MEDICAL REFORM

Newsletter of the Medical Reform Group of Ontario

Medical Reform Group of Ontario, P.O. Box 366, Station J, Toronto, Ontario M4J 4Y8 (416) 588-9167

Volume 9, Number 5 October 1989

"MEDICINE IS POLITICS WRIT LARGE" – *Rudolf Virchow*

Agenda: October MRG meeting

Friday October 13

Dinner and Discussion

Venue: Small dining room (reach via the main dining room) Trinity College, University of Toronto, (NE corner of Hoskin and Devonshire)

6:30 pm: Dinner (If you're planning to eat dinner, please RSVP to (416)588-9167 by October 10.) The cost of the dinner will be about $10.

8:00 pm: Discussion of Health Professions Legislation Review. The speakers will be Alan Burrows, Director of the Ministry of Health Professional Relations Branch, Margaret Risk, of the Ontario College of Nurses, and a third speaker from the MRG. They will be addressing the questions: How will the Health Professions Legislation Review affect the allocation of roles on the health care team? Will it lead to democratization and protect quality? Will it lead to a proliferation of health fraud? Questions and discussion will follow.

Background Reading: This newsletter has carried a number of articles on the Health Professions Legislation Review. The following are the references, for those who would like to look up the articles for background reading before the meeting:

June 1989, P. 1; December 1988, P. 7; June 1988, P. 5; February 1988, P. 7; December 1987, P. 1-2; December 1986, P. 2-3; July 1985; March 1985, P. 1-2; November 1984, P. 1.

Saturday October 14

Venue: South Riverdale Community Health Centre, 126 Pape Avenue, Toronto

8:30 am: Registration and coffee

9:00 - 11:30 am:

1. Proposed resolution supporting the licensed acts approach of the Health Professions Legislation Review (see p. 3 of this newsletter)
2. Reports from local chapters
3. Report from Primary Care Working Group
4. Financial report
5. Steering Committee report
6. Steering Committee nominations and elections
7. New business

11:30 am: Proposed resolutions on resource allocation in health care (see p. 4-5 of this newsletter)

12:30 - 1:30: Lunch

1:30 - 4:00 Resource Allocation in health care

Help steer the MRG

As of the fall general meeting, there will be four vacancies on the Medical Reform Group's Steering Committee.

Members are encouraged to consider standing for election. The Steering Committee meets once a month, with meetings alternating between Hamilton and Toronto. Interesting and challenging issues are discussed, discussions are lively, and refreshments are served.

If you are interested in being on the Steering Committee, or in discussing whether you'd like to be, please contact one of the present members, or call the MRG number (416)588-9167,

AIDS Working Group

The Medical Reform Group's AIDS Working Group has become inactive. If you are interested helping to re-activate this working group, please call Susan Stock at (416)527-0149.

Update on Occupational Health Issues: Bill 162: An Act to Amend the Ontario Workers' Compensation Act

By Susan Stock

-Bill has passed third reading in the legislature.

-Bill is strongly opposed by labour groups and advocates of injured workers who perceive it primarily as a means of cutting compensation costs and increasing the discretionary powers of the Workers' Comnpensation Board.

-Main features of the Bill:

-"Disability" is defined as the loss of earning capacity that results from an injury

-"Impairment" is defined as any physical or functional abnormality or loss including disfigurement which results from an injury and any psychological damage arising from the abnormality or loss

-Workers permanently impaired due to a work-related injury will be

Continued on Page 2

Time to renew your membership

Fall has arrived, and so has the time to renew your membership in the Medical Reform Group.

Continued and generous financial support from the members is crucial to keep the MRG an effective voice in health care issues in Ontario.

You will be receiving your membership renewal notice in the mail shortly. Please send it in promptly, and please also consider making an additional supporting membership donation – the extra contributions from supporting members are what enables the MRG's budget to stay (just barely) in the black.

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eligible for benefits that take into account future loss of earnings, non-economic loss and loss of retirement income:

-the maximum amount of average earnings upon which the loss of earnings is to be calculated is $42,000 effective the year after the Act is passed and, each year thereafter, is 175% of the average industrial wage in Ontario;

Medical Reform

MEDICAL REFORM is the newsletter of the Medical Reform Group of Ontario. Subscriptions are included with membership, or may be purchased separately at $25/year.

Articles and letters on health-related issues are welcomed. Submissions should be typed (preferably double-spaced), or submitted on IBM-compatible computer disks (any program, but tell us which program you used.)

Deadlines: The next newsletter will appear on December 2, 1989. The deadline for longer articles is October 27; shorter items such as announcements must be in by November 17.

Correspondence should be sent to Medical Reform, P.O. Box 366, Station J, Toronto M4J 4Y8. Phone: (416) 588-9167.

Opinions expressed in Medical Reform are those of the writers, and not necessarily those of the Medical Reform Group of Ontario.

Editorial Board: Haresh Kirpalani, Don Woodside, Fran Scott, Bob Frankford, Ulli Diemer.

The Medical Reform Group of Ontario is an organization of physicians, medical students, and others concerned with the health care system. The Medical Reform Group was founded in 1979 on the basis of the following principles:

1. Health Care is a Right

The Universal access of every person to high quality, appropriate health care must be guaranteed. The health care system must be administered in a manner which precludes any monetary or other deterrent to equal care.

2. Health is Political and Social in Nature

Health care workers, including physicians, should seek out and recognize the social, economic, occupational, and environmental causes of disease, and be directly involved in their eradication.

3. The Institutions of the Health System Must Be Changed

The health care system should be structured in a manner in which the equally valuable contributions of all health care workers in recognized. Both the public and health care workers should have a direct say in resource allocation and in determining the setting in which health care is provided.

-compensation for non-economic loss is calculated by multiplying the Board's assessment of the percentage of permanent impairment x $45,000 + $1,000 for each year of age of the worker below 45 at the time of the injury or -(minus) $1,000 for each year the worker is over 45; a worker can only apply twice for a review of his/her award and only following a significant and unanticipated deterioration in the compensable condition;

-compensation for future loss of earnings = 90% of the difference between the worker's net average earnings before the injury and the net average earnings that the worker is "likely to be able to earn after the injury in suitable and available employment"

-the Board must set aside additional funds equal to 10% of every payment made to the worker for a retirement pension and the worker will be eligible to receive this pension at age 65.

-The worker "may select" a physician who is on the roster that the Board provides; if no choice has been made within 30 days after receiving the roster the worker must go to the physician that the Board chooses; both the worker and the employer will receive copies of this medical assessment; a second assessment can be requested by the worker, the employer or the Board and must be chosen from a list of at least three doctors that the Board supplies; these assessments will be paid for by the Board at a rate of remuneration determined by the Board

-The Board "shall" contact a worker for early vocational rehabilitation assessment within 45 days after an accident if the worker has not returned to work and provide vocational rehabilitation "if the Board considers it appropriate to do so"; the Board "shall" offer vocational rehabilitation assessment to every worker who has not returned to work at pre-injury earnings within 6 months after the accident report is filed or when the worker is medically able to undergo assessment; worker and employer will receive copies of the assessment; it is up to the discretion of the Board to decide if the worker needs vocational rehabilitation; the Board is supposed to provide 6 months of assistance in seeking employment with only one further 6 month extension.

-Workers co-operating (sic!) in a Board-authorized vocational or medical rehabilitation programs may be eligible for supplements while they are in the program that would bring their income to 90% of the pre-injury net average earnings.

-Employers are required to re-instate or re-employ, for one year, injured workers who have worked for them continuously for at least a year prior to the injury (if the Board says the worker is fit to perform the pre-employment duties) or offer them "suitable" work "at the first opportunity" that such work becomes "available" if the Board says the worker is unable to perform the pre-injury duties but is able to do other suitable work; this section does not apply to employers with less than 20 workers or in the construction industries. There is no right of appeal to the Appeals Tribunal from a decision of the Board regarding re-instatement and re-employment.

-Employers are required to maintain employment benefits of injured workers for one year after the injury if the workers pay the worker's contribution, if any, for the benefits; penalty for not complying: maximum fine equivalent to the one year's contribution for that employee's benefits and employer is liable for any loss the worker suffers as a result of the employer's failure to make these contributions.

-The Board may divert a worker's compensation to the worker's spouse or dependents for court-ordered maintenance or support.

-Protection against civil liability is extended to members, officers and employees of the Industrial Disease Standards Panel, Office of the Employer Advisor, Office of the Worker Advisor, accident prevention associations, and to medical practitioners conducting assessments.

Criticisms of the Act made by the Ontario Legal Clinics Workers' Compensation Network:

-The bill should not be passed. It does not provide appropriate solutions to the longstanding problems in the compensation of injured workers. Its goal of cost-neutrality will result in the loss of benefits for many injured workers.

-Too many provisions of the Act are vague and left up to the discretion of the Board. Language in the act is permissive and not mandatory or vague in many key sections.

-The Board has often made unreasonably strict and narrow interpretations of the Act in the past. It has taken chaotic and inconsistent approaches to adjudication of claims and not articulated known standards by which compensation entitlement can be determined. It cannot be trusted to provide a fair and liberal interpretation of sections which create broad grants of authority.

-New regulation-making provisions enhance the autocratic nature of the Board and allow it to ignore decisions of the Appeals Tribunal (WCAT) by creating new regulations. These regulations are not subject to public review and may even subvert the intent of the legislation itself.

-Policy at the Board is very inconsistent and in-flux. There is a need for a single set of policy manuals for internal and external use.

-Compensation for non-economic losses associated with permanent disability is problematic. The process of review of the award is too limited. It discriminate against older workers. The maximum amount payable is inadequate and significantly lower than 250% of the average industrial wage proposed by the government in 1981 in the White Paper on Workers' Compensation (in 1988 terms this would be $62,000 - not $45,000). It is likely to be the only award available to lower income workers and will substantially reduce the amount of compensation they receive compared to the existing system.

-The choice of medical practitioners should not be made by the Board or employer but by the worker.

-Problems with provisions governing compensation for economic losses: it depends on the Board's interpretation of the vague phrase "suitable and available employment". In the past the Board has considered "suitable" work in which there is a risk of re-injury or aggravation of the original condition and "available" work which the worker had not actually been offered. This system bases projected loss of earnings on hypothetical jobs and often overestimates the worker's earning capacity, and, therefore, underestimates any loss of earnings entitlement. Lower income workers are likely to receive few benefits from this award.

-These amendments replace a secure, indexed pension for life with a retirement payment that is linked to the wage-loss payment which is often inadequate, up to the discretion of the Board and is of indefinite duration.

-This bill has omitted the provision that allows survivor benefits upon the death of a recipient of a 100% permanent disability award.

-The bill fails to address the need of injured workers for a legislative statement of principle that will govern vocational rehabilitation decision-making and that will serve as a measure to assess the propriety of a rehabilitation program. It does not specify any right or obligation with respect to actual rehabilitation - only the right to assessment. Nor does the bill ensure payment of benefits to injured workers while in a rehabilitation program approved by the Vocational Rehabilitation Division. In practice adjudicators from a different Division make this decision and Vocational Rehabilitation counsellors have no authority wrt benefits. This has led to injured workers being denied full benefits even though they were in an approved program. Rehabilitation is only available for a very limited period - primarily to those on temporary benefits.

-The bill does not adequately ensure re-instatement or re-employment of workers who cannot return to their initial job. There are no definitions of "suitable" job when it becomes "available". Many, if not most, workers in Ontario are not covered by the re-instatement clause because of all the exclusions.

-Many rights of appeal to the Appeals tribunal have been removed, eg decisions of the Board regarding re-instatement and re-employment, regarding non-economic loss awards.

Proposed Resolution on Licensed Acts Approach

Whereas the health care system must be changed to respect the expertise and contribution of all health care workers;

And whereas the licensed acts approach recommended by the Health Professions Legislation Review would promote democratization of the health care system;

And whereas the mechanisms for public funding of health professionals who are non-physicians are much more restricted than for physicians;

Be it resolved that the Medical Reform Group supports the implementation of the licensed acts approach to health profession regulation put forward by the Health Professions Legislation Review within a universally insured health care system.

Proposed by Don Woodside

Impossible Choices

The following comments are taken from an article written by the mother of a young boy who died from leukaemia after she tried, unsuccessfully, for over a year to get funding for a bone-marrow transplant. They underline poignantly what is at the heart of the resolution proposed by the Resource Allocation Working Group regarding effective but expensive interventions.

"State officials [in Oregon] defend their actions by saying that comparatively few people require transplants, and that the funds previously earmarked for this procedure – about $733,000 a year – were needed to support preventive health-care programs for children and low-income pregnant women, which would benefit many.

"Who decided we must choose between 2-year-olds with cancer and poor pregnant women? I'm not ready to do that and I don't think most other Americans are, either.

"I don't believe the issue is money – it's priorities. With all the bombs we make and the space shuttles we launch, isn't there anything left over to provide lifesaving treatment for a child who may have full, productive years ahead?"

-Family Circle, August 15, 1989

Proposed Resolution: Funding for Effective but Expensive Interventions

Proposed by the Resource Allocation Working Group

Demands for funding for interventions that are effective but costly receive considerable coverage in the mass media; e.g. for things such as bone marrow transplants, other transplant surgery, lithotripsy, coronary artery bypass surgery, and neonatal intensive care. Pressure to fund these interventions comes from various interest groups, including both health care providers and consumers, is dependent on the resources of the particular groups involved and is often disproportionate; i.e. groups with more resources can press their demands harder.

There are a number of reasons the MRG should get involved in the debate over these issues. First, the demands of groups seeking funds are frequently amplified and easily distorted by the opposition parties in parliament as well as the media. The MRG, because of its expertise, might provide a voice of informed reason in the debate. Second, decisions regarding the funding of expensive interventions has important consequences, in that effective treatments are not available if they are not funded and conversely, if they are funded, they consume substantial resources that subsequently are not available to be used elsewhere. Third, such issues could provide a ready platform for a group with relatively few resources to devote to raising its own issues. This could be a way for the MRG to return to the public spotlight and, having done so, raise its own agenda with respect to issues of resource allocation.

Of course, responding to these issues necessitates having a position that has been carefully thought through and can be aggressively defended. The position proposed below has been developed by the Resource Allocation Working Group based on the criteria put forward and tentatively endorsed at the last semi-annual meeting: equality, effectiveness, efficiency, a societal perspective, and attention to where resources are likely to be re-allocated.

Background to the Proposed Resolution

To be considered for funding, the effectiveness of an expensive technology should be established by rigorous scientific investigation.If this is not the case, the MRG is justified in arguing that it should only be funded in the context of research. Clearly, adequate funding should be available for research to establish whether potentially beneficial interventions are actually doing more good than harm. This is addressed in another proposed resolution regarding the allocation of resources to research.

A related issue has to do with the degree of benefit which follows from an intervention. Decisions should be based on societal preferences for the potential benefits that can be achieved if a proposal is funded, not on preferences for the intervention or program per se. Proposals may vary in appeal because of the population to whom they are directed, or the nature of the intervention itself. As much as possible, the MRG should try and direct attention to the differences in outcome that result from the intervention.

Decisions regarding the funding of expensive interventions should be made within the context of how society currently allocates resources. One can consider a hierarchy of possible ways money being considered for bone marrow transplantation, or any other effective but expensive intervention, might be spent (see Figure). First, it might be spent on interventions which, though outside the health care system, are likely to improve health and reduce inequalities. The example provided in the Figure (which, like other examples used here, is entirely arbitrary and cited only to make the issues more concrete), shelters for battered women, may be judged as very likely to reduce inequalities in health status and very cost-effective. The money might also be allocated to interventions within the health care system that are likely to reduce inequalities in health status (such as health care programs for Native Canadians). Interventions such as these, both outside and within the health care system, meet all the criteria put forward in the statement of principles regarding resource allocation, and the allocation of money to these areas should be strongly supported by the MRG. Other areas to which the money might be allocated fall below effective but expensive interventions in the hierarchy illustrated in the Figure. Health care interventions which may have some positive impact on health status, but for which the benefit is not established (such as MRI scanning) should only be funded within a research context, as noted above. Resources should not be allocated to health care interventions that are useless and may be harmful (such as a large proportion of the Caesarean sections and cholecystectomies currently performed), to areas within the health care system that do not contribute to improvements in health and are unjust (such as money that goes to excessive incomes for physicians or profits for the drug industry), or to areas outside of the health care system that do not improve health status and are unjust (such as reducing corporate taxes to maintain profits).

Given this perspective, how the MRG should respond to the question of allocating resources to an effective but expensive intervention, such as bone marrow transplantation, would depend where, if the money is not allocated to the intervention, it will be spent. If we believed it would be spent on interventions that would reduce inequalities and improve health status and resources were not concurrently being mis-allocated to areas lower down in the hierarchy, there would be no justification for supporting increased funding for interventions such as bone marrow transplantation. Otherwise, we would rather the money be spent on bone marrow transplantations and other effective but expensive interventions, which have dramatic positive impacts on the health status and the lives of the recipients.

It is our view that in the current political climate, resources withheld from effective but expensive interventions within the health care system will most likely be used to hold down taxes on corporations and privileged private citizens. Regardless of whether this assertion is accepted, a cutback in an effective health service, however expensive, should be supported only if the money that is to be saved is transferred to another program that warrants funding and the transfer of money is traceable; i.e. the money should not just disappear into the budget, or out of the health care system, and the government should be pressured to clearly identify where the money that is saved will be used.

Decisions regarding the allocation of resources should not be made on an ad hoc basis.

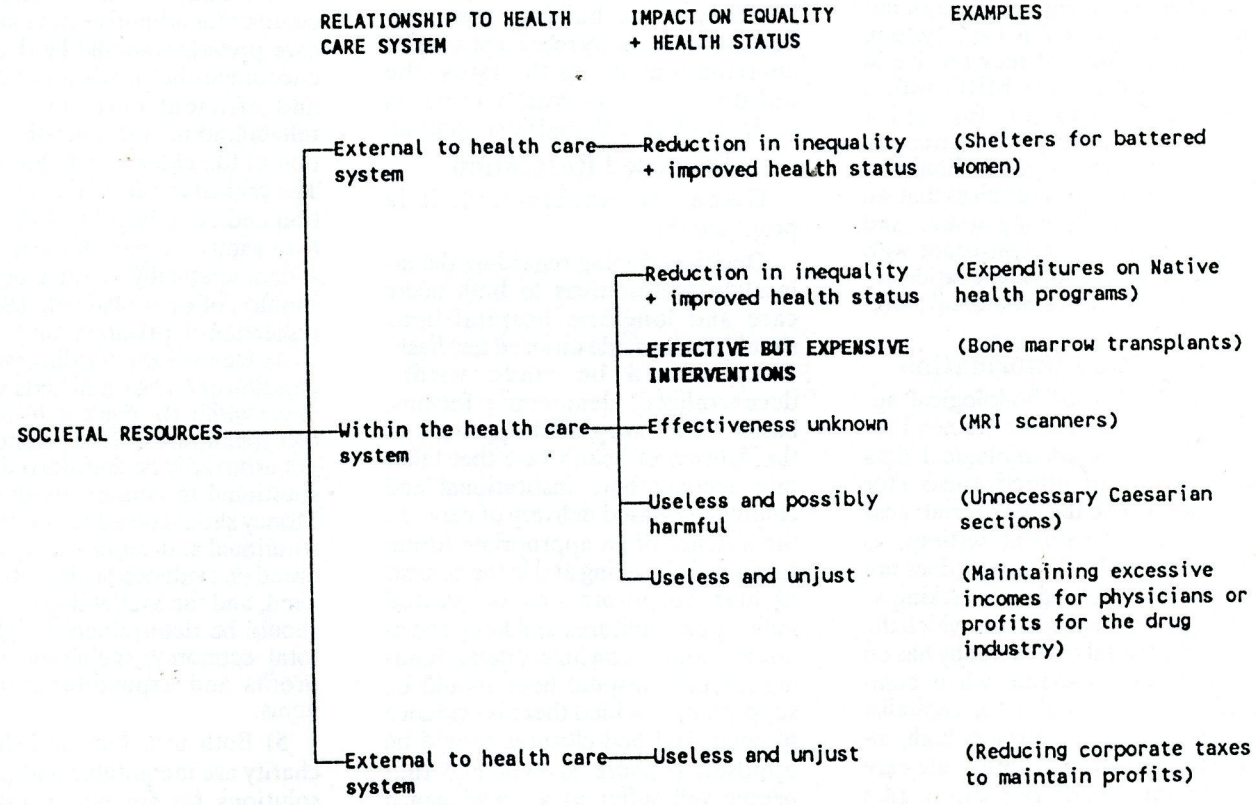
They should be made in an open democratic forum based on explicit criteria consistent with the MRG's stated principles regarding resource allocation. Within this forum the interests of minority groups should be protected.

The need for a rational and democratic decision-making process is vital. The current absence of a forum that would facilitate this process should be raised as an issue by the MRG at every opportunity, and should to a large extent dictate the MRG response to questions regarding funding for effective but costly interventions Proposed Resolution:

Given this background, the MRG Resource Allocation Working Group proposes the following policy for consideration at the next semi-annual meeting:

Decisions regarding the funding of effective but expensive interventions should be made in the context of the total economy. In the absence of an appropriate forum for decision-making and in the context of high corporate profits, wasted military expenditures and large societal expenditures on luxury items, funding for expensive interventions should not be rejected, provided there is evidence of effectiveness and need. The onus is on the government to find the money (e.g. by raising corporate taxes, taxes on luxury items, reducing tax shelters, or reducing military spending) until an open democratic forum and explicit criteria regarding resource allocation are established to guarantee that health care resources, and societal resources in general, are allocated equitably as well as efficiently.

Figure: Hierarchy of ways in which resources might be allocated



Proposed Resolution: Closing & building new hospital beds

Proposed by the Resource Allocation Working Group

With increasing frequency, hospital public relations departments are announcing to the media that they are closing beds. The public outcry that follows each closure has added to the general malaise regarding the apparent lack of beds. Meanwhile, based on international comparisons, it is argued that there are too many, rather than too few, hospital beds. Not infrequently the response to closures is orchestrated by special interest groups and played up by the media, amplifying concerns and contributing to the confusion that exists regarding the need for hospital beds.

At the same time, the government and groups such as the Premier's Council on Health Strategy are proposing that capital expenditures for hospitals should be curtailed, while various community and special interest groups are demanding additional resources to build new hospital beds. These concerns are of major importance to the health care system, and the attention that they receive in the media provide the MRG with a ready platform to put forward a progressive position on the direction that the health care system should be taking. However, this requires that we examine the underlying issues and take a clear position, consistent with the criteria for resource allocation established at the last semi-annual meeting.

Background Information

At present, a methodological approach to projections of the need for beds based on epidemiological data and evidence of effectiveness (for length of stay and the appropriateness of alternative treatment settings, as well as for specific therapies) does not exist. Furthermore, data is lacking as to the nature and magnitude which the supply of hospital beds actually has on health status. Canada, when compared to other developed, capitalist countries, boasts an already high, albeit disparate, ratio of both acute care and longterm beds per capita (4.4 acute and 2.4 longterm beds per 1000 people). Ten percent of those over 65 years old in Canada are institutionalized, compared to 6% in the USA and Australia, and 5% in the UK.

Juxtaposed on this is the increasing financial pressure coming to bear on hospitals from provincial ministries of health for a number of reasons, including: a changing economic climate, budgetary constraints, a move to disease prevention and health promotion, and the reduction of federal transfer payments to the provinces. In contrast with past practices, hospital administrators are now being mandated to operate without a deficit. This has impacted on negotiations with employees, including nurses, regarding salary and wage increases. The situation is further exacerbated by years of acquiring new and expensive technology, the use of which has inflated operating budgets. In response to this situation, hospital administrators have begun closing acute care beds.

Although bed closures do not necessarily pose a major threat to health status, indiscriminate and uncritical closures should be opposed. Similarly, while building new beds does not necessarily represent a major contribution to health status, the building of beds where there is evidence of need should be supported.

Proposed Resolution

Given this background, it is proposed that:

Decision-making regarding the allocation of resources to both acute care and longterm hospital beds should not be made on an ad hoc basis. They should be made within decentralized, democratic forums, based on an integrated approach to the delivery of health care that takes into account both institutional and community-based delivery of care. In the absence of an appropriate forum for decision-making and in the context of high corporate profits, wasted military expenditures and large societal expenditures on luxury items, funding for new hospital beds should be supported, provided there is evidence of need, and bed closures should be opposed if there is evidence that people will suffer as a consequence (e.g. due to early discharge, prolonged waits for surgery such as hip replacements, or transport to distant medical centres). The onus is on the government to find the money (e.g. by raising corporate taxes, taxes on luxury items, or reducing tax shelters) until an open democratic forum is established to guarantee that health care resources are allocated equitably as well as efficiently. More specifically:

1) Regionally-based democratic forums should be established with the mandate to determine and plan for present and future needs for institutional beds. The provision and utilization of hospital beds should be assessed and monitored by a democratic review board, elected from among representatives to the regional forums, on a scientific basis. This evaluation should include the evaluation of all hospital-based interventions, based on a review of evidence of effectiveness and need. Resources should be allocated to this board for synthesizing the available research and commissioning new research to address important gaps in the current state of knowledge.

3) Financial and professional incentives for administrators and health care providers should be designed to encourage the provision of equitable and efficient care, including the rehabilitation and de-institutionalization of the elderly and chronically ill. The critical review of the implementation and effectiveness of these incentives should be part of the mandate of a democratically elected board, and should not be privatized. (See MRG resolution re privatization.)

4) Decisions regarding overall expenditures on hospital beds should be made within the context of total societal expenditures. Thus, money should not arbitrarily be transferred from institutional to community-based care. Money should be allocated to both institutional and community-based care based on evidence of effectiveness and need, and the availability of resources should be determined in light of the total economy, including corporate profits and expenditures on luxury items.

5) Both user fees and the use of charity are inequitable and inefficient solutions for financing institutions. The MRG's opposition to user fees and the use of charity should be strongly re-iterated. (See MRG resolutions re user fees and use of charity.)

Proposed Resolution: Capping Health Care Expenditures

Proposed by the Resource Allocation Working Group

Whether there should be a cap on health care expenditures is a question that has been raised in debates concerning health care resource allocation, both by MRG members and others. The proposal that there should be a cap (i.e. a maximum level of expenditure that is set at, for example, a fixed percent of the GNP) is rooted in the belief that expenditures on health care in Canada are "out of control".

In fact, this is a questionable assumption. Recent statistics indicate that the proportion of the GNP spent on health care in Canada has not been rising in excess of inflation (Evans et al., N Engl J Med, 1989). Nonetheless, arguments for a cap can still be adduced.

Pros:

1) It is argued that a cap would foster better management of resources. Indeed, when caps are placed in a micro-environment they may engender creative and efficient solutions to resource constraints. Often this may be because the actual implementation of such decisions are retained within a small accountable area where triage or redistribution can be effective. However, when a cap is set at a more global level, it is difficult to ensure fair implementation.

2) A cap could be of major benefit in terms of planning an economy - always a nightmare. Capping would enable long term allocation of resources to be made, comfortable in the knowledge that the allocation will not need to be expanded. This is predicated, however, on a stable need for health care.

Cons:

1) Should there be a change in need, a fixed limit on expenditures implies that this would either not be met or else it would be met by virtue of cuts elsewhere in the system. An impressive example of the extent to which needs can, in fact, change is the emergence of AIDS. There has been a very expensive and unforeseen explosion of need because of the AIDS epidemic.

2) Inflation is now a major source of whittling away at the overall value of items in general. It is, in fact, very difficult to accurately gauge the true rate of inflation. In the same manner that current cost of living increases are set below the true rate of inflation, the government is likely to set adjustments of a cap below the true rate of inflation, in effect reducing the availability of health care resources.

3) It is evident that there is not an equitable sharing of the burden of the national deficit. Thus, although it may be argued that the allocation of resources to the health care sector should deteriorate as do allocations to other sectors because of the deficit, certain areas do not, in practice, experience the same magnitude of cut backs (particularly private profit).

Proposed Resolution

Given this background, it is proposed that:

1) Any attempt at imposing a global cap on health care expenditures should be resisted. Caps are not the best way of ensuring either an equitable or efficient allocation of resources. A much more logical means of ensuring equitable resource allocation is via assessment of need and effectiveness.

2) Caps on expenditures in micro-environments (e.g. on a ward or in a hospital) can be effective when there is democratic decision-making and accountability and when the cap is set at an appropriate level relative to the need for care. Given these prerequisites, capping expenditures in micro-environments warrants support.

Proposed Resolution: A Democratic Forum for Decision-Making

Proposed by the Resource Allocation Working Group

Based on the general principles discussed at the last semi-annual meeting, the Resource Allocation Working Group has formulated a series of specific policy proposals. Democratic decision-making has been emphasized as a key element of many of these. The reasons why a democratic forum for resource allocation decision-making is needed are briefly summarized below as background to a proposed resolution that specifies the characteristics of a democratic forum that we believe the MRG should advocate.

The Need for a Democratic Forum

1. Inappropriate incentives and disincentives

Currently key decision-makers are likely to be motivated in ways that are in conflict with public interests. For example, politicians' electoral concerns often constrict their vision to a time frame that is limited by the next election and their financial alliances prompt them to focus on cost-containment rather than cost-effectiveness; bureaucrats' career concerns often motivate them to focus on internal political demands rather than health needs; and physicians' economic interests often come in conflict with public interests.

Although conflicting interests are, to some extent, inevitable in any system, a democratic forum in which decision-makers are directly elected to represent the health interests of the public is the best way of ensuring that the decision-makers' interests are congruent with the interests of the people they represent.

2. Inappropriate influence

Various interest groups, particularly affluent ones, have a disproportionate influence on decisions. Making decision-makers directly accountable to those whose health interests they are elected to represent can

serve to reduce the potential for wielding financial resources to sway decisions.

3. Need for scrutiny

Many resource allocation decisions are now being made behind closed doors. An open democratic forum is essential if decision-makers are to be held accountable.

Proposed Resolution

Given this background, it is proposed that:

Resource allocation decisions should be made in an open democratic forum which is characterized by:

1) open channels of communication for input from all health workers and the lay public in a representative fashion;

2) elections, similar in nature to education board elections, of grass roots representatives organised at places of work, health care institutions and at a neighbourhood level;

3) elections among the grass roots representatives of centralized review boards with the following mandate: to set priorities for health expenditures, to ensure traceability of redistributed funds, to critically review government policies regarding resource allocations, and to meet with special interest groups to hear their views and adjudicate between differing points of view;

4) empowerment of the review boards with the right to veto Ministry of Health decisions;

5) all decisions made openly and background information made readily accessible to all interested parties;

6) all elected representatives subject to removal by the right of instant recall by their constituency.

Book review: Jim: A life with AIDS, by June Callwood

Reviewed by Susan Inwood R.N.

"I did not want to write this book." With these words, June Callwood introduces the reader to her latest book, Jim: A Life With AIDS. James St. James, suffering from AIDS, wished to write about his life and his battle with AIDS. Callwood did not want to establish that strong bond between writer and subject and then watch St. James die. She extracted a promise from him that he would not die.

Against all odds, St. James did not die during the writing of this book and continues to be Canada's longest survivor with AIDS. This book details not only his fight to survive but also his life prior to diagnosis.

Callwood, in her usual compassionate, yet straightforward manner, introduces us to a young homosexual man and details his early life. He was raised in a Jehovah's Witness family. His mother was deeply religious and raised her two daughters and two sons in this faith. This is central to the story of St. James. The faithful feel that homosexuality is "utterly despised by Jehovah" and the punishment for this sin is disfellowship, a form of excommunication or banishment. This also requires that members of the faith have no contact with one who is under this indictment. Callwood very ably helps us to feel his pain as, with the growing realization of his homosexuality, comes the understanding that he will have to choose between his faith and family and his sexuality. It is a battle that causes much anguish for many years as he attempts to deny his sexuality. Jim was eventually disfellowed from the church and cut off from his mother, although his father, who had chosen to leave both his wife and the faith, maintains a supportive relationship.

The diagnosis of AIDS in 1984 came at a time in Jim's life when he had finally reached some stability. He had come through a disastrous marriage, a period of rejection of family and faith and a time of abandoned sex, into a new career within the theatre that appeared extremely promising. Within the same week that St. James won the Theatre Ontario award for best actor, he was also diagnosed with AIDS.

Over the next four years, Jim St. James experienced tremendous physical and emotional pain. He watched his own body deteriorate from cancer and suffered the pain of chemotherapy, he experienced fear and rejection from frightened, uneducated people and he watched scores of friends suffer and die from AIDS. But very early in the course of his disease he came to terms with death and decided that he will face this disaster with dignity and will not give up easily. He states, "I have AIDS but AIDS hasn't got me."

Jim is at peace with himself as regards his sexuality and feels that AIDS provided him with the opportunity to speak out about homosexuality, to educate the public and to help dissolve prejudices. He has become a spokesperson for the gay community and a co-founder of the Toronto Persons with AIDS foundation.

I did not want to read this book. Statistics in journals about AIDS are easily digested and dealt with but one person's actual account and pain are harder to read. And it WAS difficult but I was constantly drawn back to finish. Callwood writes with great sensitivity about homosexuality, a subject with which many find it difficult to deal. Some may find the book too explicit sexually. Others may find the description of each of Jim's friends who have contracted AIDS and then died, too long and too graphic but this is the reality of Jim's life and as such is essential to understanding his emotional pain.

This book should be read by everyone! For those of us in the health care system it will hopefully inform and enlighten us. It may then enable us to care for our patients with more understanding. And although we may not encounter patients with AIDS within our own particular area of medicine or nursing, as this disease continues to spread throughout our population, at some time we will, as family or friend, know someone with AIDS. This book will provide the support and encouragement we will all need.

Susan Inwood is Nursing Head, Neo-Natal Follow-up, Mount Sinai and Hospital for Sick Children

Book Review: Health Care in Canada

Health Care in Canada – A description and analysis of Canadian Health Services, by Ralph Sutherland and M. Jane Fulton. Canadian Public Health Association, 1988, Ottawa. $28.95, or $25 per book for orders of three or more, $22 for ten or more.

Reviewed by Haresh Kirpalani

MRG members seem to have been exploding into print lately. Sutherland is a member of the MRG – as well as being Professor of health administration at Ottawa University. Fulton is a professor of strategic management and health policy at Ottawa. Though the book has been aimed at a diverse "audience (who) obviously requires straightforward language)", it does at times leave a somewhat dry taste. This would seem unavoidable given the scope of the book, and the detail that the authors have packed in. The flat and rather unemotional style of the authors actually becomes one of its overriding virtues in this reviewer's opinion. It is likely that this style will ultimately persuade more people to the views expressed herein, than a more flamboyant one. In my opinion this is a book that should be on the curriculum of Canadian medical schools. The book's main merit is that it can both:

give a very good systematic approach to both definitions of health (approvingly noting Henry Sigerist 's definition :"a joyful attitude toward life and a cheerful acceptance of the responsibility that life puts on an individual" and the current WHO working definition) and provide details of the constituent working (and non-working) parts of the Canadian Health care system. The mass of potential minutiae does not leave the authors rudderless. They are still able to point the direction in such vital thorny issues as :"Does the method of payment affect the quality of care, the doctor patient relationship and whether a physician is ethical ?"

Clearly the authors have a particular viewpoint and this is not very dissimilar to the MRG 's own. Thus a detailed analysis of the economic factors of health (citing data from Wilkins and Adams, 1983) is useful :

"Beveridge in his report in Britain in 1943, listed the 5 major evils that had to be conquered to improve the nation's health - ignorance, squalor, disease, unemployment and want. We know that in Canada in 1987, as in Britain in 1943, socioeconomic factors continue to have an influence on health status." p. 30.

The section on health promotion is particularly good.

Apropos the MRG's current debate about the merits of the Community Health Centers - the authors believe them to be still "a desirable concept " and list the potential benefits. I believe they may be rather naive in the degree to which democratization and empowerment can be achieved through the CHC. Perhaps I am ill-informed. The authors unfortunately do not substantiate their views with examples here. Not that I am against the features that they state are possible in this process - merely skeptical about the potential for social change through this vehicle alone.

It would not be honest to deny that I have some specific problems with the book. They centre around the "limits" that the authors have imposed upon themselves. Thus I do not see an explicit political discussion of whether or not a limit of society spending on health care has indeed been achieved. It is simply assumed that it has been so achieved. Further to this there is in my view an unfortunate tendency to "blame the victim ". Thus through the book the example of smoking recurs. However only on page 176 is there an explicit reference to the tobacco industry and its power. To me the power of corporations in current Western capitalism in establishing the health mores of society cannot be minimised. Thus how to fight for a better health in the population needs to explicitly weigh Corporate interests in a much more extensive fashion than the authors achieve here.

Thus my differences are political differences, and one rather of emphasis than of principle. This is an excellent, well thought out book, providing examples of tactics and one strategy for achieving reformist change.

DENNIS PRITCHARD/SASKATOON STAR-PHOENIX

Corporate-funded research may be hazardous to your health

Double-dipping professors and university administrators rarely see any harm in taking money from private industry. Nor do they take kindly to colleagues who point out problems in their research results—as one professor has learned through bitter experience.

Erdem Cantekin, former director of an ear research center at the University of Pittsburgh Medical School and co-investigator on a five-year NIH study, found that a popular children's antibiotic—the pink, bubble-gum flavored amoxicillin familiar to all parents of toddlers—is ineffective in treating ear infections, and possibly harmful. But the primary investigator on the $15 million federal grant, a colleague of Cantekin's at the medical school, interpreted the data differently: after changing the study protocol, he determined that amoxicillin *is* effective against children's ear infections.

The primary investigator had also, over the period when the government was paying for the research, accepted perquisites amounting to over $50,000 per year in lecture fees and travel money from drug companies that produce antibiotics. Between 1981 and 1986, the ear center received more than $1.6 million in research grants from pharmaceutical companies to test the effectiveness of antibiotics on ear infections. Americans spend in excess of $500 million annually on antibiotics for this one ailment.

In June 1983, three years into the NIH-funded ear study, Cantekin says: "I met with my department chairman and informed him that I had grave doubts about the scientific validity of research commissioned and funded by pharmaceutical companies seeking to prove the effectiveness of their products. He answered that I was free as a matter of personal choice to disassociate myself from industry-sponsored work, but that he could not require a primary investigator of the center to refuse industry funding."

In September 1985, unable to agree with the conclusions of the primary investigator, Cantekin bowed out as a co-author of the manuscript reporting the clinical results of the study. He then began a careful analysis of the data with Timothy McGuire, a statistical analyst at Carnegie Mellon University. They wrote a paper in which they argued that amoxicillin, while an appropriate drug for many uses, is not effective in the treatment of secretory otitis media. Hoping that peer review would determine who was correct, Cantekin submitted his dissenting viewpoint to the *New England Journal of Medicine.*

When Cantekin tried to publish his negative findings, the head researcher on the NIH study and the chairman of the department to which both belonged were distraught. Cantekin's data tapes were erased, he was taken off all the department's grants, fired as director of the ear research clinic, and forbidden by the chairman to publish the paper.

Nevertheless, Cantekin submitted his paper next to the *Journal of the American Medical Association,* which accepted it pending revisions. When JAMA was on the verge of publishing the article, the department chairman notified the journal that charges of serious "breach of research integrity" had been brought against Cantekin by a member of the medical school. He was charged with "misappropriating data" and trying to publish an article against the order of his department chairman. The primary investigator and department chairman assert that the research data are the property of the primary investigator.

Cantekin counters that because he was a co-investigator on the publicly funded NIH project and participated in the study for five years, he is entitled to analyze the data and publish his findings. In late 1986 Cantekin sought the counsel of the Senate Tenure and Academic Freedom Committee at the University of Pittsburgh, which obtained this opinion from a law professor who specializes in protection of intellectual property: "If a researcher tried to assert property interest in the research data as a basis for preventing public dissemination of criticism of the research by a dissident co-researcher, it seems unlikely that, under either copyright law or under general property law, such an assertion would be vindicated."

But a committee appointed by the dean to investigate the case drew a preliminary conclusion that there was reason to believe that Cantekin had committed a breach of research integrity. Following that finding in March 1988, the Tenure and Academic Review Committee expressed its concern "that the response of the School of Medicine to [Cantekin's] original complaint has included counter-charges against [him]" and that this sort of administrative reaction has a "chilling effect on open communication and is regrettable."

Because he has tenure, the School of Medicine cannot fire Cantekin, but he has been stripped of the resources needed to conduct research. His case has sparked a chain of investigations, however. The medical school is holding a second closed hearing on all allegations against Cantekin; NIH is investigating alleged wrongdoings by other ear center researchers; and congressional committees are monitoring both NIH and the medical school. □

—*Kathleen Hart*

Bulletin of the Atomic Scientists, April 1989, Vol. 45, No. 3

Funds end threatens information centre on health and safety

BY WILFRED LIST
Special to The Globe and Mail

The federal government has started withdrawing all financing for Canada's main source of reliable, independent information on occupational health and safety.

The decision could jeopardize the future of the Hamilton-based Canadian Centre for Occupational Health and Safety.

The centre, founded by an act of Parliament in 1978, will be progressively stripped of its $10-million in annual federal financing by 1991 and will have to find other sources of revenue if it is to continue.

The government's action has produced an angry response from Dick Martin, executive vice-president of the Canadian Labor Congress and a member of the centre's governing body.

He said the move to end financing is "a callous attempt to dismantle the centre or to privatize it."

The labor body is considering withdrawing from the centre as one option, he said. "We're not going to participate in its execution. They are talking about a whole new mandate for the centre. The bottom line will be to turn it into a marketing operation that will divert it from its role of providing authoritative information to workers and employers aimed at contributing to a healthy and safe working environment."

The government's decision has also created uncertainty about the centre's future among employers.

Gordon Lloyd, director of the legislative and technical group for the Canadian Manufacturers' Association, said the centre has been useful to many firms, especially now that they must comply with the federal Workplace Hazardous Information System.

Ken James, parliamentary assistant to Labor Minister Jean Corbeil, who attended a special meeting of the centre's board of governors last week, said the centre could eventually end up as a free- standing private institution, operating either on a non-profit basis or for profit.

The centre is about to start drafting recommendations for national standards for man-made mineral fibres. It has also helped develop national standards for chemicals in the work place through a consensus among management and labor and recently decided to broaden its electronic information service to include environmental information.

The range of the centre's activities is reflected in statistics on client services. Last year it distributed 8,000 compact discs containing information from 25 data bases on occupational health.

The centre's on-line system serves 1,200 organizations and last year was used more than 40,000 times. Its toll-free inquiry service from across Canada responded to 26,000 inquiries in the year, a 40 per cent increase over the previous year. It has sent out 150,000 technical publications on various topics.

Most of the data from the centre are available free to workers, unions, the public and employers. However, the centre recovered about $441,000 in costs in the 1988- 89 fiscal year. The money came from the sale of the computer disks and from fees for participation in workshops for workers and employers.

The centre's nine-member board of governors, made up of representatives of labor, employers and the federal and provincial governments, was told by Mr. James that the centre has to share in government cutbacks.

A set of options, including fee recovery for the centre's services, has been suggested by Mr. Corbeil, who has given the centre's president, Dr. Gordon Atherley, until October to come up with a financial plan.

News of the government's decision was kept secret at the request of Mr. Corbeil for at least two weeks until he authorized Dr. Atherley last week to tell the board.

Dr. Atherley said in an interview that there is no way the centre can cover its costs by a fee for service.

The centre will be required to raise $1.45-million this year through fees and $4.625-million next year. It must be financially self-sufficient by the 1991-92 fiscal year.

Options that may be considered next month by the 39-member council that oversees the centre's operations include tapping workers' compensation boards across Canada for funds, asking provincial governments to contribute money, a general fund-raising program or folding the centre into a department of government.

POT-SHOTS No. 376

Health Care for All—With Limits

To Avert a System Collapse, We Must Define a Basic Package

By BRIAN JOHNSTON

There is no question that the emergency medical-services system in Los Angeles is collapsing. Ask paramedics, and they will tell you how hard it is to find an open emergency department during peak hours, or when there's an outbreak of the flu. Talk to emergency physicians, and they will tell you that their departments are frequently overwhelmed by incoming patients for whom they can not find specialists or hospital beds. Ask the hospital administrators, who collectively subsidized the care of the poor by $402 million in Los Angeles County in 1988.

Our trauma-center system, with 9 of 23 centers closed, is no longer a system. Now our basic emergency system—much more fundamental than specialized trauma care—is failing.

The reason for the collapse is financial. More than one-quarter of the local population is uninsured and we have large numbers of illegal immigrants. The cost of health care is so high and rising so fast that insurance companies and employers are reducing benefits and denying payment for legitimate services as a means of controlling costs. Judging by their actions, the governor and other politicians have decided that they will pay no more for health care, regardless of the consequences. Politicians apparently have concluded that if spending more than 11% of the gross national product won't provide an acceptable standard of care in this country, then committing a larger share is unlikely to do so. In sum, government, private insurance and employers have put a cap on health-care expenditures.

In this situation there are two threats to the public: one short-term and direct and the other indirect, and in the long run more dangerous.

The short-term danger is that individuals, including the well-to-do and hard-working, will die needlessly despite their health insurance because the system will have collapsed for lack of financing. The county hospitals will be choked with poor people. Sufficient numbers of private hospitals will have closed or abolished their emergency services so that even those who have money will not be able to get care soon enough to save their lives.

The more insidious threat is that such a grave collapse would prove to be the incentive for an ill-considered ballot initiative which, while attempting to meet the real needs of the 26% who are uninsured, will destroy our health-care system for the 74% who are covered. One has only to look at our recent history to see ballot initiatives that dealt simplistically with critical and complex issues. The Jarvis and Gann tax and spending-limit initiatives, the fight over insurance reform and the AIDS quarantine initiative are good examples of key issues that were oversimplified for the ballot and then obscured by competing advertising agencies. To subject our health-care system, whatever its shortcomings, to such treatment would be stupid and tragic.

What we need instead is to develop a social consensus that will permit health-care delivery to all within a specified cost or cap. To do that we must abandon the notion that we can provide all health-care services to people regardless of their ability to pay. Instead, we must define a basic health-care package that we can afford to offer everyone. Then we need the political and moral courage to explicitly acknowledge that we will not "do everything possible" for everyone.

This must be done on the basis of a social consensus because physicians, by their training and beliefs, will not withhold services that might save a life. I will do for my patients what I would do for a member of my family. I do not want to bear individually the burden of deciding who gets what care and who is denied. The public needs to be involved in deciding the total budget and should be advised by the medical profession on which interventions are cost-effective and which are not.

Diagnostic and treatment options will have to be ranked by priority by the medical profession within a fixed budget, and when the budget has been exceeded, it should be mutually understood that further treatment will not be funded. As examples of how this might work, liver and bone-marrow transplants may benefit too few to be publicly financed, and hair transplants would most certainly not be paid for in the basic package. On the other hand, prenatal care, childhood immunizations and hypertension screenings are known to be cost-effective and most certainly would be funded. Such a system may seem hard-nosed, but it is kinder and more decent than our present system in which basic care is not defined and large numbers of persons get no care at all.

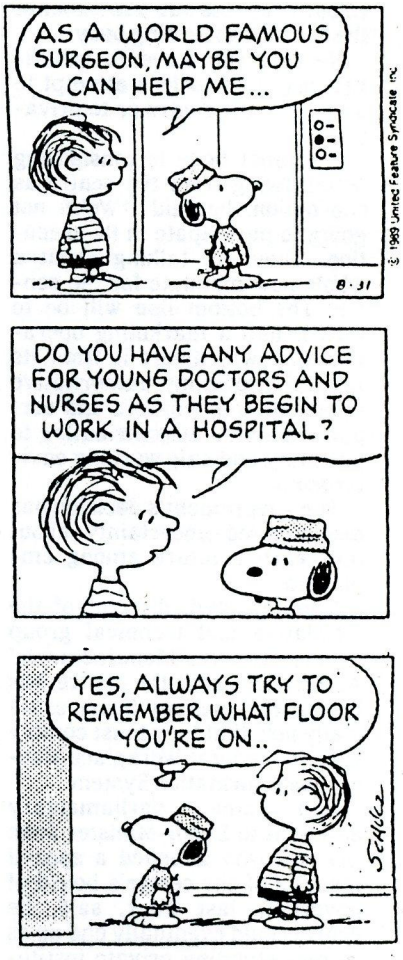
Working within a budget makes more sense than refusing to do so and thus bankrupting government and threatening the entire health-care system. We are, in fact, rationing health care today. Los Angeles County has 4,363 licensed beds, but staffs only 2,928 of those beds, while turning away the poor. That is a form of rationing not subject to medical review.

The Los Angeles County Board of Supervisors, in cooperation with the state Legislature, should assemble a panel of respected and knowledgeable persons in business, government and medicine to specifically address the issue of health-care costs and uncompensated care. We must deal with this problem promptly and dispassionately, before the collapse of our present system provokes an intemperate and irrational response that would then be indelibly incorporated into the state Constitution as a result of a ballot initiative and an ad campaign.

Brian Johnston is immediate past president of the Los Angeles Society of Emergency Physicians.

Los Angeles Times
Tuesday, July 25, 1989

Peanuts



News Briefs

Abortion Gallup poll

A new Gallup poll indicates that 57 per cent of Canadians believe a woman should be allowed to have an abortion even if the man involved in the pregnancy disagrees. Thirty-one per cent said an abortion should not be permitted under such circumstances. The poll also shows that 26 per cent believe that abortions should be legal under "any circumstances" and an additional 63 per cent believe they should be allowed "under certain circumstances". Ten per cent believe abortions should be illegal.

– Toronto Star, August 24, 1989

Tory women endorse abortion choice

The National Progressive Conservative Women's Federation has voted overwhelmingly in favour of a statement urging that abortion be considered, in most cases, an issue between a woman and her doctor.

– Globe and Mail, August 26, 1989

Lawsuit seeks to free fetus from prison

A lawyer has filed suit in Missouri contending that the state is illegally imprisoning the fetus of a pregnant female inmate. Missouri has an anti-abortion law which states that life begins at conception and that fetuses have "all the rights, privileges and immunities available to other persons." The suit contends that the fetus has been imprisoned without having been charged with a crime, allowed to consult an attorney, or sentenced.

– Globe and Mail, August 4, 1989

AIDS carrier jailed

An Alberta man who had unprotected sex with two women without telling them he is carrying the HIV virus has been sentenced to one year in jail. The man pleaded guilty to a charge of being a common nuisance after charges of aggravated assault were withdrawn when both women refused to testify in court. Both women have since tested positive for the HIV virus. A spokesperson for the Alberta Civil Liberties Association said the ruling would keep AIDS victims from seeking help. "I think the message is, 'If you suspect that you are HIV positive, be very circumspect about seeking help with it because you don't know what you'll open yourself up to,'" said association president Tony Managh.

In another case in Halifax, a man pleaded guilty to a charge of criminal negligence causing bodily harm for passing on the AIDS virus to a pregnant woman.

– Globe and Mail, August 11, September 9, 1989

AZT to be more widely available

About 1,000 Canadians infected with the HIV virus, but who do not yet have AIDS, will be able to start using the drug AZT, federal health officials have decided. About 2,000 Canadians are presently receiving the drug in clinical trials. The decision comes in the wake of a U.S. study which suggested that AZT slows the development of AIDS if given to people with early symptoms. The manufacturer, Burroughs Wellcome Co., charges patients about $10,000 a year for the drug. The government will pick up the tab, estimated to be an additional $10 million per year. Some doctors questioned whether there was enough scientific evidence of the drug's effectiveness to justify its expanded use. "No reputable scientist could defend these guidelines," said Dr. Philip Berger.

– Globe and Mail, August 11, 19, 1989

Public health won't warn wife

Ontario public health authorities have decided not to warn the wife of a bisexual man that she may be at risk of contracting the HIV virus because he has engaged in unsafe sex. The decision was criticized by Dr. Philip Berger, who treated the man between 1986 and 1988. According to Berger, the man "was having unsafe sex with men and with his wife during the time I was his doctor...This woman needs protection." The man has refused to be tested for the AIDS virus, but according to Berger showed two possible symptoms of HIV infection. Berger acknowledged that the man's "whole life could collapse if the information about him was revealed to his wife – he could lose everything." He said his decision to report the man's name to public-health authorities "is the most difficult situation I've ever found myself in in 15 years." Public health officials decided not to inform the wife partly because they did not believe there were reasonable grounds "at the moment" to assume the man has the virus, and partly because he has said that he is now using condoms during sex with his wife.

– Globe and Mail, September 20, 1989

Quebec dumps called health danger

At least 66 toxic waste dumps in Quebec pose a risk to human health and the environment, according to a provincial agency, GERLED, which has been studying the problem. GERLED has identified 372 toxic waste dumps in Quebec. It says that Quebec produces more than 350,000 tonnes of toxic waste a year, about one-third of which is dumped directly into the St. Lawrence River.

– Globe and Mail, August 22, 1989

College endorses patients' access

The College of Physicians and Surgeons of Ontario (CPSO) is supporting proposals that patients be allowed access to their medical records. At present, doctors are under no legal obligation to show patients their records. A poll commissioned by the CPSO indicated that 60 per cent of doctors were in favour of the move, as were 88 per cent of the general public.

– Toronto Star, September 19, 1989

Lesbian/Gay Challenge to OHIP

A court decision earlier this year which upheld OHIP's refusal to deny family coverage to lesbian or gay couples is to be appealed. The test case involved Karen Andrews, who has been trying since 1985 to get family OHIP coverage for her partner of ten years. Andrews' employer is willing to pay the family premium but OHIP refuses to accept it.

Anti-apartheid activists target hospitals

The South African anti-apartheid movement is targeting segregated white hospitals in its campaign to abolish race laws. Scores of black patients presented themselves at white hospitals for treatment, which in most cases they were given.

– Globe and Mail, August 3, 1989

Independent health facilities

Legislative hearings have been continuing on Bill 147, the Independent Health Facilities Act. The legislation would regulate independent health facilities performing a variety of procedures such as eye surgery, abortion, and arthroscopic knee surgery. An MRG delegation consisting of Mimi Divinsky, Bob Frankford, and Philip Berger appeared before the committee on August 16. The MRGers expressed concern that "facility fees" under the proposed legislation might a a step towards the reintroduction of extra-billing, and that the legislation would lead to a greater privatization of the health care system. They also expressed concern over the amount of discretionary power being given to the health minister, and about the inspection and assessment provisions of the act.

Others also expressed concerns to the committee. Dr. Henry Morgentaler said that the legislation as framed would threaten the existence of free-standing abortion clinics, or would let them exist only at the pleasure of the health minister. Dr. Nikki Colodny of Choice in Health Clinic said that the bill as it stands would force her clinic to close. The Ontario Medical Association expressed fears that the bill would lead to risky cost-cutting as clinics bid against each other to get licenses, and that it would endanger the confidentiality of patient records.

Cancer treatment backlog

Toronto's Princess Margaret Hospital, Canada's largest cancer treatment centre, has placed a six-week moratorium on accepting new patients for radiation therapy, and is giving patients believed to be curable priority over those needing palliative care. Emergency patients will still be accepted, but the hospital will turn away an estimated 400 new patients who will be sent to other cancer centres in Canada, if possible.

The major reason cited is a shortage of radiation technologists at a time when the number of cancer cases is growing rapidly. Other hospitals, including ones in New Brunswick and British Columbia, are reporting similar problems.

– Globe and Mail, September 13, 1989

Threats to medicare

The Canadian Health Coalition (CHC) is concerned that the free trade deal and related legislation being pushed through by the federal government poses increasing dangers to medicare. The CHC says that massive cuts in transfer payments to the provinces which the federal government is implementing is bound to mean cutbacks in health services. The CHC is also unhappy that the free trade agreement entrenches the right of American companies to manage Canadian hospitals.

U.S. MDs rejecting high-risk patients

The fear of malpractice suits is leading some U.S. doctors to turn away high-risk patients, according to a Gallup poll. Fourteen per cent of doctors surveyed said they had denied service to as many as 10 high-risk patients in the past year because of such fears; four per cent said they had refused to treat more than 10. Seventy-six per cent said they did not turn away any patients for fear of litigation.

Thirty-five per cent said there are forms of medicine they do not practice, despite being qualified, because of high liability insurance costs.

– San Francisco Chronicle, July 7, 1989

Alberta doctors can advertise

The Alberta College of Physicians and Surgeons has passed a by-law allowing its members to advertise their services for the first time. The new rules require advertising to be truthful and in good taste.

– ONA News, August 1989

Extra-billing

The Canadian Health Coalition is gathering information on ways that doctors are imposing extra charges on patients now that extra billing has been legally banned in all provinces. People who have experienced this are asked to contact the Canadian Health Coalition, c/o 2841 Riverside Dr., Ottawa, Ont. K1V 8X7.

– Medicare Monitor, Vol. 5, No. 1

Hostels sue province over funding

Five facilities that provide treatment for alcoholics and drug addicts are taking the provincial Ministry of Community and Social Services and the Regional Municipality of Ottawa-Carleton to court over what they charge is inadequate funding. The five facilities charge that the funding they are receiving is based on an arbitrary limit rather than on what is actually need to operate them.

– Globe and Mail, August 1, 1989

Rules on gifts by drug companies

The Manitoba College of Physicians and Surgeons has told its members that it is unethical to accept major benefits from pharmaceutical companies. Small gifts such pocket diaries are considered acceptable, but larger gifts such as all-expenses-paid trips to conferences, are not. Dr. James Morrison, the College Registrar, acknowledged that the guidelines are general and open to varying interpretations.

– Globe and Mail, August 21, 1989