MEDICAL REFORM

Newsletter of the Medical Reform Group of Ontario

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

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

MRG directions, media strategy, and resource allocation policies to be general meeting themes

The Medical Reform Group's Spring General Meeting has been set for Saturday April 21, 1990.

The meeting will focus on three interrelated sets of questions:

1. What direction should the MRG be taking, politically and organizationally, in the 1990s? What should our key priorities be?
2. How can we resolve the difficult issues surrounding the allocation of health care resources?
3. How can we best get our priorities and policies across to the media and the public?

The meeting will feature a morning debate, followed by a general discussion, with Gord Guyatt and Ralph Sutherland, on resource allocation issues and MRG directions.

The afternoon session will start off with small groups looking at some representative newspaper clippings to come up with ideas about how the MRG should respond publicly to the issues they raise. Note: several clippings appear in this issue of the newsletter. Please read and think about them in advance, and then bring the newsletter with you to the meeting. **Also, please bring any other news clippings which you think are of particular interest.**

The rest of the afternoon will be devoted to a plenary session which will look at the themes and ideas from the small groups, and which will try to fit them into a larger strategy for the MRG.

The meeting will be at South Riverdale Community Health Centre, 126 Pape Ave., Toronto. Registration is at 9 a.m.; lunch is from 12 to 1. The meeting is scheduled to end at 4:30 p.m. For more information call the MRG number, (416) 588-9167.

In the evening there will be a social for members and their partners/spouses at Bob Frankford's, 14 Lyall Ave., Toronto. Head over directly from the meeting, or call 694-7876 for directions.

Questionnaire

All members are urged to attend this important General Meeting. Whether you are able to come or not, please fill in the questionnaire which you will find elsewhere in this issue and send it back promptly. We want to use the responses to help guide us in our discussion of MRG directions.

Steering Committee

Members are urgently asked to consider joining the Steering Committee or taking on an associated task to help us overcome a serious shortage of person-power at the organizational level. If you think you may be interested, or would like more information about what is involved, speak to someone at the meeting, or speak to a member of the present Steering Committee (Don Woodside, Bob James, Andy Oxman, Rosana Pellizzari, Mimi Divinsky, Bob Frankford, Haresh Kirpalani, Jim Sugiyama), or call the MRG number at (416) 588-9167.

Have you renewed your membership?

Over the years, members of the Medical Reform Group have distinguished themselves both by their continuing loyalty to the organization, as indicated by the fact that our membership numbers are at an all-time high, and by the tardiness of at least some members in paying their membership fees. This year is no exception: most members have sent in their renewals; some are still outstanding. If you haven't renewed yet, why not send in your cheque now? If you have mislaid your form, call (416) 588-9167 and you'll be sent another one.

Spring Semi-Annual Meeting 1990 Did we mean what we said? Is there anyone to say it?

At the Steering Committee meeting Nov 23/89, the lack of volunteers to join the dwindling steering committee sparked a discussion about the mandate of the MRG and our collective energy. We noted our reluctance to respond to the high-profile health issues in the media recently. Some of us held that the problem was lack of a clear position on the issues of the day; others felt we mainly lacked time and energy to promote our positions. One suggestion was that we pack up rather than fade away. We decided to have an expanded steering committee meeting January 4, 1990 to look at our options.

In the interim, a working paper was circulated outlining four options:

1. Business as usual, a holding pattern till the next big issue arises.
2. Disband.
3. Amalgamate with an organization such as the Ontario Public Health Association, or become a socialist caucus within the OMA.
4. Hire a physician spokesperson, acknowledging that we are more short of time than money. Approximate cost, $20,000 per year.

On January 4, 1990 we convened a meeting of 16 members for a lively discussion.

There was little support for hiring a spokesperson, both because of the cost, and its effect on the group. As we may have to join the OMA, there was some support for becoming a caucus within it. We could also become a think tank, issuing position papers. There was recognition of the lack of energy, and career and family life issues. It was pointed out that we continue to have news coverage, but it is on page 20, not page 1. We were made aware that we have made little use of the offers by

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The MRG Dilemma

My MRG membership renewal has been put aside for months. I have been ambivalent about how to perceive the organization.

My solution is to send money but express my concerns. MRG needs to decide what it is – may I present several options:

1. The MRG can be a left wing political action group. If this is its choice then I prefer to put my time and money into the NDP as a much broader political action group for whom the full range of political issues is relevant.
2. The MRG can decide to deal with all actions relevant to health. In this case my response is the same as in #1. I fully endorse seeing all policies and actions as relevant to health but this scope is beyond the scope of the MRG and fits logically in the sphere of an organized political party.
3. The MRG can be a group of interested physicians who like to get together and discuss common interests and give advice to government. They are held together by a general disagreement with the OMA. Such a group has merit but wouldn't be worth $175 a year, especially when I live in Ottawa. A Journal club or policy club in Ottawa could do the same for little or no cost. No paid staff would be required.
4. The MRG could decide to be what it started out as – a voice of 'reform' physicians who speak and write on subject areas on which the OMA says something different. These are areas in which a group of physicians has credibility, especially when there is expertise in the group, which there is.

The MRG dilemma is similar to that faced by the PSR. This group limited its activities to anti-nuclear activities and in the process acquired a broad membership base and a lot of credibility. In Ottawa at least it carefully avoided moving outside of its anti-nuclear theme.

My hope is that the MRG will go with #4. If this is the choice then it could select for special attention, such topics as how to spend health dollars well, how to acknowledge the right of government to intrude regularly into physician decision making, how physicians can act in partnership with government to alter the way health care is delivered, how we can move rationally to formal acceptance of a two-tier health system, or how the MRG can contribute to increased public understanding of why health care costs should be controlled. Each of you will have your own agenda. When consensus is absent a subject would be dropped. Questions such as whether to buy nuclear submarines or whether corporate profits are too high would not be on the list.

All MRG members (instead of just some) will soon be members of the OMA. Will the MRG group then ask for OMA secretarial support? Will there be an organized representation at OMA meetings with regular presentation of the MRG position?

MRG will also need to decide about its commitment to the cost control difficulties faced by government. Will MRG costs be cut or will taxes be raised? The MRG does not have a perfect record in terms of internal cost control.

The MRG has served Ontario well, but without extra billing or doctor strikes it has staggered. The tough choice will be whether to, in a disciplined way, limit the agenda to health services delivery questions. There is lots of meat in this limited menu if it is chosen.

Best regards

Ralph Sutherland

Medical Reform

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

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

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

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

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

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

1. Health Care is a Right

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

2. Health is Political and Social in Nature

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

3. The Institutions of the Health System Must Be Changed

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

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members to be involved in specific tasks apart from joining the steering committee, and a questionnaire to the membership was recommended, as well as a phone tree. The possibility of convening an international conference on progressive health care was suggested, and a role in the coming conflict in the USA over health insurance.

The basic issue which emerged was lingering uncertainty over our policy on resource allocation, and echoes of disagreement over our support for high quality, high tech medical care, as against capping health spending in favour of poverty and social issues.

Spring Meeting

We had originally planned to devote this meeting to the primary care working group, which has been meeting regularly. Our need for new policy in this area is long recognized. However we have decided to organize it around media issues. We will work in small groups and articulate how we can use our resource allocation resolutions to guide public responses to high profile stories. We may resolve the discomfort some of us feel in speaking for the MRG on them, or identify the murky or divisive issues. Some representative news stories are reproduced in this edition of the newsletter.

A Glut of Doctors

John K. Iglehart: Addressing the Problem of Physician Supply
NEJM 1986 V315, 1623-28
(Third of a three part series on Canada's Health Care System)

Patrick Sullivan: Are There Too Many Doctors? CMA Seeks "Rational" Approach to Issue
CMAJ VOL 141, SEPT. 1, 1989.

Reviewed by Don Woodside

My first exposure to a doctor glut occurred in Malaysia in 1967 when a Singapore medical graduate arrived to take a job in the rural hospital at which I was working. He explained that there were no openings in the Singapore health service. A Malaysian GP friend wrote recently describing the bitter competition for patients, in which some doctors hire taxi drivers to hustle patients for them at the bus stop.

John Iglehart provides an excellent review of medical manpower figures and the historical background. "Most western nations are training more physicians than they are prepared to accommodate..." he says. Since the mid 60's, both Canada and the U.S. have doubled their output of medical grads. In 1985 in Canada, there were 44,230 active physicians, excluding interns and residents, compared to 32,561 ten years earlier. "Among western nations in 1980, Canada had 184 physicians per 100,000 population, the United States had 202, Belgium 249, Germany 226, France 182, and the United Kingdom 127. By 1984, the number ... had reached 198 in Canada and 211 in the United States."

A federal/provincial committee report in 1985 estimated a need for 56,941 physicians in year 2000, and predicted a supply 12% greater than that. Iglehart goes into some detail over the problem of geographical maldistribution, and the various attempts to rectify it, including limiting billing numbers in B.C., prorated billings in Quebec in overserviced areas, and financial incentives in Ontario. He cites research indicating that the problem is much less severe than it was thirty years ago, and that access to medical services in rural communities with apparently low access to physicians is similar to that in communities with stable medical practices, residents of the former driving further for service.

In 1984 Ontario issued 1064 new medical licences, but only graduated 608 students. One tactic presently being used to reduce the numbers in this province is a reduction in training positions. The profession and ministry agree we are training more specialists than we need, though they disagree on the numbers. A second method under consideration is a reduction in physician immigration. "In 1985 graduates of foreign medical schools represented 28.4 percent of all active Canadian physicians." A third is reduction in medical student numbers. (To be effective, this would have to be nation-wide.) Iglehart believes that Canada has a much better opportunity to address the issue of manpower than the U.S., because of our more centralized system, with vehicles for ongoing negotiation between the profession and the government. In the U.S., by contrast, the Reagan administration viewed a doctor surplus as an ally in driving down prices by free market forces on providers.

The Sullivan article is a brief review of the CMA report released in 1989 on manpower planning. The report notes that "... from 1975 to 1987, when Canada's population grew by 12.6%, the number of doctors climbed by 43%". It notes that a head count is insufficient. Because of a falling birth rate, the demand for obstetric and pediatric services is declining. Advances in some areas, like lithotripsy treatment, mean reduced demand in other areas, like surgical treatment. Canadians are becoming better educated and one side effect is improved health status. Will this reduce demand for physicians' services? Both men and women physicians are reducing the number of hours they work as they put more emphasis on quality of life issues. Suggestions arising out of the report are mentioned briefly, and lean toward "better cooperation between the medical professions and governments and more attention to service planning."

The motivation of government funders to deal with the oversupply problem is obvious. 25% of the health budget goes to physicians. Each time a new one of us hangs up a shingle it costs between $100 and $200 thousand dollars per year. Meanwhile any proposal for a new health care initiative, however critical, must undergo the most rigorous scrutiny, evaluation, and delay. One of our members described the difficulties encountered in funding a small AIDS program, by contrast.

The motivation of the profession has been less enthusiastic, but may become more so, with threats of caps on total physician expenditures. Then every time new income comes out of the old ones.

We in the MRG should consider the relevance of this issue to the introduction of new kinds of practitioners, such as midwives, into the system. If we advocate midwifery, and the job is already being done by others, then it will be an increased cost, and unlikely to succeed. If cost savings can be identified by transferring deliveries from reluctant physicians, then it will be viable. The nurse practitioner program died because there was no funding available, and it appeared to increase the costs of primary care. Restraint on physician numbers may be necessary for the development of the primary care team to include both of these practitioners.

As for methods to achieve this reduction, the MRG hasn't looked at the issue of reducing physician immigration. One could anticipate it would impose hardships on physician refugees. Shutting down a medical school or two would be effective, but where? The loss of a medical school has significant ramifications, as residency positions and researchers also depart.

Realistically there can be little doubt we have a surfeit of doctors. Was there a shortage in 1980? Even in 1975? Or rather, a poor utilization of an expensive resource?

It is in just such issues, where physician self-interest is involved, that the MRG often has the most useful things to say.

What kind of primary care model?

Prepared for the Primary Care Working Group

By Bob James

What kind of primary care model?

- We have to look at it in both the way in which it can ideally be operated, and the way in which it can politically be crafted.
- We have several documents already that talk to the ideal:
- We would like to have a community-based model, "owned" and run by the members of that community, and working in a multi-disciplinary way.
- We say that all health care disciplines have an equally important role in the health care systems we set up.
- We decry the hold that MDs have on the health care system, and we recognize that this role is underlined and upheld by the OHIP system (particularly fee-for-service)

The gatekeeper role: is it necessary?

- The government is currently caught in a budget squeeze, and is looking at ways to cut back on its funding, rather than expand it.
- The government will never allow the expansion of OHIP to other "primary care" practitioners (perhaps with the exception of the case where it can be shown to save them money). There will have to be some form of gatekeeping going on.
- It is not clear that this has to be always the physician. But it should be, at least for a lot of the time, someone with the overall knowledge of the patient, who can then act in the overall interest of the patient. I would suggest that this is often best served by the general practitioner.
- I think it is also clear that there will have to some form of very good quality assurance, so that the public is protected. Training and education play a large role in this. The FP/GP will have to be better trained than he is at present in the management systems.
- It is unrealistic to assume that the patient would be able to choose with any care or skill from a "supermarket" of different primary care professionals. While physicians do not always do this well, I suspect they do it as well as any other group could.

What do we do, then?

- Licensing of other professions: we (as members of society, not as doctors) have to be sure that there is a proper licensing body for all professions, as well as a functioning disciplinary body. This is the *sine qua non* of quality patient care.
- Payment schemes: currently, only MDs, DDS, DCS, and optometrists are allowed to bill under OHIP. As well, social workers, OTs, PTs, nutritionists, RNs and Homemakers are allowed to use OHIP funds through Home Care.
- Self-referrals to Dentists, Optometrists, Chiropodists, and possibly Chiropractors, would continue.
- Referral patterns, to and from other practitioners: again, it is not always necessary for the physician to be the starting point. But referral patterns must be laid out fairly clearly. For instance, an orthopod could refer to an OT or PT, but not to an optometrist. Similarly, an optometrist should be able to refer to an ophthalmologist, but not to a physio. This referral pattern could be enforced by the use of the payment schedule. OHIP now says that a specialist cannot be paid at the specialist rate unless there is a referral from a family doctor. It does not now enforce this, but should be told to do so.
- The payment scheme will have to work to reduce the number of off-the-street self-referrals to OHIP-funded services (in particular, to the specialists). **At the same time**, it will be important to increase the number of people to whom the GP/FP can refer. For instance, the GP will have to be able to refer to a psychologist in a formal way the OHIP recognizes and pays for.
- I think we should deal with something that is possible within the political sphere, but somewhat closer to the ideal than what is currently put forward by government. This document is seen as a step towards political action.

What about other health care professionals?

- Perhaps people will continue to present themselves to the chiropractors, dentists, etc., as they now do. Any time a patient goes to another OHIP-generating professional, there will need to be a notice going to the primary care practitioner's office. The role of communications will become even greater. Now, with telecommunications, there is not the necessity to have everyone in the same building. It would make it a lot easier in most cases, though, and improve patient compliance.

Midwives as an example

- Many questions around this issue are included in the area of the role of the midwife. Should a patient be allowed (and by this I mean, at OHIP expense) to go independently to a midwife? Should this midwife function independently? The referral patterns to and from FP's will need to be worked out. While I think that a person must have the right to choose a midwife for prenatal care if she desires, I wonder at the prudence of complete independence from that physician. It is the physician who will care for the patient after the delivery, and care for the baby after the newborn period. It is the physician who has already looked after the patient for some time before her pregnancy. I think there must be communications between these two practitioners. Ideally, the midwife should be associated with a particular physician's office; this begs the question of what the patient is to do if they refer another midwife to that association with their own GP.
- What about the MRG founding principle?
- If we really believe that there is an equally-important role for all health-care professionals, then how can we allow the doctor to maintain the primary role in the delivery of this care? Yet, if we believe in the appropriate use of the resources available for health care, how can we not enforce some kind of primary care gatekeeper?

What's wrong with Primary Care (and what can we do about it?)

Discussion Paper for the MRG Primary Care Working Group

By Brian Hutchison

The fundamental deficiency in Canadian primary health care (whatever the method of payment or practice organization) is the huge gap between available scientific evidence and current clinical practice. This gap is probably no larger in primary than in secondary, tertiary or quaternary care, but its magnitude is nonetheless disturbing. Inconsistencies between clinical practice and research evidence are confirmed by virtually every study which has addressed the issue. We do much that is useless or of uncertain benefit and we frequently fail to provide interventions of established value. The results of studies of alternative approaches to the funding and organization of primary care (such as HSO's, CHC's in Canada and HMO's in the U.S.) have demonstrated no differences or at most marginal differences in quality of care as measurably improved patient outcomes or adherence to clinical practices of established effectiveness and efficiency. In the case of HMO's, there is credible evidence of lowered use of hospital resources, not all of which represents reduced inappropriate use. Ontario's system of HSO funding has not yet been shown to be causally related to reduced levels of hospital utilization.

The sad reality is that we lack evidence that any of the existing models of primary care give rise to substantially more effective or efficient primary care than fee-for-service practice. I suspect that for many of us, this is confirmed by our experience. Looking at my own practice, I am aware of many areas in which I fail to offer interventions of demonstrated effectiveness and efficiency to the appropriate members of my practice population. This is most apparent to me in the area of prevention/health maintenance. I am also aware of my profound ignorance of most of the scientific evidence relevant to my practice. I am often unable to provide my patients with the kind of information they should have in order to make informed choices about their health care. All this in spite of my good intentions, my membership in an HSO group practice (a supposedly enlightened form of practice organization/physician payment), my voracious consumption of the health care literature, my well developed critical appraisal skills, the intellectual stimulation of an academic environment and the fairly generous levels of professional and non-professional staffing in my practice setting.

Why am I (and, I think, primary care in general) failing so miserably? Among the possible contributing factors are:

1. Vastness of the scientific literature, leading to inability to access the subset which is relevant to primary care.

2. A volume of relevant research which is beyond the ability of practitioners, either individually or in groups, to read, critically appraise and synthesize, even if they possess the necessary skills.

3. Lack of skills required to identify, critically appraise and synthesize medical information.

4. Low scientific quality of review articles.

5. Misleading information disseminated by drug and medical technology manufacturers.

6. Lack of scientific basis for "standard practice", "conventional wisdom", and expert opinion.

7. The tendency for consensus conferences and other bodies which promulgate practice guidelines to be composed of content area experts (with attendant biases) and to make recommendations which go well beyond the existing evidence.

8. Lack of practice guidelines based on a comprehensive and methodologically rigorous overview and synthesis of the relevant scientific evidence. (The Report on The Detection and Management of Asymptomatic Hypercholesterolemia issued by the Ontario Task Force on the Use and Provision of Medical Services in March 1989 represents an excellent but rare example of what can be done in this regard.)

9. Inadequate and/or ineffective dissemination to clinicians of important scientific information (such as the Task Force report on Hypercholesterolemia).

10. Lack of information systems in primary care which would permit the systematic implementation of effective, efficient interventions (for example, data systems such as age-sex and chronic disease registers and systems for managing data related to prescribing, preventive interventions and diagnostic testing, patient call-recall systems, provider feedback and reminder systems.)

11. Lack of systematic information regarding current practice performance.

12. Health care provider characteristics (e.g., desire for diagnostic certainty, desire to "do something") which might lead providers to adopt or cling to clinical practices which are useless or potentially harmful.

13. Inadequate and/or ineffective dissemination of scientific information to the public.

14. Patient beliefs and expectations at variance with scientific evidence.

15. Modes of organization and funding of primary health care which fail to facilitate or reward the provision of effective, efficient health care.

16. Health policy developed with little reference to scientific evidence.

17. Lack of funding for research to address barriers to effective, efficient (that is, appropriate) health care.

These barriers to effective, efficient primary health care need to be addressed. Issues related to organization and funding of primary health care should be examined in the context of an overall effort to reduce or eliminate such barriers.

Inside HMOs – from the USA

(A comment in response to Michael Rachlis' "Second Opinion", from Dr. Steffie Woolhandler)

Dear Doctor Rachlis:

I recently read your book "Second Opinion" which has attracted considerable attention in the growing debate over health policy in the U.S. The book was well written and interesting. However I was struck by your overly rosy analysis of HMOs and other pre-payment schemes in the United States. You seemed to imply that HMOs were the best method to assure cost effective care. Unfortunately our experience with HMOs in the United States has been much less positive than your book implies.

HMOs receive a capitation fee for each patient enrolled, and retain any money not spent on care for profits or new capital investment. Thus financial success and expansion depends on limiting the care delivered. Your book focuses on the incentive that this provides to improve the cost-effectiveness of care. However, there is strong evidence that HMOs also cut costs by placing barriers to care before patients. These barriers have little effect on middle class people, but lead to serious undercare of the poor. Thus one large HMO has had a policy of employing so few people at its clinic appointment desk that there is routinely a 30 minute wait before the phone is answered – a minor problem for many patients but a major issue for people with no telephone at home. Doctors are also frequently offered financial incentives to limit care, the reverse of the problems inherent in fee-for-service reimbursement.

The most striking evidence on the problem of undercare for the poor comes from the 78 million dollar Rand Health Insurance Experiment, the only randomized trial examining the health effects of HMO care. In this study people in Seattle were randomly assigned to HMO or fee-for-service care. The groups most vulnerable to undercare were excluded from the study – the very poor, those over 60 and anyone in very poor health. Despite these exclusions, the health of the poorest and sickest people included in the study suffered under HMO care. Their blood pressures rose significantly above those of people in the fee-for-service arm of the study, their vision deteriorated because of a lack of opthalmalogic and optometric care, and their risk of dying rose about 20%. In contrast the well-to-do appeared to fare well in the HMO. The findings were all the more disturbing because the HMO studied, Group Health of Seattle, is one of the best in the country.

There is other convincing, if less systematic, evidence that HMOs poorly serve the disadvantaged. For instance the Wisconsin Medicaid HMO experiment resulted in the death of a young child after an HMO physician refused to approve an emergency room visit for the child despite a fever of 105°F. An evaluation of that program concluded that there was evidence of systematic denial of care to the poor. A high proportion of enrollees were not informed that they could receive emergency care outside of the HMO. Similarly, when there were Medicaid experiments with HMOs in California in the mid 1970's, so many cases of mismanagement and abuse occurred that the program became a national scandal and had to be discontinued.

There is also evidence that some HMOs designed to care for the elderly have functioned poorly. International Medical Centres, the largest HMO under the U.S. Medicare Program was riddled with fraud and abuse. In effect, they took the capitation payments and ran off with the money, providing little care. Several of the executives of that HMO are now under indictment for fraud.

HMOs do generate one time cost savings due to decreased rates of hospitalization, but this savings has invariably been followed by a return to cost escalation. Unfortunately, necessary hospitalizations are decreased to a similar degree as unnecessary ones. Moreover, the administrative savings which Canada has already realized (your current system devotes about 13% of total medical costs to administration while ours in the U.S. spends 23%) would probably be eliminated by HMOs. For instance, the average administration cost of HMOs in the U.S. Medicare HMO experiment was 18%, a figure which did not include the costs of hospital administration.

A second cost issue is the tremendous effort expended by HMOs on risk selection, i.e. enrolment of healthy, low-cost members. This takes several forms: marketing only to employer groups (seeking a kind of healthy worker effect); offering generous maternity benefits (to attract young healthy families); offering free health spa membership, now done by several Boston based HMOs (which is likely to attract fitness conscious young people); situating clinics in affluent communities which have the lowest rates of ill health; and avoiding getting a reputation for taking excellent care of the chronically ill. In the most extreme examples, HMOs have placed enrolment offices on the upper floors of buildings without elevators, in order to assure that only those able to negotiate several flights of steps can become patients.

Risk selection engenders luxurious care for the low risk (whose capitation payment greatly exceeds the costs of their care) and underfunded care for the chronically ill. From a cost containment point of view, an HMO which appears to be the most efficient may actually be the one that has been most successful in excluding high cost patients, i.e. most successful in pushing costs off to elsewhere in the system. Efforts to deal with this problem by adjusting the capitation fee to reflect the patient's health status are at best a partial solution; a competent HMO administrator can usually "beat" any statistical adjustment.

Finally, allowing HMOs to retain money not spent on patient care (presumably the main incentive for improved cost effectiveness) virtually eliminates meaningful health planning. HMOs that are financially successful (often because of skimping on care and vigorous efforts to recruit low-risk patients) enjoy a generous surplus which they can devote to capital investment and expansion. Money-losers, often those providing the most community services, are rapidly driven from the market.

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HMOs do have good aspects. An HMO can function as a well organized group practice that coordinates care for patients, making all care available under one roof or within one organization. Thus, the PNHP (Physicians for a National Health Program) proposal would allow HMOs to continue to function, but under conditions meant to minimize the problems of skimping on care and risk selection. Specifically, we propose that HMOs be prohibited from retaining any surplus from operating revenues for expansion or profit. Capital funds would be appropriated separately. Our proposal would also prohibit financial rewards to physicians who ordered fewer tests, hospitalizations, etc., the "fee-for-non-service" system now prevalent in the U.S. HMOs.

This was my major disagreement with the book. Let me emphasize that I hold no brief for fee-for-service medicine; I greatly prefer salaried group practice in community based health centres. However, in my view HMO style capitation is an equally bad way of paying physicians. I should also add that I found much to laud in your book. I particularly liked the descriptions of clinical epidemiology, variations in medical practice, and the need to emphasize primary and preventive care.

Sincerely,
Steffie Woolhandler, MD

Steffie Woolhandler is an internist on the faculty of Harvard Medical School and a national coordinator of Physicians for a National Health Program, an organization of over 2500 physicians advocating a universal, comprehensive, and public NHP for the U.S.

Hello, HSO! Hello?

MRG member Steve Roedde submitted the following encounter, which was given to him by "a 65-year-old cyclist".

"Good morning, how are we today?"

"Well, uh, not too good. Who's this?"

"This is your HSO. I'm the lady at the desk who used to be rifling through fees for service and encouraging wimps to drop in. Now – how many km today?"

"Well, yesterday I did 25, but today –"

"Today you'll do 30, right?"

"No, I –"

"And are you eating well?"

"Sure, I –"

"And getting lots of sleep?"

"Yes, but –"

"Wonderful. You're a model for our HSO. Have a nice day."

"Wait! I'm not feeling good. I want to see the doctor and complain. I want a prescription and a couple of expensive tests. I want ... hello, are you there, hello ..."

MRG submission on 'fetal rights'

To: Dr. Eike Kluge
Director of Ethical and Legal Affairs
Canadian Medical Association

Dear Dr. Kluge,

Please accept the following submission from the Medical Reform Group regarding your committee's consideration of the issue of fetal rights.

To argue that one has 'rights' is to claim entitlement within a democratic society that strives to balance individual and societal needs. As perceptions of minority ethnic groups and races, women, and children transform, language and law broaden to include them as equals. In conferring equality, it is understood that they lay claim to consideration because they are able to either actively participate, willingly contribute, formulate conscious thought, or experience emotions. But it is quite clear that the fetus, as fetus, has none of these qualities; it exists only as potential, as, one could argue, is the case with human ova and sperm. The fetus is wholly dependent on, and part of, the woman who carries it. Therefore, a discussion of its rights, as distinct from hers, is moot.

To focus on the abstract argument of fetal rights, is to divert our attention from the real-life social context in which there exists no ideal method of contraception, and in which the issues of poverty, homelessness, women as low wage-earners, single parenting, wife-assault, and the legacy of child abuse and sexual abuse all influence our decisions about when and with whom to bear and raise children.

To clarify:

1. The issue of fetal rights is, essentially, moot because the qualities it possesses are only potential, not actual.

2. As term approaches, and the fetus comes closer to realizing its potential, care-givers may face rare situations in which they sense a conflict between their contract with the woman, and their soon-to-be 'second patient'. However, given that medicine, though it uses scientific method, is an art and not a science, it is difficult to justify coercing or forcing treatment on a woman (i.e. Caesarian section) in a situation of such uncertainty (i.e. the diagnosis of fetal distress and the consequences of C-section 'rescue').

3. The rights of the adult individual to self-determination of her body and her reproductive decisions must be reiterated and entrenched. The Supreme Court of Canada has, on three occasions in the last two years, made strong statements about these rights. Out of respect for the contract of the doctor-patient relationship, physicians must recognize and comply with a woman's right to make her own decisions as regards her body and her reproductive future.

Dr. M. Divinsky, MD
on behalf of the Steering Committee
Medical Reform Group of Ontario

Review: Inside Ciba-Geigy

By Olle Hansson

Published by the International Organization of Consumers Unions, 1989, U.S. $7.95. Available from IOCU, PO Box 1045, 10830 Penang, Malaysia

Reviewed by Joel Lexchin

There is a rumour that some multinational pharmaceutical companies have a position called vice-president in-charge-of-going-to-jail. If the company were ever to be convicted in criminal court then this v.p. would take the blame and the consequences. After reading *Inside Ciba-Geigy* it's not hard to understand why such a position may exist.

The book was written by the late Swedish neurologist Olle Hansson. Early in his career Hansson treated a young boy who had developed optic atrophy from using oxyquinolone. This chance development stimulated his interest in the oxyquinolone class of drugs and ultimately propelled him into a position as a leading critic of the pharmaceutical industry.

The best known of the oxyquinolones, clioquinol, was marketed under the trade name Entero-Vioform in 1934 by Ciba as an oral treatment for a variety of ill-defined intestinal disorders. In the 1950s, an increasing number of people in Japan developed a series of bizarre symptoms that were due to degenerative and irreversible changes in peripheral and optic nerves. The disease acquired the name Subacute Myelo-Optic Neuropathy or SMON, but its cause was initially a mystery. Finally, through a combination of experimental and epidemiological evidence oxyquinolone was identified as the cause of SMON, but not before at least 11,000 Japanese had fallen victim to the disease. The book opens with a moving testimony from one of these victims, a 23 year old woman who is blind and a paraplegic as a result of SMON.

These people went to court in Japan against Ciba-Geigy (Ciba and Geigy had merged in 1970) and two Japanese companies who were the main producers of oxyquinolone. Hansson was asked to testify for the plaintiffs because of his previous work on oxyquinolone and from that point on became a central figure in the story.

Ciba-Geigy's initial defence was simply that SMON was not caused by oxyquinolone. Its experts pointed out that SMON was almost exclusively a "Japanese disease" and that the drug must be safe since it had been used by millions of people world-wide for over 45 years. Hansson carefully demolishes each of these arguments and, indeed, Ciba probably didn't have much faith in its case because in 1976 after five years in court Ciba suddenly admitted that oxyquinolone had a causal relationship with SMON. The final verdict of the Japanese courts was a complete repudiation of Ciba's original defence. However, incredible as it may seem, even after losing, a lawyer for Ciba was still claiming: "Through our lawyers in court we have made clear that in Japan oxyquinolone is connected with SMON. However, this was a legal statement, since it was made in court. From a scientific point of view we still do not know what caused SMON."

Unfortunately, the victory for the Japanese SMON victims was not complete. In Japanese culture people have a duty to apologize whenever through their fault or negligence another person is harmed. It is also the custom for the most senior person in the group to apologize personally. The heads of the two Japanese companies that sold oxyquinolone did make personal apologies but even after the court case no such apology was forthcoming from Dr. Louis von Planta, chairman of the board of Ciba-Geigy.

Hansson and the Japanese people involved in the case continued to press for the apology, but while negotiations were still on-going, Hansson developed cancer. At one point during Hansson's illness, von Planta personally told him that he was prepared to do what the two other company leaders had done. When Hansson knew he was seriously ill he enlisted Milton Silverman, coauthor of Pills, Politics and Power and The Drugging of the Americas, to take over for him. The last 25 pages of the book are Silverman's story of how he and others attempted to get von Planta to fulfill his promise while Hansson was still alive and even after he died in May 1985 at age 49. But after 18 months and 100,000 miles of travel Silverman finally gave up without the apology.

However, *Inside Ciba-Geigy* is about more than SMON and oxyquinolones: Ciba-Geigy was no worse than any of the other companies marketing oxyquinolone; Japanese, Swedish, Belgian, British, they all behaved the same. Nobody was willing to say "yes this is a bad drug and we will stop making it."

The ethics of Ciba-Geigy

Entero-Vioform was not the only drug made by Ciba-Geigy that there were problems with. The list includes Ambilhar (for schistosomiasis), Butazolidin (phenylbutazone), Tanderil (oxyphenylbutazone) and Slow K. The details were different in each case but as Hansson shows the pattern was the same. When problems arose the strategy was to initially deny them and when denial was no longer an option, to make the admission as ambiguous as possible.

The ethics of marketing drugs

Hansson gives us details of an international product management meeting held by Ciba-Geigy in March 1983. It is not always the scientific evidence that dictates what a company highlights about its products. Often those decisions are based on marketing data – how can a particular drug capture the largest possible market share.

The ethics of marketing drugs in the Third World

Disclosure of information about a drug in an industrialized western country is not the same as disclosure in a Third World country. What Nigerian doctors were told about SMON and Entero-Vioform was not the same as what Swedish doctors were told as Hansson found out during a trip to Nigeria.

The ethics of the medical profession

How was Ciba-Geigy able to assemble its "panel of independent international experts of neurology" to testify in its favour about SMON and

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Entero-Vioform in spite of overwhelming evidence to the contrary?

Inside Ciba-Geigy is also not just about Olle Hansson, it shows the power of collective action. When the Swedish medical profession became aware of Ciba-Geigy's actions with respect to SMON and oxyquinolone, a boycott of the company's products was organized which cost Ciba-Geigy about £12.5 million over 2 years. Part of the impetus for the formation of Health Action International came from the coordinated world action around oxyquinolone. It was pressure from the International Organization of Consumer Unions and HAI that finally lead Ciba-Geigy to speed up their world-wide withdrawal of Entero-Vioform and later to stop making Tanderil. Collective action in Sri Lanka meant that for a time in the 1970s that country was developing a rational system of drug provision based on the concept of an essential drugs list.

Olle Hansson wasn't an enemy of the pharmaceutical industry, not even of Ciba-Geigy. He wrote this book because of his deep feeling of responsibility" "This book is an accusation against Ciba-Geigy, that they have caused, despite better knowledge, unnecessary suffering and death and that, in their greed for more profit, they have consciously endangered the life and health of people. As a physician I had no other choice, because the highest goal of physicians is to prevent suffering." Silverman ends the book on a cautiously optimistic note. Some Ciba-Geigy officials had been able to talk openly and effectively with consumers and in small ways industry and consumers had been able to work together. Perhaps people were learning some of the lessons that come out of this book. If they do, then maybe it won't be necessary to have a Vice President in charge of going to jail.

My Summer Vacation

By Clayton Ruby

It was *supposed* to be a quiet summer. I told my publisher I would not revise (yet again!) my text book on sentencing. I told my children that they could expect my undivided attention for the full two months of summer vacation. I had promised myself a steady diet of late movies on television and a lot of bass fishing towards sunset.

And so it was that when I opened the morning paper to read that an injunction had been obtained prohibiting a young woman named Dodd from obtaining an abortion, my first response was "Isn't that silly. However did it happen?"

I was familiar with the law on abortion and the availability of injunctions only because I had recently obtained an injunction prohibiting all picketing at Dr. Henry Morgentaler's Toronto Clinic. That in itself was fortuitous. Henry Morgentaler ordinarily used Morris Manning as his counsel, who had obtained his acquittal in the Supreme Court of Canada in a justly celebrated criminal case. When Dr. Morgentaler had spoken to him to see if he could obtain an injunction for him, Morris Manning had been occupied with other commitments. I was pleased and flattered when Dr. Morgentaler called me and asked me if I would do it, even agreeing to retain me after I confessed that I had never done an injunction in my life. Thus was born Morgentaler v. Wichey et al, a decision from which leave to appeal was recently refused by Isacc J.

The fortunate thing about my having had that retainer was that counsel for the anti-abortion crazies was Angela Costigan, and she made as part of her argument such varied and fascinating notions as fetal right to life, the obligation of the court to be reluctant to intervene to protect a murderer like Dr. Morgentaler, and the argument that the striking down of the abortion law in the Morgentaler case create a vacuum which substantially left abortion totally illegal in this country and fetal "life" without any limits on its protection. In the course of dealing with these arguments, I became familiar with all of the case law concerning injunctions and their availability in this context.

I did not see Barbara Dodd for the first week that we were retained. I stayed at the cottage and fretted, vainly trying to direct the work of those who had volunteered to assist in this unusual case. A principal part of the preparation had been trying to bring the application quickly enough so that time was not wasted, yet in a way that avoided having the case brought back before Mr. Justice O'Driscoll, a judge whose impartiality and objectivity inspire dread rather than respect. Harriet Sachs, with whom I live, supplied the civil expertise, and my partner Marlys Edwardh co-ordinated the substantive law. Both prepared affidavits

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Drug companies freebies

The following was sent to us by one our our members, who received this in the mail.

Dear Dr. _____

I am pleased to enclose the details regarding the Fifth International Workshop on Thrombolysis and Interventional Therapy in Acute Myocardial Infarction. As you can see in the syllabus, many of the world's leading cardiologists are on the faculty. Authors from TIMI, GISSI, ISIS and TA{MI will be speaking.

Genentech Canada would be pleased to sponsor your registration to this very interesting educational opportunity. The date is Sunday, November 12, 1989 and the program will be held in the Grand Ballroom of the New Orleans Marriott.

To arrange prior registration please contact me at (204) 444-2632. Reimbursement following the Program can also be arranged by submitting your receipt for registration through me to Genentech Canada.

Once again I take great pleasure in offering this information to you and will be happy to answer any questions regarding the arrangements for the Program that you may have.

Yours truly,

Paul M. Boulding

Genentech Canada

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and rounded up witnesses who successfully enabled us to show that Murphy, the plaintiff, had deliberately and knowingly lied to the Court when he stated that her doctor had told her there was a danger to her life and health in having an abortion, and on other central matters as well. The Supreme Court found a deliberate fraud on the Court by Murphy and set aside the injunction. Though no reasons were given, after a full argument on the merits of court orders to prevent abortion, Justice Gray declined to give such an order even for the 16 hours necessary to enable Ms Costigan to reach the Ontario Court of Appeal the next day.

And then the stunning turnaround by Ms Dodd. None of us had seen it coming nor had the slightest inclination of any unease on her part. We had seen what those who watched her on television saw: a young woman determined to free herself from domination by the court at the instance of a jilted boyfriend, a woman who asserted that she would go to jail rather than have a child she did not want. She had had no contact with anyone working for the right to choice movement until one half hour before court on the Monday morning that the application to set aside the injunction was heard, except counsel. At that time, I asked Judy Rebick, who uses sign language, to act as an interpreter and to assist Ms Dodd in dealing with the press. I was interested afterwards to note that most of the press accepted her statement that she had been pressured by the freedom of choice movement without pinning her down on who had done the pressuring or asking exactly what it had been. The exception was Susan Reisler of the Journal, then hosting As It Happens, who asked those questions. Ms Dodd was unwilling to name names, but nevertheless insisted that she had been coerced by statements such as "you have a right to an abortion" and "we will help you"! Our office had, fortunately, decided to have a thorough examination of Ms Dodd by a psychiatrist done as part of the preparation for the case. Dr. Robert Wood Hill described her to the court in an affidavit as "emotionally fragile".

In the ensuing publicity, I tried to make only two things clear. First, we had defended Ms Dodd's right to choose and felt no regret about that decision. It was her right to choose that was important, and it was a difficult choice for any woman. Moreover, If she now chose not to have an abortion, I would equally cheerfully defend her right to make that choice as well. Second, this phenomenon of sudden and inexplicable reconciliation is not unknown to lawyers. In family law, it is often the case that the ink is barely dry on an order barring a battering spouse from the marital home at the request of the battered spouse, only to find that before the ink is quite dry on the document, the inevitable phone call comes describing the loving reconciliation and the promises never to do it again. What Ms Dodd needed at this time, I suggested, was kindness and understanding.

Meanwhile, the successes of the anti-abortionists in Quebec proceeded at an alarming rate. After the Court of Appeal decision, I spoke – once again at the cottage, safely at my summer home – to the Canadian Abortion Rights Action League. We began to discuss the Daigle case. Would I be interested, they wished to know, in accepting a retainer to intervene in the Supreme Court of Canada in the Daigle case? Once again a team of volunteers was put together out of our office in Toronto under the direction of Elisabeth Widner, Dan Brodsky and Shaun Nakatsura, who drafted the necessary documents so intelligently and efficiently that we were able to serve and file our Factums more than 24 hours before the parties themselves could do so. The intervention applications were successful and the arguments that were made by CARAL and others persuaded the Supreme Court of Canada to set aside the injunction. Though restricted to civil law and avoiding the Charter issues, the Supreme Court of Canada made it clear in their decision that injunctions, absent explicit statutory language, are not to be used to force women to give birth to unwanted children.

Letter

To: The Medical Reform Group

I am the editor of an international newsletter, *Dendron News*, that provides information to people concerned about human rights in – and alternatives to – psychiatry.

Because of psychiatric labelling, people who have experienced human rights violations in this field generally remain silent or are discredited. Finding alternatives to atrocities such as forcible electroshock and coercive psychiatric drugging may ultimately involve hiring more workers to provide humane personal contact. This support must absolutely be based on a respect for the individual as an equal, and an appreciation of them as a whole person.

I write this because I have found that many progressive emotional-support workers seem to feel that simply creating an individual alternative to these atrocities is enough. It is not enough.

Progressive workers are in a unique position to speak out. They have special access to information. And they have special credibility with the public. Silence is simply complicity. Unfortunately, the economic system highly rewards a person who remains silent about these atrocities.

However, internationally, former psychiatric inmates are organizing to fight back and promote new options. We are looking for allies in this struggle.

In the August-September 1989 issue [of Medical Reform], Mimi Divinsky, M.D., speaking for the steering committee, wrote: "I think it's fair to say that most physicians do not perceive a world-wide epidemic of brain damage due to treatment..."

The sad fact, however, is that such an epidemic does exist. I challenge Dr. Divinsky to publish the rate, as established in mainstream psychiatric literature, simply of tardive dykinesia (TD) after long-term neuroleptic drug use. (There are also many other forms of brain damage caused by the neuroleptics.) Just what the hell is your steering committee's definition of an epidemic?

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Your steering committee should be ashamed of yourselves for publishing such a reassuring comment, without any data whatsoever, and without any further investigation.

It is your choice:

First, you can go along with the established psychiatric system, remain silent, feel you are doing your part by providing individual humane care and promoting small-scale reform.

Or second, you can investigate the published data on brain damage from psychiatric modalities such as neuroleptic drugs and electroshock. You can speak up as allies with an entire class of people who are being devastated by a coercive drugging. And you can help us form true alternatives, based on equality and empowerment and wholistic support.

It's your choice. Your responsibility.

Sincerely,
David Oaks

Editorial Board: Any takers? What are *your* views?

B.C. heart patients await news on bid to clear surgery backlog

Globe & Mail, February 2, 1990

BY DEBORAH WILSON
The Globe and Mail

VANCOUVER

More than 700 people in British Columbia's growing backlog for open-heart surgery continued their wait this week for news about whether the Health Ministry will send 200 patients south of the border.

But while ministry officials negotiated with Washington State hospitals for a discount in their fees before signing a deal, the B.C. Cardiac Society gathered statistics on the number of heart patients for whom any plan to clear the backlog will come too late.

Dr. Lawrence Burr, spokesman for the society, said at least 12 and as many as 20 people died on the waiting list for heart surgery in 1989.

Seventy-five-year-old Helen Cotter was one of those who could have lived, her family physician, Dr. James Hayward, said in a letter to Premier William Vander Zalm. In the letter, he blamed government budgetary restraints for her death last September.

"We as a society have the expertise to save lives such as this woman's but unfortunately the funding is not in place to perform the necessary life-saving surgery," Dr. Hayward told the Premier in the Nov. 29 letter.

The otherwise healthy woman spent three weeks on the emergency waiting list for heart surgery in North Vancouver's Lions Gate Hospital, but "kept getting bumped" from surgery to make room for other cases, he said.

"I wrote to the Premier because she really didn't have any family to write for her."

The government says the backlog is a result of a shortage of intensive-care nurses and specialized technicians. The waiting list stood at 719 as of Nov. 30, the most recent figure available from the Health Ministry.

Health Ministry spokesman Bruce Archer said the government is also concerned about reports of deaths on the waiting list.

"Everything is done within our power to keep people from dying," Mr. Archer said. "It's a situation that we're striving to overcome to ensure that no one has to die while waiting for any type of surgical procedure or medical procedure."

Ministry officials met in Seattle two weeks ago with representatives of 11 Washington hospitals to discuss sending as many as 200 heart patients there, where there is no backlog for surgery.

Keith McCandless, spokesman for the Washington State Hospital Association, said staff at the hospitals involved in the negotiations were thrilled by the prospect of such an agreement. Doctors and nurses in one heart-surgery unit "were waving Canadian flags around" after the meeting with B.C. officials, he added.

The staff would see it as a boost to their hospitals' prestige, Mr. McCandless said, but a large part of the attraction is the fact that heart surgery is an extremely lucrative procedure for both medical staff and hospitals.

Compared with Canada's, the U.S. medical system has many more specialists such as heart surgeons, who earn far more than a general practitioner, he said. Specialized technicians, whose short supply in British Columbia is cited as one of the reasons for the backlog, are often lured south to hospitals where they can earn two to three times the pay they would receive in Canada.

Traditionally, heart surgery has been "one of the bigger money-makers" for staff members, Mr. McCandless said.

Heart surgery is also welcomed as a money-maker for market-driven U.S. hospitals, with the exception of operations performed on older patients at deeply discounted Medicare rates, he said.

The state-wide average price for a bypass operation is about $24,300 (U.S.) in hospital fees plus up to $10,000 more in doctors' fees, said L. G. Blanchard, spokesman for the University of Washington Medical Centre, one of the hospitals that is interested in taking Canadian heart patients.

B.C. Medical Association president Dr. John Anderson said the Washington price tag is more than twice the cost of performing the operation in Canada. He added that the money spent sending patients south could go a long way toward addressing the problems that have caused the backlog, such as the shortage of nurses and technicians.

"We have to come up with some way of paying them enough to make the job attractive," Dr. Anderson said.

Patricia Savage, president of the British Columbia Nurses Union, acknowledged that the union has not tried to negotiate higher wages for specialized intensive-care and post-operative-care nurses to try to bring about an end to the labor shortage in those areas. She said the real problem is low pay and poor working conditions.

ALBERTA

Globe & Mail, March 17, 1990

The spectre of two-tier medicare

BY CHRISTIE McLAREN
The Globe and Mail

THREE YEARS after public outrage obliged the Alberta government to abandon the idea, the spectre of a two-tier health-care system has arisen in the province once again.

A blue-ribbon task force appointed by Premier Donald Getty has called for two levels of health care: "basic" medical services to be insured by the government and undefined "additional" services for people who want to buy them through a supplementary insurance plan. (The $2.7-million report by the Premier's Commission on Future Health Care for Albertans, led by former finance minister Lou Hyndman, does not define "basic" services; it says these will change over time.)

Reaction has ranged from indignation to indifference.

Critics say it will create one system for the rich and one for the poor.

"It chips away at the heart of medicare," said Bettie Hewes, the Liberal health critic.

Health care is a right, New Democratic Party health critic William Roberts said. "I am fundamentally opposed to a system which allows people with more money to buy better health care."

Andre Pierre Contandriopoulos, an economist who heads a health research program at the University of Montreal, said the commission has had "a bad idea" that would violate the principles of medicare by creating different health-care coverage in different provinces. "What does it mean to be a Canadian in such circumstances?"

Others, including Dr. Alex McPherson, a co-author of the Alberta report, argue that a *de facto* two-tier system already exists.

"It's a non-issue because it's already happening," agreed Dr. Michael Rachlis, co-author of a recent book examining the Canadian health-care system. "Each province has services that they cover and services they don't cover."

For instance, services such as home care, chiropractic, optometry, physiotherapy, abortion and health evaluations of the elderly are available under medicare in some provinces but not others.

The Alberta idea is throwing a spotlight on a key question facing Canada's troubled health system: which medical services will be considered "essential" and eligible for government coverage in the future?

- Will operations now considered necessary for some people — such as adult heart transplants — be deemed too expensive to be a "basic" in the future?
- Will popular but controversial procedures — such as coronary bypass surgery — be rationed or de-insured if new research concludes they are less effective than originally believed?
- Will a 50-year-old businessman be able to get open-heart surgery under his private insurance plan, while a 50-year-old factory worker without such coverage cannot?

The Canada Health Act — the federal law that governs how medicare works — says simply that provinces must provide "medically required" services. Ottawa has left it up to the provinces to decide what that means, and the provinces have traditionally left that decision to doctors.

However, times are changing.

Medicare was introduced to Canada 28 years ago, first in Saskatchewan, incorporating four basic principles: everyone is entitled to comprehensive health care, regardless of his ability to pay, under a publicly run system that is portable from province to province. Today, the provinces say this system has become too expensive.

Ottawa has slashed federal spending on social programs, including health; the population is aging; expensive new technology is multiplying; hospitals within a given region are duplicating services; and doctors' charges to provincial health-insurance plans are rising dramatically.

Health care is now gobbling one-third of every provincial budget.

"We are discovering more ways to help people than we are discovering ways to pay for the help we can give them," Dr. Charles Hollenberg, a University of Toronto medical professor and director of the Banting and Best Diabetes Centre, noted wryly. As a result, provinces are starting to take a harder look at how doctors decide what is "necessary."

"The fact is, there is bad medicine being practiced," Dr. Rachlis said. "A lot of what doctors do is inappropriate," both for the health of the patient and for the public purse. Cholesterol testing and open-heart surgery are two debatable examples.

But Dr. Ron Gregg, president of the Alberta Medical Association, said doctors are worried about cost-conscious governments deciding what is necessary. Instead, he and other observers say, society as a whole — not doctors or governments alone — must, after complex calculations, define which health services are appropriate for which types of patients, and thus eligible for public financing.

"As the costs continue to increase, I think we have to look objectively at new (medical) procedures," Dr. Gregg said.

In the near future, the decision about what is "appropriate" for government financing may be decided by teams of experts in different fields, including quality assurance and medical ethics. In Alberta, for example, the Hyndman commission wants to see a provincial ethics centre at which experts in a variety of fields would make tricky moral and financial decisions about what kind of medical services are appropriate.

Alberta is still the only province to consider a two-tier system as part of the solution. (Other recent health-care inquiries in Nova Scotia, Quebec, Ontario and New Brunswick have not broached the subject.)

In 1987, Alberta tried to introduce a parallel health-insurance scheme under legislation that would have allowed private insurance companies to compete with the Alberta Health Care Insurance Plan. A public outcry compelled

Mr. Getty to withdraw it.

In another controversial move, the province de-insured several procedures, including tubal ligations, tummy tucks (cosmetic plastic surgery), circumcision and contraceptive counselling. After public complaints, some of the services were reinstated.

Burned twice by public opinion, Mr. Getty and Health Minister Nancy Betkowski have quickly denied any further thought of instituting one system for the poor and another for the rich.

"We have no intention of moving toward a two-tiered health system," Mrs. Betkowski said flatly in an interview.

Critics remain unconvinced.

"That remains to be seen," said Mrs. Hewes, who, like Mr. Roberts, wonders whether other members of the Getty government will support Mrs. Betkowski.

"This government has been trying for a long time to get private insurance accepted," the Liberal MLA said. "The fact that the idea has surfaced over time in different ways makes me a little uneasy about what the whole (Tory) caucus believes."

Currently, Alberta insures "medically required" services — in general, everything that doctors consider necessary (except prescription drugs), as well as chiropractic, optometry, podiatry and physiotherapy at private clinics.

Dr. Hollenberg suggested that provinces could establish separate insurance systems to cover home care for the disabled and chronically ill — a service only "spottily" insured by some provinces now.

Mrs. Betkowski, who used to work for Mr. Hyndman, will not say specifically how she will respond to his recommendations, which are being reviewed by a team of six cabinet ministers.

"I can't give you an answer (about) where we're going to go as to what's 'medically required' and what's deemed to be 'necessary,' " she said.

However, she acknowledged: "The pit is not bottomless. We have to constantly ask ourselves, 'Is this the best use of the resources available to us?' "

Ontario MDs alarmed by panel's proposal for cap on medicare

Globe & Mail, April 14, 1989

BY CHRISTIE McLAREN
The Globe and Mail

Ontario doctors reacted with alarm yesterday to a proposal by a government task force to limit the total amount of money that physicians can be paid under medicare each year.

The Ontario Medical Association will withdraw from the Premier's Council on Health Strategy if the council adopts the proposal, OMA president Henry Gasmann told a news conference yesterday.

"If that's their final (recommendation) . . . yes, we will withdraw our support," Dr. Gasmann said.

"We cannot agree to an arbitrary cap on funding."

Two other provinces — Quebec and British Columbia — have set annual limits on the total amount of money doctors can bill the provincial health-insurance plan.

But Ontario doctors, who are still angry at previous government actions that have limited their incomes, will fight any attempt by the government to set an arbitrary limit on OHIP spending, Dr. Gasmann said.

He said the OMA — which represents 19,000 physicians — thinks the government is moving too quickly to reform the $12.7-billion health-care system without fully consulting doctors about how it should be done.

However, physicians are unlikely to go on strike. A bitter 1986 strike against provincial legislation to end extra-billing was widely regarded as a public-relations failure for the doctors.

Instead, Dr. Gasmann said, the OMA would like the government to negotiate a health-care budget with the doctors, with "a mutually agreed-upon method of using our scarce resources to the best of our ability."

Doctors' bills to OHIP totalled $2.96-billion in 1987-88, an increase of $500-million over the year before. A separate task force is examining that issue.

The Premier's Council on Health Strategy was set up by Premier David Peterson in December, 1987 to develop a long-term strategy for health and health-care in Ontario. Its first report is due in about four weeks.

The council includes 22 people from government, business, labor, academia and health professions, and seven cabinet ministers.

One of its members — former OMA president Hugh Scully — informed the OMA yesterday that an annual cap on OHIP spending is "one of several" proposals being discussed by a sub-committee of the council, Dr. Gasmann said.

He did not know whether the proposal has been endorsed by the subcommittee or the council as a whole.

If the government slaps a limit on OHIP spending, access to medical services will be reduced, Dr. Gasmann predicted.

The number of laboratory tests and hospital services paid for under OHIP could be curtailed, he said.

Health Minister Elinor Caplan — vice-chairman of the health council — refused to confirm whether the council is considering a cap on doctors' fees under OHIP.

She refused to comment on the doctors' threat to withdraw from the council, and refused comment on Dr. Gasmann's prediction that access to health care will suffer if the health- insurance budget is capped.

Doctors in Quebec and British Columbia live with negotiated limits on the total amount they can bill their provincial health-insurance plans each year.

In Quebec, the year is divided into four three-month periods, and there is a limit on the amount a general practitioner can bill the government in each quarter.

If a doctor's bills exceed the allotted amount, the government then begins to pay only 25 cents for every further dollar billed during the quarter.

The B.C. government has also put a cap on the amount of money available to doctors under medicare. This year, the government and the doctors agreed on a ceiling of $900-million, and the government can gradually reduce the amount it pays out if it appears that billings will exceed the limit.

Study questions need for clinics

BY GEOFFREY YORK
The Globe and Mail

WINNIPEG

As many as 13,000 Manitobans may be receiving an unnecessary duplication of services from walk-in medical clinics each year, a study by the Manitoba government suggests.

The study was commissioned by the Manitoba Health Department as a result of mounting concerns about the rapid growth of walk-in clinics in Winnipeg and other Manitoba communities.

About 150 doctors are employed at about 20 walk-in clinics in the province. By comparison, only 25 doctors were working in these clinics in 1983.

Winnipeg was one of the first Canadian cities to experience a boom in walk-in clinics, although the phenomenon has spread to most other major cities in recent years. The clinics are popular because they allow patients to visit a doctor without making an appointment in advance.

The study, obtained by The Globe and Mail under the provincial Freedom of Information Act, found that a huge number of Manitoba patients end up seeing another doctor within a few hours of visiting a doctor at a walk-in clinic.

In 1987-88, for example, a total of 13,794 patients saw a second physician within a day of visiting a doctor at a walk-in clinic. In 1986-87, there were 12,887 patients who saw another physician within 24 hours of visiting a walk-in clinic. The study suggests that these patients might be seeing their own physician to find out whether the clinic doctor made a correct diagnosis.

The cost to the Manitoba health system was $247,000 for the walk-in doctors, and $368,000 for the outside doctors, in 1987-88, the study calculated. This figure does not include the cost of laboratory tests, radiology and other services. Nor did it include the costs generated by thousands of other patients who saw another doctor within two or three days.

Wilson Parasiuk, the provincial health minister when the study was conducted in 1987 and 1988, said it is obvious that the vast majority of patients who saw two different doctors within 24 hours did not need the services of both.

"People like the convenience of having no appointment, but if someone is putting on a bandage and saying, 'Go see your doctor,' then you've added a very significant cost to the health-care system," Mr. Parasiuk said in an interview. "It's not the most efficient use of health-care costs."

Mr. Parasiuk said the health department was concerned about the rapid rise in the number of walk-in clinics. "We were wondering what it was doing, because doctors can create a demand for medical services. Walk-in clinics provide convenience, but they're also a marketing tool. That's why people have neon lights on their walk-in clinics."

Deputy health minister Frank Maynard said it is premature to draw any definite conclusions from the study. He said the department is conducting another study to see whether any consistent patterns emerge.

However, Mr. Maynard agreed that most of the patients who visited two doctors within 24 hours would seem to have been receiving unnecessary services.

"The report does identify a problem, but it's not definitive," Mr. Maynard said in an interview.

"Walk-in clinics are really a symptom of a larger problem: the concentration of general practitioners in Winnipeg," he said.

"The rapid growth raises a concern about the number of physicians. Doctors tend to congregate in the urban areas. We have questions about whether the numbers are too many."

Some health economists believe that there is a surplus of physicians in Canada's major cities. To ensure an adequate income, they open walk-in clinics to attract patients who enjoy the convenience of dropping in to see a doctor at lunch time or on the way home from work.

Critics have said that some are run by entrepreneurs who are motivated by a desire for profits. Former Manitoba health minister Laurent Desjardins once suggested that some clinics are run by businessmen who put pressure on their staff to provide unnecessary medical care to make money.

However, the owners have argued that they can save tax dollars by attracting patients who would otherwise visit a hospital emergency department.

The College of Family Physicians of Canada, in an article in a medical journal in 1987, criticized walk-in clinics for duplicating medical services and disrupting the continuity of health care provided by a family physician.

Some of these concerns are still held by medical experts such as Dr. Ken Brown, registrar of the Manitoba College of Physicians and Surgeons, who says these clinics often provide "episodic" care.

Globe & Mail, March 13, 1990

Group urges review of costly medical technologies

Globe & Mail, March 7, 1990

BY CHRISTIE McLAREN
The Globe and Mail

Expensive medical technology — old and new — should be scrutinized by an independent watchdog group for its effect on patients' health and the public purse, an Ontario government task force says.

Technologies such as CT-scans, MRI scanners and machines that pulverize kidney stones should undergo a strict review by a scientific body, at arm's length from the government, the Task Force on the Use and Provision of Medical Services said in a report released yesterday.

"A rigorous review of these technologies, whether in Ontario or other (provinces), will give the medical community the opportunity to assess, reduce or eliminate those procedures which are no longer effective, or to introduce new procedures which have been shown to be effective," says the task force, led by Toronto lawyer Graham Scott.

A formal review would help to ensure that people are not harmed by medical technology, and that government money is spent efficiently, it says.

Health Minister Elinor Caplan did not comment on the report yesterday.

No such formal review of medical technology exists in Canada as yet. In the past, provincial governments have left it up to the medical profession and hospitals to decide what kinds of medical care — including high technology — were necessary.

But health care is now eating up 30 per cent of provincial budgets, and new scientific evidence is emerging to cast doubt on the efficacy of some of those technologies. As a result, governments are taking a closer look at where their money is going.

At the moment, Ontario has no independent, impartial method of deciding which kinds of medical technology — and how much — should be financed by the public purse.

As a result, the task force says, problems and misunderstandings have arisen:

- Doctors, patients and the general public do not understand whether certain technologies are useful or not; how they benefit or harm the patient; and the ethical dilemmas involved in prolonging or stopping their use.
- Patients are not confident about whether the technology being used on them is appropriate.
- Hospitals and other institutions financed by provincial taxpayers are buying expensive high technology without government approval or without properly assessing the need for it.
- Hospitals' multimillion-dollar fund-raising campaigns are often aimed at buying "certain highly visible technologies" that can be at the expense of less-glamorous but more valuable things.
- Patients are being referred to the United States to gain access to technology that is unavailable in Canada.
- Hospitals, other institutions and special-interest groups are pressing the government for control over certain technologies. The absence of an impartial appeal body increases this pressure.
- Decisions about what part of Ontario gets what kind of technology are made by an "ad hoc approach," which is viewed as unfair and leads to attacks on the government.

Nurses have complained that the Canada-wide and international nursing shortage is caused, in part, by hospitals and governments spending a bigger proportion of their money on emerging technologies, rather than on hiring basic caregivers, such as nurses.

Last year the federal and provincial deputy ministers of health pledged to create a national office to co-ordinate the assessment of technology.

Health plans found to cut hospital costs

Globe & Mail, April 15, 1989

BY JOAN BRECKENRIDGE
The Globe and Mail

Individuals enrolled in health service organizations are hospitalized about 20 per cent less than other people living in their vicinity, according to the Association of Ontario Health Centres.

The difference in hospitalization rates can be linked to factors like the range of services the centres provide and a built-in financial incentive to not hospitalize, said a spokesman for the association.

"The figures are another signal that we may be able to make better use of the health-care dollar," Mark McGuire, executive director of the association, said yesterday.

Ontario employs about 240 physicians in 45 health service organizations, or HSOs. The centres provide comprehensive services, including health promotion and medical treatment, to people who enroll.

According to statistics compiled by the Ontario Ministry of Health, people enrolled in HSOs were hospitalized 21.7 per cent less in 1987-88, 20.3 per cent less in 1986-87 and 18.7 per cent less in 1985-86.

These numbers are even more optimistic than those touted by the Ministry of Health in early April. At that time, Health Minister Elinor Caplan said the province was going to open 18 new health clinics called comprehensive health organizations.

Based on the U.S. experience with health maintenance organizations, or HMOs, she predicted that the comprehensive organizations would cut by about 10 per cent the use of hospital beds by patients who volunteered to participate.

The 20 per cent reduction in hospitalization has placed less pressure on hospitals to open and operate new beds, so that HSOs save the health-care system $10-million per year, said Mr. McGuire.

HSOs are also supposed to be money savers because they do not use the traditional fee-for- service system but capitation — a daily rate paid for each patient on the roster based on sex and age. Physicians do not have to increase patient volume to make money.

"We have funding incentives not to admit people to hospital," said Mr. McGuire.

HSOs receive a share of the saving to the health-care system when they reduce hospital utilization. The ministry pays the HSOs one-third of the money saved on hospitalization in their area.

MDs consider limiting tests for dementia

Not enough equipment, personnel to do whole battery of exams

Globe & Mail, October 14, 1989

BY PAUL TAYLOR
The Globe and Mail

Faced with a shortage of equipment and trained personnel, Canada's medical profession is considering limiting the number of tests for dementia, one of the most widespread illnesses afflicting the elderly.

"This is going to stir up a lot of controversy, but with the passage of time I think it will be accepted," said Dr. Barry Wilson, an assistant professor of medicine at the University of Toronto.

About 25,000 new cases of dementia are diagnosed in Canada each year, and that figure is expected to triple in the next few decades, Dr. Wilson said in an interview yesterday.

Doctors, who usually order a battery of tests when they suspect dementia, have no choice but to rely on far fewer exams simply because there are not enough resources, he said.

Dr. Wilson was one of the organizers of a conference held in Montreal last week that decided to draft a new set of diagnostic guidelines for family physicians, who will have to handle the bulk of the dementia cases. The guidelines should be ready in about a month.

Dr. Wilson said the guidelines will probably recommend fewer costly CAT scans, which provide computerized images of the brain.

He added there is a positive side to having fewer tests. For one thing, a lot of CAT scans, which can be terrifying for a confused dementia patient, are unnecessary.

Dementia, which results in a loss of memory, judgment and other mental faculties, is caused by a variety of illnesses. Alzheimer's disease — an irreversible illness in which a patient becomes increasingly forgetful, confused and unable to function on his own — accounts for 50 to 60 per cent of all dementia cases.

Brain tumors, depression, multiple strokes, subdural hematomas (a buildup of blood between the brain and the skull), hydrocephalus (a swelling of the brain), alcoholism, prescripition drugs and even a lack of certain vitamins can result in dementia.

Some of these cases can be successfully treated and memory restored.

The big problem has been separating the Alzheimer's patients from the ones with reversible dementia. No simple test exists for diagnosing Alzheimer's disease. The only way to know whether a patient has the disease is to take a small brain sample and look at it under a microscope — a procedure performed only in rare circumstances.

As a result, the diagnosis of Alzheimer's has been a process of elimination: If another cause is not found for the dementia, it is assumed that it must be Alzheimer's disease. That means that elderly patients are often referred to a series of specialists and subjected to a battery of gruelling examinations, including multiple blood tests and CAT scans.

"A CAT scan room is like the bridge of the Enterprise," Dr. Wilson said. "It's very frightening for the patients. They have to put their head in a machine and lie still while people are messing around with computers."

A CAT scan can spot brain tumors, hydrocephalus and subdural hematomas, which account for only 3.5 per cent of all dementia cases, said Dr. Mark Clarfield, chief of geriatrics at the Jewish General Hospital in Montreal.

There are only 500 to 600 geriatricians, neurologists and psychiatrists specializing in treating the elderly in Canada. And multi-million-dollar CAT scan machines are in relatively short supply.

At the same time, there are more and more elderly. About 10 per cent of the Canadian population is over 65. In 50 years, that figure will soar to 25 per cent and many of them will be afflicted with dementia, estimated Dr. Gerry Hill, an epidemiologist with the federal Health and Welfare Department.

An estimated 10 per cent of those over 65 suffer from the debilitating condition and 25 per cent of those over 85 are afflicted.

Dr. Clarfield added he hopes that the new guidelines will help family physicians diagnose the cases on their own, rather than immediately turning to the specialists and their high-tech machines.

The new guidelines will provide doctors with a list of things to ask about, including family history, medication, diet and recent accidents.

News Briefs

AIDS strategy delayed

Canada's national AIDS strategy will not be ready until the summer, the government has announced, despite earlier promises by Health and Welfare Minister Perrin Beatty that the strategy would be ready by the end of 1989. AIDS community groups expressed their frustration over the delay.

AIDS compensation

Federal Health and Welfare Minister Perrin Beatty has announced that people who contracted AIDS because of tainted blood products will received $120,000 each in financial compensation. Beatty characterized the measure as an action to "ensure public confidence in Canada's blood supply". He said that 'it's not designed as an AIDS relief program as such. The Department of Health and Welfare estimates that 1,250 people in Canada, 950 of them hemophiliacs, were infected with HIV from receiving blood transfusions from 1979 to 1985.

-Globe and Mail, 15/12/89

Northern medical school?

A task force of the Ontario New Democratic Party has come out in favour of the creation of a medical school in Northern Ontario, arguing that this would be a way to keep doctors, nurses, technicians and other professionals in the North. The proposed school would also be charged with developing medical care programs more suitable to the North. The proposal has met with scepticism from the Liberal government, which argues that there are already too many doctors in Ontario.

-Toronto Star, 10/2/90

Transfer payments cut

Michael Wilson's new budget contains extensive cuts to transfer payments to the province for health care and education. Payments to Ontario alone will be cut by $378 million per year, nearly all of it money slated for health care and education.

Budget hits veterans

More than 5,000 aging Canadian war veterans confined to chronic care hospitals will have to pay more than $3000 each for their bed and board as a result of the Progressive Conservative government's new budget. Another 60,000 veterans living at home will lose some of the home care and help currently being provided to them because of cuts to the Veterans Independence Program.

New OHIP cards

The Ontario government plans to introduce new OHIP cards for all Ontario residents this year. Under the new system, each person would have a new OHIP number, and each child born in the province would receive an individual 'cradle-to-grave' card at birth. The government says the new cards will improve administration of the system and make it easier to keep track of health care trends, including billings. Critics charge that the new system would be a threat to individual privacy, and that it would open the door to OHIP numbers being used as a tracking device for unrelated purposes in the same way as social insurance numbers have become widely used.

Registry for heart patients

The Ontario government has announced a new system of networks designed to insure that people with urgent problems get heart surgery when they need it. The networks will be able to refer patients to other facilities if their own hospital has a waiting list.

Safety law weakened

Ontario's Labour Minister Gerry Phillips has tabled amendments to the Occupational Health and Safety Code which would weaken the provisions of the legislation that are supposed to safeguard workers' safety. The changes reduce the right of workers to refuse unsafe work. Criticism of the proposed changes came from a number of labour unions. Bob De Matteo, director of health and safety for the Ontario Public Service Employees Union, said that if workers do not have the right to refuse unsafe work, employers find it easy to ignore employee complaints.

B.C. electrician sues asbestos companies

George Hunt, a retired electrician from Victoria has gone to court to claim damages from 14 asbestos-related companies and industry associations. Mr. Hunt's lawyers will try to prove that he is dying of mesothelioma, and that the disease is associated with his having inhaled asbestos fibres during his work. His claim alleges that the health hazards of asbestos have been known to the industry since 1927, but that information about them was deliberately withheld.

-Globe and Mail, 27/2/90

Rural mental health

The Second International Rural Mental Health and Addictions Conference is to be held June 11-15, 1990 in North Bay. The conference is sponsored by the Canadian Rural Network, the Canadian Mental Health Association, and Canadore College. The conference will feature a First Nations day to allow delegates to discuss significant service issues and alternatives for native communities. For information contact Wayne Auchinleck, c/o Network North, Community Mental Health Group, 680 Kirkwood Dr., Sudbury P3E 1X3, (703)675-9192 x314.

Health Care Ethics

The Westminister Institute for Ethics and Human Values is sponsoring a conference titled "Health Care Ethics 2001: Issues of Justice and Responsibility." Among the issues to be examined: the allocation of scarce resources; access to health care; ethics in the hospital setting; and personal and societal responsibility for health and health care. The conference will take place in London, Ontario May 4 - 6, 1990. The fee is $125; For further information contact Michael Yeo, Westminster Institute for Ethics, 361 Windermere Rd., London, Ontario N6G 2K3, (519)673-0046.

Health Care in Germany

The MRG has received a substantial package of materials about the West German health care system. Most of the materials are in German; some are in English. These documents contain a wealth of information about resource allocation, pharmaceutical policies, health care policies, and much else. Any MRG member who would like to see these materials please call Ulli Diemer at (416)588-9167.

Announcements

Wanted:

Physician(s) to Perform Abortions 1/2 day/week at Choice in Health Clinic Training Provided

In order for women to have access to abortion in a reasonably timely manner, physicians must be prepared to do them.

Choice Clinic currently has three physicians working on a regular basis: Nikki Colodny, Debby Copes and Chantal Perrot. We have openings for two half days per week during the summer months. We are looking for one or two physicians to work those shifts, with the possibility of part-time work being available in the fall as well.

The work environment here is very congenial. Information exchange with nurses and counsellors is commonplace. It is a supportive learning environment in which to train.

In the Quebec C.L.S.C.'s where abortions are performed,d 1/2 day per week, general practitioners and family doctors provide these services. This creates a mixed practice for abortion providers, a preferable model. In Ontario we must expand the pool of g.p.'s who are able and willing to provide abortion services if we are to improve timely access for women.

Choice Clinic is a non-profit facility, committed to providing non-judgmental abortion services to women with an emphasis on counselling and education.

If you are interested in this possibility, we would be happy to give you more details. Please call Kit Chapman, administrator, at 975-0314.

Family Physician Needed

To work with another physician in a team setting to deliver primary helath care. The location is in St. Jacobs, near Kitchener and Waterloo, Ontario, with a Community Health Centre which has a strong focus on health promotion and illnes prevention. The position is available immediately and has an excellent salary and benefit package. For information contact:
Rev. Clint Rohr, Executive Director
Woolwich Community Health Centre
P.O. box 419, 35 King Street
St. Jacobs, Ontario N0B 2N0
(519)664-3794

Shortage of nurses in parts of Canada stirs new look at pay

BY CHRISTIE McLAREN
The Globe and Mail

Globe & Mail February 14, 1990

A critical shortage of nurses in some parts of Canada may force nursing unions to break with tradition, bow to the forces of the market and consider measures to pay some nurses more than others, observers say.

As hospitals across the country close dozens of beds and blame a continuing nursing shortage for their actions, doctors, inquest juries and members of the public are beginning to call for measures that will make it more attractive for nurses to stay in the profession.

For the first time, nurses and hospitals say they may have to consider new contract provisions that would pay some nurses — those working in critical care in large expensive cities, for instance — more than others.

Unions "really have to look seriously at the question of whether the market needs to be driving the salaries," Judith Ritchie, president of the Canadian Nursing Association, said in an interview yesterday.

"If we can't find people to work in those areas, and they would work there for more money . . . I think it's something we seriously have to look at," Dr Ritchie said. "I think it's something that's been rejected out of hand for many years."

Nonetheless, the prospect may make the profession uneasy. Traditionally, provincial nurses' unions in Canada have not been prepared to negotiate different pay for different jobs or different regions of the province.

The philosophy that all nurses are paid equally (based on years of experience) has led to a situation that makes it very unattractive for nurses to work in stressful jobs in downtown Montreal, Toronto or Vancouver, or in remote areas.

In three well-publicized cases in the past year, the Hospital for Sick Children in Toronto has postponed admission or surgery to three toddlers. The reason? Not enough beds are open because the hospital cannot attract enough nurses to staff them.

"A nurse who works in chronic care in Huntsville (a resort community in the Muskoka Lakes district of Ontario)) would get the same (salary) as a critical-care nurse at Sick Kids'," David Martin, president of the world-renowned childrens' hospital, said in an interview this week. "It doesn't make any sense at all."

But equal pay has always made sense to nurses, Dr. Ritchie said, because studies show that different types of nursing carry different — but equivalent — stresses.

"In general . . . . the philosophy is that while the stressful situations are different the actual level of stress is not different and there shouldn't be a difference in pay."

She questioned whether higher pay alone would be the solution to the deep dissatisfaction that is making nurses leave the profession in droves.

However, both the 52,000-member Ontario Nurses Union and the Ontario Hospital Association say they are now considering new measures such as differential pay in preparation for contract bargaining that is to begin later this year.

A three-year contract between the ONA and the OHA expires April 1, 1991.

The ONA has sent its members a questionnaire asking whether the nurses would consider the concept of differential pay, president Lesley Bell said in an interview.

Questionnaire: What should the MRG be doing? What should the newsletter be doing? We need your opinions

Dear Member:

We are circulating these questions to learn, first, what you want to see in the newsletter, and, second, what direction you want the Medical Reform Group to take.

The newsletter is a major undertaking in time and money. We want to be sure you are interested enough to *read* it, and we want to know what changes if any *you* would like us to make – content, format, reviews – *you* name it.

You can see from the articles in this issue that your steering committee is wrestling with the mandate, positions, and energy of the MRG, and is very interested in *your* ideas. Over the years the MRG has developed a broad range of solid policy positions. This questionnaire – and the Spring General Meeting, which you are urged to attend – are intended to help us work out what our *key priorities* should be at this time. At the Spring meeting, we will also be spending time looking at how we can most effectively present our positions to the media and the public.

To do this, we need your input. No news from you is *bad* news for us. It means you're bored or burned out. So show us your enthusiasm by responding promptly. A return envelope is enclosed.

We also urge all members to consider joining the Steering Committee or taking on an associated task to help us overcome a serious shortage of person-power at the organizational level.

MRG Directions and Policy

1. What issues do you think the MRG should be concentrating on?_____

   _____

2. What forms of activity do you think we should be concentrating on, e.g. lobbying or submissions to government, joint activities with other groups (which ones?), higher media profile, organizing within the medical profession?

   _____

   _____

3. What are your own particular areas of interest or expertise?_____

   _____

4. Do you agree with the Resource Allocation Group's proposals to oppose health funding cutbacks and maintain support for all proven useful health care interventions? (See June, October, and December 1989 issues of the newsletter.)

   _____

   _____

5. Have you read *Second Opinion* by Michael Rachlis (an MRG member)? If so, do you agree with his positions?

   _____

   _____

6. Do you perceive a conflict with Michael Rachlis' positions and those of the Resource Allocation Working Group?

   _____

7. Other comments?_____

   _____

Your Involvement in the MRG

8. The Steering Committee urgently needs several new members. Would you be willing to be a member of the Steering Committee? Yes ___ No ___ Maybe___

9. If you are unable to take on full Steering Committee membership, would you be willing to take on a particular organizational task? Yes ___ No ___ Maybe___

10. Do you think the MRG's fees are a deterrent to membership? Yes ___ No ___ Not sure___

11. Would you continue to pay MRG fees if all physicians were drafted into the Ontario Medical Association? Yes ___ No___

12. Are you presently a member of the OMA? Yes ___ No ___

13. Do you think the MRG should remain primarily an organization of physicians and medical students? Yes ___ No ___

14. Are you interested in attending MRG local meetings on particular subjects with guest speakers? Yes ___ No ___

15. What topics would you like to see meetings on?_____

_____

16. Would you be willing to help organize such meetings? Yes ___ No ___ Maybe___

17. Would you be willing to speak to the media or at other functions on behalf of the MRG? Yes ___ No ___ Maybe___

The Newsletter

18. Do you read the whole newsletter? Yes ___ No ___ 19. Do you show it to anyone else? Yes ___ No ___

20. What do you think the purpose of the newsletter should be:

___Reporting on information about the MRG ___News ___Analysis ___Opinion

___Reach out to people who are not members of the MRG? Other_____

21. What do you think of the different sections of the newsletter? Would you like to see more, or less, of particular kinds of things:

_____Feature Articles _____Reviews _____News Briefs _____Newspaper Clippings _____Notices and Announcements

22. What kinds of articles would you like to see in future issues of the newsletter?_____

_____

23. What do you think of the general meeting reports in the newsletter? Is there too much coverage, too little, about right? Should such reports be edited, or should they be essentially the minutes of the meeting, as now?

_____

_____

24. Do you think the newsletter should contain (paid) advertising?

For MRG members only? Yes ___ No ___ For anyone who will pay? Yes ___ No ___

Only for non-profit or advocacy groups? Yes ___ No ___

25. Would you be willing to write articles or the occasional book or journal review for the newsletter? On what subject(s)?

_____

_____

26. If you haven't written anything for the newsletter, why haven't you?_____

_____

27. If you think the newsletter ought to be used to reach people outside the MRG, would you be able to help distribute it to such people? Yes ___ No ___ How?_____

_____

28. Other comments about the newsletter?_____

_____

29. Your name_(optional)_____30. Membership category_____

31. Type of work (e.g. private practice, community clinic, hospital-based, student, retired, etc.)

_____

32. Address and phone number(s):

Please provide these if you indicated a willingness to take on any tasks within the organization.

_____

_____