MEDICAL REFORM

Newsletter of the Medical Reform Group of Ontario

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

Volume 10, Number 3, September 1990

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

Medical Reform Group Press Release Regarding Provincial Elections

Delivered at a press conference, August 29th, 1:00 PM, Toronto Press Club, 5 Wellesley Street East

In order to clarify the perspectives of the 3 main Ontario political parties towards health issues, the Medical Reform Group of Ontario submitted the enclosed questionnaire to the three parties (See appended, with replies). The MRG is a non-partisan organisation whose first founding principle is that health care with universal access is a right. In this press conference we highlight the differences among the three main parties on various issues. Though the Liberal Party did not respond its actions serve as a guide.

1) THE ROLE OF USER FEES AND "ADMINISTRATIVE CHARGES"

We note the recent re-emergence in the media of user fees as a proposed means to regulate access to health care and to cut costs. Studies have shown that user fees deter the needy and poor from seeking appropriate health care. We also note that the recent Lowy Commission (Pharmaceutical Enquiry) proposes implementing prescription co-payment charges up to $250 per year. The MRG strongly urges rejection of user fees in any guise.

The Liberal Government has taken steps towards abolition of user fees i.e. Bill 94 which bans Extra-Billing. However, we view with alarm the Liberals' intent to charge user fees for services supposedly outside the health care sector i.e. chronic care facilities. Furthermore, the Liberals have as yet made no attempt to prosecute physicians who currently violate Bill 94.

The Progressive Conservative Party has rejected any role for user fees in their reply to us. However, we note a contradiction between this, and Michael Harris' media remarks on the benefits of user fees. We are concerned that this vacillation may presage an unacceptable future endorsement of user fees by the PCP. Moreover, the PCP made no commitment at all on administrative charges, a form of extra-billing.

The New Democratic Party appears to be the only party consistently against user fees. They are also explicitly against administrative charges. They do note that in consultation with the medical profession they would be prepared to include some currently uninsured services within the schedule for billing. This closes the loopholes in Bill 94.

2) POVERTY AND ITS IMPACT ON HEALTH

Noting the many documented links between poverty and ill health, the MRG advocates significant poverty relief measures.

The Liberal Government has actually cut assistance to food banks. It has, moreover, not made any commitment to increasing the level of the minimum wage.

The Progressive Conservative Party would reverse the cuts in the food bank programme. They make no commitment on minimum wages.

The New Democratic Party would also reverse the cuts to the food banks. But in addition they would enhance the current minimum wage.

Question to Parties:

The MRG asked the three major political in the Ontario elections to respond to the following questions:

1) Of the proposals made by the Lowy Commission, which do you intend to implement and how?
2) Do you perceive the hospitals' responses to rigid enforcement of budget ceilings is satisfactory? If you perceive problems, how do you plan to deal with them?
3) Do you perceive a problem with physician administrative changes to patients? If so, how do you plan to deal with these problems?
4) What do you think are the health implications of the 1986 Social Assistance Review Committee observations of an increasing dependency upon food banks in Ontario? If there are concerns, what concrete steps to you propose?
5) What is your attitude toward increasing reliance on user fees to finance health care spending?
6) What are your plans for dealing with womens' access to abortion?

Liberal Party response

Unfortunately the Liberal Party of Ontario, despite repeated pleas and prolonged extension of the deadline, was unable to return the questionnaire prior to our print deadline. We will put the Liberal response in the next newsletter should we receive it.

Questionnaire Responses from Progressive Conservative and New Democratic parties

1) Of the proposals made by the Lowy Commission, which do you intend to implement and how?

Answer:

Progressive Conservatives: The PC party is pleased that the Report of the Pharmaceutical Inquiry of Ontario has finally been released. We are currently in the process of reviewing the recommendations. A PC government would improve the continuing education of physicians with respect to the use of new drug products, promote greater use of the knowledge and skills of pharmacists, improve the packaging, labelling and dispensing of prescription drugs and attempt to implement other recommendations designed to improve the quality of treatment involving prescription drugs.

New Democrats: New Democrats would implement some of the Lowry Commission proposals to cut the costs of drug prescriptions such as: 1) limiting the drugs on the formulary to cheaper, generic brands 2) eliminating drugs from the formulary which have not proven effective and/or may put users at risk for negative side effects and 3) greater government regulation of the prices of drugs listed on the formulary.

New Democrats are concerned that doctors over-prescribe. We strongly object to prescription drugs being used to treat victims of social or economic injustices (e.g. tranquilizers for battered women who lack the resources to leave a violent partner). We support the Lowry proposal to reduce and regulate drug prescriptions through better (i.e., more extensive and more critical) education in medical schools.

Much of the over-prescribing occurs because the medical profession depends on the drug industry for research and prescription information. The Lowry Inquiry does not, in our opinion, effectively address the problems of that relationship.

Finally, while we support efforts to reduce drug utilization, we are opposed to recommendations to charge seniors for their drug prescriptions (to a maximum of $250 per year), and we support the extension of the government drug plan to cover prescriptions for the chronically ill and low-income earners who do not have employer-sponsored drug benefit plans.

2) Do you perceive the hospitals' responses to rigid enforcement of budget ceilings is satisfactory? If you perceive problems, how do you plan to deal with them?

Answer:

Progressive Conservatives: The PC party understands why hospitals are upset with the current state of financing. They are experiencing great difficulty in meeting demands for patient care because of limited resources and increased government imposed costs such as pay equity and the payroll tax, which are going to cost hospitals almost $100 million this year alone. The PC government would not reduce hospital services until alternate support systems are available in the community. A PC government would also ensure that hospitals are involved in the move towards community care.

New Democrats: Hospitals are in a difficult position since the Liberals haven not provided direction on making budget cuts. New Democrats believe that the provincial government must establish priorities for hospital spending. We favour greater control over spending on new technology, which can be extremely expensive but not necessarily effective in saving lives or improving the quality of people's lives. The provincial government must also ensure adequate funding for provincial initiatives such as pay equity and the Employer Health Tax.

New Democrats also recognize the importance of local decision-making in setting hospital objectives. To date there has not been adequate representation of local community members and hospital staff in the decision-making process at the Board level.

3) Do you perceive a problem with physician administrative charges to patients? If so, how do you plan to deal with these problems?

Answer:

Progressive Conservatives: It would depend how great the charges are and what they are for.

New Democrats: Yes, these charges are unnecessary and attack the principle of universal accessibility to medical care. The New Democrats would prohibit their use. If necessary, after consultation with the profession, we would consider including some currently uninsured services in the schedule of approved charges.

4) What do you think are the health implications of an increasing dependency upon food banks? What step would you take?

Answer:

Progressive Conservatives: The PC party is very concerned with the dependency upon food banks in Ontario. We know that at least 25,000 children rely on them. The Peterson decision to end the $1.4 million Emergency Shelter and Assistance Program that funds food

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, Cathy Crowe, Bob Frankford, Ulli Diemer.

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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.

banks was premature. We believe that the benefits of SARC, to society as a whole and to our fellow citizens trapped in the poverty cycle, depend on the implementation of the structural reforms recommended in Transitions.

New Democrats: In Ontario, 10 percent of families live in poverty, and 60 percent of these families are headed by full-time workers. The Liberals' response to poverty is the elimination of $600,000 for food assistance programs and a minimum wage that brings misery.

New Democrats know that children in low-income families have higher rates of chronic illness. Poverty in Ontario is a major determinant of health. New Democrats believe that policies addressing poverty are a major step toward better health for Ontarians. An NDP government would introduce policies such as affordable housing, an adequate minimum wage, accessible child care, and serious reform of social assistance. These initiatives are detailed in our platform document, "An Agenda for People," which is appended.

5) What is your attitude toward increasing reliance on user fees to finance health care spending?

Answer:

Progressive Conservatives: The Progressive Conservative Party believes that, under the Canada Health Act, there is no place for user fees or co-payments for essential insured health services in Ontario. User fees or co-payments are not new. The current Liberal government expects to collect $180 million for non-medical services from those who can afford it. And, 7% of all hospital budgets now include revenue from co-payment fees.

New Democrats: New Democrat are the only party opposed to an increased reliance on user fees to fund the health system. The liberals' recently announced long-term care strategy contains an alarming reliance on user fees for "non health care services." We do not believe this distinction is sincere, and reject user fees in principle.

6) What are your plans for dealing with women's access to abortion?

Answer:

Progressive Conservatives: The Canadian Abortion Law was passed by the Federal Parliament. It is the responsibility of Provincial governments to uphold and enforce federal laws. The Ontario Progressive Conservative Party does not condone doctors or clinics which operate outside the law. It is the responsibility of the provincial government to make health services equally accessible to all citizens of the province. According to the Federal Legislation, the decision on whether a therapeutic abortion is necessary must be made by the woman and her doctor.

New Democrats: New Democrats are proud of our policy which supports women's right to choice on abortion. We know that for women to truly have choice on abortion there must be access to abortion services as well as to birth control information and services. New Democrats support the creation of community health clinics which would provide abortion services as well as other women's health services which do not require hospital settings.

Agenda

MRG General Meeting
Saturday October 13
South Riverdale C.H.C.
126 Pape Ave., Toronto

9-11	**Business**
11	**Coffee**
11:15	**Introductory Comments The HUB Model of Primary Care**
11:30	**Explanation of HUB Model of Primary Care**
12:00	**Question & Answer about HUB Model**
12:30	**Lunch**
1:30	**Small Groups Discussion The HUB Model and the democratisation of care How does my practice fit into the HUB Model? Implementation – is the HUB model just another bureaucracy?**
3:00	**Plenary**
4:00	**Adjournament**

Primary Care

The Primary Care Working Group has worked to try and bring together some of the issues that the MRG dealt with at a General Meeting about two years ago.

You will remember that we, at that time, looked at several issues around: the well-being of physicians; the scope of research and practice; and the relationship with the community.

Over the past several weeks, we have met to design a model of primary care which would take into account several principles:

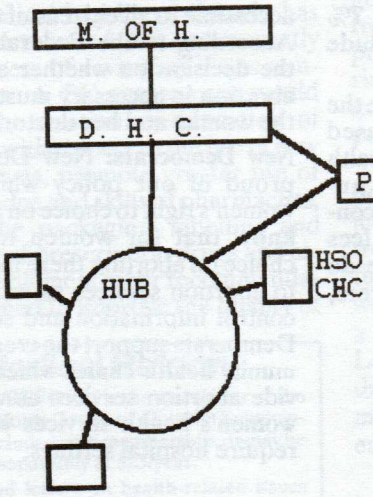
1. Health care providers' job satisfaction – whether they work in HSOs, CHCs, fee-for-service.
2. To integrate a range of health care providers for the purposes of sharing information.
   a) allow for the integration of different types of health care providers into a team approach
   b) ensure that health care is delivered according to the best use of existing knowledge and providing a network for the delivery of CME.
   c) pool population data for the purpose of health research and audit; as well as identifying and planning for community health needs.
3. To work towards the goal of higher standards of health care.

Since a very large percentage of people in the community visit their family doctors over a two or three year period, primary care physicians are in the best possible position to provide this research.

Some of the working papers that we have produced along the way have been published in the April newsletter. We would encourage you to read them. As well, we are presenting here a model of how we think that primary care could be organized to promote the joint concept of research/health promotion, along with service provision.

We think that our model will also help with the politicization and development of local democracy, by providing a focus for the community in looking out for its health care needs.

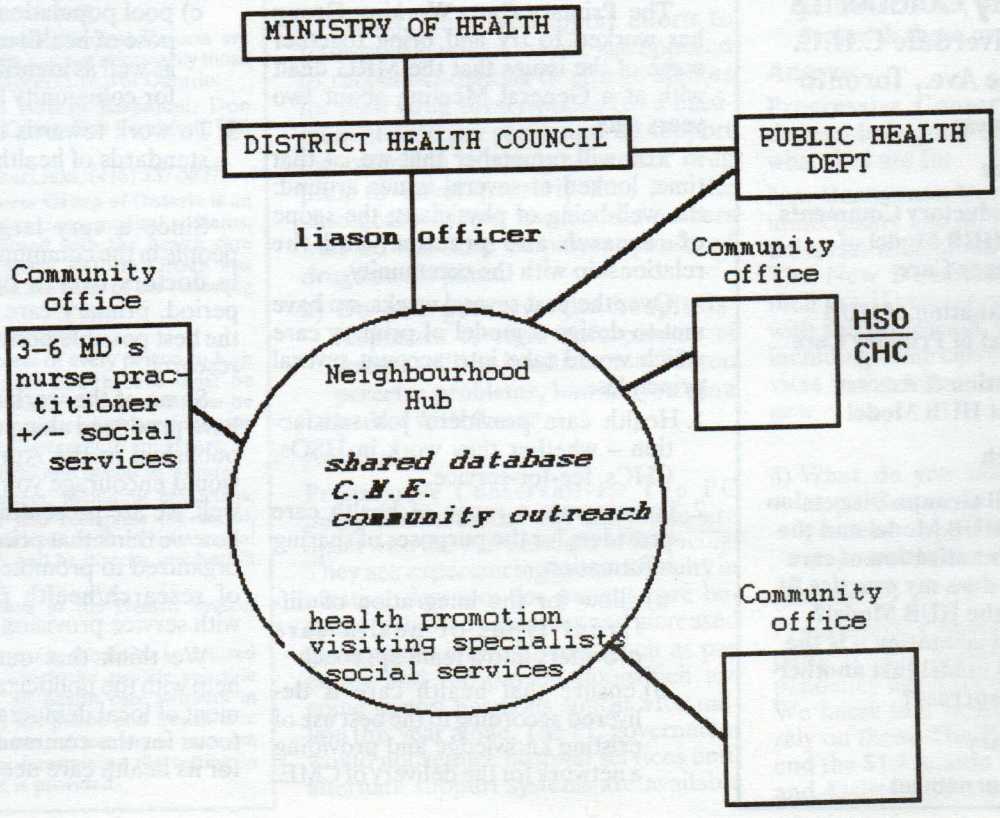
NOTES:
...the HUB becomes a focal point for community action around health issues and as such politizes both community and health
...the HUB also becomes the focal point for standars of health care thru C.M.E. and the role of the liason officer (L.O.)
...the L.O. is crucial in tying the pieces of the puzzle and works with the community, DHC, HUB, offices



SOME ISSUES OUTSTANDING:

1. public (democratic) input..how and when
   --DHC (schoolboard-like elections)
   --neighbourhood hub levels (community advisory boards)

2. how to encourage G.P.'s to join
   --benefits packages
   --C.M.E
   --administrative support (via liason officer)



Steering Committee Report August 1990

Steering Committee Membership:

Bob James stepped down from the Steering Committee in April. Thanks to him for his time and energy. His input will be missed. Gord Guyatt began a new tenure on the Committee in June. Haresh Kirpalani, Don Woodside, Mimi Divinsky, Rosanne Pellizzari, Bob Frankford and Andy Oxman continue to serve on the Committee. Haresh stepped down as chairperson in July after serving energetically over the past year. He was replaced by Mimi and Rosanne who will co-chair the Committee.

The Steering Committee continues to operate in a deficit of time and energy. **We need new Steering Committee members!** Volunteers would be welcome. Although the organization is doing well in terms of our financial status and membership, the reluctance of members to serve on the Steering Committee is threatening the viability of the MRG.

Newsletter:

Don Woodside resigned from the editorial board in July. His help has been appreciated, as has that of Ulli Diemer. Haresh Kirpalani will continue to edit the newsletter, but is in need of assistance. He was given a resounding vote of confidence by the Steering Committee, and strongly encouraged to continue editing the newsletter. Gord Guyatt and Andy Oxman both volunteered to assist by editing one newsletter per year. **Additional help is still needed!**

Local Chapters:

The Hamilton chapter has organized a couple of student meetings, with a turn-out of around 80 students. Phillippa Tattersall is coordinating the Hamilton chapter. Both the Hamilton and Toronto chapters are planning to hold meetings for the new medical students in September during orientation week. Mimi and Haresh are organizing activities in Toronto. **Someone is needed to coordinate a local chapter in Toronto!**

Media:

Mimi Divinsky, as Media Coordinator, continues to get calls regarding the MRG's position on a variety of issues. Calls directed to the MRG have also been coming to other people, including Don Woodside, Bob James, Bob Frankford, Joel Lexchin, Philip Berger and Michael Rachlis. Mimi has attempted to take a more active approach with the press; particularly at the time of the OMA Board meeting and the OMA conference in June. These events, as it turned out, were drowned in Meech Lake, and there was limited interest in what the MRG had to say. At its July meeting, the Steering Committee discussed ways of revitalizing the MRG's public image. It was agreed that subsequent to the Spring General Meeting the Steering Committee had a clear directive to speak out, that there are ample issues that we are prepared to address, and that there are ample opportunities to which we might respond and put forward our positions. However, it was concluded that until an issue like extra billing hits again, our ability to raise our profile in the media is limited by the shortage of time and energy of the Steering Committee.

Resolutions Booklet:

Ulli has done a great job editing all of the MRG's resolutions and the constitution. These can now be printed in an attractive format and should be available at the next General Meeting.

Incorporation:

Although we were told by our lawyer that the MRG's incorporation was near completion, it has been delayed for several months. The cause of the delay is not clear. It was agreed that we want to proceed with the incorporation with the same lawyer, but if we are not able to get any action from him, we will go to another lawyer and have it done.

Meeting with OMA:

A Special General Meeting of the MRG was held June 13 with Ted Boadway, Director of the Department of Health Policy of the OMA, and Carole Guzman, the out-going president of the OMA. There was an open and lively discussion of the OMA's negotiations with the Ministry of Health for binding arbitration and representation rights, and of the possibility of the MRG becoming a faction within the OMA if they are successful; that is if all physicians in Ontario are required to pay OMA dues. Although we already have policies in support of binding arbitration and the current shift in OMA policy is consistent with positions we have advocated for nearly ten years, there were mixed reactions among those present at the meeting regarding the options the MRG has if the OMA wins binding arbitration and mandatory dues.

National Health Insurance in the U.S.:

As the movement for national health insurance in the U.S. grows the U.S. is looking more and more at the Canadian health care system and the MRG is being asked increasingly to express its views in various forums. The Steering Committee has indicated its support for Physicians for National Health Program who periodically refer people to us for comments; particularly following the AMA's campaign to slander the Canadian health care system. The Democratic Socialists of America are organizing a speaking tour of up to 15 U.S. cities as part of a campaign to press for changes in the U.S. health care system, and have asked for people from the MRG to speak on this tour. Haresh, Miriam Garfinkle, Fred Freedman, Philip Berger and Michele Harding spoke at a forum organized as part of a meeting of Pugh Foundation fellows held in Toronto in May. Gord Guyatt and Michael Rachlis also spoke at the meeting. Both Gord and Andy Oxman will be travelling to the U.S. to speak to audiences there about the Canadian health care system, and Gord, Andy and Don Woodside had a letter published in the New England Journal of Medicine (June 7; 322:1675-6). The letter was written on behalf of the MRG in response to an article by Adam Linton of the OMA (322:197-9).

CMAJ Article:

An article about the MRG was published in the June 1 issue of the Canadian Medical Association Journal (142:1311-2). A letter to the CMAJ was sent in response by Don Woodside, Andy Oxman, Philip Berger and Haresh Kirpalani on behalf of the MRG.

Andy Oxman

MRGers meet with Ontario Medical Association representatives

In the wake of reports that the provincial goverment might accept the "Rand formula" – which would give the Ontario Medical Association the right to represent all doctors in the province in fee negotiations, together with the right to collect membership fees from all doctors – the Medical Reform Group's Steering Committee arranged a meeting on June 13 between MRG members and OMA representatives to hear the OMA's position on these issues.

Present representing the OMA were Basil Johnson, the newly elected OMA president, and Ted Boadway, the OMA's Director of Health Policy.

Basil Johnson said that the OMA has deferred its court challenges to the Canada Health Act and to Ontario's Bill 94 pending the implementation of fair and independent binding arbitration. He said that the court actions had come to be seen as a roadblock to dealing with other issues. He said that the OMA recognizes that while physicians are major players in the delivery of health care, they are still only one of the players. But they do want to have their role recognized.

Dr. Johnson explained that what the OMA is seeking is tripartite binding arbitration which could only be overturned by an Act of the full legislature, rather than just by an Order-in-Council. (Order-in-Council means that the cabinet can act without having to submit its actions to the legislature.)

In return for receiving the right to this form of arbitration, the OMA would not advocate strike action.

Ted Boadway said that progress had definitely been made in the OMA's negotiations with the government. When they sat down to talk 18 months ago, it would have been hard to find two parties who trusted each other less. But now they have found considerable commonality. One thing that is being looked at is the concept of a Conjoint Medical Services Committee (CMS), a joint committee of the medical profession and the government, to look at some of the big issues in health care.

Dr. Boadway stressed that in the OMA's view one of the most important priorities was to find a non-fractious method of dispute resolution in fee negotiations. The government has proposed a method of dispute resolution but is isn't acceptable to the OMA. The government has refused to even discuss the Rand formula. Since October 10, the government has been intransigent about dispute resolution. Still, Dr. Boadway said that he is optimistic that a deal acceptable to the OMA can eventually be agreed on.

Dr. Boadway made some comments about the question of factions within the OMA. He said that on most issues, opinions within the OMA 'span the spectrum'. Most differences of opinion are relatively civilized, and don't usually end up with permanent factions being formed.

He noted that there are a number of different 'sections' within the OMA, many of them based on medical speciality, e.g. psychiatrists or HSO physicians. The Independent Physicians (the "rabid extra-billers") operate as a group within the OMA but have not been formally recognized as a section.

Dr. Boadway said that the staff make sure that people are heard and facilitate them being heard.

Question and discussion period:

Ted Boadway said that the government is resisting the Rand formula because it is not in its interests. The government is actively working to split groups of doctors off from the OMA. It is approaching other groups, such as the clinical teachers, and asking them to bargain separately. Dr. Boadway characterized this as "busting the union". Asked what doctors don't want to join the OMA, Dr. Boadway said that the largest group is the anti-abortionists. He also said that a certain number of people are simply non-joiners.

Philip Berger said that he supported the OMA's three demands of Rand formula, binding arbitration, and representation rights. He said that a problem with the OMA is that there is no way for the membership to vote and ratify agreements the way members of other unions do.

Basil Johnson said that the problem with approving agreements by referendum is how do you phrase the question? He felt that the OMA's council structure, a parliamentary setup, is very democratic. **Ted Boadway** added that the OMA is the only provincial medical association to have a representative house. 250 members sit on council. When referendums have been proposed in the past, such proposals have not garned even 10 per cent support in the council.

He saw the key problem as being that the government is not recognizing the OMA as the sole bargaining agent, but is instead trying to do separate deals with separate groups of doctors. The OMA does provide the infrastructure for other groups of doctors; however, the OMA has been entirely cut out of the Sick Kids negotiations.

Basil Johnson said that factions do have independence within the OMA. What happened is that in 1986 the militant right seized the agenda.

Ted Boadway said that facilities are made available to the sections according to a rote formula. The duty of factions is to establish their own agenda. To establish a section, approval from Council is required. He thought that Physicians for Life probably would not get that approval. There is no guarantee that a section will be recognized.

At this point, Joel Lexchin read a fax message which he had received from **Barb Lent** in London, who was unable to attend the meeting in person. She said that she worked on the OMA's Wife Abuse Committee, and that she had rejoined the OMA so that she could belong to that committee. She found the work on that committee a positive experience, and she said that if were are going to have to pay OMA dues, then maybe would should play a more active role in the OMA.

Joel Lexchin wondered whether the OMA has really shifted or is it just going with the political wind. What happens if the Tories under Mike Harris get into office and push for private money to be allowed into the public system?

Basil Johnson said that he is not sure that in the long run single source of

money for the health system will suffice. He used the words of former U.S. President Lyndon Johnson to explain why he wanted MRG members to join the OMA "We'd rather have you inside the tent pissing out than outside pissing in."

Ted Boadway said that we need to have a public process for making resource allocation decisions. For OMA committees, there are often a couple of hundred volunteers for half a dozen spots.

Don Woodside said that he hadn't heard of any mechanism by which this group (the MRG) could have a say in policy formation.

Ted Boadway said that position papers would get heard although not necessarily adopted.

Don Woodside said that if the input is not welcome, then you may not get heard.

Ted Boadway said that nobody gets a guarantee that they will get heard or that they will get their hands on policy. On the issue of maintaining an organization outside the OMA as well as a section within the OMA, he said that the orthopedic physicians and the psychiatric hospital doctors both have their own associations which are outside the OMA, as well as sections within the OMA. There is probably a ninety per cent overlap in memberships between the outside group and the inside group and they tend to have the same officers for both the inside and the outside body. However, the psychiatric doctors also have some professional members who are not MDs; in fact, the next president of the group will be a dentist, while the vice-president, a physician, will be the president of the OMA section. The opthamologists section placed a special levy on their membership to pay for staff for themselves.

Responding to question of who presently does not belong to the OMA (about 20% of doctors don't belong), **Basil Johnson** said that the OMA leadership is trying to figure that out. There sense is that many of those who see no advantage in belonging. Some people are simply non-joiners.

Ted Boadway said that the big attraction of the Rand formula to the OMA is that it will stop OMA-busting rather than the financial benefits that it will bring.

Responding to a question about what the OMA means by representation rights (one of the concessions it is seeking from the government), **Basil Johnson** said that the OMA does not want to inflict itself on those who don't want to be represented, but that it wants to be able to represent any group that wants to be whether the government likes it or not. For example, in the laboratory physician's negotiations, the government refused to meet if the OMA was in the same room.

At this point, Drs. Johnson and Boadway were thanked for attending,, and discussion continued after their departure.

Fred Freedman said that the OMA is a minefield that the MRG should stay away from. He was concerned that people seemed to be taking the idea of working within the OMA seriously, and wondered why it had been seen as urgent to call this meeting.

Joel Lexchin said that working in the OMA would drain off our energy. We would just get smothered on the important issues. For example, our brief on midwifery was diametrically opposed to that of the OMA. He is not opposed to individual MRG members being active in the OMA if they wish to do so.

Philip Berger said that the terrain is shifting and the OMA is shifting. He thought the Rand formula will come in eventually, and when it does it will be suddenly and unpredictably. We have to discuss our response in advance rather than wait for events to overtake us.

Fred Freedman said that we haven't been left behind by events, we are just trying to deal with more complex issues and that takes time. The MRG's role has been to speak to the public rather than to try to convert the profession.

Haresh Kirpalani said that there is no crisis, we're just gathering information. If we could pursue sectional status within the OMA, we might consider it. If a portion of our salaries goes to the OMA, we should look to see if we can get some value or influence for the money.

Philip Berger said that we can maintain the MRG and test out the OMA to see if we could form a section. We don't have to dissolve the MRG to explore that.

Debby Copes said that we weren't formed to speak to the public but rather to change things for the better by the most appropriate means. However, we should make sure that we don't lose the right or the ability to speak to the public.

Don Woodside said that he doesn't see any possibility of the MRG as a separate group folding up because possibilities within the OMA are clearly very limited.

Speaking up for the OMA

by Bob Frankford

As a Marxist (of the Groucho faction) I have generally not wished to join a club that would have me as a member. My wife was greatly relieved when we first met to find that I belonged to the Medical Reform Group and not the OMA. Now after three years in the OMA, I believe it is a useful organization for developing the health care system I want and value my involvement with it. What happened?

I have belonged to the MRG for several years, believing in its principles, in particular the principle that health care is a right. I was glad to be part of it when supporting the Canada Health Act which entrenches that right. It is hard to know to what extent our views were persuasive, but a coherent position of support from a group of physicians must have been helpful to the politicians.

About two years ago I was part of an MRG group that met with Elinor Caplan and Martin Barkin. Almost incidentally Philip Berger asked them when they would be abolishing OHIP premiums. Barkin agreed that it should happen and now in 1990 we have health care as a right and the means to fund it equably.

Now that these legislative changes have been achieved, I believe that there is a concurrence of the interests of the public and of organized medicine. The support of government for the actual content of health care has generally been half hearted and is now even less as the fiscal side of government increasing-

ly sets the agenda with its obsession with the legendary "spiralling" health costs.

We do not see teachers' unions lobbying to lower educational spending to reduce the deficit and there is no more reason why doctors should argue for blanket reduction in health spending. Of course there are a few within the OMA who argue for this lower spending in pursuit of their vestigial belief in private spending. In the long term they will be as influential as private tutors are in teachers' unions.

In my day to day practice I constantly identify resources that my patients could use but are not readily available. I have little confidence in the will of government to respond to me alone and feel the need for an organizational voice. A strong argument that the OMA makes is the need for equity of resources. Faced with the government's constant tendency to develop (or partly develop) proposals on a piecemeal basis in response to short sighted political pressures the OMA, even if responding to the needs of individual members, is promoting equal access and services across the province.

I want to see the MRG continue. I believe there is a role in continuing to think through the implications of a democratic, socialised system. I would also like to see MRGers participate in the OMA. I am not certain that they should for a separate section. Admittedly there is a Section of Independent Physicians for the reactionary extreme; I am not sure how one would define a section for another political group. (Current OMA members might actually wish to join the Independent Physicians for amusement and with a view to eventual takeover.)

Admittedly attendance at some meetings may expose one to intemperate right wing harangues. To maintain one's composure it is best to take a clinical attitude – go with a psychiatrist friend who will observe that these individuals are in the state of rage in Kubler-Ross' stages of grieving – for their lost ideology.

The OMA and the MRG

By Fred Freedman

I was asked to summarize some negative feelings about our "joining" the OMA as a means of focussing debate within the group. First I would like to state that I don't think the MRG should spend a lot of time on this issue at this time. It was clear to me from the meeting with the OMA officials in June that conscription into the OMA is not imminent. Therefore if we join them en masse it will be voluntarily.

If all physicians are conscripted under the Rand formula, then there are a number of creative ways in which we can address the situation, which I'm sure are fairly similar to the suggestions that will be made by whoever is writing the "opposing" viewpoint in this issue of *Medical Reform*. I will not address the issue of individual membership as I feel that is a personal decision of little consequence to the group.

I start by saying I am adamantly opposed to the MRG voluntarily giving up its independent existence in order to 'join' the OMA. The MRG is presently in a state of indecision as to direction and purpose. If we joined the OMA we would face stiff opposition and battles. It would be very dangerous to face those conflicts without a clear direction to guide us. The OMA is not a group of political neophytes.

I worry greatly that our energies would be entirely subsumed in internal battles within the OMA. While I know several members of the MRG smack their lips at the prospect of a face to face confrontation with "the enemy", I fear that there will be little time or energy left for the other good work we should be doing. I don't see any hope that we would not be totally absorbed by internal OMA politics for at least one year. Getting support staff from the OMA (which we would certainly like) itself would entail a tremendous political struggle to get ourselves recognized as a legitimate section. Certainly if we are not drafted but join voluntarily, we will not have the moral authority we now enjoy.

The last reason I find compelling is our original purpose as a group. We have two functions as a group. One is as a support for like-minded physicians. This function would not be in danger. Our second, and more important in recent years, is to act as a voice of reason between the "medical establishment" and the public. That is, to break down the myths of the medical system as promulgated by the OMA and often the Ministry of Health in a public forum (the press) so the public can attempt to make rational political decisions based on fact. I really think our mission is to address the public and not the medical profession. Although we can continue to recruit new members from within the profession, our future lies in our relationship with "the people" as a go-between. If we join the OMA I know we are going to end up talking to the profession and not the public.

If all physicians do get legislated into the OMA there is no question that the MRG should maintain an independent organization. There is general support for maintaining a separate fee structure as demonstrated by the latest survey of the group. Since the OMA fee schedule is so steep, we might have to scale ours down but we may be able to use some of the OMA resources if we can win sectional status. We could still function both as a support group and a research group. We could maintain an independent group outside the OMA for publicity purposes ... much as the Association of Independent Physicians did during the OMA strike even though they had sectional status.

Putting our energy into working within the OMA would spell the death of the organization as a group which directs itself to public education. It would be a betrayal of our history and progressive directions. It is, frankly, a waste of time and energy to discuss the matter at present!

MRG's Relationship to OMA

by Barbara Lent

When I learned of the MRG's meeting to discuss our relationship with the OMA{, I wanted to share my experience with the group. Although I have not attended an MRG meeting for the last couple of years, it is important for me to know that politically like-minded physicians continue to be thoughtful and outspoken on political and economic issues in health care.

For those who don't know me, I've worked as a family physician in London since 1979 and I've been a member of the MRG for 13 or 14 years. As well, I've been involved with the OMA Committee on Wife Abuse for the past 5 years.

In fact, I had to rejoin the OMA to do that work, having previously given up my membership because of their archaic economic views. But the wife abuse work was personally enriching and, I think, socially useful. We met with a variety of community people and developed our document as we wanted, using the extensive resources of the OMA. This included secretarial support, typing, xeroxing, arranging meetings, and providing space to meet. We were also reimbursed for our expenses and our time. Later, the document was disseminated by the OMA to both professional and media contacts. All this happened even though the views on women and violence in our society that were espoused in our document were clearly not held by many Board members. Nonetheless, It is helpful when speaking to other physicians and medical students to say our document has OMA{ Board approval.

With respect to the MRG, the question is, what are the political advantages for us both as individuals and as a group of joining the OMA{? Will we have more impact on the public, and/or more credibility with our colleagues, by working from outside the OMA or from within? At first I thought the wife abuse work was successful because we were so task-oriented and the MRG has more of a role raising political awareness of social and economic issues around health care, but on reflection I'm not sure about this division. Could the MRG's work on Resource Allocation or Primary Health Care have been done within an OMA committee? The personal, working relationships that develop working on a particular focused task go a long way to break down stereotypes about MRG members as "misguided, irrational, etc."

For a long time I looked askance at the OMA and its members. But physicians are looking at health care from a broader social context, and if we are all going to have to pay OMA{ dues, perhaps we should play a more active role in policy discussions and have others hear our viewpoint.

Letter on Administrative Fees

4 June, 1990

Dear Dr. W.

I received your letter concerning your new policy on fees for "noninsured services" sometime ago. Because of this change and with a great deal of regret, I have decided to seek a new family doctor and would like to take this opportunity to explain my reasons for doing so.

You have been my doctor for a number of years and, as I think you know, I have valued your attentiveness in explaining the health questions that have come up over that time and in interpreting information and advice from specialists to whom you have referred me. I have appreciated your warmth and concern. I have recommended you to friends and, all other things being equal, would never have considered looking for another doctor. My decision to do so feels the harder because – in the face of a possible chronic health problem – the continuity of your care and your familiarity to me are especially important.

However, I object strongly to your decision to charge patients fees over and above the amount you receive from the provincial government. I am not questioning your concerns about the amount you are reimbursed through OHIP and the conditions of your work – like most patients, I am not in an informed position to do so. I believe, rather, that those are matters for negotiation between your professional association and the Ontario government and for public debate – not costs to be passed on in an ongoing fashion, at your discretion, to patients.

Contrary to your assertion on the third page of your letter, I consider that deciding to introduce your occupational bargaining issues into the doctor-patient relationship is most definitely a political gesture. I think it is a political move in two senses that I would like to highlight.

1) Passing on costs to patients effectively undermines the central principle of the medical care system in Canada: that services are universal and free at the point of service. Your decision places conditions on patients' entitlement to services – conditions that disadvantage exactly those social groups (poor people, elderly people) who experience the most health problems. In unilaterally easing the problematic conditions of your work, the interests of the most vulnerable patients are jeopardized.
2) Your decision is also a political one at the level of interpersonal power relations. Doctors have expertise and knowledge that patients need; we know that doctor-patient relations are charged with a power imbalance. Despite being relatively well-equipped to negotiate such unequal encounters (in the sense that I am articulate, well-educated, white and English-speaking) this power imbalance inevitably shapes our exchanges. For example, at the time of the extra-billing debate when you had material in your waiting room soliciting patients' support for your position, I decided not to voice my objections because I judged that it was not in my interests to antagonize you. Similarly, I waited to send this letter and let you know my objections to your billing plan until I had made satisfactory arrangements with another doctor, feeling that – until I no longer depended on your care – it was not strategic to voice complaint.

I am not suggesting either ill-will on your part or a mistrustful nature on mine in raising these points. Rather, I think they illustrate at an individual level the dependence of patients and the control of doctors. If we recognize these structured inequities, your decision to introduce fees represents the exercise of your superior power – hardly an apolitical gesture.

The decisions of doctors like yourself and your colleagues to introduce fees and the experience of them of patients like me represent important ingredients in the ongoing debate about access to health care in Ontario. As such, I think it is crucial that they not be left in the domain of private discretionary practices that, in a cumulative way, erode the basis of entitlement to health care in the province. I am, therefore, sending copies of this letter and your announcement to a number of relevant governmental and political bodies in the hope that your concerns and mine will find their way onto the public agenda.

Sincerely,

Jane Aronson

What the American Medical Press is Saying: Recent News from the NEJM

It is of interest to MRG members to know what is happening in American medicine, and how opinion leaders among American physicians are reacting. Periodically, I have taken on the task of summarizing papers from the New England Journal of Medicine for Medical Reform. This is the latest such report.
-Gord Guyatt

Levey S, Hill J.
National Health Insurance – The Triumph of Equivocation.
N Engl J Med 1989;321:1750-1753.

These authors express scepticism about the possibility that any sort of national health insurance will ever come to the United States. They cite a number of factors which have prevented national health insurance from taking hold in the past, and which are likely to continue to do so. These include resistance from special interest groups, particularly the medical profession and the insurance industry. They note that the rallying call for these groups has been resistance to "socialized medicine" and that their objections have been framed in what the authors call "the persuasive language of ideological conflict."

A second factor cited by the authors is the extent to which consumers are insulated from the effect of cost by third-part payers. These include those who are insured as part of collective bargaining agreements with large employers. The prospect of tax increases to finance a national health program is likely to meet with major resistance from these people (and from others).

A third factor is that any plans that have been suggested have met with specific criticism. Potential flaws in Employer-based plans include gaps in coverage, loss of jobs and wages, and fuelling of higher expenses for health care. Consumer-choice plans are thought to restrict patient's choices, pose a danger of underservice, and interfere in the decision making of the physician. The criticisms of a system based on the Canadian model are more ideological: it is thought that a complete government takeover of health care would be far too radical, and would not be able to withstand fears about the inefficiency of big government.

The authors conclusion is that "Americans lack the necessary level of discontent with our health care system, agreement on a widely endorsed program of universal health insurance, and the political stamina to drive legislation through Congress." Sadly, I find their argument compelling.

Welch HG.
Health care tickets for the uninsured. First class, coach, or standby?
N Engl J Med 1989; 321:1261-1264.

I found this a disturbing article, reflecting just how distorted is the American perception of the world. It is written by an author who presents himself as an advocate of those whose access to health care is currently inadequate. He argues that those who advocate first class health care for all are simply being unrealistic. He lauds the approach taken by the state of Oregon, which decided to forgo funding of organ transplantation in favour of expanding Medicaid to include more people. Oregon has subsequently ranked medical procedures with a view to making available without cost only the higher ranked procedures. While I would be comfortable with exclusion of some of the lowest ranked procedures: infertility services and plastic surgery, I would not be comfortable with the exclusion of others: routine dental care for adults, programs for eating disorders, and most organ transplantation. I would be even more uncomfortable with exclusion of the middle rung of procedures: podiatry, alcohol and drug rehabilitation, hip replacements, speech therapy, and hearing examination.

The author explicitly states that the United States, the richest country in the world, cannot afford first class health care for all. As the Canadian system has shown, this is nonsense. The author falls into the trap which has lured a number of progressive analysts; he accepts the assumption that the choice is between effective medical procedures and other social expenditures: "Are we sure that annual mammography is more important than a Head Start program?" he asks. The first question should be the effectiveness of the procedures (as it turns out, mammography saves lives and what the Head Start program accomplishes is unknown, at least to me). Unless progressive thinkers frame the choices in the broadest social perspective (mammography versus nuclear submarines, enhanced corporate profits, or mansions in Rosedale and vacations in the Alps) they will be playing into the hands of Thatcherites who wish to restrict spending on both medical care and social programs for those who do not have private funds to pay.

Grumet GW.
Health care rationing through inconvenience. The third party's secret weapon.
N Engl J Med 1989; 321:607-611.

I include some quotes from this paper only to emphasize, once again, what a disaster the American medical system has become. The author's thesis is that third parties have placed so many obstructions in the way of those attempting to obtain reimbursement for services that it is effectively deterring provision of care. The author states that "each visit to a physician's office is estimated to generate 10 pieces of paper." He describes the third party payers as "slowing and controlling the use of services and payment for services by impeding, inconveniencing, and confusing providers and consumers alike." He describes how the physician's autonomy has been eroded by "a managerial-review process in which armies of claims clerks, administrators, auditors, form processors, peer reviewers, functionaries, and technocrats of every description insinuate themselves into a complex system that authorizes, delivers, and pays for medical service."

A particularly devastating example of the results is described as follows. "A potentially lethal form of delay is observed among some HMOs who warn their patients that they must obtain authorization before using an emergency department or ambulance, unless the situation is life-threatening, or the bill will not be paid. This places patients in the predicament of having to decide whether or not they are dying. Three critically ill patients in Milwaukee nearly lost their lives because of the delays of HMO triage, which circumvented the highly effective emergency medical system of that city."

The author's conclusion is that "American health care is now controlled haphazardly and is financed by multiple cumbersome, poorly integrated bureaucracies in desperate need of coordination, simplification and streamlining." Given Levey and Hill's well-placed scepticism concerning the likelihood of a national health plan (which would provide the streamlining that Grumet is calling for) coming to pass, the nightmare that is current American medicine is likely to continue for some time yet.

Gord Guyatt

Book Review

Cross-Cultural Caring: A Handbook for Health Professionals in Western Canada

Edited by Nancy Waxler-Morrison, Joan Anderson, Elizabeth Richardson

Canada, with her history of basic political stability and good economic growth, has increasingly been the choice for relocation whether due to family, economic or political reasons. As a result, the variety of ethnic backgrounds has been rapidly multiplying over the past few decades. New immigrants bring with them a wealth of different practices and beliefs, including those that apply to health care. These may well be unknown to those providing their care and result in misunderstanding and non-compliance with treatment. The purpose of this excellent book is to increase the cultural awareness and sensitivity of health care workers by providing some basic information about various cultural groups.

The editors have chosen to highlight eight different cultural groups that are settling in Western Canada; the Vietnamese, South and Southeast Asians, Chinese, Japanese, Central Americans, West Indians and Iranians. These were chosen not because of their size or newness on the scene, rather because their members have reported difficulties with the system or have been described by health care workers as a group with which it is difficult to work. The authors are all members of the cultural group that they are describing as well as being professionals within the health care and social service system. The chapters were then reviewed by other members of the same culture in order to ensure greater accuracy.

Each chapter begins with a brief history of the country, and then presents information regarding the languages, major religions and food preferences. A good deal of information is then provided regarding the family: the beliefs and customs of marriage, family planning, pregnancy and birth, childrearing and the elderly. Traditional beliefs and practices of health care are discussed as well as the relationship between the patient and the professional, mental illness and death. A brief but valuable bibliography is found at the end of each chapter.

The editors noted that all the ethnic groups appeared to have common problems related to their immigration and resettling here in Canada. In the final chapter these were summarized and practical guidelines then offered that will assist the cinician in his or her assessment. Throughout this chapter and indeed each chapter is stressed the fact that this is general information and that each person is very individual. One's beliefs and customs will be influenced greatly by his socio-economic standing, his place of origin within the country, i.e. urban or rural, age and length of time within Canada etc. and it is important to obtain this information from the client rather than to generalize.

Cross Cultural Caring is an excellent reference book for those providing care to ethnic patients, whether one is located in Western Canada or anywhere in Canada where people from these cultures have chosen to live. It offers important basic information that will form the framework for the clinician to build upon with each individual patient in order to provide culturally sensitive health care.

By Sue Inwood

Letter on Community Care

Dear Mr. Kirpalani

Although the recent review by you and Oxman dealt primarily with resource allocation, your statements relating to community care versus hospital care and health service organizations (HSO)/community health centres (CHC) versus fee for service settings require further comment (Medical Reform Newsletter, Vol 10, No. 2 July 1990, p.5).

Regarding community health care versus hospital care, you indicate that the available evidence suggests that high quality community based care is not less expensive than hospital care. However, there is evidence from the extensive U.S. HMO literature, well summarized by Luft (1), that prepaid group practice (PPGP) model HMOs have 10% to 40% lower costs than conventional care models and the reduction in cost is due to lower hospitalization rates. Further their quality of care is at least as good and perhaps better than the more hospital intensive fee for service models (1).

You then cite the work of Abelson and Lomas (CMAJ 1990: 142: 575-581) as evidence that preventive approaches by HSO and CHCs are not, in general, significantly more applied than in fee-for-service settings. In the United States, PPGP HMOs do offer more preventive services than fee for service practice (1). Recently we have confirmed this finding for Ontario HSOs and CHCs (2). Our methods differed from those of Abelson and Lomas, in that we compared preventive services in HSOs/CHCs with preventive services in Ontario fee-for-service group practices. We found that HSOs and Chcs were significantly more likely to have recall systems for immunizations (63% vs 13%: p<.01) and for pap tests (64% vs 30%: p<.05). However, neither HSOs/CHCs or FFS group practice had much formal peer review (13%), although 50% of both required refresher courses and 30% had in-house programs of continuing education (2).

The development of alternate methods of organizing and paying for health care services is long overdue in Ontario. The Medical Reform Group has always taken the lead in supporting such innovations. Only with the more extensive implementation of new methods will we learn whether any components of the U.S. experience can be transported to Canada.

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Sincerely yours,
Eugene Vayda, Professor

The Medical Reform Group searches for a purpose

By Lynne Cohen

Editor's Note: The following are excerpts from an article about the Medical Reform Group which appeared in the Canadian Medical Association Journal, 1990: 142 (11). A response sent to the CMAJ from several MRG members follows the excerpt.

"Is there life after Bill 94?" That is Dr. Don Woodside's response to a question about the future of the Medical Reform Group of Ontario (MRG), which today comprises approximately 200 physicians. The small group – Ontario has about 19,000 doctors – gained a media profile beyond its size in 1986 when it loudly opposed the Ontario Medical Association's (OMA) fight against Bill 94, which banned extra-billing.

Today, the Hamilton psychiatrist believes the Medical Reform Group will survive, but like many members he is not sure what form it will take.

Founded... to provide physicians with a forum outside the ones offered by the medical establishment – the OMA and the CMA, for instance – the MRG found that its opposition to extra-billing was a powerful drawing card during the OMA's 1986 showdown with the provincial government: "It was the immediately precipitating issue", says Dr. Philip Berger, a founding member. "We were adamantly and unequivocably opposed to it, to hospital user fees, to OHIP premiums." Now that these three matters are virtually non-issues, what does the group do for an encore? Berger admits it is having trouble finding a focus. "It's an existential crisis", he says, "one of direction."

There is also internal strife. Dr. Ralph Sutherland, an MRG member from Ottawa, complains about the group's increasing membership dues, which have reached $200 annually *[Editor's note: actually the maximum fee is $175]*, and its newsletter. "Three-quarters of the material is irrelevant to what we're trying to do", Sutherland maintains, saying that the newsletter often reprints articles from Toronto newspapers and "is not worth what it costs".

"It's also a series of little articles published simply because someone [in the MRG] wrote them. I could get published every issue, but I don't like talking to the converted....

However, Sutherland, who teaches administration at the University of Ottawa, is more concerned about the MRG's lack of focus than with the newsletter and annual fee. "[They all go] around on their own, with the group's consent, talking about issues that are in their individual areas of interest. But I don't think that's the way it ought to operate."

He is also upset because he feels some issues are not handled in a professional manner. "I was at a meeting where members discussed for 2 or 3 hours whether they were for or against malpractice insurance. They all had opinions but they didn't understand what they were talking about."

Sutherland is worried that this kind of rambling, uninformed discussion will affect the group's credibility....

What the MRG really needs, [Woodside] says, is an issue that will attract the attention of both group members and the media the way extra-billing did: "We're having difficulty finding a direction that would be as compelling to the public as it is to us."

"The group was the media darling for sure", says Dr. David Peachey, the OMA's director of professional affairs. However, he says things have changed. For instance, while being interviewed for this article he said he had not heard the group's name mentioned for a year. "The press was looking for a disparate opinion", he says of the group's high profile in 1986, "and it got it from the MRG. For its size, the group got disproportionate press coverage."

"This doesn't mean I put down the opinions expressed. They were really important."

Although still licking its wounds after losing the battle to defend the right to extra-bill, the OMA is somewhat magnanimous about the role played by the MRG. "The group raised topics that were very worthy of debate", says Peachey. "I fully think that the profession is strongest when many ideas are being expressed."

Addressing specific issues, however, evokes the deep animosity between the two organizations. "We got so much press coverage because we researched our arguments and we made sense", says Berger. We represented the interests of the public and not the vested economic interests of our members the way the OMA did."...

As for possible directions for the MRG, Woodside, who joined the group's steering committee about 6 years ago, says it might focus on an issue such as technology assessment, or the potential for private funding of health care institutions, which it opposes, or resource allocation.

Sutherland believes the Medical Reform Group has to focus on a medical issue such as, "How should [doctors] be evaluated?" Or, "What is the role of government in affecting the decision-making of doctors?" Or, "What are the methods of payment that promote the most broadly based and efficient kinds of care?"

There is obviously no shortage of potential topics, but finding one to concentrate on in going to be both difficult and the key to the MRG's survival.

"It will die if it doesn't stop functioning like a series of little groups, each with its own mandate, says Sutherland. "If it doesn't change, I'll leave."

Letter to CMA Journal: Our principles are still a beacon

June 18, 1990

Editor, Canadian Medical Association Journal

Dear Dr. Squires:

While the Medical Reform Group (MRG) of Ontario has experienced the dilemma of finding an issue as rivetting as Bill 94 (banning extra-billing in Ontario), we are not without a purpose as suggested in the article about us in the June 1 issue of the CMAJ. Our principles are as much a beacon to us today as when they were set to paper in 1979: 1. 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 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 health care system should be structured in a manner in which the equally valuable contribution of all health care workers is recognized. Both the public and health care workers should have a direct say in resource allocation and in determining the setting in which health care is provided.

Since 1986, when the fight over Bill 94 was won, we have presented briefs on a number of issues consistent with our founding principles. We were influential in our support of midwifery before the Ontario Task Force; opposed the Patent Act at the Senate committee hearings; have had continuous involvement in the Health Professions Legislation Review in Ontario; and have supported freestanding, publicly funded abortion clinics – to name a few areas where we have been active. Our concerns brought out at the Lowy Commission about pharmaceutical advertising are reflected in the College of Physicians and Surgeons of Ontario's investigation into the relations between doctors and the drug industry.

Currently, cutbacks in federal transfer payments, the potential of the free trade agreement to open the Canadian market to U.S. for profit health care companies, and the tremendous pressure put on provincial governments to contain health care costs under the free trade agreement contribute towards creating a political and economic climate in which support for user fees might wax again, not where private insurance companies could erode universal access to health care and result in a two tier system.

We applaud the Ontario Medical Association's (OMA) decision to drop their legal challenges to Bill 94 and the Canada Health Act, as well as the OMA's efforts to secure binding arbitration. These new directions that the OMA has taken are consistent with positions that could be found in our newsletter in the early 1980's. Those who want to stay ahead in the 1990's might want to consider subscriptions to our newsletter.

Don Woodside, M.D.
Andy Oxman, M.D.
Philip Berger, M.D.
Haresh Kirpalani, M.D.
for the Medical Reform Group of Ontario

Life After Extrabilling: A brief comment.

By Haresh Kirpalani.

The sentiments espoused in the CMAJ article (excerpted above) may have raised some eyebrows amongst the MRG members. It is of course true that much concern has been voiced within the group about the MRG'slack of apparent purpose after the legislated demise of extrabilling. But that the MRG was grappling with the difficulties of the current Resources Allocation question was not made clear. Any group has to have time to find its philosophic compass. That is what was happening in the period of apparent quiet. This was recognised by Woodside and Berger.

Sutherlands' unjustified slurs on the group, on the other hand, show a dissatisfaction that deserves reply. These attacks reflect in my view, Ralph's perception that his own views were somewhat unpalatable to the members. Notably his view that there is a distinction between political views and medical views; the former being out of bounds for the MRG and the latter being the only legitimate territory for the MRG. Apart from this his attacks contain: factual inaccuracies (e.g. the newsletter consists largely of reprints from Toronto newspapers); serious charges (e.g. the recent debate about legal issues was ignorant) ,and some gratuitous inflammatory local colour (e.g. people write for the MRG who cannot get published elsewhere).

All this is only relevant because as the issues become clearer in daily life, there may well be a falling away of a few members. What does this betoken? Is it necessarily a reason to be fearful for the MRG? People may leave the MRG for differing reasons. Recently an obstetrician member left the group writing: "I have lost confidence in the ability/desire of government monopoly to provide adequate health care, especially as it applies to hospitals, and of the Canadian psyche to demand it. I now believe we need deterrent fees to reduce overuse of GP offices and energy". A health economist left saying obliquely: "I do not feel that the MRG's emerging positions any longer represent my views" Many of us surmise that he wishes to see explicit reductions in health care expenditure, but he has so far declined to state his views for the membership.

In conclusion, it is clear that the MRG is not dead but has formulated in a protracted but democratic manner, a cogent political stance. In the united front that is the MRG, not everyone will be happy all the time. But that is why the formulation of new policy is conducted openly within the MRG. Those that castigate the conclusions of the process, without participation in that process, in my view abandon their legitimacy to shout from the sidelines. If the process comes to a conclusion opposite to their own, they may well have a dilemma on their hands. A democratic and open debate becomes the only guarantee that the MRG reflects the views of its members. Jeremiads delivered from the mountain tops of the CMAJ do not help this process.

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Aural Rehabilitation Classes

The Canadian Hearing Society is conducting aural rehabilitation classes several times a year. The two-classes are held once a week over a period of 8 to 10 weeks. Intensive courses are also available. Topics include lipreading, hearing aids and other communication devices, coping skills and stress management. For more information contact: Audiology Department, The Canadian Hearing Society, 271 Spadina Road, Toronto, M5R 2V3. Telephone: 964-9595, ext. 225

MISLEADING ADVERTISING IS COMMON.

The Australian Society of Clinical and Experimental Pharmacologists surveyed advertisements in 5 journals in 1985 and 1986. They concluded that 31% were misleading or contained unjustifiable claims.[1]

In 1986 the Lancet published a report from India which concluded that aggressive promotion of useless and dangerous drugs was being replaced by more widespread, subtle and insidious promotion of drugs for inappropriate indications.[2]

The British Medical Journal commented in 1986 that "when so much is at stake and so much promotional money is being spent, ample room exists for the unscrupulous company or doctor to abuse the relationship [between them]. The powerful influence of drug companies may be the main source of post graduate education, and bias — as every researcher knows — is subtle and pervasive."[3]

DOCTORS ARE VULNERABLE.

Although doctors deny it, advertising works. The pharmaceutical industry would not spend over £5,000 per year on every GP in Britain if it did not.[3] Controlled trials have shown that advertising uses techniques which are more effective than the methods used in medical education.[4,5]

Avorn et al (1982) found that 63% of a sample of US doctors believed that advertising was of "minimal importance" in influencing their prescribing. However, 49% believed that the potency of dextropropoxyphene 32mg was greater than aspirin 300mg[6]. The only possible source of this misunderstanding was advertising.

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- Inadequate warnings of adverse effects
- Unnecessary expense.

Priority is given to misleading advertising in Africa, Asia and South America where it is more common, more extreme and more dangerous.

EVERY NEW SUBSCRIBER IS VERY IMPORTANT
Subscribers are MaLAM's only source of funds. MaLAM letters are more effective when more people sign them. Drug company executives become responsive when they realise that questionable marketing in one country may effect their profits around the world.

MaLAM's METHOD

Once a month, subscribers receive copies of a letter addressed to drug company executives about their marketing of one or more drugs. The letters compare the advertising claims with the scientific literature. The executives are asked to either justify their position or to make improvements.

The letters are checked by an international editorial board before distribution to MaLAM subscribers in over 30 countries. If subscribers agree with the letter they sign it personally and post it to the company under scrutiny.

MaLAM subscribers also receive a newsletter which explains the background to that month's topic and reports on direct correspondence between the MaLAM Secretariat and the industry.

The MaLAM Editorial Board

SUBSCRIPTION FEES:

	1 year	5 years
Individuals/Groups	$25.00	$100.00
Students/Pensioners	$10.00	$40.00

Subscriptions are free for anyone in Africa, Asia or South America who provides up to date, useful information stating source and date.

Donations are welcome.

Cheques payable to:
MaLAM Canada
C/o East End Health Centre
166 Main Street
Toronto
Ontario M4E 2V8

Enquiries are welcome

.....

Please send me MaLAM letters for 1 year ☐
5 years ☐

Name.....

Dr/Mrs/Ms/Mr/etc.....

Organisation .....

Occupation/Speciality .....

Street Address.....

Suburb or Town .....

State or Region.....

Nation.....

Postcode .....

Would you like your membership of MaLAM to remain strictly confidential? Yes ☐ No ☐

EXAMPLES OF MaLAM's RESULTS

1. Products withdrawn following MaLAM letters:

Bayer 1986 —
arsenic/strychnine/sugar/alcohol "tonic"*

Parke Davis Warner Lambert 1987 —
chloramphenicol/streptomycin "antidiarrhoeal"†

2. Drugs removed from combinations following MaLAM letters:

Grunenthal 1986 — diiodohydroxyquinoline

Scanpharm 1987 — amidopyrine

3. Promotional claims withdrawn following MaLAM letters:

Bayer 1984 ampicillin —
"effective against all Gram positive and Gram negative bacteria of practical importance"

Boots 1985 ibuprofen —
"there are no known contraindications"

Pfizer 1987 piroxicam —
"well tolerated by all ages ... low incidence of side effects"

Smith Kline & French 1986 furazolidone/kaolin/pectin —
"fast action, safety, efficacy, economy"

So far all of the responses from the companies have been unsatisfactory. They lack adequate international marketing quality control systems. However, recent improvements show that MaLAM is becoming effective.

* MaLAM acted in co-operation with Health Action International (Pakistan).
† MaLAM acted in co-operation with the Drug Action Forum (India) and the Health Action Information Network (The Philippines).

WHY WORRY ABOUT MISLEADING DRUG ADVERTISING?

ANSWER: IT IS COMMON AND DOCTORS ARE VULNERABLE.

WHEN DOCTORS ARE MISLED, PATIENTS SUFFER.