MEDICAL REFORM

Newsletter of the Medical Reform Group of Ontario

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

MRG Fall Meeting: Resource Allocation Provokes Vigorous Debate

The Medical Reform Group's General Meeting on October 14 began with further discussion of the Health Professions Legislation Review.

Don Woodside introduced his proposed resolution endorsing the **licensed acts approach of the Health Professions Legislation Review.** Some questions were raised about the resolution.

Would the effect of the resolution be to commit the MRG to the position that procedures should either be covered by OHIP, or prohibited? Should there still be room for people (drugless practitioners) to set up outside of OHIP, neither covered or prohibited? On the one hand, we want to discourage privatization of health care, and care outside of OHIP; on the other hand, we want there to be some room for people to choose treatments even though they are not recognized by OHIP, and don't want to shut off experimentation and the development of innovations and alternatives.

Paul Warbeck and Haresh Kirpalani pointed out that people other than physicians are qualified to make diagnoses in their area of expertise (e.g. lab technicians and blood tests).

The resolution was amended and passed. Following is the resolution which was passed:

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 has the potential to 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;

And whereas the licensed acts approach has the potential to enhance opportunities for non-physician health professionals and consumer choice;

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

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Comprehensive Health Organizations and Resource Allocation

By Bob Frankford

After a considerable amount of discussion and uncertainty the Government of Ontario has announced plans for the introduction of Comprehensive Health Organizations (CHOs). At the present time it has stated that CHOs are to be developed in Toronto as part of the Toronto Hospital (i.e. Toronto General/Toronto Western) and in two smaller northern communities. A grant of $250,000 has also been given to Kingston to study a CHO there.

The characteristics of a CHO will be an arrangement whereby an enrolled patient population receives comprehensive health services from an organization which is funded on a per capita basis. Services should include all medical services, including hospitalisation. The CHO will include hospitals and will be run by a non-profit corporation. The amount of funding, like many other questions, has not been definitely resolved but it is believed that it would be around $1,600 per individual member per year. This figure is equivalent to the current average per capita payment by the system for health care.

The principle of the new arrangement has much to be said in its favor. Since government is already paying out the $1,600 in a poorly planned system with numerous inefficiencies, it can be anticipated that a more effective system could be produced by providing the funds to a community sponsored body for a more rational system of care. It is probably fair to say that this approach is fundamentally acceptable to all parties, including organized medicine.

Not Without Problems

The implementation of CHOs, however, appears to present many problems. It is assumed that enrolment in the CHO will be voluntary. How then can it be assumed that enough members will choose to enroll to make the CHO viable? How can it be ensured that a sufficient mix of population will be enrolled? A population that was skewed to the healthy or the unhealthy might well

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MRG Fall Meeting

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Legislation Review. Effective services provided by alternative health care professionals should be funded within a universally insured health care system.

Toronto Chapter Report

Mimi Divinsky reported that the chapter has some new life. It had a meeting last week with Dilin Baker, a registered nurse who works with homeless street people. (See item on health care for homeless elsewhere in this issue.) The chapter hopes to make more contacts with students at the University of Toronto. People with ideas or energy for the Toronto chapter are asked to contact Mimi Divinsky or Haresh Kirpalani or contact the MRG number at (416) 588-9167.

Report from Primary Care Working Group

Bob James reported that the group has been meeting about once a month. They have been looking at CHO's, HSO's, community clinics, etc. to see how they meet the criteria of the World Health Organization (WHO) for primary care.

The group has also been looking at other issues around the delivery of primary care, especially ones in the realm of public health. They are asking, what is effective, and how can it be delivered?

One issue identified is that at present there is no incentive for HSO's to do obstetrics. One solution would be to have a portion of capitation go to obstetrics and have that go to pay a midwife on staff.

Financial Report

Fred Freedman gave a financial report for the past fiscal year, October 1, 1988 to September 30, 1989. The MRG had a surplus of about $1,000 on its operating expenses for the year, but had to dip into its reserve fund to pay Ulli Diemer for additional hours worked. Fred pointed to printing expenses as the area of expense which needs to be watched most closely because it has undergone some major fluctuations. On the income side, membership has to be watched carefully since nearly all of the MRG's in-

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Comprehensive Health Organizations

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lead to a 'profit' or 'loss' situation financially. Will enrolment limit members choice of physician or hospital and reduce the Canada Health Act's guarantee of universality of access? The answers to these questions are not yet clear.

It seems likely that the implementation problems will be least in smaller, relatively isolated centres. The CHO could represent the community and might find it a positive challenge to be allocating the revenue for its local well defined population amongst the local hospital(s), medical group(s) and other institutions. Particular local needs could be identified and planned rationally under democratic control.

Patient Loyalty

At the other extreme, a CHO originating in a teaching hospital and with the possibility of enrolling only a small proportion of the population of a metropolitan area is problematic. The population would likely be atypical in one or other respect. It is not clear how patient loyalty would be maintained with today's highly mobile populations. The relationship between patients and existing health services by other doctors or hospitals would change and it is not clear that the overall effect would be to produce a general rationalisation of services. Not even mentioned is the effect on existing health centres (CHCs and HSOs) which have already been established with alternative funding and have been around for a number of years trying to implement a more appropriate, community based approach to care.

The 1989 fall meeting of the Medical Reform Group discussed and passed resolutions on resource allocation. One of the thrusts of discussion was whether the system generally is over- or under-funded. As presently proposed, CHOs seem to avoid addressing this question and would appear to be a means of reallocating existing funding levels. (There would seem to be nothing however to stop governments in the future to use them as vehicles for restraining or increasing funding as the mood takes them.)

A resolution also called for financial and professional incentives for administrators and providers to encourage the equitable, efficient and humane care. There are risks in what appears to be the proposed CHO funding arrangement that this may not always be possible. The per capital funding arrangement will essentially be a form of global funding in which true health care needs may be delayed or rationed because of unavailability of funds.

Democratic Control

Resolutions of the MRG did strongly identify the need for decentralized, democratic forums for decision making. The resolutions advocate a modified version of district health councils. The proposed method of organizing CHOs was not mentioned. It would appear that a CHO in a small remote community might become the democratic body that is envisaged, ideally more responsive to local needs than district health councils that, whatever their other virtues or failings, cover large geographic areas. An imaginative government would take the opportunity to establish local democratic control, analogous to local school boards in education.

It is hard to be as optimistic about the Toronto Hospital proposal. Why would it be expected that a tertiary care institution with an elite board would be an appropriate vehicle for resource allocation?

The long time that it has taken for CHO proposals to get anywhere near implementation (and the various changes in designation – at one time they were called HMOs) indicate difficulty deciding within the Ministry as to whether the change is the real solution for the future. A carefully thought out approach to implementation certainly has the potential of working well for the benefit of both population and providers, at the same time allowing the Ministry to work with predictable budgets.

This writer would be glad to see well planned pilot projects but sees the likelihood that the successful ones should start small and develop from the bottom up or the periphery inward rather than from the top down.

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come comes from memberships. A loss of only a few members could send the MRG into a deficit position, so renewals and possible new members need to be pursued diligently.

Steering Committee Report

Haresh Kirpalani said that much of the Steering Committee's work had been summarized in Jim Sugiyama's letter to the membership. Activities included appearing before the Lowy Commission on Pharmaceuticals; participating in the Ministry of Health Focus Group on Comprehensive Health Organizations; speaking out strongly on the possible effects of free trade on the health care system; supporting the introduction of no-fault medical insurance; opposing proposals contained in the Ministry of Health commissioned report on Home Care; making a presentation to the legislative committee on the Independent Health Facilities Act. Haresh also pointed out that there are vacancies for new members on the Steering Committee.

Physicians and the Drug Industry

Catherine Oliver announced that the College of Physicians and Surgeons of Ontario has struck a committee to look at the **relations between the drug industry and physicians**. Joel Lexchin is one of the five members of the committee. The MRG will probably have the opportunity to make a submission to the committee at some later point. It was suggested that the MRG could endeavour to collect individual experiences and use them to compile a brief focusing on physician behaviour. (The College has no jurisdiction of what drug companies do.) A few minutes were spent sharing atrocity stories regarding drug company behaviour. Roseanne Pellizzari and Bob Frankford agreed to be the contact people on this issue. Bob mentioned that his office is the distribution centre for MLAM materials. (MLAM is Medical Lobby on Appropriate Marketing.)

Mimi Divinsky announced that the **Choice in Health Clinic** is asking people to lobby the government to keep it open under the Independent Health Facilities Act. At present, the proposed legislation would allow the Morgentaler and Scott clinics to remain open, and become fully funded, under a grandfather clause, but would force the Choice in Health Clinic to close. Fred Freedman expressed reservations. People will decide individually whether to participate in the lobbying; forms were handed out. Haresh said that he would like to devote to bulk of an issue of the newsletter to questions regarding the Independent Health Facilities Act.

Phillippa Tattersall reported on the **Hamilton chapter**. She said that attendance had been dwindling, and the chapter has decided to re-focus itself to try to have more of an active participatory approach. Members will especially be looking at issues relating to the role of drug companies in medical education. The next chapter meeting is in November.

Health Professions Legislation

Two additional resolutions regarding the **Health Professions Legislation Review** were passed:

Whereas diagnosis is a licensed act under the Health Professions Legislation Review recommendations, be it resolved that the MRG supports the licensing of health professionals to make a diagnosis within their area of expertise.

Whereas we support community involvement in the governing bodies of College Councils we support that one third of the members on the governing bodies be lay representatives and urge that a method for public accountability of these lay representatives be identified.

Resource Allocation

The afternoon session, on **Resource Allocation**, was chaired by Andy Oxman.

Haresh Kirpalani made some introductory comments about the deliberations and proposals of the Resource Allocation Working Group, (see the October newsletter).

A good deal of the ensuing discussion and questions focussed on the "democratic forum" proposed by the working group. People asked how such a democratic forum would be different from what we have now? Would it be similar to existing district health councils? Should the district health councils be given a greater role to make them into these "democratic forums"? Jack Micay stated that he felt the current system is already democratic. Haresh Kirpalani said that he felt the system is not responsive; decisions are made behind closed doors.

On the issue of spending, Gord Guyatt said that real suffering is resulting from the current push from the Ministry of Health to reduce expenditures. We should oppose indiscriminate cuts to health care budgets but we can support specific cuts directed at inappropriate expenditures. Catherine Oliver said that we all know of places where money is being wasted. How do we get at those things without hurting other areas?

Discussion then focussed on the specific proposed resolutions. On the question of funding effective but expensive interventions, most people seemed to agree on the following points: We should fund expensive interventions if they are effective. We shouldn't spend money on useless, harmful, or inefficient things within the health system. We should also oppose useless and harmful spending outside the health budget. Resources should be allocated equitably and efficiently.

Gord said that we should be making the point that it is not necessarily true to say that there is a crisis in health care spending. We could easily be saying instead that there is a crisis in corporate profits or in society's luxuries. He argued in favour of linking health care spending issues to such issues outside the health care system. Jack Micay disagreed, arguing that the health care budget is already too big, and that it would make it seem that we are pushing for even more spending on health care. Several people maintained that we should make the point that we should simultaneously look at inefficiencies in health care and at inappropriate spending outside the health care system.

Two of the four proposed resolutions were amended and passed as follows: (There was not time to deal with the other two).

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MRG Fall Meeting

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Resolution on Funding for Effective but Expensive Interventions

Decisions regarding the funding of effective but expensive interventions should be made in the context of the entire health budget and the total economy. The onus is on the government to find the money by:

1) Reallocating money from within the health care system (e.g. by reducing unnecessary hysterectomies or useless pharmaceutical advertising) or,
2) Reallocating money from within the total economy (e.g. by raising corporate taxes, taxing luxury items, reducing tax shelters, or reducing military spending).

Resolution on closing and building new hospital beds

Decisions 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 (e.g. by modifying district health councils), based on an integrated approach to the delivery of health care that takes into account both institutional and community-based delivery of care. 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). More specifically:

1) Regionally-based democratic district health councils should have the mandate to determine and plan for present and future needs for institutional beds.
2) The provision and utilization of hospital beds should be assessed and monitored on a scientific basis by the district health councils. 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 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, efficient, and humane care, including the rehabilitation and community-based care of the elderly and chronically ill.
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, but should be allocated to **both** based on evidence of effectiveness and need.
5) Because they are inequitable and inefficient solutions for financing institutions the MRG opposes user fees and hospital fundraising. (See previous resolutions on user fees and hospital fundraising.)

The meeting was adjourned at 5 p.m.

The New Health Professions Legislation scrutinized

The "professional acts approach" proposed by the Schwartz Commission in its review of Health Professions Legislation was the topic of discussion at the Medical Reform Group's meeting on Friday October 14. Three speakers looked at aspects of the proposed legislation.

The first speaker was **Alan Burrows**, Director of the Ministry of Health's Professional Relations Branch, who is heading the team implementing the Health Professions Legislation Review. Alan Burrows said that the review (aka the Schwartz Commission) was done because regulation of the health professions had become a mess. There was old, inflexible legislation in place, and groups on all sides were lobbying for new legislation.

After an extensive process of study and consultation, the review team recommended that 24 professions should be self regulating, as opposed to the current 19. About 300 groups in all had wanted to be recognized as self regulating professions. The legislative structure to be put in place is to have one overall piece of legislation, with separate pieces of legislation attached to it covering each individual profession.

The approach being adopted proposes that acts, not persons, be licensed, i.e., potentially harmful acts will be licensed. Some acts will be licensed to more than one practitioner, e.g. childbirth will be licensed to both physicians and midwives. Six of the 24 professions will have no licensed acts at all. Physicians will be licensed to perform them all.

The legislation is being attacked from two sides. The College of Physicians and Surgeons of Ontario says that it will lead to rampant quackery. Alternative healers are saying it will put them out of business.

Competency reviews under the new legislation are supposed to be compulsory, but remedial and non-punitive. The aim is to produce pressure to keep standards high, not just to find "bad guys".

The second speaker was **Margaret Risk** of the Ontario College of Nurses. She said that under the new legislation, the public will have more choice over whom they access for health care. Exclusivity will be reduced. She said there was a question about only technical acts being seen as risky; it can be argued that anyone can be trained to perform a technical act, while the decision-making process about whether or not to perform a given act contains the greater risk.

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New Health Professions Legislation

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Always some quackery

She said that there will always be some quackery out there; it can't be completely regulated.

How do you deal with someone performing a licensed act that they are not supposed to be doing? Whose responsibility is it to go after them?

The final speaker was **Bob James.** He pointed out that the discipline provisions being proposed are very close to what the MRG proposed in its submissions; not a lot of problems there.

He asked whether the government is going to be saying that if it's not a licensed act, then it won't be a paid-for act? E.g. will it take counselling out of OHIP coverage because counselling will not be a licensed act?

He said that without a team approach, there may be less efficiency, not more, under the new system, because more people are involved in care. It will be more difficult for any practitioner to have an overview of a patient's care.

He said that there is some reason to be concerned that the public may turn out to be less well protected under the new legislation than under the current legislation.

The three presentations were followed by questions and comments.

Fred Freedman said that he was concerned about a possible loss of communication under the new system. At present, the physician plays a useful role as a gatekeeper or central co-ordinator of a person's care: someone who knows what treatment the patient is getting where.

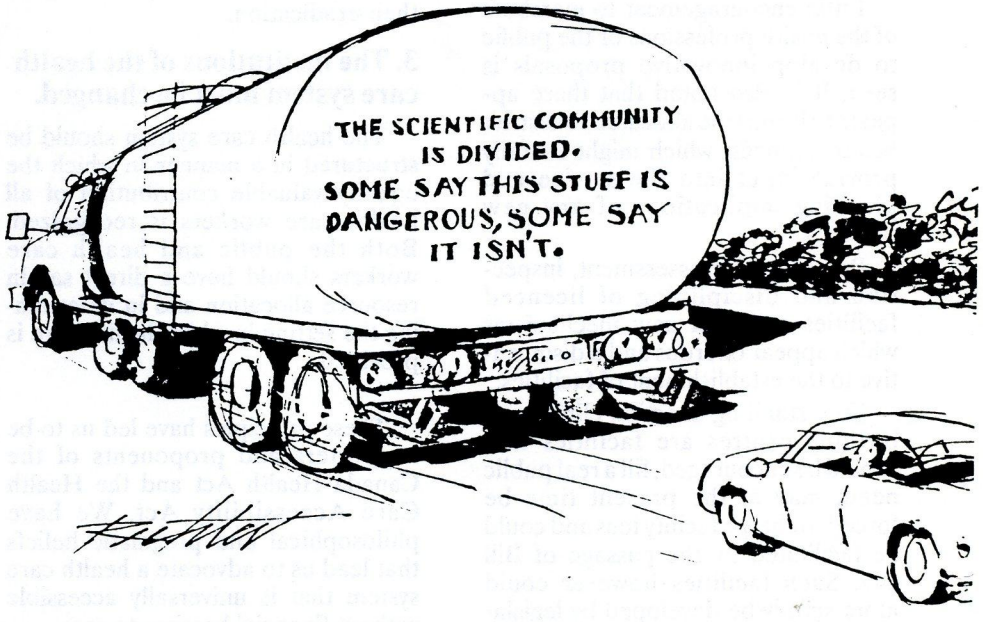
Margaret Risk said that teamwork and co-ordination are desirable, but they can't be legislated.

Don Woodside said that he was concerned about non-doctors doing point-of-entry diagnoses of unspecified ailments.

Practical Ways to Provide Health Care to Homeless People

- make sure the treatment is feasible given the clients' living situation – otherwise it can't and won't be done.
- write everything down; it helps for two reasons a) if the person doesn't understand someone can explain it to them; b) agencies and welfare workers are always asking for paper, this group of people is seldom believed
- have OHIP forms in the office and use them
- know what is covered by welfare; bandages, asa, cough syrup, etc. aren't, tensors are not covered and they are expensive. Write a note with the script, it may help the person obtain a drug card
- use samples or at least give the person enough pills to get the person through until they can get to the welfare worker. The social systems are all but closed on the weekend – starting Friday at 2 or 3
- think homeless when prescribing the drugs or recommending the treatment – think no bathroom, no sink, no tub, no privacy, no bed or quiet space
- make sure your follow up appointment is necessary, make sure the time you give them is appropriate and manageable by the client; shelters and feeding programs have very strict hours and you may force a person to chose between eating for the day or your appointment
- allow and encourage questions; more time will be needed if you rush or try to brush off the client; allow and encourage questions; physical touching and kindness cures or at least certainly helps the process; don't be afraid of the client, if you don't know, ask and be supportive
- talk to and educate; people want to know; explain procedures, talk about their body, assume they are interested, they usually are!

– Prepared by Dilin Baker of Street Health



What the MRG Said About the Independent Health Facilities Act:

Submission to Legislature Committee on Bill 147

Medical Reform Group of Ontario

August 16th, 1989

Summary

Use of the term "facility fee" in the proposed legislation appears to be a step towards the reintroduction and legitimation of extra-billing. Increased privatization of the health care system is anticipated; a profit incentive is likely to lead to over-use.

Ministerial discretion as to payment of independent facilities will lead to their being outside the overall health insurance system. It is doubtful if the profession would be able to tolerate arbitrarily variable payment rates and methods within the province wide insurance plan. A piecemeal range of facilities will lead to erosion of an equable system for all citizens. A profit incentive will encourage the over-use of procedures.

Little encouragement to members of the health professions or the public to develop innovative proposals is seen. It is also noted that there appears to be no role allocated to district health councils, which might usefully provide input into the service and planning implications of any new facilities.

Provisions for assessment, inspection and disciplining of licenced facilities establish new mechanisms which appear onerous and a disincentive to the establishment of facilities.

Free-standing abortion clinics and birthing centres are facilities that should be encouraged, fill a real public need, may at the present time be forced to charge facility fees and could be facilitated by the passage of Bill 147. Such facilities however could more simply be developed by legislation allowing for capital funding grants.

The Medical Reform Group of Ontario is glad to have the opportunity of making a presentation to the committee on Bill 147. We have previously discussed some of our concerns with officials of the Ministry of Health.

The Medical Reform Group of Ontario is a democratic, non-sectarian organization of physicians, working in a variety of settings, and medical students. The following are its founding principles:

1. Health care is a right.

The universal access to every person to high quality, appropriate health care must be guaranteed. The health care system must be administered in a manner which precludes 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 care system must be changed.

The health care system should be structured in a manner in which the equally valuable contribution of all health care workers is 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.

These principles have led us to be supporters and proponents of the Canada Health Act and the Health Care Accessibility Act. We have philosophical and pragmatic beliefs that lead us to advocate a health care system that is universally accessible without financial barriers to care.

We have therefore noted with dismay the persistence of some direct charges to patients since the introduction of Bill 64. Some of these charges may be allowable since they are payments for items not covered by existing legislation regarding their insurability. The Committee should be aware that ready acceptance of such extra charges is likely to lead to proliferation by those who read fee schedules creatively.

We are aware that payment of medical fees according to existing fee schedules may make it virtually impossible to provide certain services and procedures for which there is a clearly articulated need, such as abortions or births in free standing facilities, without extra payment by the patient. We would caution the Committee not to believe that these or other procedures constitute a major portion of medical care. We have reservations about the use of the term "facility fee" in the proposed legislation in that it appears to be a step towards the reintroduction and legitimation of extra-billing.

Section 23 of the draft legislation states that the Minister may pay all or part of the costs of services provided in an independent health facility according to whatever method the Minister may decide on. This appears to allow the proposed facilities to be outside the overall health insurance system. It is doubtful if the profession would be able to tolerate a system of arbitrarily variable payment rates and methods within the province wide insurance plan. This could also lead to a piecemeal range of facilities leading to erosion of an equable system for all citizens of the province.

The Medical Reform Group would not advocate further privatization of the health care system and the draft of Bill 147 seems to clearly recognize the possibility of profit making corporations running Independent Health Facilities. It is stated in the Toronto Star of August 9th 1989 that the bill is aimed at clinics that perform procedures as diverse as in vitro fertilization, laser surgery and cataract

removal. The Committee should consider the likelihood of a profit incentive encouraging the over-use of these or other procedures. There appears to be no requirement for Independent Health Facilities, whether run as non-profit or private entities, to submit annual audited statements. This would be a prudent requirement for facilities in receipt of public funds. A precedent for this exists in the Health Service Organization program.

The proposed act appears to generally envision facilities being established in response to the Minister requesting proposals. Some criteria for deciding to request proposals are stated. As written, the act appears to give little encouragement to members of the health professions or the public to develop innovative proposals. It should also be noted that there appears to be no role allocated to district health councils, which might usefully provide input into the service and planning implications of any new facilities. There have been criticisms in the past that the ministry plans community based care with inadequate data bases. It is surprising that this new legislation would not take the opportunity for the development of a planning process with broadly based input.

Considerable misgivings have been expressed by physicians and their representative bodies about the inspection and assessment provisions of the act. The act devotes a large part of its text to inspection and the proposed arrangements appear to mark a significant change from the traditional self regulation of health care. We note that some revisions were made, giving greater involvement to the College of Physicians and Surgeons. It would seem preferable to be moving towards a unified system of assessment of health care and health facilities and the proposed legislation seems to move in the opposite direction. Some of the types of service considered appropriate for independent facilities (such as abortion clinics, IVF and birthing centres) would appear well suited to an assessment of outcomes, but there appears to be no encouragement of this type of assessment in the legislation.

It is simplistic to believe that merely by moving the provision of procedures out of hospitals into community out-patient facilities costs will be saved. Without going into the complexities of medical economics, it is obvious that existing hospitals have large fixed operating costs. The committee should recognize that the legislation could lead to procedures being done both in hospitals and independent facilities. There may be exceptions and we would note again the case for free-standing abortion and birthing facilities. Recent entrenchment of women's rights to abortion demands improvement of access which will best be encouraged by wider availability of free-standing facilities. The growing demand for alternative settings for childbirth, along with the anticipated arrival of midwifery makes the provision of birthing centres desirable on a widespread basis. At the present time, development of these facilities is hindered by the lack of available capital, forcing those that exist or are being planned to charge facility fees. The act might be supported if it ensured that such facilities were in fact supported; however, it could be possible to reach the same goal with regulations to allow capital funding at the same time avoiding the objections to the proposed act that we have stated.

Prepared on behalf of the Medical Reform Group by Philip Berger, Mimi Divinsky, and Robert Frankford

The American disaster

A. Enthoven, R. Kronick

A consumer-choice health plan for the 1990s. N. Engl. J. Med. 1989;320:29-37.

D.U. Himmelstein, S. Woolhandler

A National Health Program for the United States. N. Engl. J. Med. 1989;320:102-108.

Reviewed by Gord Guyatt

That the American system of delivering medical care is utter disaster is being acknowledged on the pages of America's leading medical journal. The articles cited above offer the natural response to this disaster: something must be done.

Starting about the time the Reagan administration took office there was a spate of articles about the grave dangers facing the American health care system as a result of overspending. The proposed solution was a more competitive system. The political climate was right, and such a system was introduced by the Reagan administration. The consequences are vividly portrayed in the articles under review. To present some choice quotations: "Our health care system is failing. It denies access to many in need and is expensive, inefficient, and increasingly bureaucratic. The pressures of cost control, competition, and profit threaten the traditional tenets of medical practice. For patients, the misfortune of illness is often amplified by the fear of financial ruin" – Himmelstein and Woolhandler. "The health care economy of the United States is a paradox of excess and deprivation. We spend about 11.5% of the gross national product on health care, much more than any other country ... At the same time, roughly 35 million Americans have no financial protection from the expenses of medical care ... Our present system of financing health care systematically denies coverage to many who need it most" – Enthoven and Kronick.

The two proposals for a remedy for the current disarray are somewhat different. The Enthoven proposal is based on managed care health plans that would compete for contracts with employers or state-level public sponsors. Money from the system would come from employers (who would pay an 8% payroll tax), from direct tax on those not employed by others, and from the beneficiaries of care, who would pay additional amounts according to the means. The solution posed to avoiding excess remains

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An American Diaster

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competition among competing health plans.

The second proposal comes from the Working Group on Program Design which represents 442 "physicians representing virtually every state and medical specialty." Their proposal is closer to the Canadian system. They suggest a single public insurance system that would pay all health care costs from a common pool. This pool would initially be draws from present mixed sources but private insurance would gradually be phased out and the federal government would ultimately assume total responsibility.

Either plan would clearly represent a step forward for the American health care system. The latter would tread more heavily on right wing sensibilities and raise larger fears of creeping socialism. Arnold Relman, the editor of the journal, entitles his accompanying editorial: "Universal health insurance: its time has come." The need may be evident, but given the American political system, the power structure, and the sensibilities of much of the electorate, don't count on a speedy arrival.

Canada does well at controlling health costs

R.G. Evans, J. Lomas, M.L. Barer, et. al., Controlling Health Expenditures – the Canadian Reality. N. Engl. J. Med. 1989;320:571-577

Reviewed by Gord Guyatt

A few months ago the leading lights in the Canadian Health Economics scene published an article concerning Canadian health expenditures in the New England Journal of Medicine. Some MRG members may be aware of some of the personalities involved. Bob Evans from the University of British Columbia, the first author, is generally acknowledged as Canada's leading health economist. A few among the eleven authors are members of the Centre for Health Economics and Policy Analysis (CHEPA) at McMaster, a group that operates under the auspices of the Department of Clinical Epidemiology and Biostatistics. Members of this group include Greg Stoddart who presented at an MRG semi-annual meeting a few years ago, and Jonathan Lomas, an MRG member.

The essential message of this article is that Canada has done extraordinarily well at controlling health costs, and far better than has the United States. In the period of 1971 to 1985, in terms of inflation adjusted dollars per capita, Canadian health care expenditures have grown by about 3.1% a year, whereas American expenditures have grown by 4.8% a year. Americans are currently spending an average of $1,710 each on health care. If their rate of cost escalation since 1971 had been the same as Canada's, they would be spending only $1,362, or 20% less.

These differences can gain further meaning if related to the gross national product (GNP). In 1971 Canadians were spending 7.4% of the GNP on health, whereas Americans were spending 7.6%. By 1981 their spending shares were 7.7 and 9.2% respectively. In the 1982 recession, health care escaped the effects of the recession and the share of expenditures rose sharply in both countries: to 8.6% in Canada and 10.2% in the United States. The Canadian share has stabilized at this new level – preliminary estimates show 1987 expenditures remain at 8.6%. The United States share has continued to rise, with estimates of 1987 in excess of 11%.

To what do Evans and colleagues attribute the difference?

1) The administrative costs are far less in Canada: the Americans pay $95 per person in administrative costs of the health care system, Canadians less than $21.
2) Centralized approval of new hospital facilities, equipment, major renovations and the like by the government limits these activities. Recently, we have seen this process extended, with hospitals having to cut back services as a result of Ministry imposed spending constraints.

Evans et. al., in a very witty passage, comment on the process of allocating funds that arises as a result of this system. "One product that is clearly generated by the Canadian system, structured as it is to place sole responsibility for control of hospital resources on the provincial governments, is intense, continuing public debate. The rhetoric of underfunding, shortages, excessive waiting lists, and so on is an important part of the process by which providers negotiate their share of public resources – including of the process by which providers negotiate their share of public resources – including their own incomes ... The difficulty for health policy and funding is that, since the boy always cries wolf (and must do so, given the political system of funding) one does not know if the wolf is really there. The political dramatics should not mislead external observers into believing that the wolf is always at hand." I would add an additional caution: that the repeated nature of the dramatics should not mislead observers into thinking the wolf is never at hand.

3) Much larger fee increases for physicians in the United States versus Canada.

The key difference between the two systems, Evans et. al. conclude, is the degree of centralization of cost-control in the two countries (Canada being clearly much more centralized). In the typical Evans style of expression that is at the same time both acerbic and droll, the authors characterize the effects of these systems on health care providers: orchestrated outrage (Canada) versus diffuse distress (the United States). Our system, as Evans points out, serves to focus and channel issues in health care expenditures and bring them to the headlines. Such a process, I would argue, is both inherently democratic and provides a marvellous opportunity for the MRG to join in the fray.

Not bad – for a start

Dorothy L. Smith, Understanding Prescription Drugs: A Consumer's Guide to Correct Use. Toronto: Key-Porter Books, 1989, $9.95

Reviewed by Joel Lexchin

This type of book has long been overdue. Up until now Canadians have had to rely on American guides to prescription drug use, but as Dorothy Smith points out prescription drugs available in Canada are frequently different from those available in the United States even though they may be manufactured by the same pharmaceutical company and sold under the same brand name.

Smith reviews 350 of the most commonly prescribed medications in Canada. Each entry essentially takes the drug's scientific monograph and translates it into easy to understand terms. Especially useful are the sections on how to use the medication, including when and how to take the drug, and on when to call your doctor. While Smith includes special instructions for pregnant or lactating women, she does not do the same for children or the elderly, an oversight that should be corrected in any future editions. In addition to these reviews Smith includes a 25 page chapter on how to administer medications giving detailed and practical instructions for every conceivable type of drug delivery.

Scattered throughout the book are 200 little sections entitled "Did you know that?" These contain useful information such as how diabetics should adjust their insulin dosages if they cross time zones; a listing of drugs that may cause sexual problems; hints to make pill swallowing easier; and potentially dangerous food-drug interactions. Smith ends her book with three appendices about foods rich in potassium, general instructions for patients with diabetes and tips to detect tampering.

In spite of its Canadian orientation and the value of much of its information this book has a number of shortcomings which detract from its positive features. In discussing generic drugs Smith states that chronically ill patients should probably stay on the **same manufacturer's product** (emphasis in original). Smith does go on to say that it doesn't matter if it is a generic or brand name product, but such a policy will inevitably be to the favour of the multinational companies, since most doctors prescribe by brand names. If there were truly any significant differences between different products this advice would be reasonable, but despite frequent claims by the Ontario Medical Association there have not been any scientifically documented cases of patients being harmed by drug substitution.

In her opening chapter "Are you taking your medicines correctly?" Smith emphasizes the importance of patients being informed about their medications. With a doctorate in pharmacy Smith must surely be aware of the literature documenting how poor doctors can be as prescribers. While a book of this nature is not the place for a critique of physicians' prescribing habits, Smith does not even suggest to patients that they ask their doctor why a prescription is necessary or if there is a non-drug alternative. Smith seems to be advocating a blind acceptance in following the doctor's orders.

Finally, my major misgiving is about the core of this book; the information given about the drugs. For the vast majority of the drugs what Smith says is intelligent and sensible, but Smith also includes numerous irrational combination products such as Donnatal (atropine-scopolamine-hyoscyamine-phenobarbital) and Dimetane Expectorant-C (brompheniramine-phenylephrine-phenylpropanolamine-guaifenesin-codeine) and proceeds to treat them as if they were useful medications. The information that patients need about drugs such as these is "don't take them" and "don't go to any doctor who prescribes them." Similar advice should have been given about propoxyphene (Darvon).

To her credit, when Smith discusses the benzodiazepines she makes it clear that they should not be used to treat nervousness or tension from the normal pressures of day-to-day living. However, when it comes to giving information about the length of therapy she is extremely vague stating merely that benzodiazepines should not be used for longer than recommended by the doctor. In fact, for most conditions these drugs should not be used for longer than 2 to 4 weeks.

Although Smith lists dozens of doctors and pharmacists who reviewed her manuscript I think that in these instances she relied too heavily on the Compendium of Pharmaceuticals and Specialties (CPS) for her information. Monographs in the CPS are often badly out-of-date. A recently released study from the Health Protection Branch quotes a member of the Canadian Medical Association's subcommittee on drugs and pharmacotherapy to the effect that "70% to 75% of Monographs published to date are now inaccurate."

Overall, I would recommend that people buy this book, but only until a more critical alternative appears.

HERMAN

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I want you to take one of these every six months and come back to see me next Wednesday.

The Doctor's Part in Community Health

A New Kind of Doctor: The General Practitioner's Part in the Health of the Community

Julian Tudor Hart, MB, BChir, DCH, FRCGP, FRCP, The Merlin Press Ltd., London 1988

Reviewed by Robert Frankford

Dr. Julian Tudor Hart is a British physician who spent his career practising in a small Welsh mining town. "A New Kind of Doctor: The General Practitioner's Part in the Health of the Community," is a summary of his proposals for the organization of medical care.

Dr. Tudor Hart refers to the ideology of medicine in Britain and Canada since the beginning of the century as "the Oslerian paradigm."

Sir William Osler's model physician was a science-based, autonomous professional, relating to society through intimate, individual contact, whose principal task was the relief of sickness as it came to his/her door. The concept involved essentially a pursuit of excellence, based on the assumption that excellence was not, and never could be, a universal objective. The only way to get on with good clinical medicine was to exclude all demands other than those of the case in hand, and give that case total priority. This model of care, impossible in the real circumstances of practice serving unselected whole populations, was and still is taught in teaching hospitals.

The Oslerian paradigm originated in the medical milieu of its time when clinicians were either consulted on a fee-paying basis or gave their time to a limited number of patients in charitable institutions.

Universal medical insurance in Britain and Canada challenges the Oslerian paradigm. Doctors continue to provide the same approach to individual care of the sick, with the certainty that the consultation will be paid for. There is little wrong with this initially, but there are limits to consider.

Dr. Tudor Hart does not accept popular arguments for reducing the amount of medical care, citing its lack of effectiveness compared with social measures to improve general conditions. His model for effective medical care requires a transformation of the GP service into locally-controlled, population-based, need-oriented anticipatory care. He argues the effectiveness of general practitioners could be improved by providing increased resources to care for their local population.

Accepting that patients deserve long-term continuity of care, this could be done more effectively if patients were registered with family doctors who became responsible for them.

Registration is intrinsic to the organization of general practice in Britain and also to health service organizations (HSOs) in Ontario.

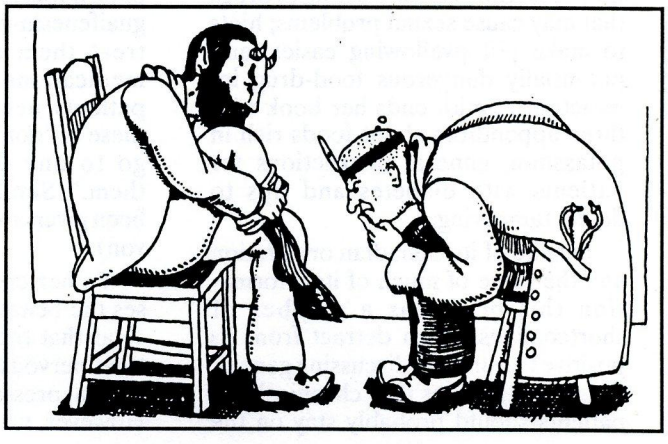
In Ontario, an accurate age/sex register is intrinsic to HSOs because payment varies by an age/sex scale. In principle, it is also easy to combine this with diagnoses to produce epidemiological data on the HSO population (a limiting factor being the archaic and inappropriate diagnostic coding provided by the Ministry of Health).

"Prevention" has become the favoured approach to health care and the justification for new approaches to delivery. There is, in fact, nothing stopping an Oslerian approach to prevention, as can be seen in the demand (frequently patient initiated) for such things as routine physical exams and cholesterol screening. Treating hypertension can be considered an exercise in the prevention of known risks, admittedly using a conventional medical approach with pharmacological intervention.

A realistic and useful approach advocated by Dr. Tudor Hart does not perceive a dichotomy of illness care and prevention, but advocates an anticipatory style of care. By accepting responsibility for the long-term care of a community – composed of individuals – the physician treats acute illness but is also in a position to help individuals make choices for their long-term well being. One hopes that this is not particularly novel and the GPs have always been able to fulfill this role. But it is valuable to see it stated and to see the potential for implementing it in newer forms of practice organization.

Doctors realize there will always be a number of individuals for whom effective care could be offered who have not yet presented themselves. Despite the advent of medicare, this is still the case, calling into question the contention that too many resources are devoted to health care. Dr. Tudor Hart notes the difficulty of reaching out; the problem is even greater in Ontario where HSO enrollment is voluntary and policies about providing access to care have been given little thought.

The current Ontario situation allowing, at least in principle, a choice of payment methods and organizational models, builds on the well-worn Oslerian model but adds population care to practice. Those insomniacs who browse through the College of Physician and Surgeons listing of physicians in the middle of the night are impressed by the remarkable distribution of doctors throughout the province. A concerted effort to upgrade and develop using alternative funding, along with an emphasis on local and self audit that Dr. Tudor Hart advocates, should develop long-term consumer and provider satisfaction.



News Briefs

Supreme Court releases Daigle ruling

The Supreme Court of Canada has released the reasons for its ruling in the Chantal Daigle case. Daigle's former boyfriend had gone to court to prevent her from having an abortion. The Court said that "A fetus is not included within the term 'human being' in the Quebec Charter and, therefore, does not enjoy the right to life." The court said that similar cases in the rest of Canada would also fail.

New abortion legislation under fire

The federal Conservative government has introduced new legislation on abortion which would make the procedure a criminal offense unless a woman's physician agrees that her mental or physical health would be at risk if she doesn't have the abortion. According to Justice Minister Douglas Lewis, the bill is a compromise which ensures women's rights to an abortion, but which also protects the fetus through the health criteria necessary to obtain the procedure. Anti-abortion groups attacked the bill because it permits abortion at all. Pro-choice groups called the bill unacceptable because it requires women to obtain a doctor's permission to obtain an abortion, and because it does nothing to guarantee equal accessibility to abortion services.

Men for Women's Choice

A new group, **Men for Women's Choice**, has formed in response to recent court cases challenging women's right to choose to have an abortion. The group says that "no man should be able to force a woman to bear a child against her will". It says that "men should have equal say and responsibility in a decision to parent. But ultimately, if there is a dispute, the decision to end a pregnancy must be a woman's choice – because it is her body." The group has placed newspaper advertisements signed by hundreds of men supporting this point of view. It can be contacted at Men for Women's Choice, 555 Bloor St. West, Toronto, Ontario M5S 1Y6, (416) 538-3086.

Anti-abortion MDs lobby CMA

Canadian Physicians for Life, an anti-abortion group, is pressuring the Canadian Medical Association to change its policy on abortion. The CMA's policy is that the decision to have an abortion is a medical one which should be made by a woman and her physician up to the twentieth week of pregnancy. The group claims that a survey it carried out indicates that Canadian physicians favour a more restrictive policy. However, critics of the survey contend that the questions in it were biased.

-Globe and Mail, November 6, 1989

Morgentaler setback in Nova Scotia

The Nova Scotia Supreme Court has granted an injunction sought by the Nova Scotia government against Dr. Henry Morgentaler. The injunction prohibits Dr. Morgentaler from performing any more abortions in his Halifax clinic until charges against him are heard in court next March. Dr. Morgentaler announced to the media that he had performed 13 abortions at the clinic and challenged the government to charge him. It did. Nova Scotia's Medical Services Act, passed last June with the express purpose of stopping Dr. Morgentaler from setting up a clinic in the province, stipulates that abortions can only be performed in provincially approved hospitals. The government maintains that free standing clinics are unnecessary, while Dr. Morgentaler says that many Nova Scotia women travel to Montreal to have an abortion because abortions are difficult to obtain locally. Dr. Morgentaler is appealing the injunction.

-Toronto Star, Globe and Mail, November 7, 1989

Planned Parenthood to fight right-wingers

The International Planned Parenthood Federation decided at its November annual meeting to go on the offensive against U.S.-based right-wing groups which are exporting an anti-choice ideology to other nations. "We can't bury our head in the sand any more," said Sharon Camp, who works for a family planning agency in Washington, D.C. In recent years, she said, the U.S.-based groups have been undermining the development of family planning programs around the world. The groups have been successful in cutting off U.S. aid to organizations which advocate family planning.

-Globe and Mail, November 10, 1989

More eligible for AIDS drug

Ontario has agreed to provide the drug AZT to about double the number of people currently eligible. It will provide the drug to anyone who is HIV-positive and who has early symptoms of the disease. The decision follows the announcement of a federal policy permitting AZT to be given to anyone who is HIV-positive and who has a white blood cell count under 500. This followed U.S. studies which suggested that early use of AZT might slow the progress of AIDS.

-Toronto Star, September 27, 1989

Man fired for AIDS gets damages

The Canadian Human Rights Commission (CHRC) has ruled that it is discriminatory for an employer to fire someone because they have AIDS or have tested positive for the HIV virus. The Commission's made its ruling in the case of a Canadian Pacific employee who was fired after he revealed that he had tested positive for AIDS. According to Michelle Falardeau-Ramsay, the CHRC's deputy head, "AIDS is not a moral issue. AIDS is an illness. Would you fire someone if that person had cancer even if that person was able to do the

work? AIDS is not contagious except when you are in contact with blood, blood-related products or semen. Education is required. Misinformation on AIDS is rampant all over the place."

-Toronto Star, October 28, 1989

Pharmacists rapped on complaints

The Consumers Association of Canada (CAC) has suggested that the Ontario College of Pharmacists is failing to investigate public complaints against pharmacists. According to Jerry Taciuk, a Toronto pharmacist and a member of the CAC's Ontario health committee, the College has not properly investigated some complaints. "If they don't want you to complain about a certain person, they circumvent the statute", he said. The College was heavily criticized in 1986 for turning a blind eye to illegal money-making practices by its members, including members of the College's governing council. However, James Dunsdon, the College's deputy registrar, says that "I think that our procedures will stand up to scrutiny."

-Globe and Mail, November 27, 1989

Fee deal seems imminent

The Ontario government and the Ontario Medical Association seem close to an agreement on fees negotiations which would involve binding arbitration to determine fees. It would be the first time the Ontario government has relinquished the final authority over the spending of public funds to an independent body. The agreement would also involve a disputes settlement panel which could settle contentious issues such as how many doctors should be allowed to practice in the province, and the criteria and standards used for medical practices. Manitoba's government adopted binding arbitration in 1985, but abandoned it again in 1987, saying the fee increases being awarded were too high. The Ontario Medical Association says that it is strongly in favour of binding arbitration.

-Toronto Star, November 4, 1989

Mulroney warns medicare cuts coming

Prime Minister Brian Mulroney has told provincial premiers that the federal government will be cutting funding to medicare and other social programs as part of its strategy for cutting the deficit.

-Globe and Mail, November 10, 1989

CHO for The Toronto Hospital

The province's first comprehensive health organization (CHO) is to be set up at The Toronto Hospital (Toronto General + Toronto Western). The establishment of CHOs was recommended by the Premier's Council on Health Strategy. CHOs are supposed to bring together "community health care resources" under one roof, and are supposed to be non-profit and self-managing, with members of the public being represented on their boards of directors. The Ministry has said that it wants to set up six CHOs per year for the next three years. Feasibility studies are under way in Fort Frances, Wawa, and Kingston. The unit at the Toronto Hospital would replace the hospital's three family practice units.

-Ministry press release; Toronto Star, September 27, 1989

Heart patients going to Detroit

Windsor doctors have developed a plan to get around long hospital waiting lists for heart patients by sending patients to a hospital in Detroit. The St. John Hospital in Detroit would perform heart bypass surgery on Canadian patients and then bill the Ontario Health Insurance Plan. The Ontario Health Ministry has not commented directly on the scheme, but it is ministry policy to pay 75 per cent of the cost of out-of-province hospital ward costs and 100 per cent of the OHIP rate for elective hospital admissions. According to Windsor surgeon Dr. David Wonham, who negotiated the agreement, Windsor heart patients wind up waiting six to 18 months for a bed.

-Toronto Star, September 27, 1989

Cancer centres warns patients to be turned away

A shortage of radiation therapists at the Toronto-Bayview Regional Cancer Centre, combined with patient overflow at the Princess Margaret Hospital, is causing the Bayview Centre to delay treatments for patients or to send them elsewhere. The Centre says that it needs another 20 radiation therapy technologists to handle the patient load.

-Toronto Star, October 23, 1989

Nurses say new regulations ignored

The Ontario Nurses' Association (ONA) says that hospital administrators are ignoring new regulations which were supposed to give nurses more power and responsibility. According to Glenna Cole Slattery of the ONA, only one hospital has complied with a new regulation requiring that nurses be put on key hospital committees by the end of September. Peter Wood of the Ontario Hospital Association denied the accusation, saying that the majority of hospitals were well on the way to changing their bylaws to permit the changes. Slattery, however, charges that the hospitals are deliberately dragging their feet.

-Toronto Star, November 15, 1989

Independent Health Facilities Act passed

The Independent Health Facilities Act passed the Ontario Legislature last month in a 54-21 vote. The act will regulate clinics and offices outside hospitals. When the law goes into effect this spring, doctors who want to operate clinics will have to apply to the government for a license. They won't be allowed to charge "administrative" fees, and will be given money by the government to operate.

Task force calls for crackdown on overbilling

According to a task force reporting to the Ontario College of Physicians and Surgeons, a few dozen doctors

over-charge the Ontario Health Insurance Plan (OHIP) for more than $1 million a year. The report urges the college to develop specific standards of practice to prevent doctors from billing for unnecessary or inappropriate services. According to the task force, many doctors who overcharge are never challenged, and many of those who are get off because there are no specific guidelines as to what is or isn't appropriate treatment.

-Toronto Star, November 28, 1989

Multicultural nursing homes being funded

The Ontario Ministry of Health is inviting proposals from multicultural groups for 600 new non-profit nursing home beds. "We want to make sure that elderly people in such institutions can communicate in their own language and that they can follow their traditional customs and diet," said Health Minister Elinor Caplan.

-Ministry of Health press release, November 3, 1989

Quebec nurses' union fined

The Quebec nurses' union and two members of its executive have been found guilty of contempt of court and fined for defying a government order to return to work during their 'illegal' strike. Diane Lavellee, president of the Quebec Federation of Nurses, and vice president Raymonde Bosse, were fined $1,000 each, while the union was fined $5,000.

Malpractice suits up

Lawsuits for malpractice have tripled in Canada over the last 15 years, according to Robert Pritchard, dean of law at the University of Toronto, who is conducting a study of the subject. Pritchard told a meeting of the Ontario Hospital Association that the size of the average award has quadrupled over the same period of time, while the proportion of patients who win their cases has doubled. About 900 suits are launched each year. Most of the complaints are against hospitals and other health-care institutions, he said. As a result, doctors and hospitals are now spending $200 million per year on medical liability insurance and insurance premiums have increased immensely.

-Globe and Mail, October 31, 1989

Nursing homes gave Liberals too much

Two of Ontario's largest nursing home chains gave illegal campaign contributions to the Ontario Liberal party during the 1987 election campaign. The two chains, Versa Care Ltd., and Leisure World Health Care Centres, Inc., each gave more money than the legal maximum. No charges were laid – instead the Commission on Election Finances simply asked the candidates and riding associations to return the money. The nursing home industry, once an important supporter of the Ontario Progressive Conservative Party, has become a major backer of the Liberals now that they are in power. The homes are the recipients of over $400 million from the provincial treasury.

-Toronto Star, November 20, 1989

Ontario Public Health Association meets

The Ontario Public Health Association adopted a number of resolutions at its November annual meeting. Among the resolutions adopted were ones calling on the province to provide condoms free to people who can't buy them; a call for gay couples to have the same rights as heterosexual couples; limited anonymous testing for the HIV virus; and an expansion of home care services.

-Toronto Star, November 21, 1989

Anti-car measures

Toronto board of health is proposing measures which would ban polluting cars from the city. One suggestion is that all cars be required to pass a test of their exhaust fumes. Only those within the set levels would be given a sticker allowing them to drive on city streets.

-Toronto Star, October 5, 1989

Government backing down on safety bill

The Ontario government is backing away from legislation which would let workers shut down work places they consider unsafe. "We had a breakdown in communication", said Industry and Trade Minister Monte Kwinter. "We were led to believe that there had been consultation [with business] and that they were onside." Business groups have been lobbying fiercely against the proposed bill, and the government has now indicated that key provisions will be changed or watered down. Many labour unions have been supporting the bill, although some have said that it is too weak. Ross Dunsmore, chairman of the Metro Toronto Board of Trade labour relations committee, said that free trade makes it necessary to weaken the legislation. "We have to compare the cost of doing business here with Buffalo or Georgia... The more impositions the government makes... the more it will cost and more companies will be pushed to the United States."

-Toronto Star, September 28, October 13, 1989

Logger's Death

A B.C. logger who was killed on the job earlier this year was working for a company that had been under close scrutiny by the Workers Compensation Board for violating provincial safety regulations, a coroner's inquest has been told. Rodney Tubbs died on July 27 after being struck by a block of cedar logs that had fallen out of a sling on a helicopter. He was working for G & R Cedar Ltd., an independent contractor working with MacMillan Bloedel. Charles Burrell, a MacMillan Bloedel manager, told the inquest he is not particularly interested in finding out whether companies subcontracted by his firm are in violation of provincial regulations. He suggested that there may be too many safety regulations in the logging industry. Mr. Tubbs was one of over 150 people to die on the job in B.C.'s logging industry since 1984.

-Globe and Mail, October 4, 1989

Barrie deaths investigated

The Ontario Ministry of Labour is investigating reports of deaths and illness said to be linked to a company that operated tanneries in Barrie, Oshawa, Kitchener, and Coburg. The Simcoe County Injured Workers As-

sociation says that it has received reports of appalling working conditions at the plants, and the dumping of hazardous chemicals into city sewers and creeks. The company, Robson Lange Leather Inc. closed in 1986. Dr. Jim Stopps, chief of health studies services for the Ministry of Labour, said that 44 reports of death and illness are being investigated.

-Toronto Star, October 12, November 1, 1989

Calendar

Health and Safety Conference

Focus on the Future: A National Conference on Health and Safety, will take place March 14 - 16, 1990, in Calgary. For more information contact Shelley Koch, Education Services, Alberta Hospital Association, Edmonton Alberta T5J 3C5, (403) 423-1776.

Death and Bereavement

Conference on **Death and Bereavement: Creative Strategies for Living,** on May 14 -16, 1990, in London, Ontario. Details from King's College, 266 Epworth Ave., London N6A 2M3, (519) 433-3491.

Occupational Health Congress

The 23rd International Congress on Occupational Health will take place in Montreal September 22 - 28, 1990. For more information contact OCOH Secretariat, 58, rue de Bresoles, Montreal H2Y 1V5, (514) 499-9835.

News Items and Clippings

In this section of Medical Reform, we are trying to present a brief survey of health-related news items. However, we are limited by the newspapers we currently receive, with the result that most items come from the Globe and Mail and Toronto Star. Readers are invited to send in relevant items from other papers and magazines to Medical Reform, Box 366, Station J, Toronto M4J 4Y8.

Let's plug the gaps in Ottawa's drug safety laws

By Joel Lexchin

THE PRACTICES of the federal government's Health Protection Branch may not be adequate to protect Canadians from hazardous side effects of prescription drugs already being sold. This disturbing conclusion comes from an examination of two recent publications: *Inside Ciba-Geigy* by the late Swedish neurologist Olle Hansson, published by the International Organization of Consumers Unions, and a 10-volume government report on the adequacy of Canada's "drug safety, quality and efficacy program."

Hansson wrote his book to expose the actions of the Swiss multinational pharmaceutical company Ciba-Geigy regarding its drug clioquinol. Clioquinol had been marketed under the trade name Entero-Vioform since 1934 as a treatment for intestinal infections.

By the mid-'50s, increasing numbers of people in Japan were becoming ill with a neurological disorder that produced degenerative and often irreversible changes leaving people paralyzed and blind. This new disease acquired the name sub-acute myelo-optic neuropathy or SMON. Eventually, an estimated 20,000 Japanese were afflicted. Despite mounting incontrovertible evidence that Entero-Vioform caused SMON, Ciba-Geigy denied the connection for years.

By 1975, both Norway and Sweden banned the drug. The Canadian reaction was to do essentially nothing and as a result Entero-Vioform remained available, on prescription, in Canada until 1985 when a campaign led by Hansson and the International Organization of Consumers Unions forced Ciba-Geigy to withdraw the drug from sale worldwide.

Why was the Canadian reaction so muted? One of Ciba's defences, once it had grudgingly admitted the connection between SMON and Entero-Vioform, was that SMON was a "Japanese disease." Careful documentation by Hansson shows that claim to have been untrue. While the majority of known cases occurred in Japan, Hansson gives details of people affected in Sweden, Switzerland and other countries.

Canada doesn't require companies to report on adverse reactions to prescription drugs that have occurred in other countries

Canadian officials seem to have completely accepted Ciba's claim. One senior Health Protection Branch official was quoted as saying that Entero-Vioform and related drugs "really were not found to be causing any serious problems (in Canada). This is what's so queer about it, it's all directly related to Japan."

The basis behind that statement was apparently the fact that the Health Protection Branch knew of only 10 minor and two serious reactions in Canada to Entero-Vioform. Were there more reactions? How many? How many were serious? The short answer is that we don't know. Entero-Vioform was marketed in Canada before 1963 and was therefore classed as an "old drug" by the Health Protection Branch.

The report on the adequacy of the drug safety, quality and efficacy program documents a startling gap in Canada's drug regulations. There is absolutely no requirement for manufacturers to report adverse reactions to old drugs to the Health Protection Branch. (They are re-

quired to do so for "new drugs," that is, drugs marketed after 1963.) Furthermore, as the report also points out, the Health Protection Branch makes only minimal efforts to encourage physicians, pharmacists and health-care institutions to report adverse reactions.

Given these deficiencies it is entirely possible that many cases of SMON would never have come to the attention of the Health Protection Branch. There are still hundreds of old drugs available in Canada today and the same inadequacies in reporting adverse reactions continue to apply to them.

Inside Ciba-Geigy also discusses a number of other products sold by the company. One of these is Tanderil. Tanderil is an anti-inflammatory medication marketed for the treatment of various forms of arthritis. When it came out in 1960, there were few other effective anti-arthritis drugs; but over the years other medications were developed which were just as effective but considerably safer.

The major problems with Tanderil were that it could cause bleeding from the stomach and blood disorders where the bone marrow stopped making one or all of the various types of blood cells. Right from the start there were reports about serious and fatal reactions to Tanderil and up to 1982, there were 405 deaths worldwide reported to Ciba-Geigy.

Despite the number of deaths, and the availability of far safer drugs including some made by Ciba, the company was very reluctant to stop making Tanderil; probably because it represented more than 2.6 per cent of Ciba's 1982 sales. It wasn't until 1985, again as a result of international pressure spearheaded by the International Organization of Consumers Unions, that Ciba-Geigy withdrew Tanderil from the market.

Tanderil remained on the Canadian market right up until its global withdrawal. About 10 per cent of the known serious reactions to Tanderil happened in Canada. Were the other 90 per cent of the reactions and deaths known to the Health Protection Branch? Probably not. The reason can be found in the drug safety, quality and efficacy program report. Canada does not require companies to report on adverse reactions that have occurred in other countries. So, if a drug is seriously injuring or killing people outside of Canada, the Health Protection Branch might never hear about it from the company making the drug.

One further deficiency with Canada's drug laws and regulations is identified in the drug safety report. This problem concerns drug monographs — documents that companies must file before they are allowed to market a drug in Canada. They contain detailed information about what problems the drug can be used for, times when the drug should not be used and reactions related to the use of the drug.

The information in these monographs forms the basis for the entries that appear in the Compendium of Pharmaceuticals and Specialties, the source of prescribing information most frequently used by Canadian doctors.

However, interviews with Health Protection Branch program staff conducted in preparation for the drug safety report revealed that there is no systematic monitoring of the medical literature to ensure that information in monographs is current. Amendments to monographs may take years to work their way through the bureaucracy at the Health Protection Branch and furthermore, companies are not required to keep monographs up to date. According to one medical source cited by the report, 75 per cent of monographs "are so out of date that they are inaccurate."

Inside Ciba-Geigy provides a practical example of an inaccurate monograph. The product in question is Slow K, a tablet for replacing potassium which is sometimes lost by people taking diuretics (water pills).

Slow K was introduced in Canada in 1970 and by 1983 was one of Ciba-Geigy's most successful products chalking up sales of almost $7 million annually.

Potassium replacements are actually seldom needed and if someone's potassium level drops too low, the simplest and safest way of raising it is through dietary changes. When medication is required, Slow K is not a good choice. Independent studies have shown that it can cause ulcerations in the stomach and intestines, especially in elderly people.

The Medical Letter, a highly respected bulletin on drugs and therapeutics that accepts no advertising, concluded that: "Slow-release potassium tablets such as Slow K . . . are dangerous and should not be used. Supplementation of the regular diet with potassium-rich foods is the safest way to prevent hypokalemia (potassium deficiency) in patients taking diuretics." *The Medical Letter* went on to recommend potassium solutions rather than potassium pills if medication was required.

The information about Slow K in the Compendium of Pharmaceuticals and Specialties doesn't say that potassium replacements are usually unnecessary, nor is there any mention about dietary supplementation being the first choice if the potassium level is too low. The incidence of side effects such as stomach and intestinal ulceration from Slow K are compared to those caused by other types of potassium tablets *not* to those caused by the safer potassium solutions.

The data in the compendium clearly contradict leading medical advice and give an erroneous impression about the usefulness and safety of Slow K.

Despite these serious flaws, Canada's drug laws and regulations are among the best in the world. The drug safety, quality and efficacy program study was undertaken to find ways of making them better. By acting on the information that is in these two publications we should be able to get closer to that objective.

☐ **Dr. Joel Lexchin is an emergency room physician in downtown Toronto. He is the author of *The Real Pushers: A Critical Analysis Of The Canadian Drug Industry.***

Shoe

Round the World

From our Correspondents

Australia

INTERNATIONAL MEDICAL ADVERTISING

THE Medical Lobby for Appropriate Marketing (MaLAM), based in Adelaide, began in 1983,[1] and now reports on correspondence with 15 companies about the promotion of 21 products. MaLAM's aim is to encourage drug companies to provide sufficient, consistent, and accurate information to enable appropriate prescribing, dispensing, and consumption of drugs. Once a month, MaLAM subscribers receive copies of letters addressed to drug company executives. The letters compare advertising claims with published evidence. The executives are asked to justify their claims, or to change them. The letters are checked by an international editorial board which includes the editors of *Drug and Therapeutics Bulletin* (UK), *La Revue Prescrire* (France), *Farmakon* (Indonesia) and *Drug Disease Doctor* (India).

Three companies have withdrawn products following MaLAM letters. Bayer announced, in December 1986, that they would stop producing a tonic in Pakistan which contained arsenic and strychnine. Parke-Davis (Warner Lambert) said that their oral streptomycin/chloramphenicol combination would be withdrawn from the Philippines in 1987. Pfizer's combinations of oxytetracycline with sulphamethizole and phenazopyridine were removed from sale in the Philippines during 1986.

Two companies altered their products: in 1985, Grunenthal removed diiodohydroxyquinoline from a combination with sulphaguanidine, streptomycin, bacitracin, kaolin, and pectin on sale in Thailand. In 1987, Scanpharm removed amidopyrine from a combination with phenylbutazone and prednisolone on sale in Fiji.

Advertising claims for seven pharmaceutical products have been withdrawn following MaLAM letters. In 1984, Bayer claimed that ampicillin was "effective against all gram-positive and gram-negative bacteria of practical importance", in Indonesia: they have since acknowledged that the claim was misleading. Boots have agreed that their claim in Kenya, in 1985, that "there are no known contraindications" to ibuprofen syrup for children with fever was not correct. Janssen (Johnson and Johnson) have deleted the word "safe" from advertising for loperamide and flunarizine. Parke-Davis (Warner Lambert) say that they will no longer promote ammonium chloride as an expectorant. Pfizer will not repeat their 1987 claim that piroxicam is "well tolerated by all ages (with a) low incidence of side effects". Smith Kline & French have withdrawn their 1986 Pakistan advertising claim of "fast action, safety, efficacy, economy" for their antidiarrhoeal furazolidone/kaolin/pectin combination. One company has not withdrawn disputed claims, but has modified the advertising. Sandoz still promote pizotifen as an appetite stimulant for children in South East Asia, but now mention that there are specific causes of failure to thrive.

Two companies have provided inadequate evidence to support their claims. Roche recommend a vitamin A and E combination for "arteriosclerosis, deafness, threatened abortion, acne vulgaris, geriatric debility, infertility" in the Philippines. None of the studies which they supplied to support these indications had control groups. Sterling Winthrop withdrew oral amrinone from clinical trials in February, 1984. However, oral amrinone was being sold without prescription in rural areas of the Philippines in April, 1986. They say that they will continue to sell oral amrinone in the Philippines, but will stop informing doctors about it. Sterling Winthrop claim that intravenous amrinone leaves "blood pressure virtually unchanged". Six of the ten studies that they provided to support their various claims reported a significant reduction in blood pressure.

Four companies have failed to provide studies to defend their advertising claims. Organon recommend ethyloestrenol for: "chronic debilitating diseases particularly in elderly patients, after major surgery, cases of anorexia, underweight, or poor general condition". Sandoz promote co-dergocrine in Pakistan for "cerebral insufficiency eg impaired memory and concentration," and in the Philippines for "mood depression, unsociability, difficulties with daily living activities and with self care (and) acute cerebrovascular disease." Schering market methenolone for a myriad of indications including: "convalescence, post-operative treatment, wasting diseases, cachexia, protein deficiency states in old age, and progressive carcinoma of the breast or genital organs in the female." Upjohn promote lincomycin as "a safe, sound, and reliable antibiotic for the treatment of more common ENT conditions" in India: the advertising fails to warn about pseudomembranous colitis.

One company has admitted that no clinical trials have been done for one of their recommended indications. Organon's advertising states that allyloestrenol "has an established safety and efficacy record in habitual and threatened abortion, and premature labour." No studies of allyloestrenol for threatened abortion have been performed. The company said that allyloestrenol is still widely used and accepted by regulatory authorities, so they feel that making it available is justified—although they failed to provide evidence to support its use for any indication.

Only one company has failed to reply to MaLAM. Medimpex Gedeon Richter market a phenylbutazone amidopyrine combination in Africa. This Hungarian corporation's advertising techniques resemble those of Western manufacturers, but they are less willing, or less able, to enter a debate about marketing standards.

Research-based pharmaceutical companies should, in theory, be able to make responsible judgments without external pressure. Unfortunately, many continue medically unjustified marketing practices until they realise that their international corporate image is at risk. All the companies questioned seemed to lack adequate marketing quality control systems.

Once doctors have been misled, they will stay misled until given correct information. No company has yet provided statements to redress their misleading claims. A few executives even reiterated them: for example, the head of Boots medical support services wrote that a study by Sheth et al "supports the view that ibuprofen lowers pyrexia to a greater degree" than paracetamol. In fact, the study showed that "the difference between the average maximum falls of the two drugs was not significant for both axillary and rectal temperatures."[2]

Improvements have followed MaLAM letters in 13 of 21 cases. Removal of arsenic/strychnine and streptomycin/chloramphenicol combinations from the market were significant advances, even though it was surprising to find such combinations still in production. Some companies seem to be changing their ways, albeit slowly. For example, Pfizer did not answer the August, 1985, MaLAM letter, but requested a meeting in July, 1987. As MaLAM continues to gain more subscribers, the impact of the MaLAM letters will increase.

MaLAM is funded by annual subscriptions of £10 sterling, $20 (US), or $25 (Australian). Further information and copies of recent MaLAM letters are available from MaLAM, 22 Renaissance Arcade, Adelaide, SA 5000, Australia; or from MaLAM UK, 10 Kirkburn Place, Bradford BD7 2BZ.

1. Anonymous. MLAM. *Lancet* 1984; ii: 861.
2. Sheth UK, Gupta K, Paul T, Pispati PK. Measurement of antipyretic activity of ibuprofen and paracetamol in children. *J Clin Pharmacol* 1980; 11: 672–75.

From The Lancet, February 13, 1989

Announcements

Documentary "Lobbying for Lives"

On April 22, 1987, the federal government announced Bill C-51, which would ban tobacco advertising in Canada and limit the sponsorship of events by tobacco firms. The proposed legislation, along with a related private member's Bill, C-204, was the first in 80 years aimed at regulating the tobacco industry. And they ushered in a frenzied lobbying battle that pitted the powerful tobacco industry against the Canadian health community – a battle that climaxed on June 28, 1988 when both bills were passed by the Senate and given Royal Assent.

The lobbying effort made by several Canadian Health groups, including the Canadian Cancer Society, was among the most intense ever mounted in this country. In the wake of that effort's success, some observers see the fight to pass Bill C-51 as a model for other groups launching a political lobby.

The story of the battle for Bill C-51 is now told in a dramatic video called "Lobbying for Lives: Lessons from the Front." The half-hour documentary includes interviews with participants on both sides of the battle, and behind-the-scenes footage explaining the rationale of crucial lobbying strategies.

"Lobbying for Lives" is being used by several national health agencies as a teaching and motivating tool for political advocacy. With a detailed discussion of the lessons that were learned from the fight for Bill C-51, the video can be a valuable "how-to-lobby" primer for any health group, social service agency, or other organization involved with government.

Those lessons – like "never underestimate your opponent," "more can be achieved by a coalition than any one group," and "the debate belongs to the side that frames the issue in its own terms" – are discussed in light of the specific fight. But they can be applied to virtually any lobbying effort.

Narrated by Doug Barr, Chief Executive Officer of the Canadian Cancer Society, "Lobbying for Lives" contains revealing interviews with the following key players:

- Jake Epp, Minister of National Health and Welfare;
- William Neville, tobacco industry lobbyist;
- Gar Mahood, Director of the Non-Smokers' Rights Association;
- Lynn McDonald, former NDP Member of Parliament;
- Shiela Copps, Liberal Member of Parliament.

Also included are interviews with experts on lobbying like journalist Graham Fraser of the Globe & Mail, and investigative reporter John Sawatsky, whose book "The Insiders" describes the intricate process of lobbying in Canada. "Lobbying for Lives" offers a look at the tactics used by health groups, including:

- advocacy ads;
- letters and phone calls to MPs;
- meetings with MPs and Ministers;
- mailings to the public;
- presentations to parliamentary committees;
- media interviews and events.

The result is a highly entertaining, informative and instructive look at one of the most controversial legislative battles in recent years – and one of the greatest lobbying efforts in Canadian History.

For organizations wishing to improve their efforts at influencing public policy, "Lobbying for Lives" is an up-to-date practical and invaluable resource.

Contact:
MEDICINEMA LTD.
131 Albany Avenue
Toronto, Ontario M5R 3C5
(416) 532-4209

Physician

Davenport-Perth Community Health Centre

is a community-based program managed by the **Davenport-Perth Neighbourhood Centre.** Our multi-service Centre responds to the needs of a high-risk community by integrating health and social service programs. Complementary services include: Primary Care, Preventative Health Care, and Health Promotion and Education; and programs for Families, Youth and Seniors.

Preferred candidates should have the following qualifications in addition to any specified below:

- demonstrated leadership abilities;
- a firm commitment to social change;
- a commitment to an interdisciplinary team management approach;
- multi-lingual language skills an asset.

The Physician will provide medical services as a member of the clinical team. The incumbent will be licensed to practice medicine in Ontario.

Responsibilities include: providing direct primary care to patients; maintaining hospital privileges; providing on-call services; advocating on patients' behalf with specialists, other agencies and/or hospitals; participating in designated Neighbourhood Centre and community committees; assisting in the ongoing development of health promotion programs and development and implementation of clinical protocols.

Salary is commensurate with Ministry of Health Guidelines, qualifications and experience. Total compensation includes an excellent employee benefits package.

Interested applicants should apply in writing by January 12, 1990 to:

Director
Davenport-Perth Community Health Centre
1944 Davenport Road
Toronto, Ontario
M6N 1C2

Is there a computer in your future?

Computerizing a medical office can be a double-edged sword. Our office computerized 4 1/2 years ago. In that period of time I have kept a close eye on the software marketplace and have reviewed about 20 medical systems. Unfortunately, doctors are poor consumers and are generally a disorganized lot. Most of the time the computer has merely added to office confusion and paperwork.

A computer cannot organize an otherwise confused situation but certainly can enhance an office that is trying to be efficient. Most software is, in fact, poorly written and over-priced. It is marketed by slick companies which promise the sky to physicians who may not have the experise to do a critical appraisal. It tends to be strong on accounting but lack a real patient and office management capability.

When our office became an HSO this summer, I began researching HSO packages. The story was the same. 'On-Line', a major marketer of software to HSO's is charging $8500 for it's software alone and at least one court case is outstanding against it for promised capabilities that remain undelivered. I finally decided that a quality programme would have to be developed from scratch. This programme would have to be able to function in an HSO or OHIP setting, be easy to instal and use, aid in patient flow in an office as well as provide for a cumulative patient profile to help medical management. I approached a software developer and we are presently working together to produce just such a product. I see no reason why progressive practices shouldn't be able to save time and money by computerizing and becoming more capable and efficient. I would welcome any suggestions as to what may be incorporated into the system. The programme will be ready to demonstrate by December. Even if you are already computerized, it may be worth seeing. My goal is to develop a quality HSO/OHIP system at a reasonable price--a system that can grow with changing needs.

Anyone who is interested can reach me at 928-0920(w), 531-2861(h), or write to:

Fred Freedman
720 Spadina Ave #404,
Toronto, M5S 2T9.

Disability Insurance

How will you pay your bills when disability strikes? Professional disability and office overhead insurance is available to all MRG members, their spouses and colleagues in shared clinics, offices or health centres. Special discounts, negotiated in 1984, are still available.

For more information call or write:

Trudy Baker, CLU
11 Allstate Parkway, Suite 200
Markham, Ontario L3R 9T8

Healthy Places – Healthy People
Healthy People – Healthy Places

A Provincial Conference, January 18, 19, 20, 1990
Sheraton Caswell Inn, Sudbury, Ontario

This three day event will examine the relationship between Health/Economy/Environment. Themes are: 'The Healthy City: Examples, Policies and the Future; Business/Industry/ Consumer Opportunities in the Healthy City; The Value of an Urban Natural Environment; Promoting the Healthy City. The Conference will encompass a multitude of Community sessions, workshops, displays, seminars, field trips and other activities for the delegate.

Fees are $75 per person for the three-day event or $300 for five people. Meals and accommodation not included. Send All Enquiries to:

"Healthy Places – Healthy People/
Healthy People – Healthy Places"
City of Sudbury
Leisure Plan
Bag 5000, Station 'A'
Sudbury, Ontario M3A 5P3
(705) 671-2231

Family Physician Required – Saskatchewan

An established consumer sponsored multiservice clinic requires family physicians to join its 5-member group practice. Remuneration is by salary and includes an excellent benefit package. Both permanent and locum tenens positions are available January 1, 1990, and full-time or part-time arrangements will be considered. Obstetrics an asset. Please direct inquiries and applications to:

Medical Co-ordinator or Executive Director
Regina Community Clinic
3765 Sherwood Drive
Regina, Sask. S4R 4A9
(306) 543-7880

Physician Wanted

In January, 1990, a part-time physician is required for the City of York's Birth Control and Sexually Transmitted Disease clinic. "Clinic 504" is open Thursday evenings from 5:00-7:30 p.m. Previous experience in family planning and/or sexually transmitted diseases is an asset. Interest in adolescent health care is required.

Please call or send resume to:

Donalda McCabe
Supervisor, Sexual Health Program
City of York Health Unit
504 Oakwood Avenue, lower level
City of York, Ontario M6E 2X1
(416) 652-3259

Family Physician Required

Community Health Centre requires a full-time family doctor beginning January 2, 1990 to work as a member of a health service team, with other professionals, and on a community board. Family practice residency an asset. Salary commensurate with experience. Attractive benefit package. If interested, please send your resume to:

Joe Leonard, Executive Director
Lakeshore Area Multi-service Project Inc. (L.A.M.P)
185-5th Street
Toronto, Ontario M8V 2Z5
(416) 252-6471