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 11, Number 5 — December 1991

MRG 'David' vows continued alternative to OMA 'Goliath'

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Some voices were heard arguing that MRGers should also devote energy to forming an 'opposition' with a reform viewpoint within the OMA, but most of those attending the meeting responded by indicating that they personally didn't have the time or energy to take on the work this would require. Concern was also expressed that if the MRG was identified as merely a faction within the OMA, it would quickly lose its ability to win a hearing from the media and from government. One member offered the opinion that 'the David and Goliath thing' was something which appealed both to the media and to MRG members themselves.

The meeting also heard a report on the extensive tour of speaking engagements which MRG members have been engaged in south of the border. Reports of the Canadian experience are being sought eagerly by U.S. groups working for a national medicare system in that country.

Members considered how to respond to the continuing pressure for cost containment in the health care system. There was agreement that a key part of the MRG's message should be that the decision-making process has to be improved to make it more open and more democratic. District Health Councils and hospital boards should be changed to make them more democratic.

Democratization was also seen as pointing to a need for practical guidelines on how spending decisions are to be made and on what basis, and for an appropriate body which has the tools to see that guidelines are actually being followed. While the MRG favours measures to improve efficiency and eliminate waste, it doesn't want across-the-board cost-cutting which cuts the good as well as the useless, nor does it want to see costs cut by, for example, contracting out hospital work to workers being paid the minimum wage.

Among the economic issues which were identified was the need for better guidelines regarding the licensing of new technology analogous to the licensing of new drugs, the need to encourage experimentation with alternatives to the present fee-for-service system, and the issue of the cost of tests done in private laboratories.

The full minutes of the fall general meeting are on page 11

MRG warns Lankin on indiscriminate cost-cutting

Medical Reform Group Steering Committee members Gord Guyatt, Haresh Kirpalani, and Rosana Pellizzari met with Health Minister Frances Lankin and her executive assistant Sue Colley on December 7.

The issues which were stressed included the dangers of an excessive focus on cost containment, the risk that, with lack of direction from the Ministry, cutbacks will be made in areas of beneficial services and patients will therefore suffer; the need for both expert counsel and public opinion to inform the decisions about where cost containment is desirable; and specific suggestions about where efficiency can be gained without sacrifice of beneficial services. The MRG delegation pointed out that ultimately the excessive focus on cost containment could result in Thatcherite consequences. Beneficial services may be restricted to the point where health care standards fall below the minimum that is acceptable to the community and the situation is "rescued" by the injec-

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Moves afoot to re-create an Ontario Health Coalition

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Participants in the meeting discussed the focus the proposed new Ontario Coalition for Health Care would have. One question was whether such a coalition should primarily target federal anti-medicare measures, or whether criticism should also be aimed at the provincial NDP government, with some expressing concern that the latter option could create divisions within the coalition. Another issue was the question of 'rationalization', with a representative from a community health centre arguing in favour of hospital cutbacks, and a trade unionist representing hospital workers arguing against.

A sub-committee was set up at the meeting to draft a proposed statement of principles. Among the principles to be included would be universality, accessibility, no user fees, appropriate planning, and democratization.

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Letter to the Health Minister

The following letter was sent by the Steering Committee to Ontario Health Minister Frances Lankin prior to the meeting with the minister in early December.

Dear Ms Lankin:

This letter is to provide background for our upcoming meeting. We are aware of the tremendous budgetary pressures on the Ministry. We see, however, tremendous danger in arbitrary cutbacks in health funding. At the very worst the NDP will become the instrument of the compromise, if not the destruction, of universal equally accessible health care. Further, individual vulnerable citizens will suffer. We believe that our perspective may help prevent this outcome.

In this note we will provide the background of the MRG position on resource allocation and the present cost crisis. We will describe our view of the dangers of arbitrary cost cuts. Finally, we will provide our perspective on how rational cost constraints could be instituted, and specific examples of areas in which money could be saved.

1.0 The fundamental structure of the Canadian Health Care System

The relative efficiency of the Canadian system (in comparison to the United States) has been something of a historical accident, or side effect of decisions made for other reasons. However, the single payer system, and the universality, have resulted in administrative efficiency, and relatively good control of hospital and physician expenditures. This fundamental structure must be retained.

2.0 Resource Allocation with the Canadian Health Care System

Currently, there are tremendous pressures regarding resource allocation within Canadian health care. The following principles should guide resource allocation decisions.

PERSPECTIVE – Decisions regarding the allocation of health care resources and other resources in relationship to health must be viewed within the context of how society allocates its resources in general.

EQUALITY – All people should have equal opportunity to live in a healthy physical and social environment, as well as equal access to health care.

EFFECTIVENESS – Health care interventions, including organizational policies, and health protection and promotion interventions should be supported only if there is evidence that they improve the length or quality of life.

EFFICIENCY – Resources should be allocated to achieve the maximum benefits possible relative to the resources expended.

RE-ALLOCATION – Re-allocation of resources should be directed towards the improvement of health, rather than to such things as military spending or excessive corporate profits.

3.0 Dangers of Focus on Cost Control

The fiscal pressures on the system can tempt the government to focus exces-

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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. Arrangements to purchase multiple copies of individual newsletters or of annual subscriptions at reduced rates can be made.

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, Cathy Crowe, Gord Guyatt, Andy Oxman, 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.

Meeting with the Minister
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tion of private funds and the reimposition of two-tiered medical care.

The Minister viewed the choices between health spending and areas such as social services and housing as necessary. She was not receptive to the suggestion that it would be better to characterize the choice as between health and social service spending on the one hand and taxing the wealthy and corporate profits on the other hand. Nor did she accept the argument that characterizing the choice as between health spending and social service spending played into the hands of the Thatcherites.

The Minister was, however, responsive to suggestions that the Ministry develop guidelines and utilize District Health Councils to monitor reductions in hospital services and ensure adequate regional delivery of beneficial services. The suggestion that recruiting expert help to develop these guidelines and monitor their implementation met with a positive response. In addition, the Minister appeared interested in continuing contact with the MRG and in a number of specific suggestions concerning more efficient health care delivery which were made. She specifically volunteered that she would like the MRG to review her speeches and to provide feedback as to when she was on the right track and when she was straying. We agreed that the Steering Committee would be happy to provide detailed feedback.

The Ministry is interested in the list of MRG members who could help with specific policy areas. In addition, the MRG will construct a list of academic investigators in areas of policy, health economics, and clinical epidemiology who will take an enlightened and knowledgeable view of the issues. The Ministry may look for help from these individuals. The Ministry is hearing only from the Right on many of these issues above. The voice of the Left has been silent or at best muted till now.

Finally the Minister's executive assistant encouraged the MRG to also meet with Michael Dekter, the Deputy Minister of Health. Plans for this meeting are under way. **— Gord Guyatt**

Reflections on speaking tour in the United States

The latest major opportunity for the MRG to participate in the struggle for a universal, single-payer scheme in the United States came at the invitation of the Democratic Socialists of America. This group is most easily understood as the American equivalent of the NDP, in a more formative pre-political party stage. The DSA has, as a central part of its mission, the creation of an equitable health care system in the United States.

I spoke in Washington, Philadelphia, to the United Auto Workers at their Educational Centre in Michigan, and in Chicago. For me, there were a number of highlights. One was my own education. I came to a better understanding of the various pieces of health-care legislation before the American Congress, and of the process by which they are being considered. The two basic sorts of proposals are "pay or play" and single-payer. The pay or play is an employer based system. The major pay or play proposal is legislation sponsored by Edward Kennedy. It is likely that the pay or play legislation, while increasing access, would be administratively and financially disastrous, and could therefore discredit the universal health-care movement.

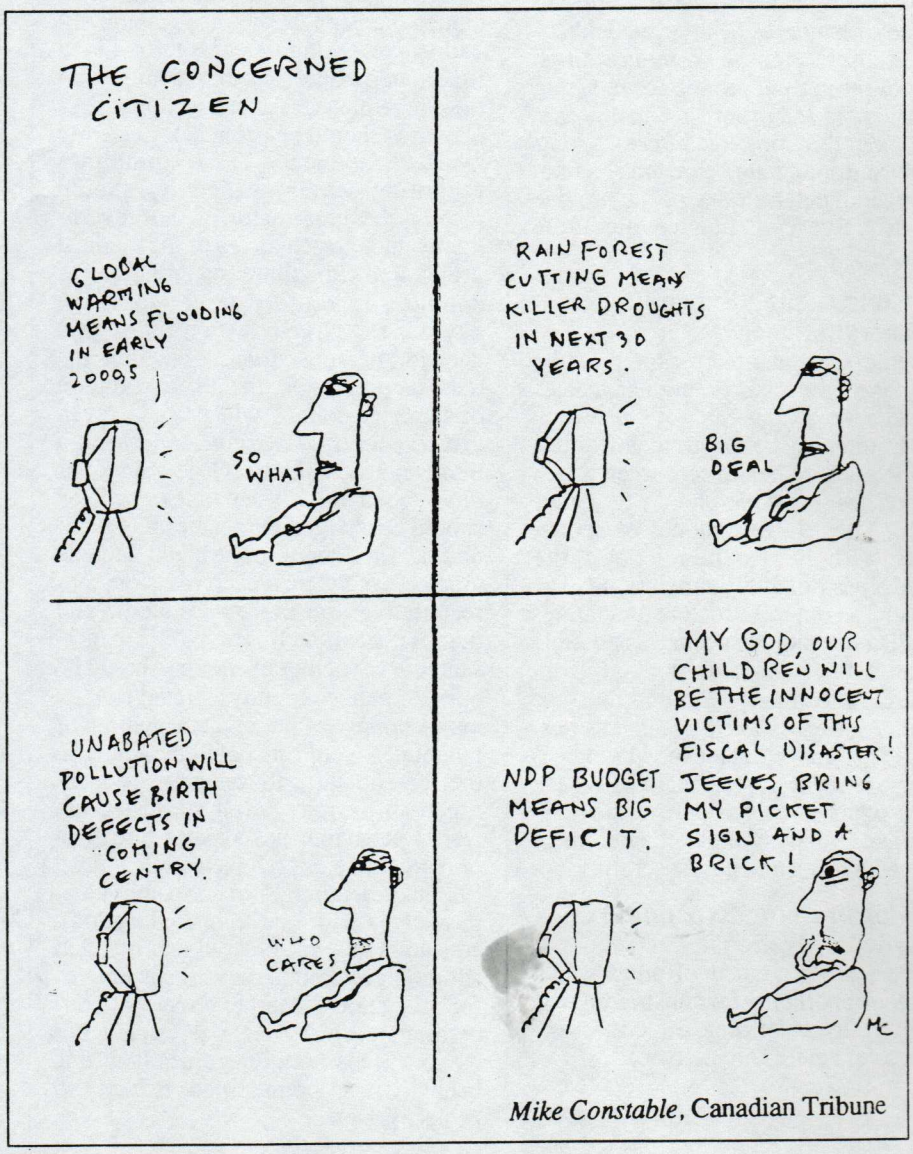
There are two categories of single payer plans. Both are based on the Canadian system. One plan would provide states with the resources to administer their own universal single-payer systems. This plan is virtually identical to Canadian legislation in which the federal government makes funds available to provinces contingent on their meeting conditions specified by the federal government. The second proposal would establish a universal single-payer plan for the whole nation. Critics on the left suggest that the state-mandated system would allow conservative states to continue with a two-tiered health care system. Its proponents suggest the state-mandated system would overcome the inertia which will prevent a national plan.

From a personal point of view a second highlight of the tour was the enthusiasm with which our message was greeted. The response, particularly from some large labour audiences, was overwhelming. It seems clear that there is a tremendous groundswell of disgust with the current American health care system and an awareness of the absolute need for an alternative. The Canadian system is (appropriately) seen by many as the best model for a transformed American health care delivery mechanism.

A final highlight has to do with our fellow speakers, members of the NDP and Canadian labour leaders. I was particularly grateful to have the opportunity to meet Don Aitken, President of the Alberta Federation of Labour, and Julie Davis, Secretary-Treasurer of the Ontario Federation of Labour. It is clear that the Canadian labour movement is extremely aware of the threat to national health care by federal legislation decreasing transfer payments to the provinces. The spectre of major health budget cuts in Ontario is making this threat even more vivid. Labour is likely to continue to lead opposition to the demolition of the universal health care in Canada, and the MRG will have the opportunity to play a role in this opposition.

To conclude, I'd like to return to the American situation. It is unlikely that any of the health care legislation currently before congress will pass. In all probability, it will require an American Democratic presidential candidate's making a health care proposal a central part of his platform to take any plan forward to the point of it actually being instituted. The pressure on the Democratic party to take this course is increasing. It is exciting to be helping a strong grass-roots movement to increase this pressure. I had the sense that by pointing out the lies and distortions about the Canadian system broadcast by the American Medical Association, and presenting an accurate picture, the MRG is providing important ammunition to American health care activists.

— Gord Guyatt



Mike Constable, Canadian Tribune

MRG in the USA

Latterly there has been much interest in the USA in the manner in which health care is delivered in Canada. As a consequence, many of the Steering Committee (and others of the MRG) have been talking in the USA about the Canadian system. The forums have been organised by a variety of different progressive interests, including broad coalitions and the American Federation of Labor and other trade union bodies. Most latterly, a complete tour through the USA was organised by the Democratic Socialists of America.

The events themselves were politically non-partisan, involving a broad front of interests concerned with advocating progressive health care reform in the USA. Several Republican Party members were present during the presentations and were in general supportive. On the other hand, private insurance representatives and their allies were present, and pretty vocal too.

On each platform was a Canadian trade unionist, a New Democrat M.P. or M.P.P., and an MRG representative. Presentations were held in a variety of venues. For myself in New York and Hartford, Connecticut, they ranged from phone-in programs, a gay TV cable network, University medical classes, trade union halls, to New York City Hall and the State Legislature in Connecticut.

Interestingly the issues which were raised in all the forums were almost identical. These focused on the deficiencies being painted about the Canadian health care system. These comments were particularly aimed at the perception that "high tech care" in Canada was limited. The experience of coronary bypass was often cited. This was rebutted along the lines that the system in Canada is responsive to public and physician demand, that the Ministry of Health made available extra funding for nurses to staff the OR's in Toronto, that in any case the Rand studies in the U.S. had demonstrated extreme variation and availability of bypass with suggestions of excess mortality in very small hospitals with inadequate experience. Furthermore, that the Ministry had supported independent physician research to establish guidelines for the appropriateness of bypass in various clinical settings, and that this "planning" is difficult to envision in the U.S.A. The independent enquiries in British Columbia rejecting allegations of inadequate facilities were also cited. All three of us on the platforms in New York and Connecticut, did point out very strongly that despite all this, the political agenda of conservative forces was Thatcherism. We also stated that this did threaten rational health care delivery.

It was most astonishing that, firstly, there was an overwhelming approval by most people about the Canadian system. Their prior ignorance was coupled with an amazement of the glories of not passing cash to a doctor in your consultation! In fact, our credibility was enhanced by pointing out the deficiencies of the Canadian health care system and then saying, "But you know what? There is simply no comparison between what is going on in the U.S.A. and Canada." Secondly, to see the potential and excitement for change that exists in the U.S.A.

Politically, there is probably for the first time a very broad class coalition that will spark effective and probably universal health care across the U.S.A. Of course the poor and the destitute have always been there and the U.S. state has not noticed. What is new and significant are the new recruits to the bandwagon for health care reform. The industrialists like Lee Iacocca are pointing out the "subsidy" of the health care system to Canadian manufacturers, and they do have a legitimate point of view from the point of view of their profits! Though historically the trade unions have been shackled by Gomperism and an excess faith in private industry, they are also now quite active in the push for reform. Furthermore the middle classes are now widely affected.

The agenda looks good for the U.S.A. The irony is to find that back home in Canada some ominous developments with an impetus to irrational cuts, and a philosophy to "Rob Peter to pay Paul".

In this context, it is important to know that there are moves afoot to revitalize the health care coalitions across the country, including Ontario. Needless to say the MRG is actively involved.

— Haresh Kirpalani

Dr. Haresh Kirpalani answers questions at a City Hall hearing in New York.

Wanted: Expertise and Experience

Earlier this year, a list was compiled of MRG members who have experience and/or expertise in various policy areas, and who would be willing to be contacted to give advice on occasion to the MRG, to the government, or to public sector organizations. An updated list is now being prepared, so members who would like to submit their names but who have not done so are asked to do so now. (If your name is already on the list, there is no need to do anything now.) Please refer to the survey form which appeared in the February 1991 issue of ***Medical Reform***, or call the MRG number at (416) 588-9167 if you do not have that issue handy.

Drug licensing changes may be imminent

The following correspondence was sent to the Medical Reform Group from the Canadian Drug Manufacturers Association, the association which represents Canadian generic drug companies.

In the past your organization has expressed concern about the rising costs of health care, and in particular, the escalating costs of pharmaceuticals.

At this moment, the foreign-owned multinational drug corporations are lobbying for lengthy world-wide drug monopolies at the General Agreement on Tariffs and Trade ("GATT") negotiations in Geneva. A strong possibility exists that a GATT agreement may be reached in January 1992.

These negotiations threaten the very existence of a successful system of compulsory licensing that has allowed Canadian-owned generic manufacturers to produce high quality, low-cost generic pharmaceuticals that compete with the high-priced brand name drugs.

The Canadian Drug Manufacturers Association ("CDMA") is encouraging the Canadian government to resist the tremendous pressure being exerted by foreign companies, and defend Canada's right to determine its own pharmaceutical policy.

We are also asking recognized and respected groups such as your own to encourage the Canadian government to follow this course by writing the following Ministers:

Prime Minister Brian Mulroney
Michael Wilson, Minister for International Trade
Pierre Blais, Minister for Consumer and Corporate Affairs
Benoit Bouchard, Minister of National Health and Welfare

To assist you is this matter, we have enclosed a copy of a letter that the CDMA will present to Michael Wilson at a meeting on Wednesday December 18, 1991, in Ottawa. Please feel free to adopt this letter as your own or to make whatever changes you feel are necessary....

Dear Mr. Wilson:

Recognizing that the foreign-owned multinational drug corporations are lobbying for lengthy world-wide drug monopolies at the GATT (General Agreement on Tariffs and Trade) negotiations in Geneva and acknowledging that a GATT agreement may be struck by January 1992, the member companies of the Canadian Drug Manufacturers Association ('CDMA') urge the Government of Canada to resist the pressure being exerted by foreign companies, and defend Canada's right to continue its successful system of compulsory drug licensing.

We believe that Canadian pharmaceutical policy must be determined in Canada, by Canadians, and must remain consistent with Canada's tradition of affordable, accessible, public health care.

Compulsory licensing has been a cornerstone of Canada's health care system for over a quarter-century. This uniquely Canadian approach to maintaining prescription drug prices at an affordable level, saves the Canadian health care system over $300 million annually. Given Canada's health care crisis, we caution you that any increase in the monopolies held by foreign companies will have a devastating effect on Canada's health care system and on the consumers of prescription drugs.

Canada's system of compulsory licensing has also allowed for the emergence of a Canadian-owned generic pharmaceutical industry, represented by the CDMA, employing thousands of Canadians in the development and production of pharmaceuticals in this country. If Canada ever hopes to develop a meaningful presence in the international pharmaceutical industry our government must foster the growth of the generic, pharmaceutical industry – which spends over 10 per cent of its sales in Canada on research and development – as the basis for a Canadian domestic pharmaceutical industry.

The Canadian public supports the federal government's efforts at these international negotiations to resist the demands for the elimination of compulsory licensing and the lengthening of pharmaceutical monopolies. A recent poll conducted by Insight Canada Research found that 70 per cent of Canadians oppose the idea of trading away Canada's right to formulate a 'made in Canada' pharmaceutical policy.

We urge you to continue to defend Canadian sovereignty at the GATT by opposing any foreign effort to force Canada to trade away its ability to formulate a pharmaceutical policy which addresses the imperatives of the Canadian health care system.

Yours sincerely,
Jack Kay,
Chairman, Canadian Drug Manufacturers Association

Mothers' Milk Threatened by Free Trade Pact

INFACT Canada has been told by representatives from Health and Welfare that the World Health Organization Code of Marketing Breast-Milk Substitutes, passed by the World Health Assembly in 1981 to protect breastmilk and breastfeeding from the aggressive marketing practices of the infant formula industry is superseded by the Free Trade Agreement with the U.S.A.

According to representatives from Health and Welfare and Consumer and Corporate Affairs, the WHO Code is perceived to be a restriction on the rights of the formula manufacturers to compete freely in the market place.

However, the marketing of breastmilk substitutes must be seen as a unique situation. The advertising of infant formulas is not merely the competition of one brand against another, but competes against a highly specialized, unique physiological process – breastfeeding. A cursory analysis of the infant formula advertising methodology readily supports its intent to directly compete against breastfeeding. The free supplies of infant formulas, bottles, nipples, soothers are all intended to interfere with the normal establishment of lactation; the ubiquitous "gift packs" via

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User fees lead to two-tiered health care

The following letter was sent to the Globe and Mail newspaper by Mimi Divinsky on behalf of the Medical Reform Group Steering Committee. An edited version of the letter was printed.

If "A majority of Canadian support the idea of imposing user fees to fight rising health-care costs" (front page, Globe and Mail, November 5, 1991) then it's time, once again, to re-iterate what we as physicians working in diverse areas of the province have known for decades and what researchers have been confirming, certainly since 1980. In that year Sotddard and Woodward published their study on "The Effect of Physician Extra-billing on Patients' Access to Care". In 1985 Health and Welfare Canada published Stoddard and Labelle's report on "Privatization in the Canadian Health Care System" in which assumptions about the effect of charges to patients on reducing alleged "frivolous" use of the system were challenged and critiqued. In fact, the research reveals that the introduction of user fees does **not** result in a more rational use of the system, nor does it save health-care dollars. Rather, rich people use the system more and poor people use it less – regardless of the urgency of the diagnosis, and even if it involves not seeking care for an ill child. It is, however, guaranteed to create a two-tiered health care system – in complete contradiction to the five principles of the Canada Health Act: that it be accessible, universal, portable, comprehensive, and publicly administered. The Act was passed by a unanimous vote of support by Parliament in 1984, unequivocally reflecting the views of Canadians that health care is a right, not a commodity in the market place.

M. Divinsky, M.D.
Steering Committee,
Medical Reform Group

Mothers' Milk
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physician offices, at hospital discharge, pharmacies etc. aim to interfere and create self doubt; and the "educational" literature full of misinformation and negative messages creates anxiety and doubt. Advertising is cunningly designed to negatively affect the two vital reflexes – the prolaction reflex and the let-down reflex – essential to successful breastfeeding.

In its eagerness to assert the legal protection of the infant formula industry's right to sabotage breastfeeding, Health and Welfare, the ministry whose mandate is to protect the health and well-being of infants and their mothers, has become but another vehicle facilitating the interests of corporate profits. The WHO Code so readily dismissed by the Government of Canada ("some of its provisions are neither applicable nor appropriate for implementation in Canada") could serve as a core document for implementing provisions that are meaningful to Canadian mothers such as the elimination of free supplies, ceasing the distribution of free sample packs, eliminating the "educational" materials and the various forms of direct advertising, etc. Surely the protection of breastfeeding is a universal requirement. To state that Canadian infants and their mothers do not have the right to such protection, yet at the same time afford infant formula and associated products the legal right to interfere with a woman's intent to breastfeed represents a failure of Health and Welfare's mandate to serve the interests of Canadian mothers and infants.

Breastfeeding must also be seen as an important development issue. By choosing not to implement international breastfeeding protection and promotion directives domestically, although Canada continues to support them at the international forums and assemblies, Canada not only does a disservice to its own citizens, but also to those from Third World countries. By negating the validity of the WHO Code because of a "Free Trade Agreement" – the upcoming trilateral agreement is to include Mexico, a developing country – the unabated promotion of bottle feeding will have disastrous results. Potentially many more infants will die because of diarrheal disease, or because of respiratory disease. Many more Mexican children will suffer from malnutrition and the long term consequences of malnutrition. Many more mothers will be duped into artificial feeding and will be unable to reverse this expensive feeding mode. According to UNICEF and research from developing countries, the mortality rate of infants who are bottle fed is 14 times greater than for breastfed infants. Even if Canada does not have the political will to implement the WHO Code for the benefit of its own citizens, the moral imperative is even greater as Canada enters into a trade agreement with Mexico.

This article is reprinted from the Fall 1991 issue of ***INFACT Newsletter****, published by the* ***Infant Feeding Action Coalition****, 10 Trinity Square, Toronto Ontario M5G 1B1, (416) 595-9819. The $25 annual membership in* ***INFACT*** *includes a subscription to the newsletter.*

Time to look at medical resource management

The Medical Reform Group's Steering Committee sent the following letter regarding the Barer-Stoddart Report on Medical Resource Management to the Ministry of Health.

The Medical Reform Group of Ontario would like to take this opportunity to comment briefly on the report, *Toward Integrated Medical Resource Policies for Canada*, by Morris L. Barer and Greg L. Stoddart. We hope to be able to add to these brief comments at a future date when specific policy recommendations are being considered.

The Medical Reform Group believes that this report provides a valuable framework for addressing issues of medical resource management and supports the general thrust of the report's recommendations. We would like to urge strongly that action be taken on this report; i.e. that it not be allowed to gather dust on a shelf. We believe that the kind of relatively long-term planning proposed by this report is crucial to the future of medicare in Canada, and we are concerned that it not be neglected in the face of the immediate issues which compete for our attention.

In our view, issues of physician supply and distribution urgently need to be addressed and efforts must be made to subject them to some form of rational planning. We also urge that particular

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Barer-Stoddart
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attention be paid to developing alternatives to the fee-for-service system of physician remuneration.

We have some concerns about the section of the report dealing with graduates of foreign medical schools. We believe it is important that any policies which are developed be non-discriminatory; i.e. that qualified immigrant physicians not be discriminated against because of their national origin.

The Medical Reform Group is particularly concerned that the process for making decisions about medical resources policies – and indeed for making decisions about the health care system generally – be open and democratic. We believe that both the public and health care workers – non-physicians as well as physicians – should have a direct say in making these decisions.

We look forward to participating in the future consideration of these issues.

Sincerely,
Medical Reform Group of Ontario

Documents and Publications Available

The Medical Reform Group has produced a number of briefs, position papers, analyses and other documents. These publications are available at the following prices:

History and Policies of the MRG $2
Constitution of the MRG $2
Brief on Canada Health Act (1984) .. $2
Submissions to Ontario Health Professions Legislation Review (1987-9) ... $2
Maternal Health Care $4
Complete Edition of MRG Newsletters, 1979-1991 ..... $35
Annual subscription to *Medical Reform* $25

vide cost-effective care must avoid these dangers.

Send orders with your name and address to: Medical Reform Group, P.O. Box 366, Station J, Toronto M4J 4Y8.

Government agencies

Queen's Park has opened its doors to interested people who want to serve on provincial government agencies, boards and commissions. The Ministry of Health alone has over 200 health-related agencies that need public representatives.

In its Throne Speech last fall, the government promised – particularly to those groups "accustomed to being on the outside of the established power structures" – that the people of Ontario would have a voice in the corridors of

Queen's Park. In light of this, the public appointments process has been revamped and public members are now being recruited in a more open and fair way. For the first time, there's a published guide describing the individual agencies and an all-party committee of the legislature that reviews new appointments.

The Ministry of Health is recruiting capable and committed people from all regions who have an interest in health and wellness and represent Ontario's diverse population. Francophones, First Nations people, persons with disabilities, members of visible minorities and women are especially encouraged to apply.

People are needed for many types of health-related agencies. For example, district health councils are local health planning boards where members plan services for their communities. Members are needed for community advisory boards, which provide links between communities and the provincial psychiatric hospitals. They are needed for the governing bodies of the health professions, which set standards for the professions. When passed – in its present form, the new Regulated Health Professions Act will require more members of the public to service on health professions governing bodies.

Anyone interested in serving can send an applications, letter or resume to the Public Appointments Secretariat, Room M 2-70, Macdonald Block, Queen's Park, Toronto, Ontario M7A 1A1. Or call the ministry's Public Appointments Registrar at (416) 327-8495. Applications forms are available in the new publication "A Guide – Agencies, Boards and Commissions – Government of Ontario. This publication can be found in public libraries, community information centres and M.P.P. constituency offices.

Access Alliance – Multicultural Community Health Centre

Access Alliance Multicultural Community Health Centre is a coalition of ethnic-cultural communities that works toward the promotion of health and better access to Health for the multicultural community. We do this by removing linguistic, cultural, racial and structural barriers to access and by promoting equity and full participation in Canadian society.

Access Alliance is recruiting a physician to work on its clinical team, comprised of one other physician, two nurses, a medical secretary and receptionist, and a clinical program coordinator. This is a full-time, permanent salaried position. In addition to his/her clinical duties, this physicians will work in collaboration with community health promoters and other professional staff in the area of health promotion as defined by the Ottawa Charter and the Alma-Ata declaration of the World Health Organization.

Essential criteria include:

license to practice medicine in Ontario, preferably with expertise in family medicine and/or some competence in obstetrics

commitment to community-based medicine and an interest in the concept of community health centres

interest in working with different ethnic groups on behalf of the multicultural community

The ability to speak languages other than English, and particularly Spanish. Portuguese, Korean and/or Vietnamese would be a valuable asset.

Salary range: $84,800 to $116,600 plus a generous benefits package.

Interested candidates are asked to send a C.V., names of three referees. and a statement about their interest in community-based medicine, by January 24, 1992, to:

John Paterson, Executive Director
Access Alliance Multicultural Community Health Centre, 509 College Street, Toronto to, Ontario M6G 1A8. fax: (416) 324-9074.

Concern about Bill 135

I am an associate member of the Medical Reform Group, a professor of Pharmacology at McMaster University and currently President of McMaster Faculty Association. I am writing to express my personal concern about the way academic physicians and basic medical scientists are being dealt with under Bill 135. Irrespective of their wishes, they apparently will be incorporated into OMA-directed clinical faculty groupings. At Queen's University, as I understand it, an alternate practice plan is being negotiated which will incorporate all members of the medical faculty, irrespective of whether they are licensed physicians or not, in other words, including people like me.

I can understand the value of APP's in medical schools as a model for young physicians in contrast to the current payments models. However, there are deep concerns. At McMaster similar negotiations are underway and, up to now, non-clinical faculty are not at the table and were unaware until we learned about them by chance recently that such negotiations were underway. This looks very like a legislated raid on University faculties mandated by Bill 135. What happens to all the academic characteristics of Medical faculties under these arrangements? What about university autonomy, academic standards, academic tenure, academic freedom, evaluation for merit in scholarship and education promotion based on contributions to scholarship and education? Basic science faculty and I suspect, most academic clinical faculty are unwilling to give away these values of university medical schools. They should be issues in any bargaining and such negotiations should be in the open with all concerned parties at the table. So far, there is no indication that attention is being paid to any of these matters and no indication that academic clinical and non-clinical faculty are to be given any say in their fate.

I am writing to MRG to alert them to aspects of the fall-out from Bill 135 of which they may not be aware. My understanding is that similar APPs are to be negotiated at all Medical schools in Ontario, if possible. I want my representatives involved in such negotiations, and I want to be able to reject any outcome that does not maintain academic freedom and autonomy, does not reward scholarship and good teaching or places non-clinicians under the thrall of the OMA.

E. E. Daniel, Ph.D.
Professor

Health Services for Street Youth

An opportunity to work with a difficult but challenging community. Street youth in downtown Toronto at central and satellite clinics and in street settings. Full-time permanent. Excellent communication skills. Must be sensitive to street youth and their issues. Able to work independently and as part of a multidisciplinary team. Languages and cultures an asset.

Physician: Community oriented primary care. Light on-call duties. 3 - 5 years of primary care/community health. Salary to $121,900.

Primary Care Nurses (Nurse Practitioners): Primary health care to individual, groups and communities. Light on-call duties. Strong clinical skills. 3 - 5 years of primary care/community health. BScN or equivalent. Salary to $52,000.

Submit resume by January 10 to: Program Manager, Health Services for Street Youth, West Central Community Health Centre, 64 Augusta, Toronto M5T 2L1.

Position wanted

R.N. (MRG member) seeks employment in doctor's office/clinic. Have completed Occupational Health and Family Practice Nursing courses. Experienced in psychiatric and occupational health nursing. Reply c/o Medical Reform Group, Box 366, Station J, Toronto, Ontario M4J 4Y8, Attn: Drawer B.

Have you renewed yet?

Some members still have not sent in their membership renewals for the 1991-92 year. If you haven't done so yet, please dig out the form and send it in now. Members are reminded that it is MRG policy that fees should not be a barrier to membership. Members who cannot afford to pay the full fee may pay a reduced amount.

News Briefs

Out-of-country OHIP cut

The Ontario Ministry of Health has announced a new policy on paying for out-of-country health care services. In most instances, the Ministry will now pay U.S. hospitals and physicians the same rates as are paid to Canadian hospitals and physicians. Health Minister Frances Lankin said that "Ontario taxpayers can't afford to provide an open-ended subsidy to the profit-driven U.S. medical system if we want to preserve medicare and improve health services in Canada." The Ministry will now cover the full cost of out-of-country hospital treatment only if the service is unavailable in Ontario and the patient is threatened in terms of life or irreversible damage to their health.

Inter-provincial committee to look at costs

Canada's health ministers have set up an inter-provincial committee to look at ways of controlling health care costs. The committee is to prepare recommendations to be considered at another conference in mid-1992. Among the issues and suggestions to be looked at by the committee are reducing enrollments in medical schools by 10 per cent, as recommended in a report by Morris Barer and Greg Stoddart; alternatives to the fee-for-service system; and reducing the concentration of doctors in urban areas and increasing services to rural and northern areas.

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B.C. Royal Commission recommends changes

British Columbia's Royal Commission on Health Care and Costs released its report in mid-November. Among the 359 recommendations contained in its 400-page report, ***Closer to Home***, were a substantial shift of resources from hospital care to less costly institutions and to home care. Specifically, the Commission recommended that 25 per cent of the province's acute-care budget be cut by 1995. It called for an immediate increase in provincial welfare rates, a school meals program, a ban on liquor and tobacco advertising, health warnings on bottles of alcohol, sharp controls on the province's doctor supply, a global cap on payments to doctors, monitoring of billing practices, regular audits of doctors' billings, and mandatory AIDS testing for pregnant women, health-care staff, and patients undergoing medical procedures in a hospital. It called for five principles of medicare to be entrenched in law: universality, accessibility, comprehensiveness, portability, and public administration, as a way of stopping threats to medicare such as extra-billing, user fees, and a two-tiered system. The health minister in British Columbia's new NDP government said that many of the recommendations were in accord with NDP policy, but that it would take time to study all the recommendations. The British Columbia Medical Association said that the report was biased against doctors.

Cuts coming, Lankin says

Ontario Health Minister Frances Lankin told the Ontario Hospital Association on November 13 that the government is looking at ways of reducing wasteful spending in the health care system. Citing estimates that "25 to 30 per cent of everything we currently do in the health care system has no proven value", she said that cholesterol testing, caesarian sections, and in-vitro fertilization are being considered as areas where costs could be cut.

Lab fees cut

The Ontario government has imposed a five per cent reduction in fees paid to medical testing laboratories. The across-the-board cut in fees paid by OHIP to the test labs come into effect January 1, 1992. "We haven't had a fee increase since July 1990", said John Rogers of MDS Laboratories, which operates 53 laboratories in the province. "Clearly we are not pleased." Ministry of Health spokesman Layne Verbeek said billings by commercial laboratories have increased by an average of 15 per cent a year over the past decade. For the 1990-91 fiscal year, OHIP paid out about $450 million in lab fees. There are 173 private testing labs in the province. Paul Gould, president of the Ontario Association of Medical Laboratories, criticized the government for taking unilateral action while it was simultaneously engaged in fee negotiations with the labs.

AIDS drug lawsuits

Burroughs-Wellcome Inc. is suing Apotex Inc. of Toronto and Interpharm of the Bahamas for patent infringement on zidovadine (sold as AZT) and acyclovir (sold as Zovirax). Burroughs-Wellcome is seeking an injunction to prevent the two companies from selling these two drugs. Meanwhile, Apotex has launched a patent challenge to win the right to produce the drug. Apotex and another company, Novapharm Ltd. of Toronto, claim Burroughs-Wellcome should not have been granted the AZT patent because it did not invent it: the Michigan Cancer Institute did so in 1964. According to Apotex president Barry Sherman, Apotex can sell AZT at a price between 25 and 50 per cent less than Burroughs-Wellcome.

– Source: Globe and Mail, 26 October 1991

Unions target workplace violence

Violence in the workplace is a serious threat to many workers in the service sector, delegates to a union-sponsored conference on workplace violence were told in November. Dick Martin, executive vice-president of the Canadian Labour Congress, said those most at risk include bus drivers, school staff, prison guards, social workers, security guards, police officers, medical workers and those who work alone. "There are angry clients, disturbed patients, dangerous criminals – workers come into contact with them every day as part of their job," he said. "For example, in one rehabilitation hospital where members of CUPE work, 80 per cent of the nursing staff suffered injuries due to physical assault over a 20-month period." According to CUPE president Judy Darcy, nursing homes often see incidents of violence against staff. She said that understaffing, poor living conditions, and neglect of residents' needs raised frustration levels in nursing homes and made violence more likely. *– Source:* Globe and Mail, *9 November 1991*

Injured workers blast government

After a four-year battle to receive compensation for aluminum- and asbestos-related disabilities, workers at McDonnell Douglas say they have been betrayed by members of Ontario's NDP government. At a demonstration at Queen's Park, the workers said that Ontario Premier Bob Rae and Labour Minister Bob Mackenzie had strongly supported their cause before coming to power. Nick DeCarlo of the Canadian Auto Workers union said Mr. Rae and Mr. Mackenzie appeared at demonstrations and denounced the previous Liberal government for its policies on aluminum poisoning and asbestosis. Mr. DeCarlo said that several former McDonnel Douglas workers have been refused compensation from the Workers' Compensation Board for illnesses related to aluminum and asbestos exposure. In 1988, tests conducted by researchers at the University of Western Ontario found that high levels of aluminum were found in 450 or 1,300 workers tested.

Welfare rights

The Welfare Rights Group, an advocacy organization for people receiving social assistance, is calling on the government to take steps to make it easier for people receiving benefits to cash cheques. The group is calling on the Ministry of Community and Social Services to stop automatically dating Family Benefits cheques for the last day of the month. The group wants either the month only or the actual date of issue to appear on the cheque. This would enable recipients to cash their cheque on the day they receive it. The groups is also calling on the government to develop a free, universal form of ID which would be acceptable to banks. This would lessen recipients' reliance on cheque-cashing companies which charge fees to cash cheques.

For more information contact Pam Chapman, Welfare Rights Group, 473 Queen Street East, Toronto Ontario M5A 1T9, (416) 863-0499.

Cigarette smuggling

Cigarette smuggling is on the way to becoming a $500-million per year business, according to the Royal Canadian Mounted Police. The massive increase in smuggling is linked to high taxes on tobacco products. It is estimated that the federal and provincial governments lose

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$350 million per year in tax revenue as a result of smuggled cigarettes. A report by the RCMP's customs and excise branch says that the problem gets worse every time tobacco taxes are raised because each increase acts "as an additional incentive to smuggle, as profit margins for smuggling increase in direct proportion to the amount of the tax increase."

"Granny dumping"

Elderly Americans are being abandoned at hospital emergency departments in a new phenomenon known as "granny-dumping", according to the American Association of Retired Persons (AARP). According to the AARP, the old persons are usually left in the emergency waiting room by relatives. By the time hospital staff realize that the old person is not sick, the relatives have disappeared. Some just drop off the relative from a car and summon staff by sounding the horn, before driving away. According to Dr. Tom Mitchell, the head of emergency at Tampa General Hospital, which sees two or three such cases a week, people dumping relatives "feel overwhelmed. They have reached the point where they can no longer care for the old person." Medicare in the United States does not pay for care in nursing homes, or for long-term care at home, and temporary help is difficult to obtain.

– Source: Manchester Guardian Weekly, 29 September 1991

Publications

A Healthy Business: World Health and the Pharmaceutical Industry

By Andrew Chetley

A Healthy Business examines the faults of the pharmaceutical industry, including failures to develop drugs most needed by the world's poor, rushing drugs to market before adequate testing, and promotional strategies which encourage irrational drug use. The campaign for rational prescribing is also examined.

Zed Books, 57 Caledonian Road, London, N1 9BU, United Kingdom

Ways to Go: Evaluating the Role of the Automobile: A Municipal Strategy

A Special Report by the Healthy City Office, City of Toronto

This short report lays out a strategy of achieving less traffic and cleaner air, and suggests some ways of achieving these goals. Suggestions from the public are solicited.

Healthy City Toronto, 40 Dundas Street West, Toronto Ontario M5G 2C2, (416) 392-0099

Working Towards a Healthy Toronto in the Year 2000

This 23-report summarizes progress made toward achieving the 89 recommendations set out in the ***Healthy Toronto 2000*** report adopted by the City of Toronto in 1988.

Healthy City Toronto, 40 Dundas Street West, Toronto Ontario M5G 2C2, (416) 392-0099

AIDS/HIV Legal Project

The Advocacy Centre for the Handicapped has established a new program to help people who are experiencing legal problems because of AIDS and HIV infection. A brochure explaining the program is available for display in doctors' offices, social service agencies, etc.

Advocacy Resource Centgre for the Handicapped, 40 Orchard View Boulevard, Suite 255, Toronto, Ontario M4R 1B9, (416) 482-8255.

OMA debated at Fall Meeting

The Medical Reform Group held its fall general meeting on October 17. The minutes of the meeting appear below:

Membership:

Jim Sugiyama reported that the first membership renewal letter is going out in shortly. We experienced a small net loss of members over the past year. We need to make more efforts to reach students, especially at the first year level.

Campaign for U.S. health plan

Gord Guyatt reported that various initiatives are under way in the United States to bring in some kind of a universal single payer system. These initiatives have been gaining momentum. The best argument that the Americans who are pushing these initiatives have, is the Canadian system. Things are so bad in the U.S. that they find it hard to grasp the realities of the Canadian system. Several MRG members have made trips to the U.S. over the past year to speak about medicare in Canada.

This fall the **Democratic Socialists of America** (whose political stance is comparable to the NDP here) organized a Canadian speakers tour of a number of U.S. cities. Gord Guyatt, Rosana Pellizzari, Mimi Divinsky, Andy Oxman, Don Woodside, and Haresh Kirpalani have all done one or more speaking engagements. At various engagements, people from the Canadian labour movement and the NDP have also participated. All the speakers reported a very positive response, and enjoyed the experience very much.

Andy Oxman said that **Physicians for a National Health Program** have done a lot of work on this issue and have passed the MRG's name around to other organizations. One possibility is that a medicare program will be brought in state by state.

Mimi Divinsky said that the issue virtually speaks for itself and that there has been a lot of media attention in the U.S., including good coverage of MRG speakers.

Resource Allocation

Andy Oxman recalled that three MRG representatives met Evelyn Gigantes, then the Health Minister, in March. At that time, it was clear that the Minister's major focus was cost containment. There is every reason to believe that the same thing is true now under the

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new minister, Frances Lankin. MRG representatives are hoping to have a meeting with Lankin in the near future. The message that we tried to convey last time was that while we recognize that the budget has to be balanced, it is dangerous to over-emphasize the issue of cost containment.

A key part of our message to the new minister will be that the decision-making process has to be improved to make it **more open and more democratic**. For example, we see the Independent Health Facilities Act as a good act, and we would like to see advantage taken of the opportunities it offers to create a forum which is more open and democratic. We need **practical guidelines on how spending decisions are to be made** and on what basis, and there has to be an appropriate body that has the tools to see that these guidelines are actually followed. We don't want across-the-board cost-cutting which cuts the good as well as the useless.

There need to be better guidelines regarding the **licensing of new technology**, analogous to the licensing of new drugs.

We also want to focus attention on the **Hospitals Act**, which is due to be revamped. Hospital Boards needs to be made more open and democratic.

The potential use of **District Health Councils** as a forum for democratic public input needs to be explored.

The issue of **physicians payments** needs to be looked ad. We need to encourage experimentation with alternative payment mechanisms.

Guidelines for making spending decisions

Debby Copes said that we have to convince the government that in order to control costs it is necessary to improve accountability.

Joel Lexchin said that we have to make sure that cuts are made openly and democratically with clear guidelines. For example, we don't want hospitals to cut costs by contracting out work to private contractors who will pay workers $6 per hour.

Rosana Pellizzari said that we have to convince the ministry that we have something to contribute which they are not getting from the OMA.

Debby Copes said that the government seems to be appallingly uninformed about the basics. They have to learn that they can't bring in important changes to the system without involving the community in the process.

John Frank said that the long term planning process has been improved, e.g. the Premier's Council. It is a good process because it brings different points of view to bear. The day to day firefighting is handled differently, by different people.

Joel Lexchin quoteed Jonathan Lomas on the Ministry's agreement with the OMA: "Wrestling the doctors to the ceiling."

Doctor supply issue

Don Woodside mentioned the report by Stoddart and Barer which looked at the issue of doctor supply. He thought that we could/should endorse this report. The report says that we are way overdoctored. In the long term, we could save a lot of money by addressing this problem, but in the short term, the remedies in the report (e.g. cutting enrollment in medical schools by 10 per cent) won't have any appreciable impact, which may be why governments, with their eye on re-election chances in the near future, aren't doing anything about these kinds of important long-range measures.

Private control of labs

Bob James said that another good cost-cutting measure would be to take labs out of private control and put them under hospital control. Private labs are taking huge profits out of the system. The financing of nursing homes is another area to look at.

Physician payment system

Fred Freedman said that the reason doctors get away with some of the things they get away with is fee-for-service. However, the Ministry has put alternatives to fee-for-service on hold while they are 'under review'. No one knows how long the review will go on. The bureaucracy imposed the review, and it is not clear whether the NDP government even knew that the decision to do so had been made.

Gord Guyatt said that the evidence is that physicians will do anything necessary to maintain their incomes, and that they become very agitated if they can't. Could the Steering Committee, in consultation with the Resource Allocation Committee, draft a resolution endorsing the Barer-Stoddart proposal to cut medical school enrollments?

Debby Copes said that we could certainly suggest that this issue needs to be considered seriously, even if we don't have a policy on what exactly the measures taken should be.

Decentralization

John Frank said that decentralization is not necessarily more democratic. We have to keep this in mind, because some kinds of decentralization, when not accompanied by democratization, can be just as bad a centralized decision-making.

Bob James said that to the Ministry, decentralization means going to the District Health Council level. But really decentralization should go a lot further than that.

OMA: Confrontation or Collaboration?

The meeting now turned to the main topic of the evening, the question of the Ontario Medical Association, and how progressive physicians (specifically the MRG) should relate to it. This portion of the meeting was chaired by Haresh Kirpalani. Some comments on this issue appeared in the October 1991 issue of *Medical Reform*.

Joel Lexchin said that the one issue which seemed to really galvanize the whole organization (the MRG) was the issue of opting out. Now different members of the group are focussed on different issues, but there is not one simple clear-cut issue which everyone can focus on.

Meanwhile the OMA has shifted its ground and taken positions which are closer to the ones we have been advocating for years. The MRG has been less visibly active, and as a result the media have been less interested in us.

Joel said that he felt that joining the OMA is an individual decision. Some members such as Barb Lent and Bob Frankford, have been involved in particular working groups or sections of the OMA because of a personal interest in those issues.

Our position on health care is still fundamentally different from that of the OMA and will almost certainly remain so. There is little likelihood of us being able to have any significant influence on the OMA's policies and directions. Nor are we likely to get sectional status if we ask for it.

There are other organizations whose goals Joel shares, but they are single-issue groups; they don't have the MRG's broad vision. But if the MRG wasn't

active, then having a broad vision isn't going to be enough.

Fred Freedman said that while he had had some ambivalent feelings about the MRG, it is 'the only game in town'. It is the only broad-based group that looks at the whole range of health care issues. He thought that sectional status within the OMA could possibly be useful strictly from a mercenary point of view, if funds were available, but aside from that, focussing attention on the OMA and its internal politics is dangerous and would distract attention from what we should be doing. The MRG's role is to present our views on health care to the public, not to the medical profession.

Don Woodside said that it was made clear to us at our meeting with the OMA representatives that we could not reasonably expect to receive money from the OMA if we are busy opposing OMA policy.

Jim Sugiyama reported that a moratorium has been declared on new sub-sections in the OMA. No new ones are being registered.

Haresh Kirpalani said that rather than focussing on the technical-organizational question of forming a section, we ought to be asking whether an 'opposition' representing a reform viewpoint ought to be formed within the OMA. Haresh said that he felt that it would be good if an opposition was formed within the OMA, not as an alternative to MRG activities, but on the grounds that reform views should be advocated in a variety of forums, including the OMA.

Fred Freedman suggested that those members who saw working within the OMA in this way as a priority could form an OMA Working Group, in the same way as we have a Resource Allocation Working Group, a Primary Care Working Group, etc. He asked whether anyone present was actually interested in belonging to such a working group. No one volunteered.

Debby Copes said that she couldn't see the relevance of even discussing the OMA at this meeting. A significant minority of MRG members have also held membership in the OMA for years and they haven't chosen to get involved in OMA politics. The one or two members who have worked in the OMA did so as members of very specific subgroups working on a particular issue. And we still don't have to be members of the OMA: we just have to pay fees. If anyone stops paying MRG fees because of having to pay OMA fees, it will be more because of personal lack of interest in the goals of the MRG.

Rosana Pellizzari said that she felt that since she now had to pay OMA fees, she wanted to get something out of it if possible.

Robbie Chase said that he couldn't see what was to be gained by working in the OMA. The MRG's public profile would inevitably diminish and we would lose credibility in the eyes of the public and the media. The profile we are currently developing south of the border would also be much less if we were simply a section of the OMA.

Mimi Divinsky said that said that she saw it as a trade union issue. We now belong to this union, the OMA, so we ought to be involved in trying to influencing its direction. It might even inspire us with new energy. However, if we can't get sectional status then there would be no point.

Joel Lexchin said that sections of the OMA don't get a lot of resources. If you want to get involved in the OMA around some issue, you are free to do so.

Fran Scott said that they might want to see us in.

Fred Freedman said that he joined the MRG to speak to the world at large, not to do internal politicking in a professional association. The OMA will never be interested in the kind of democratization we are in favour of, whereas for us it is a cornerstone.

Haresh Kirpalani said that we should ask ourselves how do we best position ourselves to state an alternative point of view. We should expose the OMA for what they are.

Fred Freedman asked who are we exposing them to? To their own membership? The public isn't going to hear about it.

Bob James said that we have limited resources. We need to prioritize. We don't have the resources to take on the OMA, and it shouldn't be one of our top priorities.

Gord Guyatt said that when something comes up that galvanizes us, we find additional energy. We have been putting tremendous amounts of time into the speaking tour we have been doing of American cities. We did the same around the doctors' strike. The commonalty was that in each case there was an important public issue with far-ranging consequences, and there were other groups as well ourselves involved. In both of these instances, we were able to make an important contribution to an important cause, something no one else could provide.

He has come to the conclusion that the purpose of the MRG is to spring into action in times of crisis. It is useful for the MRG to be around in between crises, but it is when there is a major issue that we can play a key role. We are too small a group to be able to generate our own issues. We have to wait until the issue comes up, and then jump in. The trips to the U.S.A. have been wonderful and energizing experiences for all those who have participated. In these U.S. engagements, we have been part of a team with labour people from Canada and the U.S., and that too has been gratifying. The time will come when these issues come to a head again in this country, thanks to the policies being followed by the federal government, Bill C-69 and the rest. The leadership of organized labour sees this as a major issue.

Joint Management Committee

Rosana Pellizzari said that we also need to pay urgent attention to the **Joint Management Committee (JMC)** which was set up as a result of the agreement between the government and the OMA. Only the government and the OMA are represented on the Joint Management Committee, no one else. All the other stakeholders in the health care system have been excluded. The Joint Management Committee potentially has a great deal of power over many of the key decisions being made in the health care system. As one example, the budgets of community health centres have been held up for months so the JMC could get to it on its agenda. In the meantime, CHC's are being forced to lay off staff because they have no budget. Why should the JMC have any decision-making power over community health centres? The Association of Health Centres is demanding that CHC's be taken off the JMC's agenda. If there is to be a committee making decisions affecting HSO;s, then it should not be a committee on which only the OMA is represented. As long as the JMC has its current composition, it should not have the jurisdiction to look at anything except physician remuneration. The rest of its mandate should be abandoned.

Don Woodside said that he was persuaded that the cost of OMA membership by the MRG as an organization would be loss of independence and loss of public profile and credibility.

Rosana Pellizzari said that there was a strong argument that we need to remain

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independent for the sake of our public profile. Our only reason to join the OMA would be an opportunistic one.

David Etlin said that we would pay a high price for what we would gain. Among other things, you would become dependent on their financial subsidy. You wind up holding back on criticisms and independent action, sub-consciously or consciously. He said that he likes the 'David and Goliath thing' which has characterized our relationship to the OMA.

Debby Copes said that Mimi's idea of getting new energy from involvement in the OMA is an appealing fantasy, but it's not reality.

Robbie Chase said that it would create another level of identify crisis in the MRG.

Mimi Divinsky proposed that we hold a press conference, say that we are asking for a guarantee of section status within the OMA and a seat on the management board.

Joel Lexchin said that it would be silly to ask for that. The OMA has a constitution which they have to follow. They would tell us to submit an application in the regular way and it would be considered.

Gord Guyatt said that the OMA isn't going to let section get their hands on any real power.

Haresh Kirpalani said that before we discuss how we will ask for sectional status, we need to discuss whether we would even want sectional status if we could have it.

A straw vote was held to see who was interested in pursuing the possibility of sectional status within the OMA. Only three or four people said yes, the rest no, so the idea was dropped.

Catherine Oliver said that this year's membership renewals will be an effective referendum on whether having to pay OMA dues will hurt our ability to collect membership fees.

Fran Scott said that she had heard that the employer is responsible for paying OMA dues for salaried members.

Several people said that they have been deducting both OMA and MRG fees on their tax returns.

The meeting was adjourned

Excellence in Medical Care Award

Murray Enkin, a member of the Medical Reform Group Steering Committee, was recently awarded the Excellence in Medical Care Award by the College of Physicians and Surgeons on Ontario. The text of the award appears below:

EXCELLENCE IN MEDICAL CARE AWARD RECIPIENT

Dr. Murray W. Enkin

Throughout his career as an obstetrical/gynaecological specialist, Dr. Enkin has made outstanding, internationally recognized contributions in the area of pregnancy and childbirth; most notably in his sponsorship of family centred maternity care in labour and birth.

Dr. Enkin graduated from the University of Toronto in 1947 and qualified as a specialist in Obstetrics and Gynaecology in 1955. He practised in Hamilton from 1955 until 1988. From 1972 until 1976 he was the Chief of Obstetrics and Gynaecology at St. Joseph's Hospital, Hamilton.

As early as 1973, Dr. Enkin's advocacy of family centred maternity care began with publications which focused on the patient, the family and their needs during labour and birth. By 1979, Dr. Enkin had received recognition in the form of a position on the board of the International Childbirth Education Association and he was invited to join the editorial boards of *Birth* and the *Journal of Psychosomatic Obstetrics and Gynaecology*. The publication in 1980 of his article evaluating the Leboyer approach to maternity care in the *New England Journal of Medicine* opened the way for international acceptance of the family centred concept and resulted in less resistance to changing some birth practices.

In collaboration with Ian Chalmers of the Oxford University National Perinatal Epidemiology Unit, Dr. Enkin was largely responsible for the textbook *Effective Care in Pregnancy and Childbirth*. This text has been described as the most important contribution to continuing medical education in obstetrics. Dr. Enkin was an important member of the text's editorial team and is the author or lead author of several chapters.

In the last decade, Dr. Enkin has become a knowlegeable clinical epidemiologist and has made major contributions to the understanding of how changes to medical practice take place by contributing his expertise to the design and implementation of the Canadian Caesarian Consensus exercise.

In 1986, Dr. Enkin was awarded the Research Award of the American Society for Psychoprophylaxis in Obstetrics, and, in 1987 became a Visiting Scholar to Green College, Oxford and a Scholar in Residence at the Rockefeller Foundation Residence in Bellagio, Italy, The Villa Serbelloni.