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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Cap on high billers is a step in the right direction

(This press release was distributed by members of the Medical Reform Group prior to the meeting of the Ontario Medical Association in Maple Leaf Gardens on May 24, 1991)

The agreement between the Ontario Medical Association (OMA) and the provincial government reflects an encouraging trend toward co-operation between the medical profession and the Ministry of Health.

The Medical Reform Group of Ontario, an organization of socially-concerned physicians and medical students, supports the positive features contained in this agreement as a step in the right direction. These include:

The adoption of binding arbitration as a means to settle fee disputes.

The particularly important fact that the medical profession is agreeing to share responsibility for increases in physician charges.

Also important is the restriction of outrageous physician charges to the provincial health care plan. Physicians who selfishly and nearsightedly oppose the pact because of restrictions on incomes over $400,000 threaten the cooperation between government and the medical profession.

Despite its positive features, the present agreement has limitations. The Medical Reform Group believes that the following concerns should be addressed:

Under the terms of the agreement, all physicians will be penalized if collective billings exceed a certain level.

Contiinued on Page 2

MRG fall meeting set for Thursday October 17

The Medical Reform Group's fall general meeting has been set for Thursday October 17. The meeting will be at 536 Euclid Avenue in Toronto, and will begin at 6:30 p.m. The first half-hour to 45 minutes will be devoted to business matters; the next 45 minutes to an hour will look at Resource Allocation issues.

From 8 to 10 p.m., the evening's theme discussion is to look at recent developments relating to the Ontario Medical Association, including the now-compulsory membership of all physicians. The suggested title for the evening's discussion is "OMA: Confrontation or Collaboration?" The intent is to look at the question of how progressive physicians, and MRG members in particular, should relate to the OMA. For example, should working within the OMA – establishing visility and a presence inside it – become a focus, or should MRG activities continue to be directed at influencing the public, the media, and government?

Comments and contributions on this topic are also sought for the next issue of Medical Reform. Deadline for this issue is September 23. Mail your letters, comments, thoughts, contribution to MRG, P.O. Box 366, Station J, Toronto M4J 4Y8 or fax it to (416) 588-9167.

Proposal to change format of MRG general meetings

The Steering Committee feels that while the format for the semi-annual meetings which we have used over the years has worked well, it is now time to try some new alternatives. We are under the impression that the personal and professional obligations of group members may make a weekday evening meeting more suitable than the full Saturday meetings which have been our tradition. We believe that an evening meeting coincident with a Steering Committee meeting would allow considerable flexibility, is likely to encourage attendance, and overall is an alternative that would better meet the current needs of the group.

The primary purpose of most meetings would be to provide an opportunity for members to express their feelings about important policy issues. The discussions would then guide the Steering Committee in their role as public spokespeople. There would not

Continued on Page 2

Inside this issue:

New format for general meeting

Continued from Page 1

be the same concern with arriving at an agenda that would attract people to the meeting.

There are other purposes for which the meetings could be held. These include a social function for the group, educational events, media events, meetings with other organizations or with government leaders, encouraging new members, and filling the membership in on the activities of the Steering Committee and what in general the group is up to.

These varying objectives suggest a number of ideas for these evening meetings which include the following.

1) They may be held three (or even four) times, rather than twice a year.

2) There may be special additional meetings, focused on issues which need prompt resolution.

3) They may be preceded by a mail-in ballot, and/or mail-in commentary, on issue(s) to be discussed at the meeting. Provision would be made for fax, E-Mail, and regular mail responses.

4) Certain special events may be more easily accommodated on a week-day evening. For instance, having the Minister of Health address the group would be facilitated by a week-day evening meeting. This might also be true of meetings with other organizations, or special speakers.

5) On occasion, the meeting could be held at a restaurant (or a place like Hart House), and include a group dinner. Other possible social events could include a picnic, or a party.

The Steering Committee has decided to provisionally institute this policy for the autumn meeting, and has therefore planned the fall general meeting to take place on Thursday October 17 at 7 p.m. at 536 Euclid Avenue in Toronto.

Any MRG member who wishes to provide feedback on this issue (i.e. the format of general meetings) should leave a message with Ulli Diemer at the MRG phone number: (416) 588-9167 and a Steering Committee member will get back to you. You can also contact one of the Steering Committee members directly, or you can send a fax to the MRG's fax machine at (416) 588-9167.

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 Fax: (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, Gord Guyatt, Andy Oxman, Cathy Crowe, 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.

Cap on high billers

Continued from Page 1

This means that responsible hard-working physicians will suffer the same penalties as those who practise "revolving-door medicine". The Medical Reform Group believes that the agreement on fees should be structured to discourage production-line medicine and that penalties should fall on those who exceed the ceilings.

Action is urgently needed to deal with the continuing problem of various kinds of extra charges to patients. The Medical Reform Group believes that physicians should be prohibited from charging any fees to patients for services which flow directly from insured services. Action is needed to research and remedy the widespread use of such charges.

Measures to control health care costs must go hand in hand with appropriate resource allocation. Future agreements should include provisions for increased quality assurance and for improving the efficiency of the health care system.

Members of the Medical Reform Group will be present outside Maple Leaf Gardens at 8:40 a.m. to answer questions from the media.

Patented Medicines Review Board

The Patented Medicine Prices Review Board has just released its annual report: drug prices are rising more slowly than the overall rate of inflation and the multinational pharmaceutical companies are steadily increasing the amount of money that they spend on research and development. If we take a superficial look at the situation it would seem that a lot of the pharmaceutical issue the MRG has been talking about over the past decade have been laid to rest. But, in fact, not much has changed.

Let's look at drug prices for a start. Remember Bill C-22, that's the one that gave the multinational drug companies 7 to 10 years of protection from generic copies of their mew drugs. When that bill was being debated, one of the MRG's concerns was about its effect on prices. Generic competition means lower prices; for instance in Ontario if two companies market the same drug then there is a price difference of about 20%, if five companies market the same drug then the price difference between the most expensive and least expensive brands is about 50%. It's the savings from price competition that keeps the cost of provincial drug plans from rising any faster than they have been.

But now with Bill C-22, new drugs won't have any competition for seven to ten years. Their prices may not go up faster than inflation, but there won't be any 50% savings from generics either.

As part of the deal on Bill C-22, the drug companies promised to increase

Continued on Page 4

College looks at physicians' relationship to pharmaceutical industry

A Committee of the Royal College of Physicians and Surgeons is preparing guidelines for physicians in their relationship with the Pharmaceutical Industry. MRG member Joel Lexchin is a member of this committee. The Committee's draft guidelines include "General Principles" and specific guidelines regarding prescribing, clinical research, continuing medical education, and promotional gifts.

An MRG working group made a submission to the Committee in response to its draft guidelines. In general, the working group viewed the guidelines as quite progressive. They include stipulations that physicians should not accept gifts from the industry, should ensure the ethical acceptability of any pharmaceutical research in which they participate, and should disclose relations with the pharmaceutical industry when participating in continuing medical education. Following the submission, Rosana Pellizzari and Gordon Guyatt, as members of the working group, met with the committee. Following an expression of appreciation for the work of the Committee, the thought that had clearly gone into the guidelines, and their general progressive nature, they made the following points.

i) One of the principles reads: "The pharmaceutical industry may be perceived as attempting to market a drug to a physician...rather than facilitating the flow of pharmaceutical information". The industry may not only be perceived as attempting to market drugs to physicians, they are attempting to market drugs. Inevitably, the information presented to physicians by the industry will be biased. If it weren't biased, the Marketing departments of industry firms would not be doing their jobs properly. The Committee should explicitly acknowledge this, and bear it in mind in making their recommendations.

ii) Another of the principles states that "The physician should acquire drug prescribing information from a number of sources". This implies that a physician who obtains information exclusively from the peer-reviewed literature is in error. To the extent that physicians restrict their sources of information to those without consistent bias (most appropriately the peer-reviewed literature), their patients will be better off.

iii) In terms of accepting gifts from the industry, the Committee's recommendations state that in general "physicians must not accept any benefit, gift, or money". The exception is that if their activities would be acceptable to public scrutiny, they may accept gifts. The specific example of when the Committee feels this criterion would be met is "meals...where the expense would be justifiable to public scrutiny". The general public should not be subsidizing physicians' nutrition. Physicians are adequately reimbursed so that they can meet their own needs in this regard. The public is unlikely, if they understood this subsidy, to find it acceptable.

iv) The committee makes no specific recommendations with respect to postgraduate medical education. Drug lunches for house staff should not be considered acceptable. Residency programs should not facilitate access of pharmaceutical representatives to house staff. The topics for educational sessions, and their conduct, should be the sole responsibility of educators and the residents, and should not be dictated by the industry.

v) The Committee makes no reference to monitoring or enforcement of guidelines. Recommendations that monitoring and enforcement strategies should be developed should be made. The Committee should recognize that ultimately, the primary goal of their recommendation is to improve prescribing behaviour. This will not be ensured unless a process for monitoring of individual prescribing behaviour, and feedback to individual physicians, is developed.

The presenters had the impression that the Committee listened carefully to the suggestions, and was not without sympathy for the ideas. On the other hand, the pharmaceutical representative were silent throughout, and there was no opportunity for debate or discussion. It will be very interesting to see the final guidelines.

Gord Guyatt

Patented Medicines Review Board

Continued from Page 3

their R&D expenditures from 4% of sales in 1986 to 10% of sales in 1996. In 1990, they were up to 8.9%. Only about 25% of this money is going into basic research, or about $70 million. That might sound like a lot of money, but according to the drug industry it takes $250 million to develop a single new drug, so there will be few if any new drugs coming out of Canadian laboratories.

The bulk of the money that the companies are spending on R&D goes into clinical research – running drug trials. Many of these trials are quite useful in developing new indications for drugs or in defining their role in therapy, but there is also some suspicion that some drug trials are nothing more than marketing efforts in disguise. While clinicians are finding it easier to get funding for their research from the drug companies it's still not really clear how valuable the extra R&D funding really has been to Canadian medicine.

One other promise that the drug companies made during the debate over Bill C-22 was to create 3,000 new "high tech" jobs by 1996. I keep a pretty close eye on the publicity from the drug industry, but they very rarely say anything now about job creation. However, over the past two years there have been at least 550 jobs lost in the industry from plant closings.

The drug industry is also not finished with patents and compulsory licensing. The ultimate goal is to get rid of compulsory licensing entirely. Terry Mailloux, then chairman of the Pharmaceutical Manufacturers Association of Canada (PMAC) Patent Committee, made that clear when he was testifying to a parliamentary committee on Bill C-22. PMAC wants no generic competition for the entire patent life of a drug – up to 17 years and it is devoting a lot of money and resources to achieving that end. Bill C-22 comes up for a cabinet review sometime this winter and there will be a full parliamentary review in 1996 and PMAC is trying to make sure that the politicians get its message. It is currently sponsoring a travelling show about the pharmaceutical industry; television ads praise the efforts of the multinational companies; and it has hired some of the most expensive lobbying companies in the country.

Another concern of the MRG has been about the quality of prescribing by physicians. When the MRG presented its brief to the provincial Lowy Inquiry we pointed out that the evidence showed that prescribing practices were far from optimal. The Lowy Report showed that cost of the Ontario Drug Benefit program had risen to 5.% of provincial spending on health care in 1988/89 from half that level a decade ago or $630 million a year. This year the ODB will come close to costing $1 billion.

About 80% of the cost of the OBD are spent on prescriptions for those 65 and over and a great deal of the rise in costs can be explained by changes in the way that doctors prescribe for this group of people. The number of people covered by the ODB has been increasing, but doctors have also been prescribing to a greater percentage of the people that they see. Although the age/sex structure of the Ontario population remained basically stable during from 1976 to 1986, the average number of physician consultations per person rose by 10% between 1978 and 1985 and the average number of prescriptions per consultation went from 3.6 to 4.4 over the same period. Doctors are also prescribing more expensive drugs for the people that they see. ACE inhibitors, calcium channel blockers are replacing the cheaper diuretics and beta blockers as treatment for hypertension; the number of prescriptions for cholesterol lowering agents doubled from 1988 to 1990; ranitidine has replaced cimetidine as the H2-receptor antagonist of choice, but generic ranitidine is also four times as generic cimetidine.

There is no good evidence that any of these changes in prescribing patterns to the elderly have actually improved their health. What has been driving these changes, particularly the use of more expensive newer drugs?

This question leads to the third area that the MRG has been active in and that is the relationship between the medical profession and the pharmaceutical industry. Whether doctors choose to admit it or not, the way that we prescribe is heavily influenced by the drug companies. And why not? The drug companies are spending about $10,000 per doctor each year trying to convince us to use their particular product.

Some companies spend over $1 million a year just on journal ads for a single new drug. Drug ads generate a significant amount of revenue for medical journals and in the past the Canadian Medical Association Journal has taken editorial positions almost identical to those of PMAC. In the fight over Bill-22 the CMA was clearly in PMAC;s court.

The issue of the relationship between the medical profession and the drug industry came to a head a couple of years ago over Squibb's giveaway of computers to general practitioners under the guise of a postmarketing study. As a result of the controversy that was generated the College of Physicians and Surgeons of Ontario set up a task force to look into the topic. I was one of the members of the task force and the MRG submitted two briefs to the committee and made an oral submission all of which were very well received by the two other physicians on the task force. The guidelines that will be coming out, probably in the fall, are not perfect but they are significantly stronger than any others that have been produced anywhere else in the world, including the U.S. and the U.K.

There are still plenty of drug issues around: prices, patents, prescribing and the relationship between the medical profession and the pharmaceutical industry. They are not going to go away.

Joel Lexchin.

Relationships between Health Science faculties and the Canadian Pharmaceutical Industry

Note: This is an abridged version of a longer paper.

Introduction

Throughout the western world tighter links are being forged between universities and industry. This move is driven by the increasing gap between the money governments are prepared to pay for university-based education and research, and the increasing expense of mounting excellent programs in both these areas. Further, modern technological societies survive on innovation, the application of advanced technology in their industrial sectors, and through minimizing the time between new knowledge being gained through basic research and its industrial application.

The pharmaceutical industry is potentially the largest industrial partner for faculties of medicine and health sciences. Unfortunately, this relationship is clouded by the important role that members of health science faculties and graduates from these faculties, also play in the successful marketing of pharmaceutical products. Thus, potentially healthy inter-dependence in research and development must be contrasted with potentially unhealthy self-interest in the promotion and marketing of the same products. There has been concern that a part of the relationship of the pharmaceutical industry to Faculties of Health Science serves to distort the education of health professionals in order to better serve the industry's marketing strategies.

Both research and educational endeavours of Health Science faculties are subject to significant influence from industry.

General remarks concerning industry-sponsored research

The Food & Drug Act requires that new drugs pass through successive phases of development and clinical trials prior to marketing. The need for pharmaceutical companies to have access to patients (for clinical trials) to bring their products to market presents the Faculty of Health Sciences with ongoing difficulties in judging whether individual trials provide real benefit either to patients or to the academic objectives of the faculty.

All research involving human subjects must be approved by an institutional review board any Faculty of Health Sciences is obliged to operate. This body should take the approach that bad research is unethical research: if the design of the study is flawed in terms of its stated objectives, the review board should press for improved trial design, or reject the study.

There are broadly two types of research conducted on behalf of the pharmaceutical industry by members of faculties of health sciences. At the one extreme is **genuine research** which aims to answer a question of scientific importance and where the academic goals of the institution are entirely consonant with the planned research. This constitutes true research and development, and also constitutes the greater part of collaborative work between the Faculty of Health Sciences and various pharmaceutical companies.

At the other extreme stand studies which can be better labeled **"promotional"**. There are various situations which are typical: the conclusion sought may already have been rendered trivial by work conducted outside Canada. The study may be of a relatively weak design with insufficient subjects recruited, so that no rigorous conclusion is possible, or the study may compare a new drug with a placebo rather than with an established preparation because of an apparent wish to avoid a this more stringent (and relevant) test. (In general, much larger numbers of subjects would be required to demonstrate benefit if the comparison was between a new drug and the best available drug, than between the new drug and placebo).

Promotional, or marketing oriented projects

As a new drug approaches marketing, the industry may be required to conduct specifically Canadian studies and it may also wish to introduce the drug to leaders in a relevant clinical area who will gain experience with it, possibly endorse it, and/or write about it. Late phase III studies of this type can provide the institutional review boards with a considerable amount of soul-searching. It is in studies of this type that insufficient subjects are most likely to be specified, the methodology may be weak in other ways, analysis of the outcome may not be independent of the sponsor, and the feeling often exists that the work is designed more to advertise the drug than to provide new scientific information. However, such research is attractive to members of the health sciences faculties because it is usually generously supported. Retainer fees, travel allowances, invitations to special symposia and publicity go hand in hand with the work. However, as adequate data has usually been collected regarding the safety of the drug, no major ethical issues are raised relative to subject safety. If the research is disallowed by one institution, members of that faculty could be disadvantaged, relative to their colleagues at other faculties.

The Bureau of Prescription Drugs of Health & Welfare Canada is by no means innocent insofar as a problem exists with work of this type: if the Bureau was rigorous in its requirement for good scientific research when it approves clinical trials for Investigational Drugs, faculties of health science and their members, as well as independent practitioners, would not be faced with the ethical dilemma of either participating in flawed research, or foregoing the advantage of early experience with important new pharmaceutical agents.

No one institution alone can deal with this problem alone.

Financial aspects

In 1984-85, 2.13 million dollars (8.4% of total research support) was obtained from the pharmaceutical industry to support the research endeavours at one faculty of health sciences. By 1988-89 this figure had risen to 4.32 million dollars, or 12.7% of the total research expenditures of the Faculty. Ninety-one percent of industry-derived support came from the pharmaceutical industry. This is both an important and growing source of income at a time when funding for re-

search ventures is harder to obtain and is less likely to be obtained free of contractual obligations.

Impact of pharmaceutical industry on education of pre-clerkship medical students

The issue of undue influence by pharmaceutical companies on medical students has been extensively debated through the years. A typical policy adopted by one education program is that no pharmaceutical company representative should make an individual approach to one of the students. If access is to be allowed to the class, either directly or through the provision of learning resources, the material being delivered is to be screened by faculty for academic content and undue bias prior to its adoption.

Students tend to lead opinion in this area: they have, in the past, rejected the gifts offered to medical students by pharmaceutical representatives and they have been vociferous in their anti-industry stand when the matter has been debated.

Iimpact of pharmaceutical industry on education of Interns, Residents and Medical Students in Clinical Clerkships

Clinical clerks and "house staff" as these groups are known, are hospital-based, are responsible for the majority of drug orders on our clinical teaching units, and thirst for knowledge regarding the pharmaceutical preparations they spend so much of their time ordering and using. They are thus at an impressionable stage in their training and many will be leaving academic institutions to go into private practice in the near future.

This group is therefore the target of a considerable amount of promotional activity by major pharmaceutical companies. These companies are willing to sponsor speakers for the regular academic exercises arranged for and by house staff (the "academic half days"). There need be no close relationship between the topic of the speaker and the products of the company: acknowledgement of support is usually all that is requested. "Drug lunches" are provided in clinical teaching units in many medical schools. The frequency of these varies from once weekly to once every few weeks, food is usually provided by a pharmaceutical company, and the occasion is an opportunity for the company to both demonstrate and promote its wares.

In theory, the content of these presentations should be screened in advance, but this seldom occurs. Even if the Director of Postgraduate Education (responsible for the training of interns and residents) favours the exclusion of drug company representatives from contact of this type, the activities are popular with the students (undergraduate and postgraduate) and alternative sources of funding do not exist to support speakers at these functions.

One way in which drug utilization by trainee physicians can be controlled is by the provision of, and enforced use of, a limited drug formulary. Maintenance of a drug formulary is an accreditation standard for hospital pharmacies and the teaching hospitals of faculties of health sciences adhere to this standard with varying degrees of enthusiasm. However, the task of persuading clinical clerks and housestaff to learn drugs by their generic names, to order them by their generic name and to adhere to the limited formulary is an ongoing battle which is never won. Reasons for this are that consultant staff do not adhere to these rules, that it is not possible to exclude drug representatives from promoting drugs directly to the housestaff (by trade, not generic, name), and because so much of the information readily available to housestaff concerning drugs, comes directly from the pharmaceutical industry.

Consulting Staff

Pharmaceutical companies are a ready source of funds to support visiting speakers for academic exercises in clinical departments of our faculty. Such speakers do not necessarily promote a particular drug and they are often speakers of the highest academic quality. As with presentations to housestaff, acknowledgment of the source of funds may be the only promotion that is sought. On the other hand, lectures and symposia designed to promote particular products, or groups of products, are an important part of academic life in these departments. Promotion includes refreshments, lavish meals, and sometimes travel and accommodation as well. The dissemination of valid scientific information and the promotion of the products are usually blended to a greater or lesser degree.

Continuing Medical Education

The quality of continuing medical education programs is, in part, a function of the amount of money available for their support. As with programs already mentioned, the pharmaceutical companies are an important source for such funds and it is often not possible to pay speakers from other sources. If a speaker is invited from outside our own institution to present material at a continuing medical education program, it is accepted practice to provide an honorarium. If the topic is related to the interests of a particular pharmaceutical company, this company can usually be relied upon to at least provide the honorarium. In a single year, pharmaceutical companies provided a total of $56,275 to support Continuing Medical Education functions.

Concluding Remarks

The pharmaceutical industry is a business like any other. Its markets are differently structured in that its advertising and other representations must be made to physicians and allied health professionals who determine drug use by patients, as well as directly to the patient population. The regulations which govern these activities have been only partially successful. This submission has emphasized the excellence of much research supported by the drug industry, but it has criticized some research which is more promotional than scientific. Also, it has suggested that promotion aimed at doctors in training may be inappropriate. Nevertheless, it may be better that students (undergraduate or postgraduate) be trained to deal critically with promotions from pharmaceutical companies as they will have to in the real world, rather than they be protected from this. This calls for better training in pharmacology, clinical pharmacology, and in the critical appraisal of evidence. Perhaps the most inappropriate influence by pharmaceutical companies on the academic environment in which students train is their support of research which is scientifically flawed. Because this is a value judgment, it is difficult to regulate and the argument is frequently raised that "if we don't do it, someone else will, and get the advantage of the money earned to pursue legitimate academic goals". There is a need for the Bureau of Prescription Drugs of Health & Welfare Canada to be more stringent in its requirement for sound scientific design before approving re-

search protocols embodied in new drug applications.

If it is accepted that a considerable amount of money is directed by pharmaceutical companies to clinical studies with a promotional, as opposed to a purely research goal, it would be reasonable to establish a fund in which money is deposited against particular pharmaceutical agents: for each dollar made available to support research directed by the pharmaceutical company, an equal dollar amount could be earmarked for research on the same product but to answer questions which the pharmaceutical company may have been reluctant to ask. Various independent scientific bodies could administer such funds.

Finally, there is the matter of monitoring standards and behaviour. The medical profession has been reluctant to see their relatively ineffectual "self-policing" replaced by public disciplinary hearings. The Pharmaceutical Manufacturers Association of Canada (PMAC) would doubtless be reluctant to be policed by a board where hearings were public and where representation was appropriately broad. But this is a matter of very public interest and there is no reason to believe that we can continue to live without clearly-stated standards and rules, and teeth to enforce them.

George D.Sweeney

Medical Residency policy concerning the pharmaceutical industry

Prepared by Gord Guyatt

The issue of the relationship of the university and the pharmaceutical industry has generated recent interest. Questions as to how we should behave in relation to the industry arise repeatedly. Believing the McMaster Medical Residency should have a policy concerning relations with the industry. I prepared a draft discussion document which is reproduced below. If anyone has comments, I would be pleased to hear about them.

POLICY CONCERNING THE PHARMACEUTICAL INDUSTRY

The following is a suggested policy for the Medical Residency Program regarding interaction with the pharmaceutical industry. This document reviews the assumptions underlying the policy, and suggests specific guidelines.

Underlying Assumptions

General Assumptions

1) The primary interest of the pharmaceutical industry is in making a profit. Within the structure of our society, this is both inevitable and appropriate. Other values may be important: these include improving patient well-being by making better drugs available, and improving physician prescribing. Nevertheless, the primary interest in making a profit is likely to influence every aspect of industry behaviour.

2) The best way that the industry can achieve its goal is through the physicians who prescribe their products. Thus, much of the marketing activity of the industry will be directed at physicians.

3) Questions have been raised about industry's practices with respect to marketing their products to physicians. Concerns have included the proportion of industry budget that is spent on promotional activity and the nature of the promotional activity (that is, the practice of providing gifts to physicians which have ranged from the trivial [such as pads, pens, calendars, meals] to the substantial [computers], to the extraordinary [paid vacations for physicians and families in luxurious settings to attend lectures].

4) It is evident that marketing departments have concluded that marketing strategies directed at physicians-in-training are likely to influence their current and future prescribing behaviour. In response to this conclusion, efforts on the part of the industry to influence these physicians have been considerably greater in the last decade than in the decade previous.

The conclusions of this document do not depend on one agreeing with the industry that the prescribing practices of physicians-in-training will be influenced by interaction with the industry. Furthermore, if one accepts that their behaviour is likely to be influenced, it doesn't imply that a particularly tasty luncheon is sufficient to "buy" the average resident. What is indisputable is that the residency program allowing non-educational handouts to physicians puts them at risk of being influenced by industry generosity, and gives the message that accepting such gifts is appropriate behaviour. It is also indisputable that there is an opportunity cost in conducting industry-sponsored educational activities that are not in keeping with the educational philosophy of the program.

Previous and Current Activities in the Residency Program

The main focus of the pharmaceutical industry within the medical residency program has been what have been called "drug lunches". While providing a lunch which is superior (and considerably less expensive) than what the residents can obtain in the cafeteria, a film which makes direct or indirect reference to the industry's product is shown. In one Hamilton hospital, a strategy was adopted by the CTU Director such that medical texts have been provided, rather than lunches, by the companies. There has been, at times, a proliferation of drug lunches so that several lunch time educational sessions each week have been occupied. Recently, there have been attempts to control this proliferation, including a requirement that films be screened by the Chief Resident and/or CTU Director, and/or that drug lunches be limited to once weekly. Resident attitudes toward drug lunches are variable, but in general they seem to be quite popular.

The industry has also been contributing to the Academic Half-day (in the past without even a public acknowledgement of their contribution) without any influence on the Half-day activities.

Philosophy of the Medical Residency

A number of principles of the educational philosophy of the medical residency program can be seen to bear on the optimal approach to the industry and its activities.

1) Learning should, as far as possible, be problem-based and self-directed.

2) The objectives and the learning agenda should be set by the residents and the faculty.

3) Residents should be encouraged to practice evidence-based medicine. This implies that one's clinical decisions should, as far as possible, be based on an objective assessment of available evidence.

4) The opportunities for the residents to interact in a vigorous and stimulating fashion with the academic faculty should be maximized (note could be made here that, at least at MUMC, the perception among academic faculty is that the opportunities for this interaction have been unduly limited).

5) Medical residents should be encouraged to take a broad view of their practice, the influences on their practice, and the relation between their practice and society as a whole.

Rationale for Limiting the Involvement of the Industry in Medical Education

It follows from the above that Drug lunches are not a good idea. The specific reasons are:

1) Watching films is the antithesis of problem-based, self-directed learning.

2) Acting as censor for such films is not a particularly productive activity for either the Chief Resident or the CTU Director.

3) Given the industry's goals, there is a risk that subtle, if not explicit, biases in presentation of information are likely to exist, and may be undetected by even critical observers.

4) Handing over the agenda for an educational sessions to the industry clearly violates the goal of program which states that the objectives and areas of focus should be determined by residents and faculty.

5) Time spent watching industry films takes away from time that might be spent with the residents interacting with faculty.

6) Giving lunches to physicians in no way enhances their education. Consumers of drug products (either the government, employers, or the individual patient) are very unlikely to be happy when they consider that part of their expenditure is on nutrition of individual physicians-in-training. Their discomfiture at this notion would be justified. To the extent that physicians feel grateful for this nutritional largesse, and their prescribing habits are thus influenced, it would be unfortunate.

Ideally, industry involvement with medical education should be restricted to instances in which the residents or educators believe that the industry could help them achieve a specific educational goal at which they have independently arrived. Under no circumstances would financial assistance from the industry be accepted, nor would handouts from the industry for individual physicians be accepted. All things considered, however, this would not be the optimal policy. The other factors that bear on this decision are considered in the next section.

The Current Financial Climate

Medical schools derive most of their income directly from the government, or from government agencies. Governments are currently under a great deal of financial pressure. There is a perception of the health care system using proportionally increasing, and perhaps excessive resources. Under these circumstances, government expenditures on medical schools have not been sufficient to fulfil the expectations and desires of medical educators. These constraints are likely to get worse, not better, in the future.

Clearly, turning to private industry for funds is one possible solution to the dilemma in which medical schools find themselves. This solution has been actively encouraged by the government. An example of this encouragement is government money being set aside to encourage collaboration between the pharmaceutical industry and medical researchers.

Under these circumstances it could be considered self-destructive for the university to altogether eschew funding from the industry for medical education. Given what has been pointed out previously, however, the compromise should be made with care, and the integrity of the institution, and its goals, should be compromised as little as possible.

Guidelines for Interaction with the Industry

1. The medical residency program should in no way be party to residents being the beneficiary of non-educational largesse from the industry (such as food, trips, pens and stationary, etc.).

2. The medical residency should in no way facilitate access of drug representatives to the residents.

3. If it is known that the industry has a particular educational resource which would help fulfil an independently derived educational goal, that resource should be sought. In addition, industry sponsorship for educational events which are seen as high priority for the Residency Program, and for which funding which is not available from the Department or Faculty is required, can be sought.

If such funding is obtained the support of the industry can be acknowledged (with, for instance, a statement that support comes from a particular company at the beginning or end of educational materials which have been produced with the help of industry funding).

There are a number of expectations the industry might have if they are funding educational activities. These would include participation in the nature of the educational activity (including a film of the drug company's choice, for instance), or allowing an industry representative to attend, and subsequently to chat with the residents. Acceding to such requests is not acceptable. If funding is contingent on industry input into the program, or the residency program making residents accessible to representatives of the industry, the funding should be declined.

News Briefs

OHIP curbs payouts to U.S. hospitals

The Ontario Health Insurance Plan is now paying only the Ontario per diem rate for Ontario residents hospitalized in the United States. Previously, OHIP had paid the full amount, which is often double the comparable Canadian per diem rate. OHIP will continue to pay 100% of the treatment in U.S. institutions if comparable treatment is not available in Canada and if prior approval has been obtained. Out-of-country health costs have more than doubled in Ontario to $225 million in 1990-91 from $100 million in 1988-89. The government said that it would work to reduce the need for the most frequently used out-of-country services, such as cardiac care, brain-injury treatment and alcohol and drug rehabilitation be expanding Ontario facilities and by setting up registries to guide doctors and patients to them.

Tories want user fees

Delegates to the national Progressive Conservative convention in Toronto voted in favour of imposing user fees for medical treatments despite warnings that this would create a two-tier system of medicare. The resolution becomes party policy, but the government is not obligated to act on it, and federal health minister Benoit Bouchard said subsequently that he was opposed to user fees.

Alberta to charge for oxygen

The Alberta government has started charging chronically ill seniors who use oxygen tanks 25 per cent of the cost of the oxygen, to a maximum of $500 per year. Previously the tanks were provided free.

Study calls for reduced med school admissions

A study into the question of physician supply commissioned by the conference of deputy ministers of health is said to urge that the number of students admitted to Canadian medical schools be reduced by 10 per cent. The report, prepared by Greg Stoddart of McMaster University and Morris Barer of the University of British Columbia, concludes that "the long-term trend of annual increases in the rate of growth of physician supply in excess of population growth continues without obvious or compelling justification." The number of doctors in Canada rose 3.5 per cent per year from 1981 to 1987, while the population increased 1 per cent per year.

Quebec MDs told to solve physician supply problems

The Quebec government has told physicians that they have 18 months to come up with solutions for the chronic shortage of physicians in outlying regions. If they are unable to do so, then the government will impose sanctions to force physicians out of metropolitan areas. Provincial health minister Marc-Yvan Cote made the announcement as part of a series of measures he introduced to revamp the province's health care system. Bill 120 proposes that medicare fees for doctors in cities be cut until all posts were filled in outlying regions and that licences be denied for new private practices in urban areas where there are staffing shortages in emergency rooms and health clinics. The doctors' proposal is that all physicians with less than 10 years of service spend a portion of their time working in clinics, emergency rooms or home care. Those who refuse would face cuts in their medicare fees. The legislation also calls for the creation of a medical council of Quebec and of 17 regional medical commissions.

Abortion clinics funded

The Ontario government has started providing full funding for Toronto's four free-standing abortion clinics. The funding means that the clinics will stop charging women a fee of $200 to $300 per abortion.

Insanity law annulled

The federal government has introduced new legislative proposals to replace the law on criminal insanity struck down earlier this year by the Supreme Court. The Court ruled this spring that a law which forced those not guilty of a crime by reason of insanity to be automatically committed to a mental institution violated a person's rights under the Canadian Charter of Rights and Freedoms because it called for indefinite confinement without regard to whether the person is a danger to society. The court granted the federal government a six-month period to pass legislation to replace the old law. About 1,000 people are confined across Canada under such warrants. The federal justice department had new legislation ready since 1986, but had made no effort to introduce it. Under the new proposals, in most cases an offender with mental disorders would be given a detention period with a maximum specified.

Forced drugging struck down

The Ontario Court of Appeal has struck down provisions in the Mental Health Act that allowed doctors to administer anti-psychotic drugs to inmates of psychiatric institutions against their wishes.

Tobacco ad ban overturned

The Quebec Superior Court has ruled that the federal ban on cigarette advertising violates the right of tobacco companies to free speech as guaranteed in the Charter of Rights and Freedoms. In striking down the law, the court also negates provisions requiring tobacco companies to print health warnings on packages.

Drugstore Tobacco ban urged

The Ontario College of Pharmacists has recommended that the Ontario government ban the sale of tobacco in drugstores by July 1, 1993. At present, about 24 per cent of all tobacco sold in Canada is sold in drugstores, a total of $2 billion annually, including $800 million in Ontario. The recommendation was criticized for delaying too much by Gar Mahood of the Non-Smokers Rights Association. "The Shoppers Drug Mart-led pro-tobacco lobby is simply out to delay this measure for as long as possible," he said, noting that Shoppers Drug Mart is owned by Imasco, which owns Imperial Tobacco.

Safety agency plans overhaul

The Ontario Workplace Health and Safety Agency, the new agency charged with overseeing health and safety issues in the workplace, is planning a major overhaul of the delivery of health and safety services which are currently provided by 12 separate organizations in Ontario. The agency has not yet announced what changes it proposes.

AIDS Centre wins reprieve

Federal Health and Welfare Minister Benoit Bouchard has put a halt, at least temporarily, to plans to close down the Federal Centre for AIDS. Community activists were alarmed by the plan because they feared that without an identifiable national body, AIDS issues might become lost in a bureaucratic maze. The centre was established in 1987, and has come in for repeated criticism for failing to fulfil all its functions effectively.

Couple jailed for nursing home death

A Muskoka couple have been sentenced to prison for 20 and four months respectively for failing to provide a resident of their unlicensed nursing home with "adequate and proper care." The patient died after suffering burns in a bathtub. The sentence marks the first time that a nursing home operator in Canada has been convicted of criminal negligence for failing to provide proper care.

Meeting explores ideas for democratizing health care

The Medical Reform Group's Spring General Meeting took place on Saturday April 27, 1991, at the South Riverdale Community Health Centre in Toronto.

The meeting began with John Frank delivering the Steering Committee report, expanding on the report which appeared in the April newsletter.

Health cards

Philip Berger gave an update on the new OHIP cards, He received a letter from the Minister of Health which said that the Ministry planned expanded efforts to sign people up to the new health numbers. Special forms are to be made available to doctors' offices to claim payment for patients who do not have a number. The bottom of the forms will have a tear-off portion to be used in signing up the patient for the number. Philip said that he was satisfied with the steps being taken by the Ministry to deal with the problems created by the implementation of the new numbers. Fred Freedman pointed out a problem being faced by HSOs: patients who don't have a number will be cut off their patient rosters after the deadline. Rosana Pellizzari said that the Association of Ontario Health Centres is looking at the issue.

Occupational Health Group

Robbie Chase reported that the group has had two or three meetings. He and Maritza Tennassee are working on a proposal for a system of occupational disease surveillance which would be separate from Workers' Compensation record-keeping. Anyone interested in being involved should contact Maritza Tennassee or Susan Stock.

Native Health Group

Rosana Pellizzari said that there is interest in forming a Native Health Working Group. Anyone interested in being involved should contact her.

Primary Care Group

Joel Lexchin reported that the group – Fred Freedman, Bob James, and himself – has been meeting every four to six weeks and talking about the model of primary care which was presented to last year's general meeting. They feel that the model needs more work but that they have gone about as far as they can go on their own, and that they need outside input to go any further with it. They are interested in setting up a pilot project based on the model, perhaps in Toronto, more likely in Hamilton. Anyone interested in having input should contact one of the working group members.

Resource Allocation Group

Andy Oxman reported that the Resource Allocation Working Group has not met recently but a meeting is planned in about two weeks.

Speaking in the U.S.

Reports of MRG speakers in the U.S. appeared in the April issue of the newsletter. Rosana provided some additional details. She said that there has been a range of audiences, from staff people of unions or coalitions working for a national health plan in the U.S., to members of the general public who wanted to know how the system works in Canada.

Requests for speakers continue to come in and more people willing to go and speak would be welcomed. People interested in speaking should contact Ulli Diemer at 416-588-9167. Travel expenses and accommodation are paid for by the group requesting the speaker.

Pharmaceuticals

Gord Guyatt and Rosana Pellizzari have drafted a response to the CPSO Task Force looking at the relationship between drug companies and doctors; they hope to also make an oral submission. People who have anecdotes illustrating this relationship are asked to send them to Rosana or Gord.

It was reported that Ralph Sutherland has been hired to review the Ontario Drug Benefit Plan. It was noted that one way of approaching increasing costs is to take measures aimed simply at cutting costs; another approach would be to develop incentives to encourage better prescribing habits.

Membership

People were reminded of the letters which they are being asked to send out to prospective new members.

Budget

Fred Freedman presented the proposed budget for 1991-92. . The budget was passed unanimously.

The budget appears below:

The main assumptions of this budget are (a) that the number of members will remain constant; (b) membership fees will remain the same; (c) expenses will rise by an average of 5%.

Income

Supporting Member Donations 2,500
Physician Memberships 17,000
Other Memberships 2,400
Sundry 1,400
Total Income 23,300

Expenses

Administrative fees 14,790
Printing & photocopying 2,900
Postage 1,500
Supplies, Misc admin. 3,000
Meeting expenses 800
Local chapters 200
Total Expenses 23,190
Net Surplus 110

Ontario Medical Association

The question of the implications for the MRG of the new deal negotiated between the Ontario Medical Association and the Ministry of Health was raised. According to the questionnaire circulated last year, an overwhelming majority of MRG members intend to remain members of the MRG if they are forced to belong to the OMA. One possibility that was raised last year was forming a 'reform' section within the OMA of doctors who agree with MRG principles. Several people commented that if this were to happen, it would still be important for the MRG to continue as a separate organization and not simply fold into the OMA. Rosana Pellizzari said that the OMA could easily turn down a request to form such a section. Don Woodside said that the message he got from the meeting with the OMA people last year was that it was very unlikely that such a section would be approved by the OMA. Rosana also pointed out that we have over 30 associate, affiliate, and organizational members who would not be eligible to belong to the OMA.

Philip Berger said that, leaving aside any question of forming a section, we should in any case discuss our role within the OMA.

Philip, Jim Sugiyama, Don Woodside, and Fred Freedman all expressed an interest in exploring what the MRG's attitude to the OMA should be.

Letter on Gulf Crisis

With Don Woodside in the chair, Fred Freedman stated his objection, as outlined in the April newsletter, to the fact that the Steering Committee sent a letter to the Prime Minister on the Gulf Crisis. He said that this action was undemocratic because the MRG has no policy on any issues relating to war or the Gulf. Fred said that the MRG has never previously taken a stand on an important issue like this without at least conducting a telephone poll of members. For the Steering Committee to do take this stand without obtaining a wider sampling of membership opinion, and in the absence of policy, was quite wrong. Getting involved in these kinds of issues can be very divisive for an organization.

Joel Lexchin said that he agreed with Fred on the question of process, though he was glad nonetheless at the time to have any voice speaking out against the war. A phone poll could have been conducted in a day with each Steering Committee phoning two or three people.

Philip Berger said that he disagreed that the situation was an urgent last-minute thing. The Steering Committee had all fall to come up with a position on the developing crisis; they didn't have to wait until the last minute in January. He recognized that people were swept up in the emotion of the issue: he himself was duped by the pro-war propaganda at the time. However, this was no reason for sloppy procedure. We didn't take positions on many other important international issues, such as East Timor, South Africa, Tienanmen Square, Oka. This was a serious departure from our 12-year history of not taking stands on these kinds of issues.

Cathy Crowe commended the Steering Committee for writing the letter. She pointed to the MRG's second founding principle, which states that "health is political and social in nature" and that we should seek out, recognize and help eradicate the social and political causes of ill health. She said that she didn't see the letter, which was very mild in tone, as a policy issue. She is surprised that it is even being discussed.

John Frank said that he agreed there was definitely room for debate on whether the process was proper. However, the issue, including the question of process, was discussed at length at the Steering Committee meeting and the members of the Steering Committee unanimously came to the conclusion, in good faith, that it was appropriate to act because of the urgency of the situation.

John said that there was a key distinction between this issue and other international issues, on which the MRG did not take stands. The distinction is that our country, Canada, was about to go to war. One's country going to war is not an issue like other issues. It a matter of enormous significance, and this made him feel that it was something that the Steering Committee of an organization like the MRG should speak out on. Given the calls at the previous general meeting for the Steering Committee to take some risks in making statements if it seemed appropriate in its judgement to do so, he felt that the Steering Committee acted responsibly in taking the risk of speaking out.

Miriam Garfinkle said that this action was not checked out properly. It should have been thought out better.

Michael Rachlis said that he felt sympathy for John's position. However, his own feeling is that the MRG isn't as active as it should be on health issues. Getting involved in this kind of issue drains away energy from the MRG's main purpose, which is to deal with pressing health issues.

Catherine Oliver said that she thought it was very good that the Steering Committee made the decision that it did. It is all very well to say the Steering Committee should have anticipated the issue and acted earlier, but that's easier to say with hindsight than to do at the time. Many of us were taken by surprise at how quickly things moved towards war.

Rosana Pellizzari said that we need to look at the process and put something in place that defines how the Steering Committee should act in such a situation. When war was about to break out, we were anticipating the possibility of huge numbers of deaths and the likely use of chemical, biological, and nuclear weapons. This was not just another international issue. This was our own country going to war.

Irv Brown said that he felt this was too far from what the group is about. We need to stick to medical reform types of things.

Philip Berger said that the Steering

Committee should take note of this discussion and the potential of this kind of issue for creating divisiveness.

Rosana proposed that the Steering Committee be asked to come up with some kind of suggested process on how to handle such a situation, to be discussed at the next general meeting. This proposal was carried unanimously, with some abstentions.

Cutbacks in federal funding

Michael Rachlis gave a brief overview of the history of federal-provincial funding arrangements as they pertain to medicare. The Hospitals Insurance Act of 1957 established a *50-50 cost-sharing* arrangement between the federal government and the provinces. Medicare, brought in nationally in 1966, also had 50-50 cost-sharing. In 1977, the Established Programs Financing Act (EPF) brought in *bloc funding*, under which the federal government provides the provinces with a set amount of money. Under this system, the federal contribution, made up of a combination of tax points and cash, grew at *the same rate as the GNP*. In 1986, the Mulroney government changed this arrangement to *GNP minus 2 per cent*. The 1990 federal budget, as implemented by Bill C-69, changed this formula to *GNP minus 3 per cent*. In addition, it froze the federal contribution for two years, thereby *reducing it by 10 per cent in real terms* due to the effects of inflation.

The 1991 Budget extended this freeze: the federal contribution is now to be *frozen for five years*.

As a result, within 10 to 12 years, *no provinces will be receiving any cash from the federal government for medicare*.

This means that the Canada Health Act will become entirely toothless, because the only way that the provisions of the Canada Health Act against user fees and extra billing can be enforced is by withholding cash from provincial governments that violate the Act. Once no more cash is being transferred, there will be no more penalties to be enforced.

The financial effects of these cutbacks are even worse on the poor provinces, because they already spend a greater proportion of their incomes on health care. For example, Newfoundland's government spends 13 per cent of its budget on health care, while Alberta spends 7 per cent. Even so, Newfoundland cannot afford to provide the same level of services as Alberta. Therefore it will be that much harder for a poor province like Newfoundland to make up the difference as federal funding is taken away.

Social service funding is also being cut. The Canada Assistance Plan (CAP) was based on a 50-50 federal-provincial share of funding for social programs. The Mulroney government has now made cuts in the CAP to Ontario, Alberta, and British Columbia.

This program of federal funding cutbacks meshes with the agenda of Quebec, which wants total control of health care and social programs, and of other conservative provincial governments, which also want to get rid of the Canada Health Act. The agenda is to get the federal government out of all areas of shared jurisdiction or shared funding.

Joel Lexchin said that Free Trade and the desire to 'harmonize' the Canadian system with the U.S. also play a part.

Michael Rachlis said that one thing that is being planned is to inundate the Commons Finance Committee with letters and briefs and requests to make oral submissions. Positive alternatives also need to be presented. The Canadian Health Coalition has been active in opposing these measures. It is also hoping to involve or 'jump-start' moribund provincial health coalitions.

Don Woodside drew attention to the context of the constitutional debate in which this will be debated over the coming year. Some of those who want to preserve medicare are nonetheless in favour of more power to the provincial governments, and for that reason may not speak out against these actions of the Mulroney government.

The following **resolutions** were moved and passed:

Federal Funding Cuts and the End of Medicare

(MRG69)

The 1991 federal budget, in combination with the 1985 and 1990 budgets, will end medicare in Canada. There are also dire consequences for social services and public health programs.

These three budgets have cut the federal transfers to the provinces under the Established Programs Financing Act (EPF) to the point that by 1995, Quebec will receive no cash from EPF. The federal government will cease to transfer cash to Ontario by 1998, and by 2002 no province will receive any cash under EPF.

When the federal government no longer transfers cash under EPF it will lose the ability to enforce the Canada Health Act. The Canadian constitution gives the provinces control over health care. The federal government's only authority is its ability under the Canada Health Act to withhold EPF cash from the provinces which fail to uphold the national standards for health insurance found in the Canada Health Act.

When the federal government ceases to transfer cash under EPF, the provinces will be completely free to institute user charges (like extra-billing) and private insurance. Quebec and British Columbia have urged Ottawa to abandon national standards as soon as possible. Unless the tide is reversed, medicare as Canadians have know it will be dead.

The issue of the federal provincial arrangements for health policy is intimately linked with the larger issues of fiscal federalism and the constitution. Major decisions are being made about the health of Canadians without involving Canadians themselves. Canadians who provide health and social services have not been consulted either. In fact, neither the provincial ministries of health nor the national Department of Health and Welfare are being offered much of a role in the decision-making.

The federal government has taken a politically sophisticated approach by dismantling medicare over the long-term by gradually eliminating transfer payments. The three major steps have been taken by financial not health legislation. Until now the discussion of these issues have been largely conducted behind closed doors by the ministers of finance. There are no formal plans to introduce health legislation. There are no plans to involve Canadians formally in the debate about their most cherished government policies. Therefore:

1) The Medical Reform Group reaffirms its support for a national health care system with national standards for health insurance which preclude user charges for acute hospital and medical care.

2) The Medical Reform Group asks the federal government to reverse its policy of decreasing federal contributions to the provinces for health care. It should reinstate a formula for EPF

such as that which existed prior to 1986. That is, the overall federal contribution should grow at a rate equal to the growth of the GNP. This act would simultaneously ease the funding pressures on the provinces (particularly the poorer provinces) and protect the Canada Health Act.

Reforming Canadian Health Policy

(MRG70)

The reinstatement of a funding formula similar to the Established Programs Financing Act as it existed prior to 1986, i.e. one in which the federal contribution grows at a rate equal to the growth of the GNP, will relieve the acute funding pressures in provincial health care systems. Then, the federal government should fulfill the promises of *A New Perspective on the Health of Canadians* (The Lalonde Report) and *A Framework for Health Promotion* (The Epp Report) to reform Canadian health policy. Specifically, the federal government should:

a) Fund and convene a representative and democratic process to establish national health goals.

b) Conduct a national health survey and other health status assessments on a regular basis to monitor progress towards these health goals.

c) Assist the provinces in reforming their health care systems so they can more effectively achieve the national health goals.

Federal Social Service Funding Cuts

(MRG71)

The MRG asks the federal government to reverse its policy of decreasing federal contributions to the provinces for social services. It should reinstate a formula such as the Canadian Assistance Plan which exited prior to 1990. That is, the overall federal contribution should grow according to growth in provincial spending on social services covered by the Canadian Assistance Plan.

Panel on Democratization

Fran Scott took over the chair and introduced the three invited speakers. They were Michael Hurley, the President of the Ontario Council of Hospital Unions (CUPE), Elsabeth Jensen, Past President of the Registered Nurses Association of Ontario (RNAO), and Janet Wright of the Ontario Public Service Employees Union (OPSEU).

Janet Wright

Janet Wright said that the lack of democracy in the health care system has been a constant irritant to her. There is a lack of real community input and of health care worker input. Her union has been trying to achieve some input through collective bargaining; this seems to be the only route that is open to workers to have any degree of input.

One important problem facing health care workers is that of workload. Getting workload addressed in collective agreements seems to be the only way to achieve any action. Management may agree to talk about it on committees, etc., but they won't act, and there is no recourse when they refuse to act on problems. Unionized workers are also trying to address the issue of control over the work environment. Reasonable layoff and recall procedures are an issue, as a job postings.

People who work in units know what is going on in them. They should have input into the decisions. Another issue is competency maintenance. No provisions are made or facilities provided for competency maintenance. How do health care workers who don't live in or near major centres find the time or the resources to keep up? Collective agreements should take this into account.

OPSEU is involved in trying to start a coalition of health care unions. In addition to co-operation at the top between unions, there should also be cooperation within individual hospitals and other settings. We have to band together to do something. We need to be part of the boards and the decision-making.

Elsabeth Jensen

Elsabeth Jensen said that she was happy to read the MRG's materials and positions. The Medical Reform Group has been a very effective voice. There is a perception on the outside that the MRG is a credible voice.

The four reports just released by the Premier's Council on Health Strategy are very important. The Premier's Council by its very existence says that health is broader than health care. The goals which it is adopting will mean important changes in the system.

Elinor Caplan as Health Minister last year set up the Orser Commission in Southwestern Ontario, which is looking at ways to adapt the principles and goals set out by the Premier's Council, to Southwestern Ontario. It is looking at How do we restructure the system to emphasize health promotion and prevention? New ideas are being discussed, e.g. Winnebagos to bring services to the communities rather than making everyone in the communities come to the institutions for services. We need to change the current system which is centred on institutions. For example, if we have a facility or program, we go and find patients to fill it if we don't have enough. The system is driven by the logic and imperatives of the institutions. For example, there is nothing to ensure that people will have enough food to eat. But if you are malnourished, then you are guaranteed a hospital bed and treatment for your malnourishment.

But how do you do it? How do you shift to promotion and prevention?

The Health Professions Legislation is a good step and should be supported. The Ontario Hospitals Act is being redrafted: a draft of the proposed legislation is supposed to be available in June and should contain positive changes like more community control over hospitals.

When changes are proposed for the system, the key thing is to make sure they actually happen. We all need to change for the system to change. The MRG has an important role to play in influencing the evolution of the system.

Michael Hurley

Michael Hurley said that the processes which evolved the documents people are referring to – the Premier's Health Council reports, the new Ontario Hospitals Act, etc. – were not democratic. As a result, the documents themselves are deeply flawed. These documents and recommendations were developed by the same elites groups of bureaucrats and consultants who have always evolved policy.

What is needed is real democratization. Democratization is needed in the

processes that develop policy and create change, and in the structures and bodies that are created. For example, boards should be elected, not appointed. Community programs should be run by the community, not just for the community. The public has rights as a public, not just as individual consumers of health care. The transformation of the system should not just be for economic reasons (i.e. to save money) but should lead to real democracy. His fear is that much of the impetus for reform comes from a cost-cutting agenda. It is important to point out that there is a resource gathering problem as well as a spending problem. Tax reform is needed to create a fairer tax system.

His union wants to move the debate outside the confines of elites and into the public. Bureaucrats must have less control over the process and the institutions. A key question we have to deal with is how do we take the debate to the public? If we don't successfully democratize the process, then what we will end up with is a new and different bureaucracy, but a bureaucracy with bureaucratic control just the same, e.g. hospitals may be cannibalized and more of their resources shifted to 'community' organizations with a new bureaucracy controlling those 'community' organizations.

Questions and Discussion

The presentations of the three speakers were followed by a question and discussion period.

Joel Lexchin said that since priorities get established at a provincial level rather than at the level of individual institutions, how do you get democratic control over that?

Elsabeth Jensen said that decisions can't be made in Toronto about what is important for us. The province can set the standards and goals, and then the district units decide how to influence that. Part of the process has to involve educating and informing the public much more openly and consistently. We need to give them the information they need to know how to make educated decisions.

Janet Wright said that at the level of district health councils, we need a blend of elected and appointed positions, some way of putting representatives of responsible interest groups on the boards. Elections in politics are not real, they can be manipulated and stacked.

Elsabeth Jensen said that there is a lack of co-ordination. There has to be more information-sharing. Everyone sees the world in terms of their own program or institution. For example, in-patient services thinks that in-patient services are the answer to a problem. Out-patient services think out-patient services are the answer.

We in Southwestern Ontario were given the recommendations of the Premier's Council together with the job of deciding through the Orser Commission which ones are relevant to Southwestern Ontario.

Voluntary associations, like the Cancer Society or the Heart Society, also have an important role to play.

Goal setting should involve setting specific targets, such as a given percentage of funds must go to community services.

Andy Oxman said that decentralization doesn't necessarily lead to democratization. He worked in Norway, which carried out a radical decentralization of the health care system, which didn't improve either democracy or equity. Decentralization can be an excuse for cost containment. How do you make collective bargaining more democratic?

Janet Wright said that Number One is education. Her concern is that we will shift power from one little group to another little group. We need mechanisms for accountability to public in terms of health outcomes.

We talk about providing "beds" but we really receive services, not "beds". When we get people used to thinking and talking in terms of services rather than "beds", then it becomes easier to ask is there a better way to provide these services.

Michael Hurley agreed that democratic processes may lead to results we don't like or agree with, but that is also what democracy is about.

Elsabeth Jensen said that it is important that the MRG not give up its role. Someone has to dream the vision of what the health care system could be. The OMA will get more caught up in its union role and will likely be even less able than now to develop new visions.

Philip Berger said that we have to look at how doctors practice medicine. Will this proposed democratization affect the actual health of actual people? Maybe we should in any case be concentrating more on things like providing employment. He is skeptical about the NDP bringing about the changes we want to see. Almost the entire left has been neutralized because they're all working for the government now.

Michael Hurley said that the government's agreement with the OMA was pathetic on cost containment.

Elsabeth Jensen said that there are a lot of dishonest doctors out there, and their sense of being entitled to be dishonest is almost pathological.

Catherine Oliver said that Evelyn Gigantes should have resigned because of the agreement with the OMA.

John Frank said that there are very few experiences of real democracy to draw on in our own lives. The few there are are usually in small groups. Things go awry when we get up to bigger organizations.

Janet Wright said that often co-operation between unions doesn't seem to get communicated to the local level.

Michael Hurley said that the Ontario Nurses Association (ONA) has formally rejected co-operation with other unions on issues of cutbacks and funding. So his union is working with the OMA — not its first choice.

Janet Wright said that we have to keep on finding causes that we can fight jointly.

Don Woodside raised the problem of vocal minorities taking control of bodies like hospital boards or school boards, e.g. single-issue groups like anti-abortion groups.

Elsabeth Jensen said that to some extent the effects of this can be counteracted by setting provincial targets that have to be met, like decreasing family violence by 50% by the year 2000.

Janet Wright said that the Ontario Federation of Labour (OFL) is a forum for unions to work together and lobby. Unions allied in the Equal Pay Coalition on the pay equity issue.

Elsabeth Jensen said that it would be helpful for the MRG to get hooked into the InterHealth Coalition. We should contact the RNAO for information abut it. A regular connection between the MRG and RNAO would be good.

Michael Hurley reported that his union is starting to work with a group of academics. The union is aiming to have a conference for health care providers in the Spring of 1992.

Action for U.S. health plan continues

On Wednesday, May 15, the Journal of the American Medical Association (JAMA) published a special edition which was devoted exclusively to suggestions as to how to deal with America's uninsured, and underinsured. One of the papers was from the Physicians for a National Health Plan (PHNP). This group, which now has over 4,000 members, advocates a Canadian-style universal, single-payer system.

Like most major journals, JAMA has a press blackout preventing premature release of media reports. The press blackout has, for a long time, been terminated at 3 p.m. on the day before publication. In this case, that would have been Tuesday, May 14 at 3 p.m.

At 9 A.M. on Monday May 13, the American Medical Association (AMA) held a press conference to publicize the issue. The PHNP was holding a press conference to present their view, and educate the press, at noon on the same day. The event was organized by two leaders of the PHNP, David Himmelstein and Steffi Woolhandler. The educational session was planned for the entire afternoon. Gordon Guyatt was invited to attend, speaking as a Canadian physician, and on behalf of the MRG.

That morning, JAMA spokespeople announced that the for the first time ever, the press blackout had been moved to 12 noon that day. This would mean that, to be competitive in terms of getting their stories out promptly, the press would have to have their material ready by noon that day. The change in the press blackout was a tactic to sabotage the PHNP educational session.

It is difficult to judge the effectiveness of the AMA tactic; certainly, the press turnout for the PHNP event was not as large as was hoped. Nevertheless, there were quite a few people there, the presentations were excellent, and there was a lively discussion with the press.

The ferment within American Health Care continues. The situation is likely to evolve for some considerable period of time.

Gord Guyatt

The Spectator Friday May 24, 1991

No pot of gold at end of U.S. rainbow, doctors warned

TORONTO — A Canadian doctors' group is reacting strongly to a bid to lure doctors south of the border with promises of more money.

Dr. Gordon Guyatt, spokesman for the 350-member Medical Reform Group, said yesterday doctors seduced by a Toronto job fair earlier this week will only be disappointed if they leave practices in Canada to set up in the United States.

More than 400 doctors showed up at Wednesday's job fair to hear about U.S. job opportunities.

Dr. Guyatt said promises of multi-digit incomes can be misleading because the net income of most U.S. doctors is not much more than the earnings of Canadian practitioners.

"Their administrative costs are twice as high as ours, they pay insurance rates four times higher than in Canada.

"Only a tiny proportion (of specialists) earn substantially more and it is almost obscene to see them making grossly exorbitant incomes."

Dr. Guyatt said doctors should also consider their desire "to help people" — something he says is more difficult to do in the United States.

He said anyone who reads a U.S. medical journal knows the U.S. health care system is a disaster that forces doctors to treat patients on the basis of what they can afford, not what they need.

From Canadian Press

GUARDIAN WEEKLY, July 21, 1991

Black marks against Blue Cross

American Diary by Martin Walker

TOILING yet again over a monstrous mass of forms and medical bills, my wife recently estimated that we spend an average of four working days each month simply processing the paperwork for our medical insurance. It is a frightful and frustrating chore, and one that has made me an even more fervent supporter of our own National Health Service. Any politician who even dreams of replacing it with the US-style system should be condemned for life to the Blue Cross-Blue Shield insurance system.

The most recent example of this dreadful bureaucracy concerns our younger daughter, who is six. On the Tuesday, she got conjunctivitis, which the Americans call pink-eye. She was taken to our paediatrician (no such thing as GPs over here), who prescribed medicine and said to keep her off school. On the Thursday, she began to throw up, could not keep down any food or liquid, and at lunchtime suddenly began to vomit cupfuls of blood.

Horrified, we rang the paediatrician. There are no house calls in this country. At an average income of over $150,000 a year, American doctors are far too grand for that. For their convenience, you must take your sick child to the doctor's office. But of course it was lunchtime, so we only got his answerphone.

The child was still vomiting blood, so we drove to the nearest hospital. She vomited more blood while they verified that we did indeed have medical insurance, and we signed a legal form assuming full financial responsibility for the treatment we were to get. Finally she was admitted, and the doctor dug around for an agonising while in her arm before he could locate the vein and install a drip feed.

The reception staff took notes of her illness, and when it had begun. This was later to prove important. Then this local suburban hospital informed us they had no facilities to keep her in overnight. Her main problem was dehydration, so they had to keep in the drip feed. This meant hiring an ambulance (another $165) to take her the five-mile journey to the childrens' ward in Georgetown University Hospital. The ambulance nurse was a jolly type, who entertained the child by showing her the vast metal shears used to free people trapped in car crashes. He even cut a penny in half and gave her a bit as a souvenir.

Once at the university hospital, there was another long process of registration, checking on our medical insurance, and another financial guarantee form to sign. My wife was allowed, indeed encouraged, to stay at her side overnight. For the first night, this meant sleeping in a chair. The second night, a bed was provided.

Our paediatrician turned up, conferred with the hospital staff, and the treatment was very good. So it should be, at a total of almost $2,000. The child recovered, and various blood tests showed that the drip feed and the medication had done the trick, and after two nights in hospital the drip was removed and she was discharged. Then came the grim part of sending in the forms to the insurance company to reclaim the costs.

This is bureaucracy gone mad. We are signed up with Empire Blue Cross in New York City, as part of the employment group of the staff of the Manchester Guardian Weekly who are based there. So we sent off the paperwork, and within a week received a letter from Blue Cross in Albany, New York. This warned us that "there are certain conditions that must be met at the time of admission. For instance, your contract may have limitations and exclusions that affect the amount of benefit payment or whether any payment will be made at all".

This turned out to be fair warning. We then got another letter two weeks later from Empire Blue Cross in New York City. This said they would not pay the claim because "benefits are extended provided the onset of such illness is both so sudden and acute as to require immediate use of the hospital emergency room within 12 hours after the first appearance of the symptoms of the illness".

I rang the person who had signed this letter, to be told "she does not take incoming calls". To cut a long story short, after identifying myself by name, number, claim number and hospital number, we established that the first hospital had informed Blue Cross that the symptoms had first appeared two days before the child was brought to the hospital. That was for the conjunctivitis, I explained. She was brought to the hospital as soon as she started to throw up blood.

We now have to re-submit my forms in a formal appeal process. And we shall have to do it all over again for the second claim, which they are still considering, for the second hospital. And probably we shall have to do it yet once more for the ambulance fee.

This is but the latest phase of a tedious saga, of claims ignored or mislocated, of sums paid direct to the doctor but with no copy to us so that we can recover our refund from his office. American friends tell us that they suffer a similar fate, which may explain why 24 cent of every health dollar goes to administration.

By American standards, we are well covered by insurance. Indeed, one American in six has no insurance at all. Our family is reasonably healthy. But each year we have been here we have paid out in cheques an average $2,600 more than we finally get back — not counting the cost of the initial insurance.

This is why America spends 12 per cent of GNP on health care, and has a worse infant mortality record than Britain, which spends less than seven per cent of GNP on health. At all costs, preserve the NHS, and keep this ridiculous system away from our shores.