co-operative Federation is sponsoring a national conference on "Community Health Centres: Requirements for Growth."

The Community Health Co-operative Federation is the Provincial Association of Community Health Associations in Saskatchewan which operate community clinics in eight centres, serving 15% of the Saskatchewan population.

The conference will bring together representatives from Health Centres of all types from across Canada. We also expect many other organizations with an interest in alternate methods of health care delivery to participate.

The conference will examine the growth of community health centres (obstacles and opportunities) and discuss policy and strategies for the future. At the same time it will look at Health Centres in Canada today, along with the varied programs they offer.

The conference will be hosted by the Co-operative Health Centre in Prince Albert Saskatchewan June 10, 11, and 12 1987.

We invite individuals and organizations to submit papers for presentation at the conference on any of the general themes. These may be loosely grouped under the following headings: (1) Opportunities for Growth, (2) Obstacles to Growth, (3) Community Health Centres as Agents for Change, (4) Programs for the Future. Please send submissions by January 15, 1987 to Program Committee Conference 1987, The Co-operative Health Centre, 110 - 8th Street East, Prince Albert Saskatchewan S6V 0V7.

Medical Personnel in Lebanon

SUCO and the Centre d'Etudes Arabes pour le Developpment (CEAD) are looking for a physician/nurse to undertake work and provide training in emergency care in Beirut. The project is in collaboration with UNICEF/ Lebanon. Its duration is for six months starting March 1987 and the contract can be renewed. Send your c.v. to CEAD/recrutement, 3738 St. Dominique, Montreal H2X 2X9.

Feature Article

After the Doctors' Strike: Where do we go from here?

Ralph W. Sutherland, MD., Associate Professor, Program in Health Administration, University of Ottawa

As a society we should by now have learned that a service is not always going to be there just because we think it should be. Most Canadians have, at some time or other, felt threatened in one way or another by work stoppages or other job action by policemen, air traffic controllers, hospital non professional staff, teachers, post office workers, nurses, telephone workers, hydro staff, garbage collectors, etc. Doctors have recently confirmed their place on the list, (something we knew already anyhow).

In the recent dispute over extra billing, there were least two quite separate issues. The first one was whether governments or doctors determine health policy, in this case a policy strongly endorsed by the public. This issue has momentarily been settled and the government and the public have won as they should in these situations.

The second issue has not been settled and that is whether society wishes to protect itself against future similar action by the physicians. It is my guess that the public does want protection. A doctors' strike can lead to the loss of services that are obviously essential e.g. emergency departments and obstetrical services, the loss of services which are more routine although also important e.g. elective surgery and the services provided from physicians' offfices or hospital outpatient departments, or both.

Protection against the loss of high profile services associated with immediate threats to life or health is easiest. These services are primarily based in hospitals and the Minister of Health has through the Public Hospitals Act immense control over hospitals and over the relationship between doctors and hospitals.

The Minister should immediately open discussions aimed at amending the Public Hospitals Act, and/or other appropriate Acts, so that physicians who are part of the active medical staff of a hospital will collectively and individually know that their medical staff appointment carries obligations for continuous delivery of essential services. These obligations would be clearly described in the contractual relationship that is created when a physician accepts a medical staff appointment. Financial and/or professional penalties would apply if the guaranteed minimum level of services was not maintained. This approach would be consistent with other clauses of the Public Hospital Act and Hospital By-Laws which already define individual and collective medical staff responsibilities with respect to such things as participation in Committee work, completion of medical records and compliance with hospital policies.

The obligation to assure continuation of essential hospital services should be in legislation rather than assigned to hospital Boards although Boards would by virtue of their Medical Staff bylaws be able to prescribe new conditions for the granting of medical staff privileges if they so wished and the Minister agreed.

Protection against the loss of clearly essential hospital based services will also be easy because almost all of the public and a great many physicians will see it as reasonable and because the power of the law is used to keep essential workers on the job. But what of health services that can be seen as less essential?

Should the law be used to make physicians keep their private offices open? I hope not. Communities, citizens and Ministries who wish routine medical services to be more stable than they recently were should instead encourage the growth of Community Health Centres and the development of expanded roles for nurses, physiotherapists and other health care providers.

Expansion of our community health centre network is sensible at all times but especially sensible now. CHC's provide primary multidisciplinary medical care and are accountable to a community board. They are praised in print, wanted by many communities but very difficult to start. If they are to grow as an alternate source of primary health care the Minister must reach down into his bureaucracy and immediately alter the obstructive regulations that govern the establishment of CHC's. It is difficult to be certain that CHC's are cheaper than traditional health care, although they probably are, and whether they give better care is also under dispute although perhaps they do, but what is known is that CHC's are designed by, operated by and are responsible to the community. A private practice fee-for-service office can be opened anywhere anytime and no asks whether it is needed or whether it will give good care; why does a widely respected alternative source of health care have to jump through interminable hoops before it can open its doors?

Many groups support expanded roles for nurse specialists, including midwives and nurse practitioners, and for physiotherapists and other health workers. These increased roles are not likely to emerge, however, and perhaps are not even desirable, unless we produce fewer doctors and unless the relevant professional acts are changed. The provincial government should therefore reduce enrollments in medical schools, continue to tighten controls over the entry of foreign medical graduates, and enact or alter legislation to allow greater use of nurse practitioners, physiotherapists, etc. The results of these actions will not be fully felt for many years but long term benefits will never arrive unless a beginning is made. Spending more on physicians is not the best way to improve the health of Canadians.

The suggested changes should be approached sensibly, patiently, with sensitivity and with clear objectives. Throughout all planning governments must always invite participation by all physicians groups, especially the OMA, and listen to all physicians including the OMA. Government should not consider OMA support to be essential before health policy is created or amended but physicians are an important worker group whose comments are always worthy of attention, (as are the comments of every other worker group whose interests are at stake).

Throughout all activities designed to reduce the impact of future doctor strikes there should be recognition of the extent to which our society respects the collective bargaining process and the right of individuals to protest. Careless interpretation of the term "essential services" can unnecessarily interfere with the collective and individual rights of physicians, (or any other category of workers).

Having been so bold as to give some advice to various Ministers it seems consistent to give some advice to those of my Ontario medical colleagues who were the militant leaders of the last doctors' strike.

If you are absolutely and irretrievably committed to making damn fools of yourselves please do it with class. Go on hunger strikes; move to Chile; burn your hospital medical staff membership care; put your personal funds into for-profit hospitals; ride around the world in maternity stirrups, but don't recommend any more badly conceived and counter productive emergency room closures. These closures are in the same category as refusing to deliver old age pension cheques.

If however, you do have the best interests of medicine and the public at heart, and despite past events it is my belief that a fair number of medical leaders do, then a different set of activities are worth your consideration. Become acquainted with the corporate takeover of American medicine

so that you can better work with others to prevent the same thing happening in Canada. Become aware of the impossibility of ever being the free wheeling unconstrained professional that MD's were forty years ago, and having become aware of the degree of professional autonomy that has been lost, and of how much more will be lost, learn why things are changing. You will discover it is not a communist plot and not the product of government; it is the inevitable product of the computer age and the cost of health care. When this is understood many of you will, one hopes, become influential in managing the endless data that are behind the loss of professional autonomy. Spending money wisely is a legitimate objective and wise spending demands control over those who run up the bills.

Stop assigning bad motives to everyone who disagrees with you. Start talking to someone other than other doctors. Stop thinking you are responsible for the health of the nation or have the right to speak for the people who use your services. Learn how government works--you will be surprised to find that it is much more difficult to write good policy than good prescriptions. Learn to rank things by their importance. Learn the meaning of 'tradeoffs' and the art of compromise. You have an important point of view to deliver but the message is difficult to accept from the uninformed and the inflexible.

To all of the physicians who belong to the OMA but don't play a leadership role; -- chose your leaders carefully and be active in your union.

In summary, -- three points. The Minister of Health should assure the maintenance of essential hospital services by amendments to the Public Hospitals Act. Communities with the active support of the Minister and Ministry of Health should rapidly expand the network of Community Health Centres. The physicians, especially the OMA leaders, should start learning.

Ralph Sutherland is a member of the Medical Reform Group.

Get consent for AIDS test, doctor urges

BY CRAIG McINNES
The Globe and Mail

Blood tests for the presence of AIDS antibodies should never be done without a patient's informed consent, family physicians in Toronto were told yesterday.

Patients must be made aware of the possibility that the test can do more harm than good, said Dr. John Frank, assistant professor at the University of Toronto and a staff physician at Toronto General Hospital.

Dr. Frank was speaking, during a business and scientific meeting at the annual convention of the College of Family Physicians and Surgeons, about the value of various standard tests used to screen patients for disease.

Unlike the results from most routine screening tests, the results of the AIDS antibody test are of little use to the physician or the patient, Dr. Frank argued.

The results neither tell the doctor whether the patient has the disease nor allow treatment, because there is none.

And the patient risks having the harmful effects of the knowledge of the test results getting out — to insurance companies, for example, which could then refuse life insurance, Dr. Frank said.

Most of the benefits of the test accrue to others, such as people to whom the virus might be spread.

"The test itself has few benefits to the person being tested," Dr. Frank said.

The only situation where mass screening is justified, he said, is in the case of the screening of blood donors.

"It's a test that people should be given with informed consent except with transfusions, where we have to, literally, protect the blood bank," Dr. Frank said.

"People need to know what all the implications are, positive or negative, just like they would if they went in for heart surgery. This test could have just as big an implication for their lives."

Dr. Jack Fowler, whose downtown Toronto practice consists almost entirely of homosexual men, told the conference that he routinely does the test, but only with the informed consent of his patients. "The patient knows what he is going to learn."

The test shows only whether a person has antibodies to the AIDS virus, not whether the AIDS virus is present.

Dr. Frank also questioned the use of routine chest X-rays for detecting lung cancer in high-risk patients such as older people who smoke.

"There is no evidence it will help those patients one whit. It would be much better to get them to quit smoking."

By the time lung cancer shows up on X-rays, there are already other symptoms of the disease, Dr. Frank said. Oct 24/1986

John Frank is a member of the MRG.

Who finally decides

Dr. F. William Danby gives a score of zero those readers who think that "you or your doctors" will define consumer health needs in Ontario (letter — Sept. 27). He feels that the "government wants total control of (the) health-care system."

Dr. Danby fails to mention the public's right, through the electoral process, to determine who will be defining the requirements of the health-care system. The public can depose governments that do not meet the health-care needs of society, and elect more suitable governments. The public has no such right with the political leadership of the doctors. And if it did, judging by that leadership's performance over the past year, the public would score the doctors a gigantic zero.

Philip B. Berger, MD
Toronto

Oct. 1, 1986
Globe + Mail

Medical mistakes slip through testing net, authors say

BY ANN SILVERSIDES
The Globe and Mail

Dec 6/1986

CANADA IS getting less for its health-care dollars than it could because new medical technologies are not routinely subjected to rigorous scientific trials, the authors of a new document on health policy say.

Patients also are ill-served by the system because they sometimes are treated with unevaluated innovations, say the authors of Health Care Technology: Effectiveness, Efficiency and Public Policy.

To organize early trials of health-care technologies, and disseminate the results, the authors of the 270-page volume — published by the independent Institute for Research on Public Policy — propose that Canada establish a National Health Technology Assessment Council.

In recent years, procedures that the medical community genuinely believed to be useful have been discredited after being subjected to random-control trials.

The majority of surgeons, for instance, stopped performing most radical mastectomies after a random trial found that the disfiguring operation was in most cases no more effective than a partial mastectomy.

Similarly, a recent trial found that screening on a routine basis for fetal distress during labor resulted in increased numbers of caesarean sections, but did not result in a decrease in fetal morbidity compared with the control group.

Despite such results, however, and although new technologies are a major source of increased hospital costs, Canada has no co-ordinated system to ensure medical innovations are subjected to rigorous trials, the book says.

Some provinces and hospitals conduct random-control trials, but health-technology assessment in Canada is underfinanced and fragmented, said economist David Feeny, who co-edited the volume with McMaster University colleagues Dr. Gordon Guyatt and Dr. Peter Tugwell.

"Now it depends on serendipity. . . . A new procedure may get tested if a group of doctors is interested," Prof. Feeny told a recent Toronto seminar.

For instance, Canadian investigators now attempting to launch a North American trial of a common and established stroke-prevention operation, the carotid endarterectomy, say they are running into vocal opposition from associations, primarily in the United States, which represent neurosurgeons and vascular surgeons.

"We're trying to put together as perfect a grant application as we can . . . because many people are speaking out very publicly against the trial," neurologist Dr. Henry Barnett of London, Ont., said in a telephone interview.

The authors also stress that incentives have to be put into the system to push health-care providers to act on clinical trial results.

Policy options include making changes in the internal organization of hospitals so that clinical teams are financially responsible.

Changes are necessary because at the moment "there are no incentives for these individuals (health-care providers) to align their own goals and interests with a broader public interest in a cost-effective delivery system," the book says.

The basic question to be posed about a therapeutic or diagnostic innovation is whether it does more good than harm, Dr. Guyatt said.

But the proposed National Health Technology Assessment Council also would evaluate new technologies for economic efficiency. Researchers would compare the cost and consequences of the options.

Such an emphasis would probably exert some pressure in the marketplace, Prof. Feeny said. "To date, the attitude in Canada has been, 'if it's better, we'll take it, no matter how much it costs.' And so manufacturers have developed neat, expensive equipment.

"But if we start making demands for economic efficiency, asking for cost-effective innovations, suppliers will respond."

Currently, many evaluations of medical innovations are "rudimentary and crude," he told the seminar. They are often performed "by people with vested interests, typically by well-intentioned providers who are nevertheless often advocates rather than by agnostic methodologists," he said.

Yet history shows that "one can be terribly deceived about, for instance, a surgical procedure if there have not been any control trials," Dr. Guyatt told the seminar.

"Thirty years ago, it seemed reasonable to adopt an 'intuitive' approach . . . but now we are aware that you need very careful criteria to avoid mistakes in evaluation."

Dr. Guyatt said that false results flow from insufficiently rigorous research for at least four reasons: natural history, because patients sometimes get better anyway; the placebo effect, in which the belief that an effective treatment has been given sometimes has the same effect as the real treatment; bias in the population studies, such as non-comparable control groups; and bias in observation reported, for example, when patients don't want to disappoint their doctor.

When innovations are subjected to random-control trials, the trial is too often conducted *after* an innovation has been adopted by professional groups, endorsed by insurers, accepted by the public, and been the subject of observational reports, the book says.

And at that stage, the trials are often threatening to practitioners.

Gord Guyatt is a member of the MRG.

Job threatened over studies of cancer links, MD says

THE TORONTO STAR, WEDNESDAY, OCTOBER 22, 1986

By John Deverell Toronto Star

A specialist doctor at McMaster University says he and a faculty colleague were told they would be fired if they didn't quit working in their off-hours for an independent clinic that investigates workplace health hazards.

Dr. John Chong said the threat to him and Dr. Ted Haines came from Dr. David Muir, director of McMaster's occupational medicine program, and was reinforced by Dr. Dennis McCalla, a vice-president of the university.

Both Muir and McCalla deny they threatened the two faculty members with dismissal. McCalla said, however, that the involvement of Chong and Haines with the Ontario Workers Health Centre has caused "fallout" and "tensions" and said it is incompatible with the goals of McMaster's occupational medicine program.

The clinic is run by Stan Gray, a former union official who has documented a number of cases in which Ontario Ministry of Labor officials failed to force companies to take effective action to protect worker health.

Government inquiry

Among the workplaces that have come under the clinic's scrutiny are de Havilland Aircraft in Downsview, American Can, Stelco and Westinghouse in Hamilton, and Ferranti-Packard in St. Catharines.

Earlier this month, Gray testified at a government inquiry headed by lawyer John I. Laskin that McMaster's Dr. Muir had altered and reinterpreted a report by Chong and Haines on worker illness caused by toxic chemicals at Domtar's Cassidy Works in Hamilton.

Based on the Muir reinterpretation at Domtar, and the pressures exerted by McMaster on the two doctors to quit the Ontario Workers Health Centre, Gray said it seems that McMaster has been attempting over the past year to muzzle the two specialists in both their university and outside work.

Both Dr. Chong and Rae Erskine, the union safety chairman at Domtar, agree that Gray is right. Dr. Haines will not confirm or deny any of the events.

Lung cancer

Gray alleged to the inquiry that the Ministry of Labor was aware of efforts by Domtar to have the unfavorable medical findings rewritten. In their original August, 1985, report, Chong and Haines found that 45 of 74 Domtar workers were exhibiting or had experienced symptoms definitely or probably related to exposure to coal tar pitch volatiles.

The gases, which are created during the reprocessing of residues from steel mill blast furnaces, cause eye and skin problems and can cause lung and other cancers. The Ministry of Labor has been aware of the excess exposure problem at Domtar since at least 1977.

In what Muir called an "interpretation" of the Chong-Haines health report, he reported that only 15 workers were suffering ill health from coal tar pitch exposures.

Muir said this second revised report, which he prepared without examining the patients, had the full approval of the two examining physicians. It was written after he discussed the individual patient charts with Chong and Haines, but does not bear their signatures. Chong, recognized by the Ministry of Labor as a leading authority on the effects of coal tar pitch, said he disagreed with it and refused to sign.

The clash at McMaster reflects two medical approaches to identifying industrial illness, Chong said. "One demands absolute proof of workplace causation — a 100 per cent probability" and is used by companies and the Workers' Compensation Board to arrive at very sparse findings of industrial disease. "The other approach," Chong said, "makes the determination on the balance of probabilities, which places a lesser burden of proof on the worker and more on the workplace."

Dr. Muir, a long-time consultant to the Workers' Compensation Board, said his goal is to preserve his program's credibility in the eyes of both workers and employers, and that means avoiding advocacy on behalf of patients. "I'm not willing to lose that (neutral image) for myself or by association," he said.

The McMaster program receives about $500,000 a year in outside funding from the Ministry of Labor and corporate clients, Muir said.

Erskine, the union safety chairman at Domtar, said he was elated when the first McMaster report supported his long-standing complaint that there have been consequences to the company's failure to comply with ministry control orders on coal tar pitch.

'Company doctor'

Erskine's enthusiasm evaporated, however, when Domtar told him it would shut down the factory unless the Chong-Haines report was kept secret.

Domtar then, according to internal company documents, attacked the scientific validity of the report. A senior Domtar executive informed the ministry that the report would be rewritten before Muir officially consented to "review and interpret" it.

Erskine acquiesced reluctantly as Muir supplanted Chong and Haines in the Cassidy Works medical program, but became increasingly unhappy with the downplaying of health problems that resulted. "I thought he (Muir) was fairly credible," Erskine said, "but as he took control he acted more and more like a company doctor."

Muir and McCalla both said that neither Chong nor Haines has offended professional or scientific standards of conduct.

McCalla, however, who is also chairman of the Ministry of Labor's Advisory Council on Occupational Health and Safety, said some other role for the two specialists at the university may be more appropriate. "The advocacy role of the Ontario Workers Health Centre makes it difficult (for Muir's program) to maintain an even-handed reputation," he said.

Chong said he and Haines were both threatened in late 1985 before the second Domtar report was produced and while their term ap-

pointments at McMaster were up for renewal. "We were told by our director that we had to 'part ways' immediately unless we dissociated ourselves from the Ontario Workers Health Centre," he said.

Their appointments were renewed but they were subjected to further pressures over the clinic connection again this fall, he said.

Chong said that in his view independent worker health clinics are "the coming thing" for the identification, compensation, treatment and prevention of job-linked illness.

Doctor defends toned-down study on worker health

By John Deverell Toronto Star

A McMaster University official who reinterpreted a medical report by two faculty doctors on industrial illness at a Hamilton factory says criticism of his action in the Ontario Legislature has been "extreme and unjustified."

NDP safety critic Elie Martel this week suggested that the McMaster report on symptoms of illness among Domtar employees was rewritten in response to private complaints by company officials. Martel demanded a public inquiry into the Domtar events, which coincided with threats against the employment of the two faculty members by the same official.

The university has been trying to force Dr. John Chong and Dr. Ted Haines to stop working part-time with the Ontario Workers Health Centre, an independent clinic that has investigated and documented industrial diseases in a number of Ontario factories.

Dr. David Muir, director of McMaster's occupational medicine program, said yesterday that he acted in good faith last year when he lowered from 45 to 15 McMaster's assessment of the number of Domtar workers suffering ill effects from exposure to coal tar pitch gases. The chemicals cause eye and skin problems and can cause cancer.

But Muir shifted ground yesterday, arguing that his estimate of only 15 problem cases doesn't scrub the others from the record and that 15 "serious" cases among 74 workers is still "incredible, one of the higher prevalancies I have found.

Should be 'horrified'

"I would have thought they (Domtar) would be horrified."

Muir defended his actions at a press conference also attended by Chong and Haines, the two faculty members who originally reported finding evidence of ill effects from coal tars among 45 of 74 Domtar employees they examined.

Muir said he had attempted to focus on the current problem at Domtar, and indicated that many of the cases identified by Chong and Haines might have resulted from exposures to coal tar pitch somewhere else.

Chong, however, said that he stood by the findings of the original report which attributed the symptoms observed or reported by the workers to their work at Domtar's Cassidy Works. Hygiene reports document excessive levels of the gas in the plant over a period of at least nine years.

Chong reaffirmed his comments in The Star earlier this week about the difference between his approach to identifying industrial disease and Muir's. Commenting for the first time, Haines said he had approved the first report and modified his clinical findings very little while reviewing them with Muir before Muir wrote the second report.

Dodged comment

"Depending on the criteria one uses one can change a summary," Chong said while trying to dodge direct comment on his superior's actions. "It's an issue of probabilities," he said, indicating that the stiff criteria used by Muir to identify industrial illnesses are a matter of ongoing debate within the medical program.

The severity of eye and skin symptoms "are not an accurate indicator of latency problems" as implied in the approach adopted by Muir, Chong said.

In his written report to Domtar and the employees last January, however, Muir did not use any of yesterday's strong language.

In the document he described symptoms in most of the 15 cases as "mild" or "slight" and said it was "not easy to determine" whether they were caused by coal tar exposures.

Muir said he made an "administrative error" when he met privately with four Domtar officials last year to hear their complaints about the Chong-Haines findings, but insisted the conversation had no influence on his subsequent actions.

A letter from Domtar to the Ministry of Labor, written before Muir had given any formal indication of his intention to "review and interpret" the first report, said unnamed McMaster doctors were aware of "deficiencies" in the first report "and have agreed to produce a new report with more scientific content."

Muir said he had performed the review following a joint request by union and management at the plant.

Union safety chairman Rae Erskine has said that he wanted guidance on a cleanup strategy, not a watering down of the evidence of health problems, but was manoeuvred into the relationship with Muir by Domtar's threat to shut down the factory if the Chong-Haines report became public.

Power shifts to insurers in U.S. medical system

September 15, 1986

BY ANN SILVERSIDES
The Globe and Mail

LOS ANGELES

When Mark Granoff joined the Prairie Medical Group in Los Angeles in 1979, the doctor-partners were practicing medicine the same way as doctors had 20 years earlier.

It was a standard fee-for-service practice: doctors billed their patients for each service.

In 1980, the multi-specialty group began to accept some patients on a radically different basis. Instead of an open-ended system, in which they charged for everything they did, the doctors agreed to provide medical care for a set annual fee.

Today, 60 per cent of the group's patients are cared for on a prepaid basis.

The radical change in Dr. Granoff's practice is symptomatic of the widespread pressure to slash health care costs in the United States.

In Canada, governments have left untouched the fee-for-service method of paying doctors. But in the United States, private insurers — competing to cover the employees of cost-conscious corporations — have used their clout in the marketplace to control doctors and hospitals.

Federal and state government medical insurance programs, suffering from serious cutbacks in financing, have also sought to rein in their spending. A key result has been truncated hospital stays.

"It is the pace of the change that has been the shock for most physicians," said Dr. Jack McCleary, president of the 10,000-member Los Angeles County Medical Association.

"When I was younger, the term socialized medicine was fearsome. Today, the fear is of being regulated by sources over which you have no control and into which you have no input."

U.S. physicians "are starting to come under more and more control," Dr. Granoff said in an interview. "In this city, a lot of doctors are seeing their incomes go down."

Newly graduated doctors have difficulty getting bank loans to set up in private practice, and a lot of older physicians are not adapting, he said.

While the breakneck pace of change has left many doctors and hospitals reeling, some patients are paying less.

Prepaid medicine has proved significantly less expensive than the more traditional method of payment, and insurers have driven down many doctors' and hospitals' fees.

But it is not clear how far the revolution in health-care financing will go, and how it will ultimately affect the quality and accessibility of health care in the United States.

What has happened is "a shift in real power from the providers of care to the payers," said Paul Torrens, professor of public health at the University of California at Los Angeles.

That shift is particularly noticeable in California, a state where, Dr. McCleary notes wryly, "everything seems to come to a crisis sooner."

In Dr. Torrens' view, a major reason for the shift in power was the "unrestrained and lavish use of medical services. . . . Doctors have brought it on themselves."

Many physicians agree with that view. "Doctors in fee-for-service medicine killed the goose that laid the golden egg," said Dr. Edmund Butts, chief of internal medicine for the Kaiser Permanente medical group in Southern California.

"They brought on these changes because they were more interested in money, in fee-splitting with medical laboratories and getting fees for hospital visits."

Dr. Butts thinks there was a lot of waste in the system. But like other doctors, he wonders about the future and cites the metaphor of surgery: you can cut so much fat from the system, but there comes a point when the fat is gone and you hit the bone.

In an effort to wrestle down spiralling health care costs, private insurers and governments have used their purchasing power to change the rules of the game.

The most significant change has been the widespread introduction of various forms of prepaid medical care, but there are other wrinkles.

For instance, insurers typically cover about 80 per cent of the cost of care provided by a traditional fee-for-service doctor. The patient pays the remaining 20 per cent out-of-pocket.

But increasingly, insurers are making deals with doctors: if doctors agree to accept 80 per cent of their fee as full payment, insurers will promote those doctors to would-be patients as "preferred providers."

A recent California Medical Association report found that almost 77 per cent of its members had signed agreements to provide care on a preferred-provider basis. Almost one-third of those doctors had signed on with three or more agreements.

When it comes to prepaid medicine, Medicare — the federally financed health insurance program that provides partial coverage for the elderly and disabled — has carved out a new approach to hospitalization.

The plan now reimburses hospitals for a predetermined number of days in hospital based on the patient's diagnosis. If the patient is in hospital for less than the set number of days, the hospital benefits. If the stay is longer than average, the institution suffers a financial penalty.

The system can put the brakes on unnecessary hospitalization, but there are drawbacks, said Martin Shapiro, an assistant professor of medicine at UCLA.

"Maybe you have an old sick woman who lives a long distance from the hospital and it is extraordinarily difficult for her to get to and from the hospital. But she needs a series of tests.

"In the old days, you could admit her and get all the tests done at once. Today, such an admission would be denied under Medicare rules and probably by private insurers as well. And so perhaps she doesn't get the tests done."

For those who are admitted under the new scheme, "one can't help but believe that sometimes people end up leaving hospital a little too early," Dr. Shapiro said.

Indeed, Dr. James Davis, director of geriatrid services at UCLA, predicts that the push to shorten the hospital stays of Medicare patients is bringing on a crisis in the provision of home health care.

"Family members and visiting nurses are being asked to do more and more sophisticated things because people are coming home earlier. It is really robbing Peter to pay Paul."

Although not to the same degree, private insurers have also moved to restrict hospitalization and it is becoming standard practice for them to require justifications for hospital stays, Dr. Shapiro said.

"In the old days, five or 10 years ago, you could be hospitalized for just about anything. What we see now are much sicker patients," said Paula Correia, public relations officer for Cedars-Sinai Medical Centre in Los Angeles.

The occupancy rate at Cedars-Sinai, famous as the hospital where movie stars stay, is about 75 to 80 per cent. The average occupancy for all hospitals in California, where there are 3.28 beds for every 1,000 people, is about 65 per cent. By comparison, the average occupancy rate in Ontario, where there are 3.9 beds per 1,000, is 87 per cent.

The main vehicles for prepaid medical care are Health Maintenance Organizations, which agree to provide health care to individuals for a predetermined sum, no matter how many medical services they draw upon.

In California, 25 per cent of the population is enrolled in HMOs, while nation-wide the figure is about 7 per cent. More than half of doctors in the recent CMA survey had entered into HMO contracts.

Some HMOs, like the non-profit Kaiser Permanente, operate their own hospitals and hire their own doctors. (Kaiser, one of the oldest and the largest of the HMOs, grew out of a comprehensive health plan that industrialist Henry J. Kaiser set up during the the Second World War for workers in his West Coast shipyards and steel mills.)

Others, like Los-Angeles based Maxicare Health Plans Inc., a publicly traded company, contract with individual hospitals and doctors such as those in Dr. Granoff's Prairie Medical Group.

HMOs have achieved significant cost savings, compared with traditional fee-for-service medicine primarily because HMO subscribers spend significantly less than the average time in hospital, which is the big-ticket item in the health care system.

In fact, said John Ware, a health policy analyst with the Rand Corp. in Los Angeles, HMOs have succeeded in reducing hospitalization by 40 per cent, thus achieving a net 25 per cent reduction in health care expenditures.

Many analysts applaud the close scrutiny of use at HMOs, which has reduced unnecessary overuse of medical services.

And organizations such as HMOs may provide "the necessary countervailing force to the pressure on doctors and hospitals to do more in order to make more money," Dr. Shapiro said.

But there remains a concern about potential abuses arising from what Dr. Shapiro calls the "antagonistic economic interests" of the HMO provider and the patient.

Many physicians say that concern is underscored as commercial HMOs gain an increasing market share.

When Dr. Grayson Norquist returned from a year's absence to work at a Ross-Loos clinic in Los Angeles, he found that the doctor-partners, who had run the HMO on a non-profit basis, had sold out to a large corporation.

"The new owners told us to make sure to move people through. We were being treated like assembly line workers. At the end of the week we were told we weren't carrying our share if we didn't see enough patients," Dr. Norquist recalled.

"I remember one of the new managers said it would be great if they could run the clinics like McDonald's (restaurants)."

Unrest grew at the clinics, which employed several hundred doctors in the Los Angeles area, and the physicians formed an association with an eye to establishing their own union.

"Doctors are a conservative group, but what really scared us was the loss of medical input. There was a real cost-saving push and you couldn't order a test without getting prior approval," Dr. Norquist said of his experiences five years ago.

But the unionization drive fell apart. Just before the doctors were going to vote on unionizing — the ballots had been prepared — the owners laid off a number of physicians, including Dr. Norquist.

"They called me in. They had cancelled all my appointments and gave me my severance pay," said Dr. Norquist, now a Robert Wood Johnson clinical scholar at UCLA.

Commercial HMOs are posing a serious challenge not just to fee-for-service medicine but also to the non-profit Kaiser Permanente, Dr. Butts said.

"The average physician here is just becoming aware that if we don't shape up, we will become the dinosaurs. We're the ones everyone is shooting at."

Dr. Butts joined Kaiser in 1968 to develop a dialysis program and has been paid by salary for the past 18 years.

"I could do better (financially) outside, yes, in yesterday's world. But in today's world, with government and insurance controls. . . ?"

NEXT: Disparities in the system

Martin Shapiro is a member of the Medical Reform Group.

THE GLOBE AND MAIL, TUESDAY, SEPTEMBER 16, 1986

Technology serves the rich while the poor wait for care

Market pressures and cuts in federal and state government medical insurance have forced radical changes in the U.S. health-care system in the past few years. Those competitive, cost-cutting pressures have also widened the gap between medical care for the poor and for the well-insured. This is the second of a three-part series examining the changing face of free-enterprise medicine.

BY ANN SILVERSIDES
The Globe and Mail

LOS ANGELES

It is 5:30 p.m. on Thursday, and Diane Foray has just finished loading boxes of medical supplies, portable screens and a set of scales into a battered blue station wagon.

At her destination, the Bible Tabernacle shelter for homeless people, she will set up a "MASH unit" in the basement.

Ms Foray, two doctors and a public health student will spend the next three hours providing free medical care to many of the 170 homeless people who sleep side-by-side on the floor and in the pews upstairs.

Most of these, like 35 million other Americans, have no health insurance.

For them, medical care without a price tag is a novelty.

"A lot of them don't understand the word 'free' when it comes to medical care. They look at you like there has to be a string attached somewhere," said Mona Iwarski, who lives and works at the shelter.

With the increasing pressure on major deliverers of health care to control costs, and with cuts in Government medical-insurance programs for the old, the poor and the disabled, the U.S. health-care system is rapidly becoming two-tiered.

"The disparities are getting much worse," said Dr. Martin Shapiro, an assistant medical professor at the University of California at Los Angeles. His research specialty is access to health care.

"In the U.S. system, there is abundant sophisticated technology and no reluctance to leave no stone unturned for effective therapy for the sick who have good insurance, or adequate financial resources," Dr. Shapiro said.

"But there is an enormous number of people without access to care, or who have difficulty getting access because the resources set aside for them are overwhelmed by the numbers they are required to serve."

The elderly are particularly vulnerable. Medicare, the federal health-insurance program for those over 65, provided full coverage with no deductible when it was introduced in the sixties. But today, Medicare recipients face hefty deductibles for hospital care, and the result can be near-crippling medical bills. According to some studies, the poor and the near-poor elderly spend about 25 per cent of their income for health care, Dr. Shapiro said.

At the same time, cost-control pressures, increased by competition from the commercial delivery system, have eliminated much of the "gentlemen's-agreement" medical care traditionally provided to the poor, said John Ware, a health policy analyst with the Rand Corp.

For instance, competition has forced even non-profit hospitals to behave like their commercial neighbors. There has been an increase in "dumping" of seriously ill patients who show up at private hospital emergency wards without insurance or with Medical, California's program for certain low-income families.

Such patients are increasingly likely to be shipped out to the publicly financed county hospitals, which are already overburdened. "Stabilized and transferred" is the term, although county hospital officials say the procedure is sometimes a real danger to patients' health.

Increasing numbers of doctors are also refusing to treat patients covered by Medical because it pays them only about 40 or 50 per cent of their usual fees and is a bureaucratic headache.

"In West Los Angeles, if you are pregnant and covered by Medical, it is virtually impossible to get an obstetrician," Dr. Shapiro said. "You have to go to a clinic at the county hospital."

In Santa Monica, patients such as pregnant women without any insurance can turn for medical care to the Venice Family Clinic, where Ms Foray, who organizes the outreach program at Bible Tabernacle, is coordinator of services for the homeless.

The 16-year-old clinic, which serves the local poor, has experienced a staggering 75 per cent increase in its patient load in the past two years, said Mandy Johnson, director of the program.

The clinic operates primarily with volunteer medical help and private donations — three of the 21 full-time staff members are fund raisers.

Only 5 per cent of clinic patients have any form of medical insurance. Without the clinic, the uninsured would have to turn to the nearest publicly financed county hospital, a two-hour bus ride away, and the help they would get there is not necessarily free.

At the Los Angeles County Hospital on a recent evening, the emergency ward waiting room was full. Large signs advised that an emergency ward visit costs $266. If the patient pays within seven days, the charge is reduced to $35, a clerk advised.

Those who cannot afford this charge and ask that it be waived must go through a financial-screening interview to which they are advised to bring such items as pay stubs, bank and property-tax statements and life-insurance policies.

The atmosphere is rather different in the carpeted hallways of the Cedars-Sinai Medical Centre. That hospital is a favorite among Hollywood stars, and its walls are adorned by one of the world's largest modern art collections outside a gallery.

"It is a very classy operation," public relations officer Paula Correia says. "Americans are willing to pay for medical care. There is always room for the Rolls-Royce."

Like many other private hospitals, the Cedars-Sinai Medical Centre recently stopped accepting patients covered by Medical.

Such patients used to be able to go to any hospital, but in a recent move to contain costs, the state put Medical contracts out to tender and signed an agreement with a limited number of hospitals. That move put more pressure on county hospitals, which are obligated to provide medical care to the indigent but are already overwhelmed by demand for their services.

For instance, the Martin Luther King Jr. General Hospital, built in Watts in the wake of the 1965 riots, has a 100 per cent occupancy rate, as do most other county hospitals. (By comparison, the average occupancy rate for all California hospitals is 65 per cent.)

And like other county hospitals, it has experienced an increase in "dumping" of seriously ill patients. In one recent case, a private hospital transferred a woman who it thought was indigent to the Martin Luther King hospital, but demanded her back when it was discovered she had $40,000 in the bank, said Tessie Cleveland, director of social services at the county hospital.

The 404-bed hospital, which handled more gunshot wounds last year than any other U.S. hospital, is already under a great deal of strain. But because of cuts in state financing, it is now facing a possible $10-million drop in its operating budget.

"There are services where we have a capacity to treat 10 people and we treat 24. Our obstetrical load should be 4,000, but last year we delivered 8,700 babies. . . . Yes, there are serious concerns about the standard of care we can offer," Ms Cleveland said.

In the past four years, the hospital has seen a dramatic increase in patient load, in part because of California's decision to remove able-bodied working poor adults from Medical rolls, forcing them to go to county hospitals for care.

Dr. Shapiro and several colleagues kept track of 186 UCLA patients who lost Medical coverage, to see whether they suffered in any way. "Some went to the county hospitals, some didn't; some said they would rather die than go there," Dr. Shapiro said.

The study, published in the New England Journal of Medicine, revealed that before losing their benefits, 96 per cent could identify a regular source of medical care. Afterward, only 50 per cent could.

Seven of the 186 patients died within a year of losing benefits, and problems with access to care played a part in at least four of those deaths, the researchers concluded.

One woman with high blood pressure, who could not afford her medications, died of a brain hemorrhage, which is "a well-known complication of uncontrolled hypertension," Dr. Shapiro said.

A man with an ulcer, who was vomiting blood, did not go to an emergency ward because he felt he could not afford the fee. He finally went after 10 days, too late to save his life.

At the Martin Luther King hospital, budget cuts have meant that almost all outreach, follow-up and health-promotion work has been cancelled, Ms Cleveland said.

Since many of the hospital's patients are not accustomed to seeking regular care, the consequences can be serious, she said. "It is not uncommon for a woman to come in for a regular delivery, have an abnormal pap smear, and then we won't see her again until she turns up as a Stage 3 cancer."

At Ms Cleveland's hospital, the patient population is young — the mean age is 21 for women and 25 for men. But Dr. James Davis, director of the geriatric service at UCLA, said it is the elderly who suffer most from the inequities in the U.S. health-care system.

The elderly with Medicare coverage now face deductibles of more than $400 for each of their first two hospitalizations a year. In addition, the plan covers only 80 per cent of doctors' fees, and many tests are not covered.

When Lillian Russek's husband became ill with liver cancer two years ago, the couple had both Medicare and Blue Cross insurance coverage. But Mrs. Russek, 80, was still left having to pay almost $5,000 out of the $28,000 bill for her husband's hospital stay.

There were other bills. Medicare restricts the number of hospital days for which it will pay, depending on a patient's diagnosis. After her dying husband had been discharged from hospital, Mrs. Russek could not care for him at home and so she took him to an emergency ward, only to be told that he could not be admitted.

"I was told to look for a convalescent nursing home. The one I found cost $90 a day, and I had to bring them a cheque for a 30-day stay before they would admit him. He died after 17 days."

Mrs. Russek, who has only a modest income, had to pay the entire bill from the nursing home, since neither Medicare nor Blue Cross covered her husband's stay.

After her husband died, Mrs. Russek began going to the Senior Health and Peer Counselling Centre, which was established to provide free, preventive health care to the elderly, including complete physical examinations.

Such examinations are not covered by Medicare and typically cost between $200 and $300, centre director Bernice Bratten said.

Dr. David says that in the United States "so much money is spent on high-technology health care, such as heart and liver transplants, neither of which is available to the elderly.

"We have all these exotic diagnostic tests, and yet we don't feel badly that so many of our elderly live under conditions where they can't get basic care."

Community clinics called sane route to health services

THE GLOBE AND MAIL, TUESDAY, SEPTEMBER 2, 1986

BY ANN SILVERSIDES
The Globe and Mail

Most patients arrive on foot at the Parkdale Community Medical Clinic, a bustling centre in Toronto's west end housed in a building that was formerly home to a used-furniture store.

About 50 kilometres away, a large parking lot encircles the Caroline Medical Group building in Burlington. Patients typically arrive by car and wait for their appointments in an austere grey- and salmon-pink reception area.

The clinics serve very different communities. The average income in Parkdale is the lowest in Toronto; Burlington, next door to Hamilton, is a well-to-do suburb.

But at both centres, physicians are paid in unorthodox ways.

Parkdale, a community health centre almost two years old, gets an annual budget from the Ontario Ministry of Health and doctors are on salary.

The Caroline group, started in the early 1970s, is a health-service organization financed on a per-capita basis: for each patient enrolled, the centre gets a set monthly amount from the ministry. Patients pay no extra fees at either clinic.

Only about 3 per cent of Ontario's population is served by such centres.

The majority of the province's residents go to doctors who are paid on a fee-for-service basis, which means the amount they earn is determined by the number of patient visits and procedures performed.

But to Dr. Doug Sider of the Parkdale clinic, being salaried is "the only sane way to work" in the west-end Toronto community.

"I don't have to worry about how much income I can generate from each patient visit, so I am free to focus on people's medical needs and work on prevention," he said.

"That is gratifying because people in our community have a greater-than-average number of health problems."

Parkdale patient Donna-Jean Lazzara, a single mother, says she never feels she is being rushed out the door. "I really feel free to ask questions," she said.

Happy as patients may be, many in the medical profession still view the alternative setups with suspicion.

"I know some doctors see us growing and wonder whether what we do is right, legal or honest," said Dr. Michael Mills, one of the four general-practitioner partners in the Caroline group practice.

Moreover, in the aftermath of the 26-day Ontario doctors' strike, "anything that smells of co-operation with the Ministry of Health is not looked on favorably by most doctors," he aid.

Dr. Mills, however, is a true believer. Per-capita financing allows the Caroline Centre, which is run by the doctors, to offer patients a broad range of services. (Of the 25 other health-service organizations like the Caroline in Ontario, 17 are sponsored by doctors, five by hospitals and three by community groups.)

Centre staff, all paid out of the per-capita pot, include two specially trained nurse practitioners who handle minor medical problems and do health-promotion counselling, and two part-time social workers whose services are available to patients at no extra cost.

Patient Marlene Murphy said she goes to the nurse practitioners "for a lot of things like pre-school medicals and prenatal visits. That way you don't have to take up the doctors' time and they are more available to help people who are ill."

Indeed, because doctors spend more than the usual amount of time with each patient, their diagnoses are improved and Caroline-group doctors make fewer-than-average referrals to specialists, Dr. Mills said.

Both Dr. Mills and Dr. Sider stress that medical care is improved when family doctors have more time to spend with patients. "There is a saying in medicine that (patient) history and the physical are everything," Dr. Sider noted.

At Parkdale, patients the doctors know are booked in for minimum 15-minute appointments, while new patients are allotted about 20 minutes. The practice is "low volume but high intensity," Dr. Sider said.

At the Caroline group, the minimum time for an appointment is 10 minutes, but patients may be booked for 20 or 30 minutes with a doctor, Dr. Mills said. Observers say the average time patients spend with fee-for-service general practitioners is about eight minutes.

At the Burlington clinic, physicians take a six-month sabbatical every seven years. Dr. Mills recently spent his time off working at a busy group practice in England.

"You can just see it happening as your time is squeezed. The prescription pad gets smaller and your problem solving becomes more bizarre.

"Time constraint is a significant factor in the way you manage patients. The less time you have, the more medication you prescribe and the more referrals (to specialists) you make."

Poverty and illness go hand in hand, and thus there are high-risk groups in the Parkdale community, Dr. Sider said. (While the over-all average household income in Toronto climbed 11.5 per cent in real terms from 1970 to 1980, it dropped by 6.2 per cent in Parkdale.)

The community has a high proportion of ex-psychiatric patients, single mothers, homeless people and new immigrants, some of whom are in Canada illegally. (The clinic will provide medical care to people without Ontario Health Insurance Plan coverage, because it is budget-financed.)

"These people can't be dealt with using a factory-line approach. . . . So many of their health problems are related to things like poor housing and poverty," Dr. Sider said.

The magnitude of the social problems means clinic staff "sometimes feel impotent," said Parkdale co-ordinator Almerinda Rebelo. "The challenges we face include how to deal with the underlying influences on health, such as the appalling housing conditions."

To tackle some of those problems, Parkdale has on staff Alison Stirling, a full-time community health educator. Some new immigrants in the community live without heat or hot water, she says, "and thus have quite severe respiratory problems. . . . We help them look at their food and shelter needs."

Ms Stirling recently organized a meeting of single mothers on welfare "because they wanted information on how to feed their children. They shared ideas about how to stretch their budget and get enough

to eat."

The health educator has also organized a self-help group for battered women and Alastair Martin, 70, said it was at her urging that he formed a tenants' association at the seniors' apartment building where he lives.

"Security is the big problem at the apartment," Mr. Martin said.

Doctors at the two centres are not taking a financial bath by working in non-traditional settings. Dr. Mills says he earns as much, or perhaps slightly more, than Burlington doctors who work on a fee-for-service basis.

In 1984-85, general practitioners in Canada earned about $80,000, after expenses, from provincial medicare plans, according to the federal Department of Health and Welfare.

The salaries for the two Parkdale clinic doctors, Dr. Sider and Dr. Debbie Honickman, are spelled out by the Ministry of Health. The top salary under those guidelines is $65,166, according to the ministry, and Dr. Sider said he considers his salary "very generous."

Doug Sider and Debbie Honickman are members of the Medical Reform Group.

THE GLOBE AND MAIL, WEDNESDAY, SEPTEMBER 17, 1986

U.S. leads the way in controlling health care costs

Market pressures and cuts in federal and state medical insurance have forced radical changes in the U.S. health care system in the past few years. While the push for cost-control has not reached the same pitch in Canada, we can look south and learn. The last of a series.

BY ANN SILVERSIDES
The Globe and Mail

Canada's health care system is both more comprehensive and less expensive than its U.S. counterpart, but escalating expenses will soon put the cost of care squarely on the political agenda in Canada.

And despite critical differences between the two health care systems, Canada does stand to learn from some of the U.S. experiments in cost control.

The United States spends about 10.6 per cent of its gross national product on health care; the comparable figure in Canada is 8.5 per cent.

South of the border, government and private insurers have, in a push to slash rising costs, brought about significant changes in the health delivery system.

The results of some of the U.S. innovations underscore the need for Canada to scrutinize more closely the inefficiencies in its own health care system — inefficiencies that, if unattended, will jeopardize the quality and availability of care.

Experiments in the United States have, for example, pointed directly at hospital use as an area rife with inefficiencies.

Subscribers to prepaid health care in the United States are typically put in hospital at a rate 40 per cent below that of patients of fee-for-service doctors, said John Ware, health policy analyst with the Rand Corp. in Los Angeles.

Under the prepaid system, increasingly popular with cost-conscious insurers, subscribers pay a set annual amount for health care no matter how many services they use.

"In the United States, the changes we are making now are the easy changes. We're eliminating some of the unnecessary hospitalization. . . . We've seen the first big flow-through of savings," Mr. Ware said.

Whether or not Canadian policy-makers decide to embrace prepaid health schemes wholeheartedly, the U.S. experience indicates that there is a lot of scope to scrutinize patterns of hospital use, the big-ticket item in the health care system.

This information is being used to advantage at Foothills Hospital in Calgary, one of several hospitals across Canada taking part in a special project called the Value Improvement Program.

But Ralph Coombs, president of Foothills, said that in most Canadian hospitals, the budgeting system actually discourages efficiency.

"There is a tendency to admit early and discharge late because there is no inducement to use patient time wisely. Indeed, if a hospital wants to end up with money at the end of the year, it is beneficial to admit people who aren't very ill and keep them for a long time."

The project at Foothills, which involves close examination of patterns of hospital usage, has led to some significant changes, and savings.

For instance, the average length of stay for a patient who suffered an uncomplicated heart attack is now eight days at Foothills, compared with 10.8 days when the project began, Mr. Coombs said. (The average length at the five hospitals taking part in the project was, at the outset, 12.31 days.)

The cost per case has fallen by about 25 per cent, to $2,100 from $2,790.

To achieve the shorter stay, patients received more concentrated medical care and that, in the view of doctors who evaluated the changes, meant medical care actually improved, Mr. Coombs said.

The close examination of use at Foothills has been given another push because, on a trial basis, the hospital is also being financed in an innovative manner. Instead of lump-sum financing, it receives $2,155 for each admission, regardless of the diagnosis or length of stay, Mr. Coombs said.

"When you get one big bag of money, it is harder to focus on the cost of a unit of work. This scheme encourages us to look at units of work, and at the end of the year we, unlike most hospitals, have to demonstrate that we have done a certain amount of work."

The innovative financing scheme at Foothills is not unlike one pioneered in the United States by Medicare, the federal health insurance program that provides partial coverage for the elderly and the disabled.

Under that scheme, patients are covered for a certain number of hospital days based on the diagnosis when they are admitted.

Medicare holds the reins to that system and many U.S. physicians worry that the scheme means some patients are short-changed on care and released too early.

By contrast, Foothills doctors have, with an eye to improving quality of medical care, been intimately involved in the scrutiny of hospital stays, Mr. Coombs said.

Indeed, many health policy analysts warn that if Canadian doctors want to retain their clinical freedom, they must take the lead in monitoring the system for inappropriate use.

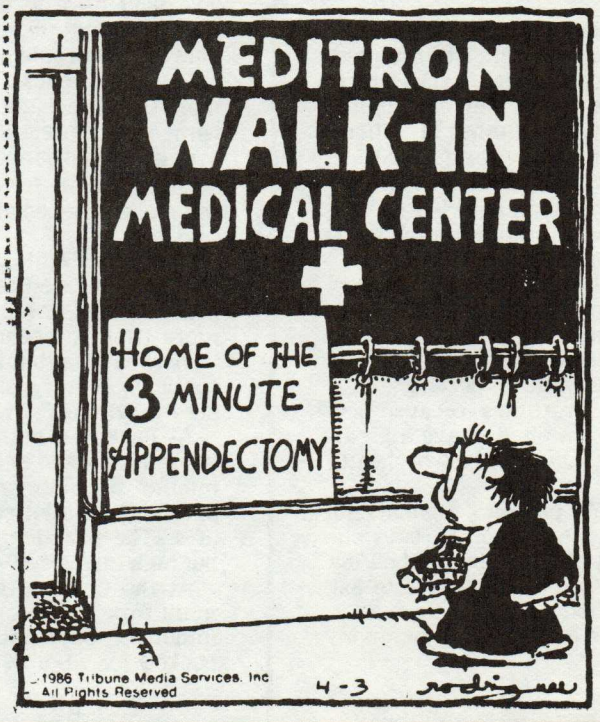
If doctors do not tackle inefficiencies in the system, they will leave the field open to cost-conscious bureaucrats. Doctors will, in turn, find their activities coming under more scrutiny, and subject to more control, the analysts said.

"I don't think there will ever be real progress until the medical profession gets its act together," said Bob Brook, a doctor and health policy analyst with the Rand Corp.

"They've got to come clean . . . they have to show convincingly that they are dealing with inefficiencies in the system."

In Canada, where there is already almost total equity in access to medical care, the key issue is potential over-use of the system, Dr. Brook said in an interview.

"There is a real concern that doctors will create their own demand. You want a monitoring system to detect that over-use."



Toronto Star, Nov 5/1986

New fees allowed MDs slammed by medical group

By Lillian Newbery Toronto Star

The Ontario Medical Association's new guidelines to physicians for charges for uninsured services illustrate the "incompetence" of their leadership, says a member of the Medical Reform Group.

If the OMA had negotiated in good faith with the Ontario government over the past year, the association "might have been able to negotiate coverage of uninsured services" under the Ontario Health Insurance Plan, Dr. Philip Berger said in an interview yesterday.

"This document is completely useless and an embarrassment to the association."

But cardiologist Stuart Klein said he thinks the OMA has provided a "good set of guidelines" and while some uninsured services might better be covered by OHIP, others, such as insurance forms and legal letters, take varying lengths of time and should be billed on an individual basis by the physician.

Klein said members of society have a right to charge for services for which they are not reimbursed. "You would never think of calling a lawyer for expert advice and not expecting a bill."

Klein said in an interview he spent more than an hour on the phone yesterday calling two chronic hospitals trying to get information about a form to be filled out to admit a patient and such efforts are not covered by OHIP.

Berger said the guidelines encourage doctors, especially general practitioners, to bill patients directly for uninsured services, in much the same way the association used to encourage specialists to extra-bill for insured services.

The Health Care Accessibility Act passed in July makes it illegal for doctors to bill patients for insured services.

Klein said some doctors will charge for some of the uninsured services, some for all and some for none. "They're just guidelines — the OMA is a voluntary organization."

He said family physicians will be likely to charge more frequently for prescription renewals and specialists for group conferences with other health professionals.

A fee for telephone advice may discourage "some of the more frivolous phone calls" from patients, Klein said, and the fee of $30 for 15 minutes is "not out of line in any way with rates in society."

Berger said the recommended fee for telephone advice will inhibit people from seeking that advice because they will fear, particularly the poor, they cannot afford it."

Women get worse medical care than men, female doctor says

CALGARY (CP) — Women receive worse medical care than men, a female doctor and author says.

Dr. Cynthia Carver, the keynote speaker at a recent health conference, said women get misdiagnosed because doctors don't listen to them and make assumptions about women.

They are also uncomfortable with women's problems and often lack knowledge because of the scarcity of scientific research into women's medical concerns, she added.

A "quick fix" philosophy has developed as a result and was especially evident in the over-prescription of tranquillizers to women in the 1970s, the doctor told 750 delegates to the Women's Health 86 conference.

Carver, an outspoken critic of her profession and author of the book *Patient Beware: Dealing With Doctors And Other Medical Dilemmas*, said doctors often fail to take the time to find out what is giving their women patients pain.

She referred to studies showing high rates of unnecessary surgery, especially hysterectomies and caesarean sections.

But women traditionally have been docile patients who accepted what they were told, Carver said.

"Women need to start thinking of themselves as a partner in the decision-making," she said, adding they must insist on explanations of procedures and drug side-effects.

"I don't think the care we get is horrendous," she said. "There are good doctors around. But you need to know a lot more, be more assertive, be a partner." →

Cynthia Carver is a member of the MRG.

Toronto Star, Nov 5/86

Health News Briefs

Lead levels deemed dangerous

Hundreds of properties in Toronto's Riverdale area are polluted by lead at levels considered dangerous, according to a report by the provincial environment ministry. The soil at nearly 200 of 389 properties in South Riverdale contains lead in concentrations above 1,000 parts per million. According to the study, contmination at the levels found in South Riverdale may pose a potential danger to young children in direct contact with the soil.

Toronto Star Oct.23, 1986

Physicians organize against smoking

A group called Physicians for a Smoke-Free Canada has announced that every time one of its member's patients dies of a tobacco-related disease, it plans to send a black-bordered postacrd to the patient's MP. "It is time politicians understood the real dimensions of the tobacco problem," Dr. Bob Rivington said. Physicians for a Smoke-Free Canada has been lobbying for comprehensive controls on tobacco, including a total ban on advertising, higher tobacco taxes, protection of the rights of non-smokers and help for tobacco farmers who want to switch to other crops.

Globe and Mail, 31/10/86

Court bans forced sterilization

The Supreme Court of Canada has ruled that judges cannot order a mentally handicapped woman to undergo sterilization for non-medical reasons. The decision was hailed as a landmark by mental health advocacy groups. "The importance of maintaining the physical integrity of a human being ranks high in our scale of values, particularily as it affects the privilege of giving life," Mr. Justice Gerard La Forest said. "I cannot agree that a court can deprive a women of that privilege for purely social or other non-therapeutic purposes without her consent. The fact that others may suffer inconvenience or hardship from failure to do so cannot be taken into account." Commenting on the decision, Kathleen Ruff of the Canadian Human Rights Advocate said that "Sterilization of the mentally handicapped has been terribly abused in the past. It has been authorized without any evidence that it is beneficial or appropriate.

Toronto Star 24/10/86

Compulsory drug testing attacked

Compulsory drug testing for new employees at Air Canada and American Motors is a "fundamental violation of human rights," says Canadian Auto Workers president Bob White, who has called for immediate legislation to end the practice. Both companies have acknowledged that they now use urinanalysis screening as part of a mandatory medical examination for all new employees. White, whose union represents 140,000 Canadian auto workers and 3,300 Air Canada ticket agents, said that 'we're not animals, we're not horses in a race, they've got no right to do this."

--Globe & Mail/Toronto Star, 5/11/86

Stelco workers seek tests after PCB scare

Electricians at Hamilton's Stelco plant are volunteering for medical tests to check their PCB levels in a cancer scare among workers who are exposed daily to the chemical. After a colleague was found to have abnormally high levels of PCB's in his system, about 30 Stelco workers booked medical appointments at the Ontario Workers Health Centre. The health centre is an independent entity sponsored by several Ontario labour unions. PCBs are used as a coolant in electrical transformers and have been linked to cancer, liver disease, headaches and pregnancy difficulties. Electricians used to become "soaked to the armpits" in the collant when repairing transformers, health centre director Stan Gray said.

--Toronto Star, 20/10/86

New regulation for workplace toxins

Ontario has promulgated a new regulation to make it easier to prosecute employers who expose workers to excessive hazards from 600 toxic industrial substances, Labour Minister Bill Wrye has announced. The new regulation sets numerical standards for most of the common toxic substances used in industry. The standards are the same as the figures previously used by the ministry as guidelines. However, by placing specific legal limits on the substances, the ministry says it will have more clout to prosecute employers. However, the legal controls on the 600 chemicals will still be significantly weaker than the detailed assessment and

continued....

Health News Briefs

Workplace toxins (continued)

control programs Ontario now requires for 11 designated substances including lead, mercury, asbestos, and arsenic. NDP safety critic said the new regulation has "nothing to do with health protection" and said that the guidelines were developed without any input from labour. Stan Gray of the Ontario Workers Health Centre said the new regulation is "a slick public relations ploy" by the Liberal government. The move is designed to deflect attention from the Ministry's reluctance to enforce standards, Gray said.

Toronto Star, 7/11/86

NDP attacks nursing home standards

Some private nursing home owners in Ontario spend $2.10 per day to feed their elderly residents, NDP Leader Bob Rae has said. Rae said the information came from a report released by Health Minister Murray Elston. Rae said that by comparison Toronto General Hospital spends $5.28 per day per patient and detention centres in Ontario spend $4.29 per day for each prisoner.

--Toronto Star, 22/10/86

Nursing home inspectors called overworked

Ontario Government nursing home inspectors suffer from poor morale, a stressful work environment and too little training in monitoring the care and living conditions of elderly people in institutions, says a report commissioned last spring by the Ministry of Health. The 90-page report, by Woods Gordon management consultants, paints a picture of demoralized, overworked inspectors working in cramped quarters without proper supervision or a clear mandate. In addition, it says that the Government has had trouble in recent years getting convictions in cases where nursing home owners have breached the Nursing Homes Act.

--Globe and Mail 29/10/86

Drug patent legislation introduced

After a number of false starts, the federal government has finally introduced the long-awaited bill to protect patents on prescription drugs. The bill would strip the so-called generic manufacturers of the right to market cheaper versions of drugs. Consumer Minister Harvie Andre maintained that the new law would usher in $1 billion in new investment, creating 3,000 new jobs. Critics have said that the bill will cost Canadian consumers up to $650 million a year more in drug costs without doing anything concrete to guarantee a single new job.

--Globe and Mail/Toronto Star 8/11/86

New forms of extra billing

New forms of extra billing were the subject of numerous media reports in the period since the doctors' strike ended. Among the events reported were:

NDP Leader Bob Rae unveiled a letter from an ophthalmologist asking a patient for a $500 donation before an eye operation.

OMA president Dr. Richard Railton said that the OMA is embarrassed by some the the fees which have been publicized. He called on physicians to be responsible in setting new "administrative" and other fees.

A Toronto obstetrician was revealed to be charging patients administrative fees which in some cases are greater than the fee paid to him by OHIP to treat the patient. NDP MPP cited one incident in which the MD charged a $150 "administrative fee" for a procedure for which he was paid $139 by OHIP.

Other fees being charged by MD's included, for example, $10 per visit to "cover overhead items" such as salaries and rent, $15 per page for each form or letter required; $15 for re-ordering a prescription over the phone.

The OMA released its own set of guidelines in November to cover administrative fees. These state that it is acceptable to charge "at an acceptable professional rate", for e.g. $30 per quarter hour, for such things as telephone advice, doctor's certificates, chart summaries, renewal of prescriptions, and medical supplies.

SUBMISSION TO THE COMMITTEE ON PRIVATIZATION FROM THE MEDICAL REFORM GROUP OF ONTARIO

INTRODUCTION

In considering the structure of delivery of health care services, at least three goals are paramount. Health care services should be of the highest quality, they should be delivered in an equitable fashion to all members of society, and they should be delivered as efficiently as possible. It is clear that any private system, insofar as access to services is dependent on ability to pay, threatens the goal of equitable delivery of services. Those who favour a health care system financed by private capital and administered by private institutions would argue that problems with equity can be minimized, and that advantages in quality, and particularly in efficiency, more than compensate for any losses in equity.

In any consideration of these issues, the Medical Reform Group believes that the underlying values of the society will be the major determinant of the choices made. However, we also believe that a careful examination of the evidence regarding the effects of alternate funding and health care delivery systems on quality, equity, and efficiency is crucial for making rational decisions. However, we do not see our role as providing a comprehensive or scholarly review of the available evidence regarding the impact of private versus public health care systems. Such a review can be found in "Privatization in the Canadian Health Care System: Assertions, Evidence, Ideology, and Options," by health economists Greg Stoddart and Roberta Labelle. Professors Stoddart and Labelle are acting as consultants to the committee, which will as a result have excellent access to and presentation of the relevant evidence. Our brief makes liberal use of Stoddart and Labelle's monograph, but highlights some of the issues and evidence that we believe are particularly important, from the viewpoint of practicing physicians.

CANADA AND THE UNITED STATES

Considerable insight into the consequences of public versus private health care can be gleaned from comparing the American and Canadian health care systems. In effect, a natural experiment has occurred in North America. Two large and wealthy countries, the United States and Canada, exist side by side. Although the United States is, population-wise, much larger, the two countries are similar in their cultural heritage, wealth, and the aspirations of the populace. They have elected to go two quite different ways with respect to administering their health care systems. Canada has opted for what is essentially a government run system. The provincial governments administer the

health plan, are responsible for the hospitals, and are the sole insurers. For most of the populace medical care is in many ways a free ride; you can attend the majority of physicians and (in most provinces) be admitted to hospital without paying any extra fees.

In the United States, in contrast, the government role is restricted to being the third party payer for some of the indigent and for a proportion of the costs of those over 65. Private health insurance is big business, and a large and growing proportion of the hospitals are privately owned. Patients pay a substantial proportion of their medical costs as out-of-pocket expenses, or through private health insurance. If the free-enterprise dogma regarding the greater efficiency of a privately run health care system were true, a number of consequences would follow from this state of affairs. First, the administrative costs of health care would be higher in Canada, given the unwieldy bureaucracy that runs the system; private for-profit hospitals would run more efficiently than their public counterparts; and overall, given all the incentives to be efficient and avoid going for unnecessary care, the American medical system would be less expensive.

ADMINISTRATIVE COSTS

To begin then, administrative costs can be examined considering the administrative costs of private and public health insurance plans. The administrative costs of these plans constitute 2.5% of total health care costs in Canada, and only 1.5% of these costs are accounted for by public plans. Similar costs in the United States for private and public plans combined represent 8.3% of total health care costs, and rise to 12% for only private plans (Stoddart and Labelle).

The reduction in costs is not restricted to administration of health insurance, but extends to hospital administration, and even to administrative costs of physicians in private practice. In an estimate that included hospital administration, nursing-home administration, and physicians' overhead, American administrative spending was calculated as consuming 22% of all health care expenditures (Himmelstein and Woolhandler). These same authors estimated that the comparable figure in Canada is 13.8%.

The case of nursing home administrative costs is interesting. In Canada, nursing home care is reimbursed through payments by private insurance or direct payments by residents: a system similar to that of the United States. The result is that administrative costs are comparable to those in the United States (10.5%) and greater than those in Canada's acute care hospitals (Himmelstein and Woolhandler). In Britain, where nursing homes are part of the National Health Service, administrative costs are 5.7% of total spending. This suggests that bringing nursing

homes within the provincial health service would save appreciably on administrative expenses.

These results are not surprising when one examines the administrative systems. In Canada there are a total of 10 administrative bodies--one in each province. These are charged with all the paperwork associated with health insurance in the province--and that is their sole responsibility. In the United States there are literally hundreds of insurers. Thus, one disadvantage for the Americans is that they lose economies of scale.

There are, however, other major disadvantages of the American approach. In addition to administering health insurance the insurers have another job--get as much business as possible. This requires advertising, and hiring sales people--an expensive proposition. In addition, they have to compete for senior executives who command extremely high salaries.

The waste of the American system extends into the hospitals. American hospitals require a sophisticated billing department with an extensive internal accounting structure that is necessary to attribute all costs and charges to individual patients and physicians. This is unnecessary in Canadian hospitals. In addition, physician billing is simplified by universal health insurance, reducing the overhead of individual physicians. When one considers all these factors together it is no wonder public programs are so much cheaper to administer.

A final irony of the relative administrative costs of Canada and the United States is, as pointed out by Himmelstein and Woolhandler, that the additional American administrative costs are necessary to enforce the restrictions that limit access to health by the poor.

PUBLIC VERSUS PRIVATE HOSPITALS

There has been a widespread opinion among economists and others who believe in the market solution to the cost-containment problem that for-profit hospitals must be more efficient because they have the appropriate incentives to be responsive to market forces. Although there are no data comparing Canadian and American institutions, there are data examining public and private hospitals in the U.S. Information is available from a number of studies; the results are consistent and convincing. We shall briefly review three representative studies. In the first study 53 investor-owned hospitals in California, Florida, and Texas were compared with 53 closely matched nonprofit hospitals in the same states (Lewin et. al.). Total operating expenses per admission were 4% higher in the investor-owned hospitals, which nevertheless managed to generate a greater net income by virtue of their higher charges.

A second source of information is data from the Florida Hospital Cost Containment Board comparing all proprietary and not-for-profit hospitals in that state for the years 1980 and 1981 (Relman). Again, the private hospitals had operating expenses that were 4% higher.

A third study examined voluntary non-profit hospitals, public hospitals, and investor-owned chain and independent hospitals in California (Pattison and Katz). Total operating expenses per admission were 2% higher in the investor-owned chains than in the voluntary hospitals. Interestingly, this study demonstrated that one problem for the for-profit chains was administrative costs, which included each hospital's share of the costs of corporate headquarters. In addition, the for-profit hospitals conducted more tests and used more supplies per admission as well as charging a higher price per test or unit supply.

It is interesting to note another successful strategy for improving profits utilized by the private hospitals. There are groups of patients, generally the sicker and more complicated, who are more expensive to take care of, and who thus threaten the profit margin. Private hospitals have often been successful in shunting such patients to the public system. This process, while making the private hospitals, in isolation, look better, increases transportation costs and therefore actually makes the total system more costly.

The conclusions are indisputable:the success of investor-owned hospitals in the United States has been a function of their marketing of services and manipulation of prices rather than their ability to control costs. Not-for-profit hospitals are actually more efficient and less costly than their for-profit counterparts.

Of course, Canada could turn to paying private administrative firms to run its hospitals, without changing the hospitals themselves into for-profit institutions. Less data is available concerning this issue. However, one does hear stories of private administrative firms turning at least one Canadian hospital (Hawkesbury) from a financial disaster area to an efficiently and profitably run institution. Even if one accepts that the situation at Hawkesbury was improved by the introduction of private management, it would be inappropriate to generalize beyond this single case. Private management is likely to be introduced in a hospital that is in trouble, particularly at a time of crisis. If a hospital is being particularly badly managed, any change in management structure, whether public or private, will improve the situation. Further, hospitals financial status, just as patients' physical status, tends to fluctuate. If one introduces an intervention when a patient (or a hospital) is doing particularly badly, the natural history of the situation (spontaneous improvement) will likely make the intervention look good. Systematic studies, rather than a single

anecdote, are required before the private management argument can be given any credence.

AN OVERALL COMPARISON OF HEALTH CARE IN CANADA AND THE U.S.A.

Finally, let us turn to the bigger picture, total health care costs in Canada versus the United States. In the early 1960's, before the introduction of nationwide universal health insurance in Canada, the proportion of the gross national product devoted to health was the same in both countries. Since that time, however, health costs have accelerated at a considerably greater rate in the United States than they have in Canada. Presently, just over 8% of Canada's gross national product is spent on health, whereas the comparable figure in the United States is almost 11%. The difference is even greater when one considers that the per capita GNP is larger in the U.S. than in Canada. The conclusion is inescapable: planning at a provincial level has been more effective in controlling health costs than the market forces at play in the United States.

Up to now, we have focused primarily on the issue of cost. The reason is that, given that the private system is unlikely to provide advantages in terms of quality, and will certainly undermine equity, if costs are equal or greater (as turns out to be the case) the private option need be given no further consideration. However, it is worthwhile briefly looking at the quality and equity issues.

Could it be that American health costs are higher because the Americans deliver higher quality health care? The answer is no. Despite the lower expenditures on health care, all the conventional indices of health, including life expectancy and infant mortality, are actually better in Canada than in the U.S. Further, it is worth noting that before the introduction of universal free access to care in Canada and Great Britain, both countries had age-adjusted mortality rates that were higher than those in the United States. Within a decade of the introduction of free access, a sharp decline in mortality occurred, so that the levels in both Canada and Great Britain are now lower than in the United States (Himmelstein and Woolhandler).

The fact that, overall, health status is better in Canada than in the United States is not surprising when one considers that the barriers to high quality health care for the poor (who have higher morbidity and mortality than do the more affluent) are far more formidable in the United States than in Canada. Particularly disturbing are practices such as "dumping", in which sick patients who cannot pay are transferred, often while still unstable, to public institutions. This is an extreme example of the behaviour that results from introduction of the incentives of the marketplace into the practice of medicine. From the physician's point of view, an ethical practice of medicine is difficult, if not impossible, in the American private system of

health care delivery. A publicly funded and publicly administered system allows patient needs to remain the sole consideration in physicians' decisions concerning the nature of the services an individual patient should receive.

CONCLUSIONS

It is clear from the data that the oft-quoted story of the relative efficiency of free market, free enterprise, capitalist methods are, when it comes to health care in North America, a myth. "Socialized" medicine in Canada has produced a superior product, and a healthier populace, at a lower cost, than the free enterprise American system. Further, the quality of health care delivered to the entire populace is better, and the gross inequities of the American system have been avoided.

Canadians should work to preserve public funding and public administration in the areas where they already exist. In areas where the public system is threatened, such as "uninsured services" delivered by physicians, remedial action should be taken. The spectrum of such uninsured services should be drastically reduced. In the arena of the fee-for-service system, consideration should be given to reimbursement of services such as physicians' telephone consultations with patients. Consideration should also be given to moving toward public financing and public administration of health services, such as nursing homes, where the problems with quality, efficiency, and equity that characterize the private system still exist.

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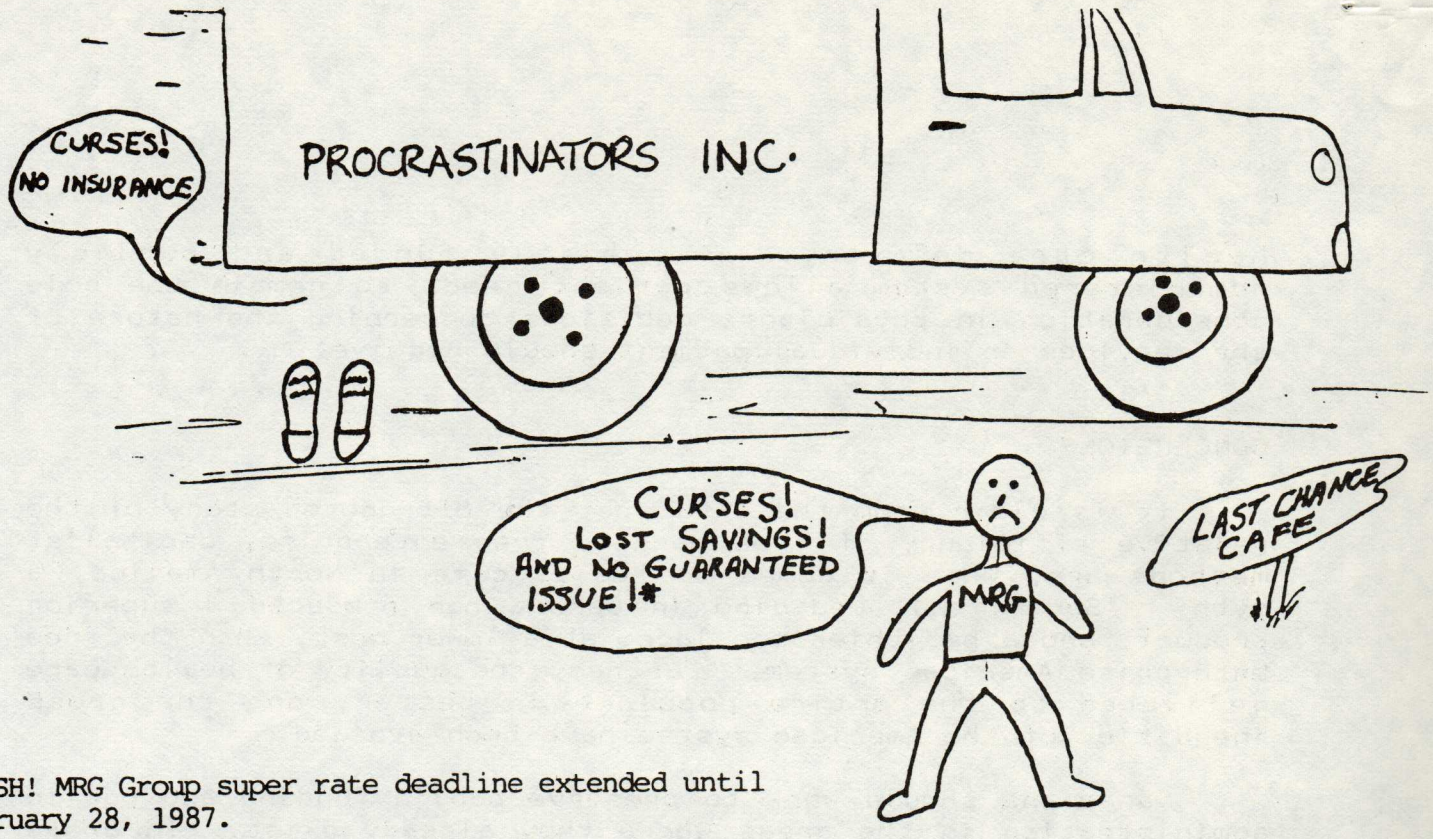
This draft brief was written on behalf of the MRG by Dr. Gord Guyatt.



FLASH! MRG Group super rate deadline extended until February 28, 1987.

Wake up! Smell the coffee! Then call Trudy Baker at 960-1736 for your disability and/or office overhead insurance now.

OPTIONS
- 1st time coverage (yes, you have been busy)
- extend your present coverage
- drop your present coverage and go with the MRG plan.

WHO QUALIFIES?
- any MRG member M.D., associates included
- any M.D.'s spouse
- any M.D.'s office employee.

Any of the above options counts towards getting the required minimum number of insured members for the guaranteed issue* bonus and an extra 5% discount on premiums.

* guaranteed issue is Great West Life's promise to pay $1500/mo. disability to any member disabled in the future regardless of their present state of health.

Presently we have 4 members who are uninsurable by any other insurance company and who could be insured if we all sign up now!

QUESTIONNAIRE

Would you consider participating in the group disability insurance plan made available to MRG members and associate members by the association:

|_| YES NO |_|

Please provide the data requested to assist Baker & Baker in providing the above discussed benefits for you to facilitate expedient processing.

NOTE: THIS IS NOT AN APPLICATION

The information provided will be kept in strict confidence whether or not you decide to participate in any part of the plan.

PERSONAL DATA

NAME_____ ADDRESS_____

TEL: BUS._____ RES._____ MALE |_| FEMALE |_|

DATE OF BIRTH _____
DAY MONTH YEAR

OCCUPATION OR SPECIALTY_____

ESTIMATED PRETAX EARNINGS_____ ANNUALLY

HAVE YOU SMOKED CIGARETTES IN THE PAST YEAR YES |_| NO|_|

DISABILITY COVERAGE (LTD)

A. BENEFIT AMOUNT REQUESTED $_____ MONTHLY (NON TAXABLE)

B. WAITING PERIOD - 31 DAYS |_|, 91 DAYS |_|, 121 DAYS |_|, 61 DAYS |_|

AVAILABLE OPTIONS

C. FUTURE EARNINGS PROTECTION |_|

D. COST OF LIVING INDEXING |_|

E. PARTIAL DISABILITY |_|

F. SPECIALIST OPTION |_|

OFFICE OVERHEAD

BENEFIT AMOUNT REQUESTED $_____ MONTHLY

STARTING DATE: 15 DAYS |_| 30 DAYS |_|

DURATION: 12 MOS |_| 18 MOS |_| 24 MOS |_|

Please return to: BAKER & BAKER, 1075 BAY ST., Ste. 605, TORONTO M5S 2B1
OR CALL TRUDY BAKER AT 1-416-960 1736 BUS. or 1-416-766-4277 RES.