MRG Newsletter

Medical Reform Group of Ontario, P.O. Box 366, Station J, Toronto, Ontario M4J 4Y8 (416) 537-5877

VOLUME 7, NUMBER 3 JUNE 1987

MRG General Meeting

The Medical Reform Group's semi-annual general meeting took place on May 2, 1987 at the South Riverdale Community Health Centre in Toronto.

The business part of the meeting heard reports from the Toronto and Hamilton chapters. The **Toronto chapter** has had little activity since the last General Meeting, but Doug Sider promised that the level of activity would pick up and announced that a series of meetings was now being planned. The **Hamilton chapter**, reported Phillippa Tattersall, has had monthly meetings and has also developed a social network of support. Joel Lexchin spoke to one meeting on pharmaceuticals issues, and Michael Rachlis to another on alternatives to fee for service. Members of the chapter did work on the patent act, with one member, Roseanne Pellizzari, delivering a presentation to the House of Commons committee holding hearings on the proposed new pharmaceuticals act. The chapter has 55 members.

Haresh Kirpalani presented a **Treasurer's Report** which indicates that the MRG will have a small surplus at the end of the year even after purchasing a photocopier.

In the **Steering Committee report,** Catherine Oliver reviewed the areas in which the MRG and its Steering Committee have been active. Areas of activity included extra-billing, the drug patent act, abortion, AIDS and AZT, the Spasoff committee on health care goals, and the Ontario government's select committee on privatization.

Members were reminded that they are welcome to attend and partipate in Steering Committee meetings. Meetings are usually the last Thursday of each month, and normally alternate between Toronto and Hamilton. For information about specific times and places, contact MRG Secretary at 537-5877.

Michael Rachlis reported on the work of the sub-group working on **extra charges.** Members of the group met with members of Murray Elston's staff, and with members of the Progressive Conservative and New Democratic parties. The working group's conclusion is that there is little interest in or political will for tackling this issue.

There was discussion at the meeting about how the MRG ought to deal with the issue. One suggestion made was to take out an advertisement in the Globe and Mail regarding the issue. Another suggestion was to pay the Gallup organization to tack on a question about extra charges to its monthly poll. Another opinion was that the MRG ought to give more priority to its stand of opposing OHIP premiums, which are arguably more of a deterrent to more people than administrative fees charged by doctors.

Finally, a motion was passed by a 12 - 10 vote *authorizing the Steering Committee to spend up to $1000 to research the extent of extra charges if it thinks it necessary and appropriate to do so.*

Bob Frankford reported on activity relating to the **Drug Patent Act**. He and Joel Lexchin met with Consumer and Corporate Affairs Minister Harvie Andre, and he and Roseanne Pellizzari appeared before the House of Commons committee holding hearings on the bill. The bill has now passed the Commons, and Senate hearings are getting under way. The MRG has asked to make a submission to the Senate committee.

Bob Frankford and Joel Lexchin were also asked to be members of a drug price review committee being set up by the Toronto Star.

Mimi Divinsky reported on **abortion-related issues.** She gave a summary of the Powell report, which Marion Powell has now been hired to implement. Criticisms were made of the Powell report's heavy reliance on a hospital-based model. Catherine Oliver summed up her position as being "luke-warm". She felt that the Powell initiatives are not likely to work out very well in practice, that hospitals are not very interested in taking an iniative on increasing abortion access. Several members stated that the MRG should continue to state its position that free-standing clinics are the only solution and should point out that the Minister of Health has the power to make such clinics hospitals so that they will fall within the legal requirements.

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Newsletter Deadlines

The publication date of the next MRG Newsletter is August 7, 1987. The deadline to submit items for the issue is July 20. Longer opinion and feature articles should be submitted earlier, by June 25.

The publication date for the subsequent issue is Spetember 11. The deadline for that issue is August 24. Longer opinion and feature articles should be submitted earlier, by July 30.

Toronto chapter meeting

The Toronto chapter of the Medical Reform Group will meet Tuesday June 9, 1987 at 8 p.m. at the South Riverdale Community Health Centre. (Please note the change in venue: the meeting was originally scheduled for the Parkdale Community Health Centre.)

The meeting topic is "The Role of Preventive Medicine in Primary Practice. Can You Practice it in the Office? Will It Make Any Difference?" John Frank will be the guest speaker, and a good deal of time for discussion will be provided.

Contact person: Doug Sider 537-2455(W); 532-3273(H).

Medical Reform Group Spring General Meeting

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The Steering Committee was asked to *organize a special meeting specifically on the abortion issue.*

Philip Berger reported on the **MRG Newsletter.** He urged members to submit original articles, and letters to the editor. The newsletter is seen as a forum for the discussion of issues within the MRG.

Philip Berger also reported on the **capital punishment** issue. He represents the MRG on the Coalition on the Death Penalty. He noted that the MRG's position is that doctors should not get involved in the death penalty.

Steve Hirshfeld announced the formation of an **AIDS Working Group.** He said that there are a lot of AIDS-related issues now emerging, and that the MRG has no position on them. A working group is seen as a way of developing these positions. Steve noted that there are two types of organizations involved in AIDS-related issues, community health organizations and public health departments. Many of the community organizations are incorporated as charitable bodies, which places restrictions on their ability to speak out on political issues. Public health departments are often oriented to doing their work in a way that maintains the public morals of the day. Steve felt that there was a definite place for an organization like the MRG to bring its own perspectives to the AIDS issue. People interested in being on the AIDS Working Group should contact Steve Hirshfeld at (416) 925-7221 (H) or (416) 252-6475 (W).

It was also suggested that one or more articles be prepared for the Newsletter on AIDS-related topics.

Steve Hirshfeld also reported on the question of **MRG incorporation.** He reviewed the benefits (protection against liability, etc.) and requirements of being incorporated. *The meeting authorized the Steering Committee to proceed with incorporation, with final approval to come to the fall general meeting.*

Michael Rachlis reported on the activities of the **Ontario Health Coalition** and **the Canadian Health Coalition**. The OHC has a new executive assistant, and has set up a policy advisory committee chaired by Cliff Pilkey. The CHC's main concern has been the drug patent act. The CHC's annual general meeting will be in Prince Albert in June.

Michael Rachlis also reported on the **Evans Task Force** on health care. It is expected to present its report to the Premier sometime this month.

Bob Frankford spoke about an MRG **Working Group on Methods of Remuneration**. He noted that the MRG does not have a clear position on how physicians should be remunerated. The working group would be charged with developing positions on this. People who are interested in being on the working group should contact Bob Frankford.

The afternoon session was devoted to a panel on **Psychiatry and Current Issues of Patient Rights**. The speakers were Ms Carla McCague, Dr. Tyrone Turner, and Dr. Sam Malcomson. All three speakers have been invited, and have agreed, to prepare submissions for the MRG Newsletter. These should be published in the August issue.

Book Review

A Savage Enquiry: Who Controls Childbirth?
By Wendy Savage
London: Virago Press, 1986
Paperback, $8.95 (Canadian)

In April 1985, Ms Wendy Savage, a consultant in obstetrics/gynecology in east London (U.K.), was suspended from her position on the grounds of alleged incompetence. She and her supporters fought the suspension in all possible forums, including public demonstrations, court applications, and finally a six week long enquiry into her management of 5 obstetrics patients. Finally in July 1986 she was reinstated and in October 1986 she returned to work. This book is her story of this ordeal and her analysis of the reasons the process was set in motion and continued for so long. The book is lucid, easy to read (in spite of the difficulties a Canadian has in following the organizational complexities of the National Health Service) and remarkably free of personal vindictiveness.

Why is this story of interest to Canadian physicians? Perhaps it is not really "the case that rocked the medical world" as the blurb on the back cover of the book claims. But it does explain quite a lot about what it means to be a woman in a male-dominated world. Wendy Savage details her training and experience as a doctor in chapters 2 and 3 of the book. She started to work at Mile End Hospital in 1976 where she helped to establish a daycare abortion service and to strengthen the role of the GPs and midwives in maternity care.

The battle within the Division of Ob/Gyn began in 1981 when the chairman, who had been responsible for her appointment, resigned. The new professor arrived in early 1983 and during his first year criticized her clinical judgment in such cases as her decision to carry out an abortion on a twelve year old girl who was carrying an advanced pregnancy. Wendy Savage describes a meeting in the professor's office in which "the professor said...my colleagues did not like my clothes, my politics, or my style... and that I was 'disruptive'." She and the professor finally joined battle over a plan to centralise obstetrics at the main teaching hospital to the detriment, as she saw it, of her more community based practice. Most of the rest of the book details the charges of incompetence and the legal enquiry into those charges which in the end exonerated her completely.

"The Public Protests" (Chapter 6) outlines the public mobilization to support Wendy Savage. Significantly, the GPs of the area were very much behind her; 68 of the 83 local GPs signed an early petition to the District Health Authority. A group of GPs formed the Appeal Fund Committee which eventually raised sixty thousand pounds for her legal fees.

In the final chapter Wendy Savage summarizes six important issues arising from her suspension. Four of these directly concern the profession itself - accountability, incompetence, discipline and academic freedom. The other two speak to the broader issues of who controls childbirth and what kind of services do women want.

The women of Tower Hamlets are fortunate to have Wendy Savage back as their consultant ob/gyn. Those of us who are concerned about the issues her case raises are fortunate that she took the time to write this book.

By Catherine Oliver

From the Canadian Health Coalition

Dear Friends:

Canada's highly valued Medicare system is once again being threatened. Most Canadians believe that quality health-care will always be available to them. This is not so, even though our current federal government had pledged they would maintain Medicare as a "Sacred Trust", recent initiatives show that no such commitment exists.

Sacred Trust?

The federal government has made massive cuts in transfer payments which fund provincial Medicare plans. On December 13th Finance Minister Michael Wilson announced he would withdraw half of a $175-million equalization payment to the poorer provinces. These provinces expected, and desperately need sufficient funding to maintain their provincial health services. In addition to this funding withdrawal, major funding cuts have taken place through changes in the Established Programmes Financing Act.

Drug Costs

While the federal government is underfunding Medicare it is promoting changes to our drug patent legislation which will increase provincial drug costs. Canada's current drug legislation has enabled our provinces to maintain their provincial Medicare plans by ensuring low-cost generic substitutes are accessible to Medicare patients in hospital and to seniors through provincial drug subsidy plans. With funding cutbacks and more costly drugs, maintenance of provincial Medicare plans will be very difficult.

At The Provincial Level

Provincial administration of Medicare plans is also a problem. After the elimination of extra-billing, a trend is developing where the actual number of Medicare insured services is being cut back. In conjuction with these service cutbacks some provinces are permitting physicians to charge extra for administrative fees. These extra charges must be paid for by the consumer, so they really are a very real problem. The ban on extra-billing has prompted provincial medical associations to pressure provincial governments into offering huge increases in physician income packages. These increases are funded through our tax dollars. Other damaging provincial initiatives include the promotion of profit making interests in health-care.

Threats to Medicare

Threats to our Medicare system are not new, our universal Medicare system has been constantly under attack since its establishment. It was believed that the passage of the Canada Health Act would help stabilize the system. Since this Act was made law other forms of erosion, much more dangerous than extra-billing, have gained a foothold. We need to maintain our current level of health services, as well as ensure Medicare grows with the increased needs of our rapidly aging population.

CHC Needs Your Help!

This letter has outlined just a few of the current problems facing Medicare. At our 1979 founding conference the Canadian Health Coalition adopted a mandate to improve and preserve Canada's Medicare system. Through our membership we represent over 2.5 million Canadians. Given the current situation we need the Canadian Health Coalition knew more than ever to speak with one voice, for the health-care rights of all Canadians. The CHC must receive financial support in order to sustain and increase the pressure to ensure that our politiciaans are made acutely aware that Canadians will not tolerate the erosion of Medicare. To this effect we ask you to renew your commitment to Medicare in 1987 by making a contribution to the Canadian Health Coalition.

Sincerely,

Guy Adam,
Chairperson

Individuals are invited to become contributing sponsors of the Canadian Health Coalition. All financial contributors will receive four issues of the CHC quarterly publication "Medicare Monitor".

Name_____

Address_____

_____

Sponsor dues: low-income $15; other $25

Canadian Health Coalition
2841 Riverside Drive
Ottawa, Ontario K1V 8X7

JOB OPENING

The Lakeshore Area Multi-Service Project (LAMP) Occupational Health Program requires a physician to work on salary in a community health centre up to 17 ½ hours per week. Will be required to do individual health assessments, Worker's Compensation Board claims assessments and group assessments for medical monitoring programs.

Training and/or experience in occupational medicine is essential. Knowledge or experience of community based service delivery an asset.

Remuneration in keeping with salaries paid in other community health centres.

Starting date: immediately.

Apply to: LAMP Occupational Health Program
185 Fifth Street
Toronto, Ont
M8V 2Z5
(416) 252-6471
Attention: Bonnie Heath, Co-ordinator

Feature Articles

The following feature articles are intended to contribute to a discussion of issues. They do not necessarily represent MRG policy. Letters, rebuttals, and original articles are welcomed. Please send them to: MRG Newsletter, P.O. Box 366, Station J, Toronto, Ontario M4J 4Y8.

Women's Health Initiatives: Steps Forward or Sideways?

By Fran Scott

The Medical Reform Group has been concerned about women's health issues since the group was formed. In May 1980, a resolution on "Women and Health care" was passed by the membership at a general meeting. This resolution reads as follows:

"WHEREAS the medical profession is not adequately meeting the needs of women, particularly in the areas of obstetrics and gynecology, counselling on sexuality, parenting, contraception, abortion, role conflicts, and health education,

WHEREAS we recognize that the medical profession has historically regarded women's physical symptoms with less rigor than those of men, and has tended to treat their psychological problems with psychotropic drugs rather than working with them to increase coping skills,

WHEREAS the medical profession has taken from women control of child-bearing, abortion, and birth control,

BE IT THEREFORE RESOLVED THAT:

1. Centres be made available and easily accessible for primary care including: contraception, abortion, pre-pregnancy counselling, prenatal counselling, natural childbirth classes and childbirth education, minor gynecolocic problems, Pap smears, and breast examination
2. Abortion be removed from the criminal code and be recognized as a matter of a woman's personal conscience
3. Free-standing (i.e. non-hospital) abortion clinics be established in which women can obtain first trimester abortions quickly, safely, and in a sympathetic environment
4. Any physician unwilling to be involved in abortion or abortion counselling be obligated to promptly refer a woman desiring these services to another physician or agency who will help her
5. Safe alternatives in childbirth be made available to women including in-hospital birth centres, out-of-hospital birth centres, and adequate supports for home birth
6. Breast-feeding and natural childbirth be actively supported by physicians involved in birth, and family-centred birth become the norm
7. Gynecologists, general/family practitioners, and other health care workers receive more training in office gynecology, sexuality, marital and sexual dysfunction
8. Family physicians, psychiatrists, and other health care workers receive more training in women's problems, women's roles in society today, and the conflicts women face in regard to their roles as mothers, wives, and workers
9. All sexist material in medical journal advertisements and in medical textbooks be eliminated."

Since 1980, the MRG has actively advocated around issues such as abortion access and midwifery.

Recently the Ontario Government announced a series of women's health initiatives which will be funded. These initiatives are as follows:

"At a news conference today at Queen's Park, Health Minister Murray Elston announced a comprehensive range of new women's services, expansion of existing health programs and a central focus for women's health issues within government. For 1987/88, the government will provide more than $9 million in new funding, with approximately $7.5 million from Health and $1.5 million from other ministries.

- Women's Health Bureau to be established in the Ministry of Health: Responsible for promoting greater awareness and sensitivity to women's health issues among ministry program staff. Will act as a ministry liaison with the Ontario Women's Directorate and women's organizations and associations. Will be staffed and operational by early summer. Annual funding for 1987-88, $280,000.
- Birthing Centres: Establishment of three hospital-affiliated birthing centres, to be located in Metro Toronto, Ottawa and Northern Ontario. Proposals will be accepted from hospitals. Each centre will be home-like, private, comfortable and with limited obstetrical interventions. Families may choose early discharge and there will be minimal separation of parents and new-born infants. Estimated cost approximately $6.5 million over the next two to three years.
- Birthing Conference: To be held in Toronto this fall and sponsored by the Ministry of Health. Speakers and representatives from Canada, the U.S. and Europe will exchange information and learn from experiences in other jurisdictions. Conference will assist ministry in setting future directions for childbirth care.
- Expansion of family planning programs: Ontario's public health units will receive additional funding of more than $1.5 million over the next two years bringing the total on family planning programs to over $9 million next year. Health units will be able to expand community outreach programs and clinical services. Health units in underserviced areas will be able to introduce new programs in family planning and hire the staff required.
- New curriculum guidelines for schools: The Ministry of Education is revising the curriculum guidelines for physical and health education in intermediate and senior divisions. It will focus on health education, wise decision-making, and the development of personal responsibility in health and sexual matters. The new guidelines will be released next winter in time for 1988-89 year.
- Resource materials: Resources will be developed for parents, teachers, students and other groups to complement family planning support programs.

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– The Women's Directorate and the Ministry of Education will develop new materials for all students in Grades 7-12, their parents and teachers. The Women's Directorate will supplement this effort with grants to community organizations wishing to undertake family planning initiatives. Estimated total cost for the next three years will be $825,000.
– Translation of "Your Guide to Birth Control and Family Planning": Ministry of Health will translate this guide into five languages in addition to English and French. Estimated cost, $260,000.
– Family planning techniques: Ministry of Health to develop, print and translate new pamphlets. Estimated cost, $164,000.
– New data base in family planning: The Ministry of Education to establish a new data base which will be accessible to all school boards. Estimated cost for 1987-88, $25,000.
– TV Ontario programming: The Ministry of Education will discuss the development of appropriate health education programs for school-aged children.
– Ministry of Community and Social Services will support social service agencies in implementing family planning education programs for their clients. Estimated first year budget, $30,000.
– Since these family planning programs will involve a number of ministries and a broad group of community organizations, funds will be made available for the training of staff members and volunteers. This will include seminars, workshops, continuing education programs and the production of training resource materials. Estimated cost for 1987-88 will be $320,000.

- Implementation of Powell Report: Ministry will work with Ontario Medical Association and hospitals to develop a range of hospital programs for women – including comprehensive pregnancy testing and counselling, abortion and port abortion services – within the framework of Canadian law. Dr. Powell will work with hospitals, physicians and nurses to develop proposals on how these services might be re-organized and re-structured. Annual funding will be up to $2.5 million.
  – Ministry staff will consult with hospitals and the OMA to develop alternate funding methods for these new programs and for the payment of professional fees.
  – With the co-operation of hospitals and physicians, the ministry will encourage the study of new clinical techniques and promote further research into the incidence of second trimester abortion.
  – Ministry will also explore Dr. Powell's recommendation that general practitioners in Ontario be educated and trained in therapeutic abortion and that they be provided with access to the needed facilities.
- Short-term Psychotherapy Program – Women's College Hospital: Outpatient service for women in crisis situations; designed to prevent the development of serious psychiatric illness. Annual funding will be $260,000.
- Sexual Assault Treatment Centres: Twelve new sexual assault treatment centres are to be designated in hospitals throughout Ontario in addition to the three existing centres located at St. Joseph's Hospital in London, Chedoke McMaster Hospitals in Hamilton and Women's College Hospital in Toronto. The new sexual assault treatment centres have all been recommended by local district health councils. The hospitals involved have all done the necessary preparatory work. Staffing and program implementation will now move ahead quickly. Annual funding will be $300,000. To be located at:
  Brockville General Hospital
  Dufferin Area Hospital, Orangeville
  Guelph General Hospital
  Hospital for Sick Children, Toronto
  Mississauga Hospital
  Peterborough Civic Hospital
  Plummer Memorial Public Hospital, Sault Ste. Marie
  Salvation Army Grace Hospital, Scarborough
  St. Joseph's Hospital, Sarnia
  Sudbury General/Sudbury Algoma Hospitals
  Victoria Hospital, London
  Whitby General Hospital
- Public Education Program on Sexual Assault: The Ontario Women's Directorate will be developing a public education campaign to increase public awareness about sexual assault. The program is scheduled to begin this fall. Estimated cost will be $600,000 over the next two years.
- Rape Crisis Centres: The Ministry of the Solicitor General will provide annual funding directly to rape crisis centres. Beginning April 1, the centres will receive a total of $300,000 – a 100 per cent increase over last year's funding. In addition, the head office of thee Coalition of Rape Crisis Centres will receive $38,000. Rape crisis centres are volunteer programs organized and operated by local community groups. Centres should ensure that applications for funding reach the ministry by April 1.
- Research on Women's Health: Ministry of Health will provide grants for 14 research programs in women's health. Programs will include a project at Hospital for Sick Children which will examine the effects of exposure to drugs and chemicals during pregnancies; a project at the University of Ottawa which will study changing attitudes and practices in obstetrics and childbirth; a project at McMaster University which will examine the therapeutic effects of exercise on elderly women with bone disease; and a project at the Ontario Cancer Institute to study the effectiveness of techniques for breast cancer screening. Funding will be approximately $500,000."

It is interesting to compare our resolution with these initatives and comment on the direction the Ministry is heading. At first glance, looking at the initiatives, it appears that the Ministry almost directly responded to our concerns, albeit seven years late. More family planning clinics, greater awareness of women's health issues, improved abortion access, birth centres: all of these programs reflect concerns in our resolution. In addition, funding will be going to services for women who have experienced violence, clearly an important priority and into research in other aspects of women's health.

However, it is necessary to look at this news with some

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caution. Both the birthing centres and abortion services will be provided within hospitals settings. These services have both been implemented in free standing settings in other provinces and other countries. Why is the government preoccupied with hospital affiliation? We know that with the best of intentions hospitals get bogged down with the size of their bureaucracy and details of administration and have difficulty responding to needs of the smaller programs within the institution.

In terms of T.A. access, the government has made it clear that it expects the system to work within the framework of Canadian law. Again, hospital affiliation and therapeutic abortion committees may continue to reduce the access of women to services regardless of the other changes which may be made in the implementation of the Powell report.

It is interesting to note that twelve new sexual assault treatment centres are to be funded with an annual budget of $300,000. This means that each centre will need to run on a budget of $25,000 each. That amount may cover one salary which hardly seems sufficient. I also wonder about spending $600,000 on a public education campaign on sexual assault. With all of the funds going to treatment and education, one wonders whether the money might be better spent attempting to deal with the root causes of violence against women, for example unemployment.

Are these initiatives merely good intentions, subject to bureaucratic bungling, are they meant to get votes or are we really going to see changes for the good of women's health in the province of Ontario?

The Medical Reform group has a continuing role to play as watchdog over the follow-up of these initiatives. This government has some good ideas but as we know from Bill 94, they need encouragement, close monitoring and loud criticism as necessary if these promises are to be borne out.

Fran Scott

Fran Scott is a member of the MRG Steering Committee.

Health News Briefs

Call for laws to protect people with AIDS

The British Columbia Civil Liberties Association has urged the federal and provincial governments to pass anti-discrimination laws quickly to protect people with AIDS.

The association states that the absence of these laws may inadvertently be contributing to the spread of AIDS because people are deterred from taking the AIDS antibody test because they fear the results will not remain confidential.

"If you test postively, it's far more likely you will change your behaviour and this will slow the spread of the disease,' said John Dixon, president of the liberties association. "We must create a climate that will encourage the maximum number to test their blood to see whether they're infected" according to Mr. Dixon.

—Globe and Mail, April 3, 1987

AIDS test needed for insurance coverage

Canadians buying large amounts of life or health insurance must now take a mandatory AIDS antibody test or risk being denied coverage, insurance industry spokespeople say.

According to Charles Black, vice-president of insurance operations for the Canadian Life and Health Insurance Association, the testing begins on policies ranging from $200,000 to $500,000 and up. Because policies are considered "a good-faith contract, if one party says they won't take the test, the other (the insurance company) will say no way" to granting a policy, he said.

"Right now anybody with a positive AIDS antibody test is considered uninsurable," according to Dr. Walter Schlech, an expert on infectious diseases who is a member of the National Advisory Committee on AIDS.

—Globe and Mail, April 4, 1987

Agreement reached on AZT

The federal and provincial governments have reached an agreement in principle with Burroughs Wellcome Inc. to expand the use of the experimental anti-AIDS drug AZT in Canada. The drug will be made available for the first time to AIDS patients with a variety of viral, parasitic and bacterial infections, federal Health Minister Jake Epp announced May 22. Previously the drug was available only to patients with PCP. The health department said Burroughs Wellcome would be paid for the drug, but it has not yet been decided where the money will come from. The cost of treatment is about $10,000 a year. Burroughs Wellcome was originally to provide the drug free of charge for clinical trials that would last 18 months—the standard procedure when new drugs are being tested prior to licensing. A few months into the trials, however, Burroughs Wellcome changed its mind, threatening to curtail future supplies unless it was paid for the drug and unless the government agreed to waive the normal licensing procedure for new drugs. Mr. Epp criticized the company's pressure tactics, pointing out that the government is already proceeding with its drug-patent legislation which benefits companies such as Burroughs Wellcome. The company has done well by the introduction: in the first three months of the year, its share prices went up 360 per cent.

—Toronto Star, Globe and Mail, & Fortune, April, May 1987

Health News Briefs

Alberta plans cuts in medical insurance plan

The Alberta government is planning to drop services such as birth control counselling, vasectomies, tubal ligations and premarital counselling from Alberta's medical insurance plan beginning August 1. The plans have come under strong attack from critics who say that the moves, designed to save money, are shortsighted and will only increase costs in the long run. "This is a big mistake, a great big error in judgment," said Dr. Gerald Bonham, Calgary's medical officer of health. "It seems that anything to do with choice in sex or reproduction is treated as if it is optional...the province does not appreciate the consequences, such as an increased demand for abortions, of putting up barriers to these services." The province also plans to de-insure services such as contact lens fitting and eye examinations for patients between 18 and 65, and it will reduce the amount it will cover for visits to chiropodists, physiotherapists and podiatrists.

—Globe and Mail, May 23, 1987

Probe wants WCB hospital to be public

Queen's Park should cut ties between the Workers Compensation Board and its 522-bed Downsview rehabilitation centre make make it a public hospital, a task force has recommended in a report presented to the Ontario Legislature by Labour Minister Bill Wrye. The report of the review team headed by W. Vickery Stoughton says that both patients and staff at the Downsview centre are caught in a climate of mistrust and frustration because of the contradictory requirements of medical treatment, rehabilitation and compensation benefit control. "Patients were distrustful or suspicious of some rehabilitation activities because these might be used to influence negatively their assessment for compensation" the report said.

—Toronto Star, April 30, 1987

Law Reform Commission criticizes workplace safety

The Law Reform Commission of Canada has criticized laws on workplace safety in a recently released report.

The Commission says that there are "strikingly few" inspectors across Canada to help enforce the laws, that the laws provide for weak penalties, and that these are further diluted by bargains hammered out with governments that see prosecutions as a last resort.

"By declining to invoke sanctions, they are in effect issuing permits for activities which may endanger employee's health or environmental quality."

The Commission notes that between 1972 and 1981, 10,000 Canadians died from injuries received on the job.

—Globe and Mail, January 22, 1987

Health committees receive low marks

Many of the 8,000 labour-management committees at the heart of Ontario's workplace health and safety system are employer-controlled and unable to protect workers' interests, according to a report presented to Ontario Labour Minister Bill Wrye.

The report, by SPR Associates, casts doubt on the entire scheme by describing a health and safety committee system that in hundreds of workplaces exists not at all or only on paper. The report says that many of the most effective workplace committees include local union officers who sometimes engage in "negotiating" or adversarial tactics rather than using the co-operative sytle favoured by employers and labour ministry officials. It concludes that workplace committees, unless backed by strong law enforcement by labour ministry inspectors, "lead not to self-regulation but to self-deception."

Among the report findings:

- The committees are often perceived as ineffective in the most dangerous workplaces.
- The ministry concentrates its inspection resources on large, unionized workplaces.
- Nearly 80 per cent of all workplaces are in violation of the law in some manner.
- In 35 per cent of workplaces, worker safety representatives are selected by management and not by workers, in direct violation of the law.
- Thirty-three per cent of workplaces with 20 or fewer employees which use designated toxic substances have no safety committees, again in violation of the law.
- In 1,500 workplaces in which the ministry says there are no designated toxic substances in use, workers and management reported the use of designated substances

—Toronto Star, February 11, 1987

Toronto to make capital grants to hospitals

In a hotly debated move, Toronto City Council has voted 13 to 10 to set up a health care fund which will make capital grants to city hospitals. The fund starts with $300,000 this year, and is slated to go up to $3,000,000 over the next three years. The hospitals lobbied for the funds, arguing that they are underfunded by the province and that municipalities ought to support their local hospitals. Many Ontario municipalities give money to local hospitals, but Toronto has instead put its money into public health programs.

The move was strongly opposed by public health advocates who supported increased emphasis on preventive and community-based programs, and who argued that these programs would be gutted if Toronto puts most of its health funds into hospitals. Said Toronto alderman Jack Layton, "We are facing an AIDS epidemic. Should we invest in hospitals that care for people after they have gots AIDS? Or should we be working on prevention that helps people from getting AIDS?"

—Globe and Mail, April 22, 1987

Health News Briefs

Nova Scotia pharmacy body charged

The Nova Scotia Pharmaceutical Society and the province's pharmacy association are among 13 pharmacies and other organizations and individuals charged with conspiring to restrict competition. The charges, laid under the federal Competition Act span the period from January 1974 to June 1986. The charges deal with private pre-paid prescription plans as well as with prices to the general public.

—Canadian Press, March 18, 1987

End to tobacco ads planned

Federal Health Minister Jake Epp has announced that the federal government plans to eliminate all tobacco advertising and phase out smoking in federal offices. He said the new measures are to be contained in a new Tobacco Products Control Act to be imposed in the next two years. Newspaper advertising of tobacco is to stop by January 1, 1988, electronic media ads July 1, 1988, and magazine ads January 1, 1989. Tobacco companies will no longer be able to deduct advertising expenses for advertisements placed in foreign magazines which reach the Canadian market. —Globe and Mail, April 23, 1987

Polish trained MDs lose court case

A group of Polish-trained doctors have lost their court challenge of an Ontario governmnet policy restricting their access to internships. Under Ontario policy, the province finances 603 internships and reserves those positions for graduates of Ontario medical schools, although graduates of other accredited medical schools are eligible under certain circumstances. Only medical schools in Canada and the U.S. are accredited, so graduates of other schools are not eligible for internships. A new policy to become effective this fall creates 24 pre-internships—and subsequent internship positions—reserved for doctors trained outside the currently accredited medical schools. The Polish doctors had argued that the provincial rules violate their constitutional right to equal benefit of the law without discrimination.

—Globe and Mail, April 17, 1987

Chronic pain ruling says WCB should pay

The Workers Compensation Board (WCB) has been ordered for the first time to pay money to workers for chronic pain that continues after injuries heal. The Workers Compensation Appeals Tribunal said on May 22 that the WCB has been wrong in taking the view that psychogenic pain is not directly caused by workplace accidents. The decision—which the tribunal says constitutes 'a historic change for the Ontario board'—could ultimately increase payments for many workers.

—Globe and Mail, May 23, 1987

Last two provinces comply with Canada Health Act

British Columbia and New Brunswick, the last two provinces to allow user fees or extra billing, have ended the practices in time to meet the deadline for complying with the Canada Health Act. The Canada Health Act states that any province which did not comply with the Act by March 31 would lose any money withheld since 1984. The law provides that provinces allowing extra billing or user fees will lose federal transfer payments equivalent to the amount charged patients.

British Columbia recouped about $85 million withheld by Ottawa over the past three years when it ended user fees. New Brunswick recovered about $353,000.

—Globe and Mail, March 26, 1987

Figures indicate low turnout in MD's strike

Ontario Health Ministry figures show that OHIP billings in June of last year, when some Ontario doctors went on strike over the extra billing ban, went down by only eight or nine per cent. The figures seem to indicate that participation in the strike was much lower than was claimed by the Ontario Medical Association, which estimated last year that 55 to 60 per cent of doctors closed their offices or curbed services to protest the ban.

—Toronto Star, April 15, 1987

Hospital spending rising

Hospital costs have been rising faster than health spending generally, a study by the Economic Council of Canada shows. The Council's Report on Canadian Hospital Costs and Productivity indicates that health spending climbed from $2.1 billion in 1960 to $22 billion in 1980, with rising hospital costs accounting for 40 per cent of the increase. The study found that while Canada's population was growing 1.5 per cent per year, the volume of hospital services was growing 5 per cent per year.

The report also revealed some striking regional variations in hospital admission rates, with Quebec's rate being 17 per cent below the national average and Saskatchewan's being 38 per cent above.

—Globe and Mail, April 23, 1987

New MRG Phone Number

Effective April 20, the Medical Reform Group has a new telephone number. The new number is (416) 537-5877.

Hospitals' bold assault on City treasury

A new definition of *chutzpah* has been kindly offered by our friendly local hospitals.

Chutzpah (pronounced hoot — as in good — zpah) is a Yiddish word usually explained by telling a story: A boy kills his mother and father and then demands mercy from the court because he's an orphan. That's what you call *chutzpah.*

We now have the Hospital Council of Metropolitan Toronto asking Toronto City Council to give them some $3 million a year of the taxpayers' money with no conditions attached. Hospitals would like to decide all by themselves how to spend that money without any nosy interference from City Council.

That, too, is what you call *chutzpah.* Nobody else claims a right to public money without any public control on how that money is spent.

But we still think of hospitals as such a worthy cause that the hospital council very nearly got what it wanted from the city executive committee last week. They might well pull off their little coup when the matter comes before the full City Council tomorrow.

What's at stake here is the future of public health in Toronto. There isn't enough money to go around.

Toronto taxpayers cannot support the 19 city hospitals in the style to which they would like to become accustomed and at the same time pay for an expanding public health program.

Councillor Jack Layton, who is also chairman of the board of health, put the problem very succinctly to the executive committee last Wednesday: "We are facing an AIDS epidemic. Should we invest in hospitals that care for people after they have got AIDS? Or should we be working on prevention that helps people from getting AIDS?"

The board of health has been preparing Healthy Toronto 2000, a bold plan to turn the whole city into a health-creating and health-preserving environment. The emphasis would be on education, health promotion and small community clinics.

Nobody is suggesting that these activities replace what hospitals do. The healthy city movement and the hospitals would be complementary.

But, since money is limited, the hospitals have decided to make their pitch early, before the politicians even have a chance to look at the draft for Healthy Toronto 2000.

It's a tough choice for the politicians.

Toronto puts more money into public health than any municipality in Ontario. Most of this comes from the property tax.

Hospitals get most of their money from Queen's Park. Should they also be trying to get municipalities to support them, too?

Hospitals say they don't have much choice. Queen's Park gives them money to operate but if they want to put up new buildings or renovate old ones, the province has a cruel system for doling out funds. Queen's Park funds only about two-thirds of the cost of hospital construction. The province forces the hospitals to hustle up the final third in their own communities.

That's why you see hospitals running those big, slick fundraising campaigns. But the public is growing weary, so hospitals have taken to hitting local politicians.

They already get a direct contribution from Metro Council, but they want money from the borough and city councils, too.

When I first wrote about this fight in Toronto a couple of weeks ago, Scarborough Controller Frank Faubert got in touch with me.

"Scarborough helped build the new Grace Hospital and now Scarborough General wants a renal dialysis," Faubert said. "There is no end to it.

"I don't want to be a hospital basher, but it seems to me that the larger the institution gets, the more money it needs. Its per diem rate for patients becomes larger because that money has to go to support the whole complex.

"I don't believe the property tax was ever meant to pay the capital costs for hospitals."

Within the city of Toronto, the province has approved a stunning $341.8 million worth of hospital construction and renovation.

The hospitals have to raise between $100 million and $150 million of that themselves. Small wonder they are putting the arm on everybody in sight.

Still, Toronto City Council should not vote to give them money.

A few years ago, the provincial government under the Progressive Conservatives was shutting down wards and trying to close whole hospitals claiming we were overbuilt and the taxpayers couldn't afford it all.

Now we have a Liberal government in Queen's Park approving an ambitious and expensive building plan.

Something is a little out of whack here. Toronto City Council ought to take a longer, colder look at what the hospitals want to do with Toronto taxpayers' money.

And the politicians ought to wait until they have the plans for Healthy Toronto 2000 in front of them before they make any commitment to the hospitals.

Toronto Star, April 20, 1987

Prognosis for walk-in clinics: Good health throughout '80s

By Stephen Nicholls
The Canadian Press

It's 8 a.m. and you're on the way to work — just enough time to stop for a coffee and a physical.

Maybe on your lunch hour you can drop into the downtown shopping concourse for that eye test you've been meaning to get. And tonight, back in the suburbs, you can go to the neighborhood mall for teeth cleaning and some chiropractic adjustments.

For many Canadians, the days of having to book weeks ahead to see a dentist are gone. And a visit to the doctor doesn't mean a couple of hours off work and a trek to an out-of-the-way medical building.

The health-care industry has come to where consumers "live" — the shopping mall. This is the age of the walk-in, storefront clinic.

"They fit in with people's lifestyles right now," says Brian Price, co-founder of Tridont Health Care Inc., which has more than 80 dental clinics across the country.

Added convenience

"With two people in the household working, together with many single parents, you just have to really conform to what the consumer needs," Price says.

"People want their professionals, including dentists and doctors, there when they need them, not when the professional wants to be there. People just don't want to take time off work."

The consumer's demand for added convenience has come at a time when health-care professions have a more-than-healthy number of practitioners. Many, faced with stiff competition, have opted to set up practice in those meccas for mass merchandising — the malls.

Price, 39, takes credit for launching the movement.

He and another Toronto dentist, Howard Rocket, set up a clinic in a department store in 1980. Defying tradition, they approached the profession as a business. And the business, they concluded, offered a market that was "50 per cent untapped."

In the '60s and '70s, when "business was booming, the dentist didn't have to worry about the business aspect of his practice," Price says.

"But in the '80s, it started to get competitive . . . it became a business and an industry."

Price's prognosis proved correct: the clinic flourished. The partners began marketing their concept to other dentists, selling franchises for similar store-front clinics at $50,000 to $75,000 each. Now, Tridont is listed on the Toronto stock market and says its dental division earns $60 million a year.

Other health-service chains have since sprung up, and many independent professionals have moved into malls, some working extended hours and offering 24-hour emergency service.

"We've gone from renegades to renaissance," boasts Price, whose ebony curls brush the shoulders of his pinstripe, double-breasted, charcoal suit.

On his lapel a gold pin of the Tridont logo glitters — a toothbrush underscoring the words We Care.

"The dentists realize the patient is patient-consumer, and I think it's good for the profession and good for the patients."

The Canadian Dental Association agrees. Spokesman Donald MacFarlane, a Vancouver dentist, says the increased convenience and accessibilty have led to more people seeking dental care that they had put off.

Just the visibility of a storefront clinic can draw in the timid.

"People tend to approach you and ask you dental questions," says Jodi Pollard, a lab-coated receptionist who sits amid dusty-rose and dove-gray furnishings of a dental clinic in a downtown Toronto mall.

"I have had people who walk by smiling for three weeks, then finally come in. Some of these people are scared to death, but they finally make that first step."

Open Saturdays

A few doors away another storefront declares in bold red letters: "Walk In Medical Clinic. No appointment necessary." It's open weekday evenings and Saturdays, and even has its own x-ray department.

On this morning, a few minutes after eight, four patients have already lined up to see a doctor.

"Our busiest time is lunch hour," says the receptionist, adding the clinic's three doctors treat 70 to 80 people a day.

The Consumers' Association of Canada generally thinks the storefront medical clinics are fine, although it does have a couple of concerns.

"Most of these doctors do not have hospital privileges," says association spokesman Richard Plain, a Calgary health-care economist.

That's because Canada has a "gross oversupply" of doctors, he says, and not enough hospital beds to go around.

Another problem, says Plain, is the danger that a retail setting may affect the way some clinics operate.

"If the owners of the mall are taking a percentage of the sales in the lease, as they're doing in the retail sector, or are getting into partnership in the (medical) corporation, then we may have some grounds for concern.

"I don't want a developer or silent partner pushing a physician to do more for sales."

Toronto Star, March 10, 1987

Prepaid plans: will dentists bite?

BY MARINA STRAUSS
The Globe and Mail

Almost four years ago, Toronto dentist Sheldon Baker bucked the dental establishment and joined a chain of shopping mall clinics as a way of enhancing his practice.

Today, Dr. Baker again finds himself on the outskirts of accepted dental thinking as he prepares to join a new type of prepaid insurance plan that he believes can give him more patients and a bigger income.

Prepaid dental insurance programs, which are just beginning to catch on in the United States, are being offered by a growing number of Canadian insurance companies that have been losing money on traditional dental plans. They say the new programs can provide cheaper coverage, or better coverage for the same price.

Canadian dentists' opposition to the new plans is so strong that the Ontario Dental Association alone has already collected about $700,000 from its 5,000 members to campaign against the prepaid programs.

Nevertheless, many industry officials say it is only a matter of time before the plans become widely available in Canada. They generally involve a network of participating dentists receiving a set fee for every individual or family enrolled, regardless of the work performed.

They get paid the same amount whether the person enrolled never goes to a dentist, has one tooth filled or six extracted.

Traditional plans pay for each dental service done, and the patients get to choose any dentist rather than selecting one from a panel of dentists.

The extent of the opposition to the plans is also reflected in the fact that many dentists participating in the new programs don't want publicity for fear of harassment by their colleagues.

Dr. Baker, who works with Tridont Health Care Inc. of Toronto, still feels willing to give the new plans a shot.

"I don't believe quality will suffer," said the 38-year-old dentist, responding to the dental association's concerns about production-line dentistry. "You're setting up a contract with the insurance company and you act as a provider for them.

"A patient still has a choice of going with the capitation-type plan (which is how the prepaid programs are referred to) or staying with the regular plan. If they choose the capitation plan, then, as a provider, you'll get those patients.

"We'll definitely get more patients . . . . If you have empty chair time, you might as well fill it with patients."

Ontario has been the testing ground for the insurance industry in launching capitation dental programs because the industry is centred in Ontario and the province has a large number of employers and employees who might join the plans.

Organized dentistry fears that under the plans, the financial risks will shift from the insurer to the dentists and that an inexperienced risk-bearer might attempt to limit that risk by rationing care or limiting choice in treatment plans.

"It is our view that capitation does not mean cheaper dentistry; it means cheapened dentistry," a recent Ontario Dental Association newsletter said.

"We view the current scene in terms of attempts to 'corporatize' dentistry. When third or fourth party interests grab hold of a profession, they inevitably attempt to dictate standards of practice. This too is completely unacceptable."

Dental associations also say the capitation concept takes away a patient's right to choose his own dentist.

The patient's lack of choice means "nothing less than a 'grab' of patients by participating dentists from non-participating dentists," the association says.

The economics of the capitation plans have also led to a stiff confrontation between the insurance industry and organized dentists.

Promoters of prepaid plans say they can be up to 40 per cent less expensive than the traditional fee for service. The dentists warn that these savings will come from dentists' pockets or from severely limiting benefits to the patient.

The ODA is urging its members to boycott capitation networks. It has hired an insurance consultant and a public relations specialist for a major publicity campaign about good dental plans and good dentistry.

The dentists have been advised that a straight anti-capitation campaign will not find favor in the marketplace.

Meanwhile, the insurance companies are trying to drum up business.

Among those being approached is the Canadian Auto Workers union. With 143,000 members across the country, it is considering prepaid dental plans after "overwhelming success" with prepaid legal plans.

"The arguments of the dental profession against the plans are very similar to the arguments of the legal profession (against the prepaid legal plans)," said Sym Gill, the union's national representative in its research department, who was involved in setting up Canada's largest prepaid legal package for the CAW.

"Most of the arguments are pretty specious. I don't think they hold up very well."

London Life Insurance Co. of London, Ont., stirred up the most controversy when it bought a 30 per cent interest in Neighborhood Dental Services Ltd. of Burlington, Ont., for $5.5-million last May.

It now has 15 dental offices in the London, Oshawa and Hamilton areas, with Neighborhood Dental providing management services. London Life's 2,000 employees have been given the option of the fee-for-service or prepaid systems, under which employees must go to a Neighborhood dentist.

Steven Warren, manager of group market development for London Life, would not say how many employees have opted for the prepaid package. But he said the company can offer the prepaid package for up to 40 per cent less than the cost of an equivalent fee-for-service plan.

Dr. Knute Keire, president of Neighborhood Dental, said it is simply "a network of clinics organized in a business manner so that a dentist doesn't have to worry about hiring and firing" and other administrative matters.

Some of the dentists bill their clients on a fee-for-service basis, while others prefer to work on guaranteed incomes, receiving a set amount, he said.

The latest entry into the fray is Aetna Canada of Toronto, which formed a joint venture with Tridont last month to market and administer the prepaid programs. Aetna expects to invest $2-million in Dental Maintenance Organization Inc. of Toronto, which will administer the plans for Aetna and Tridont.

Tridont has 89 dental clinics, mostly in shopping malls. DMO will not own any dental offices, but it will have contracts with dentists to provide services to patients.

Kenneth Davis, president of DMO, said fee-for-service plans can discourage long-term preventive dental care and reward dentists for short-term services.

Capitation plans, on the other hand, encourage dentists to do a lot of work quickly to bring a patient's teeth into top condition and then maintain that care over the years, with little work necessary.

The prepaid programs also eliminate about 80 per cent of the paperwork usually required under fee-for-service plans because the prepaid package gives the dentist a single cheque for all of the patients using the office, as opposed to separate forms for each patient, Mr. Davis said.

The veteran in the field is Future Focus Health Systems Ltd., which has been operating capitation systems in Toronto for more than seven years. It was bought last year by Metropolitan Life Holdings Ltd. of Ottawa. Future Focus says it has about 15,000 patients under its care in about 100 dental offices.

Crown Life Insurance Co. of Toronto intends to use Future Focus' services. Like other insurance companies, it will set three-year rates for prepaid plans, rather than the traditional one-year terms, which should keep costs down.

Costs for dental plans have spiralled in the past decade because more patients than expected have gone to dentists. Dentists, in turn, have performed more procedures than anticipated.

One convert to the prepaid plan is Dr. Donald McFarlane, former assistant to the registrar of the Royal College of Dental Surgeons of Ontario. He is now responsible for developing and administering a prepaid plan for Toronto-based Prudential Insurance Co. of America.

Dr. McFarlane said fee-for-service plans inherently promote overuse by dentists, while capitation programs encourage dentists to do only what is necessary for their patients.

Prudential plans to pay dentists in the prepaid plan a fee for service for more complicated procedures such as root canals, Dr. McFarlane said. "We're buying dentists' unused time at a slightly discounted rate. For the dentist, he can fill up his time and increase his income."

Charles Spina, a spokesman for Crown Life, said it is to Crown's advantage to ensure that top quality dental care is provided because "we're being linked in the patient's mind to the delivery of care. Before, we were seen as at arm's length with the services."

Future Focus said it has checks in the system to make sure that dentists don't skimp on their work, including regular inspections of participating dentists' offices, reviews of eligible patients' records and an internal peer review mechanism.

As for Dr. Baker at Tridont, he said that when he starts working under a prepaid plan in a few months, he thinks it will involve not more than 15 per cent of his practice. "Once people understand it, it won't be scary," he said. "It can be a very positive thing for dentistry."

Globe and Mail, February 9, 1987

Doctors' blood pressure climbs when income drops, study finds

DALLAS — When the average income of doctors goes down, their blood pressure tends to go up, according to a long-term study of medical school graduates reported here at a meeting of the American Heart Association yesterday.

The study followed 1,130 male physicians graduating from Johns Hopkins medical school in Baltimore from 1948 to 1964. It found that a 10 percent decrease in the average income for U.S. physicians for one year was followed the next year by about a 25 per cent increase in the rate of high blood pressure cases in the study group.

Novel law enforcement

Your article Extra-Billed Patients Given $7,000: No Action Taken Against Doctors (Jan. 29) gives us insight into advances in law enforcement and crime prevention.

We are informed that although many Ontario doctors are acting illegally in extra-billing patients, "Health Minister Murray Elston has said the province is holding back from laying charges because it wants to see what patterns of illegal charges develop."

What a novel approach. Perhaps police departments should consider its merits in dealing with offences such as drug trafficking, drunken driving, convenience-store robberies and so on. Or are there two approaches to law enforcement and crime prevention — one for the doctors and one for the rest of us?

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Globe and Mail, February 16, 1987

Health care field provides no cure for gambling urge

THE TORONTO STAR, THURSDAY, APRIL 9, 1987

Chains of nursing or retirement homes are being purchased by natural gas distributors, miners, real estate developers and financial services companies.

And there's a frantic search by speculatively minded investors for what they hope may be jackpots in shares of companies that in some way, at some time, will perfect something for the treatment or prevention of AIDS.

Do these things tell you something? They should.

Health care is hot — anything from blood storage techniques and drugs to contract research and lab services. That's why CDC Life Sciences, Canada's only major pharmaceutical stock, sells for more than four times its 1985 low.

Companies and investors are rummaging for ways to prosper in an industry that's heavily government- or non-profit-controlled but one of undoubted growth.

(The word industry is misleading because many of its parts have little relation to one another and few trends in common.)

The reasons for growth are clear. Older people — heavy users of both health care facilities and products — are a rising percentage of the population. And the rest of the population is more health-conscious.

There's also new turmoil in our thinking about the best ways of providing services and products that account for a huge slice of almost 10 per cent of the economy. If this results in major changes, it also may open opportunities for those who invest early.

And there's AIDS. This deadly, fast-spreading and highly publicized condition — acquired immune deficiency syndrome — has caused an explosive demand for good ways to attack it and prevent its spread.

As grim as it seems, AIDS has the potential for highly profitable business for companies seeking useful methods and products and for investors in shares of the companies.

Dramatic swings

Some foreign stocks have swung dramatically — in both directions — on the ebb and flow of such speculation.

Obviously, private investment opportunities in the health industry are much less extensive than the size of the business suggests, especially in Canada.

A high proportion of the activity is not profit-oriented because, philosophically, many voters think it shouldn't be. Canadians shudder at the patchwork nature and heavier costs of the U.S. system, with its higher proportion of private investment.

We lack the hospital stocks found in the U.S. Nor do we have a range of pharmaceutical shares since few Canadian companies have stock available, often being fully foreign-owned.

Whether there should be more private investment — or less — is another subject. It is a fact that it's limited, even in the U.S.

And it's not clear that the long-term trend will be otherwise, since voter distaste may well bar major moves to privatization.

CDC Life is a Canadian example of the enthusiasm that can be touched off in the stock market.

When Canada Development Corp. said it might sell its 25 per cent in CDC Life — with its insulin, vaccines and other products — the already high shares zoomed $6 in a few days before slipping back.

That reverses a common reaction. The possibility of such a sale often knocks down the price because of the bigger supply that may be available and the speculation on why the owner would want to sell.

CDC Life stock at a recent $27.50 compares with a low of $6.38 two years ago.

And shares of small Magnetics International shot from a $1.30 low in '85 to more than $8 last year as Magnetics got into needleless injectors — you're not the only one with a phobia about needles — and began transforming itself into a health products company.

AIDS-related

Some of the AIDS-related yoyoing in U.S. stock markets reveals how powerful the gambling urge can be. Remember there's nothing yet approaching a cure for AIDS.

In shares of companies mentioned as doing work relevant in some way to treatment or prevention, Daxor, at a recent $16.25, has a vast 52-week trading range of $37 to $4.50.

Imreg at a recent $12 is more than double its 52-week low; ICN at $16.38 compares with a low of $10.25 but a high of more than $30.

In makers of condoms — their use is recommended as a protective — Mentor jumped early this year to more than $23 from $13.50 before sliding to a recent $15.63, still more than twice its 52-week low. Carter Wallace, though condoms are a small percentage of its business, almost doubled to $151 early in the year and lately is $110.

Some Canadian health-related stocks are in the table. This small and fragmented group includes the labs and other services of MDS Health Group; the store-front dental and other ventures of young Tridont; the cemeteries and funeral homes of Arbor Capital; the health services, products and research of Continental Pharma Cryosan.

Much larger Crownx doesn't really belong, though it's a giant in nursing homes and a supplier of other health services. It's a conglomerate, owning Crown Life Insurance and stakes in information technology and other industries.

Bad news for Crownx earnings and stock was Crown Life's sharply lower profit last year.

The table compares recent share prices with approximate ranges in '86-87 and the lows of '85.

THE TORONTO STAR, SATURDAY, MARCH 14, 1987

Keeping the lid on the health-care pressure cooker

ROSEMARY SPEIRS
Queen's Park

If, as one expert has described it, the Canadian health insurance system is "a pressure cooker building up steam," then Murray Elston, minister of health for the most populous province, is the man desperately trying to hold down the lid.

Elston, until two years ago a backbench Liberal MPP and smalltown solicitor, now manages an $11 billion budget, by far the biggest portion of Ontario's spending, and growing rapidly.

Driven ever upward by the demands of an aging population, by expensive new technology that can perform miracles at millions per patient, by an over-emphasis on acute hospital care when nursing home or homecare beds might do, by rising drug costs and increasing patient demand, Ontario's health-care system threatens in 15 years to bankrupt the province.

When he came into office in May, 1985, Premier David Peterson made effective long term health-care planning a priority. As his health minister, Elston has appeared more prepared than his Conservative predecessors (with the exception of former health minister Larry Grossman) to tackle some of the hard questions of using health resources more efficiently. He has little choice — past unwillingness to rock the boat of the health-care establishment, in particular the powerful doctors' lobby, means Elston has only a few years to achieve important reforms.

In that context, the government's determined fight last year against the province's 17,000 doctors over the ban on extra-billing, appeared a diversion from the real battle. Extra-billing, per se, was hardly at the root of our health care cost problems. Banning the practice came at the cost of a bitter 25-day strike and sour relations with the medical profession.

One immediate effect of the clash between the government and the doctors was a delay, almost a year long, before John Evans' study of the health-care system (how to maintain quality while containing costs over the long term) could get underway. Evans, former president of the University of Toronto, postponed rather than proceed without Hugh Scully, vice-president of the Ontario Medical Association, who'd quit in protest over the government's action.

Now, however, the Evans committee, with Scully aboard, is well under way, and is expected to make its first report in May. In achieving that, the extra-billing ban appears to have had an important symbolic value. Elston made it clear that he will not back off from changes just because the medical profession is outraged. The ban, of little value in itself, jolted the health community into taking Elston, and health-care reform, seriously.

Several initiatives are under way, and it will be some months before we can judge Liberal progress. The Evans' committee isn't likely to do more than indicate directions: how to approach the problem of an over-supply of physicians (since more doctors mean more OHIP bills) when the province faces shortages in some specialities and some geographic areas? Can salaried, clinic-based group medical practices reduce costs while offering more preventive health-care? How to care for the elderly outside the expensive hospital setting?

Whether Evans will offer pragmatic alternatives is open to question. But the participants on his committee — ranging from the OMA's Scully to consumer advocate Rose Rubino — say the process itself is important. For once, all major groups in health care are trying to hammer out common goals.

Meantime, Toronto lawyer Alan Schwartz is dealing with the health-care professions. Schwartz has roused a storm of controversy by proposing changes to the Health Disciplines Act which would give the minister of health the power to direct the supposedly self-governing medical colleges to undertake investigations or discipline their members.

Schwartz' recommendations have delivered a second jolt, perhaps as tough as the extra-billing ban, to professions which in the past ignored ministers of health, or failed to exercise control over their members. Faced with the alternative of government control, the medical professions may now be willing to do a better job of self-regulation: for example: by pressuring doctors to stop charging patients extra for so-called "standby fees."

Next on Schwartz' agenda are the "scope of practice" questions: Do we really need doctors for simple procedures that could be performed cheaper by nurse-practitioners or dentists supervising when dental hygienists are cleaning teeth? By freeing the "female-led" health professions, Schwartz will open doors to cheaper basic health care.

Recently, Elston gave a $1.4 million grant over five years to McMaster University to develop a centre for health economics and analysis. McMaster's Gregg Stoddart will direct studies aimed at evaluating the costs, risks and benefits of new medical technology and studying alternative health-care delivery systems. Studies will be done to determine whether the American medical model of health maintenance organizations, which provide prepaid group medical care rather than fee-for-service, can really cut costs in Canada which has a universal medicare plan.

At the University of Ottawa, epidemiologist Robert Spassoff is heading a group which has been asked by Elston to set health goals for the province. Spassoff is looking 15 years ahead at objectives such as reducing heart disease by 10 per cent, or improving nutrition for the poor.

Put together, these initiatives could go far to rationalize health-care planning in Ontario. Or the reports could be left to moulder on bureaucratic desks.

The depth of Peterson's commitment to change may be measured by how long he leaves Elston in the health portfolio. Quiet in manner, and easily dismissed among his more forceful cabinet mates, Elston appears to be tackling tough issues behind-the-scenes.

But he needs to be there for the next couple of years to do it.